S. HRG. 108–325

NURSING HOME QUALITY REVISITED: THE GOOD, THE BAD, AND THE UGLY

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

JULY 17, 2003

Printed for the use of the Committee on Finance

NURSING HOME QUALITY REVISITED: THE GOOD, THE BAD, AND THE UGLY

S. HRG. 108–325

NURSING HOME QUALITY REVISITED: THE GOOD, THE BAD, AND THE UGLY

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

JULY 17, 2003

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

91–231—PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON FINANCE

CHARLES E. GRASSLEY, Iowa, *Chairman*

ORRIN G. HATCH, Utah	MAX BAUCUS, Montana
DON NICKLES, Oklahoma	JOHN D. ROCKEFELLER IV, West Virginia
TRENT LOTT, Mississippi	TOM DASCHLE, South Dakota
OLYMPIA J. SNOWE, Maine	JOHN BREAUX, Louisiana
JON KYL, Arizona	KENT CONRAD, North Dakota
CRAIG THOMAS, Wyoming	BOB GRAHAM, Florida
RICK SANTORUM, Pennsylvania	JAMES M. JEFFORDS (I), Vermont
BILL FRIST, Tennessee	JEFF BINGAMAN, New Mexico
GORDON SMITH, Oregon	JOHN F. KERRY, Massachusetts
JIM BUNNING, Kentucky	BLANCHE L. LINCOLN, Arkansas

KOLAN DAVIS, *Staff Director and Chief Counsel*
JEFF FORBES, *Democratic Staff Director*

CONTENTS

OPENING STATEMENTS

CONGRESSIONAL WITNESS

AGENCY WITNESSES

PUBLIC WITNESSES

ALPHABETICAL LISTING AND APPENDIX MATERIAL

COMMUNICATIONS

NURSING HOME QUALITY REVISITED: THE GOOD, THE BAD, AND THE UGLY

THURSDAY, JULY 17, 2003

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Baucus and Breaux.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning everybody. As Chairman of this committee, working closely with Senator Baucus, I am particularly pleased that we have a hearing following up on extensive work that I started when I chaired the Special Committee on Aging.

The Finance Committee has had plenty on its plate this session, but I am proud of our accomplishments in many areas, and doing it in a bipartisan way, and now having some time to continue making sure that nursing home residents have quality of care, the purpose of this hearing.

Today, greater numbers of Americans are blessed with longevity and, thus, are able to enjoy more time with loved ones. Take it from me, it is a treasure to watch your grandchildren grow up, and an incredible pleasure to congratulate a granddaughter on the birth of their own child.

But as Americans break new age barriers, society must cope with the changing needs of aging and expanding populations. This hearing is an opportunity to revisit and assess the quality of care of America's nursing homes. Today we will hear that there is still much to be done at the state level, Federal level, and by the industry.

I think it is fair to say that some progress has been made, although it remains difficult to say exactly how much. We do know, however, that we can and must do more to protect vulnerable nursing home residents.

Some have said that this hearing is about nothing new. With that, I disagree. I think it is an opportunity for a wake-up call to America. It is a reminder that the oldest and neediest among us deserve to live their final years with dignity.

The people assembled here today, the tireless advocates and family members, the members of the nursing home industry, govern-

ment regulators, and elected policymakers, many of us are dedicated to keeping this issue on the front burner of priorities.

We must always keep in mind that the goal, simply put, is improving the quality of care in nursing homes. It is important to note that our primary concern in this regard is about genuinely poor care to residents.

We are talking about preventing basic, but life-threatening problems such as dehydration, malnutrition, and injury prevention, including prevention of pressure sores, falls, and other serious injuries that result from substandard care.

Just as an example, we are not talking about somebody having a black-and-blue spot when we are talking about pressure sores. We are talking about real problems that people have, a real lack of quality care.

We need to target bad actors who do not do a good job, and in the process do a disservice to all the good homes that are out there. I want to emphasize that the majority of nursing homes are greatly concerned about providing quality care.

For instance, I had an opportunity to visit a home in Iowa called the United Presbyterian Home. I have a letter from them that explains their interest in not wanting to be blackened by the reputation of some poor quality people in the industry.

We have to give credit to nursing homes like that and their quality staff. I would like to believe that all nursing homes are as diligent. However, we know that there are too many bad homes where abuse, neglect, and life-threatening problems exist.

We should always keep in mind that any death due to substandard care is one death too many. I believe that too often we here in Congress get bogged down in data and statistics and do not think about the human lives and untold stories that are behind those statistics.

That is why we will hear this morning from a panel of everyday Americans, their family members dealing with the tragic consequences of substandard care. We must listen to them because what they will tell us is truly tragic and all too common.

Each has come before this committee today as a living reminder that quality care in nursing homes is not about numbers, it is about life, and too frequently resulting in tragic death.

I have long championed the idea of sunshine being the best disinfectant. I believe openness in any system helps to cleanse the impurities, educate the public, and hold people accountable. American consumers are growing increasingly accustomed to the right to know when it comes to purchasing products, choosing services, and even buying groceries.

When it comes to finding high-quality care for a loved one, they have a right to know about the standards of care provided at their local nursing home. Everyone should know that there's a huge gap in quality among nursing homes across America.

There are homes with tremendous care and compassion being provided, and then there are homes where horrendous neglect and preventable death exists.

I have been working on nursing home quality for almost 8 years. At my request, the General Accounting Office has issued a series of reports documenting severe problems.

Today we learn about the GAO's most recent findings, so we welcome back Dr. Bill Scanlon, who has testified numerous times about the quality of nursing home care and was behind the nursing home initiative at the beginning of 1998. He will testify about the latest in a series of several important GAO reports.

In addition, we will welcome before our committee a person who is already at the table, Senator Bond, Chairman of the Aging Subcommittee.

Also, we will hear from Department of Health and Human Services' Office of Inspector General to discuss that agency's work in nursing home quality.

As always we have invited Administrator Tom Scully to be with us. CMS's Federal role in overseeing nursing homes and implementing initiatives to improve care is of paramount importance, and we look forward to that testimony. One of the positive policy initiatives to emerge from CBS was the launch of the national online database.

The Nursing Homes Compared, is what it is called, a web site offering consumers comprehensive, user-friendly resources to assist with difficult decisions of choosing a nursing home for a loved one.

I am keeping close tabs on the web site because, as we will learn today, flaws and gaps still exist in the information. I continue to say that consumers need to be aware that this is one resource among many resources that they ought to use. Or, as President Reagan said on a diplomatic effort, you ought to trust, but also verify.

As always, we will also talk about money today. The Federal Government pays vast sums for quality care and oversight and enforcement. Over the past couple of months, we have been hearing about a proposed $6.9 billion Federal increase in payments to the nursing home industry over the next 10 years.

From my point of view, that should be directed to improve hands-on patient care. We must ensure that the nursing home industry does not line its pockets with the money. I expect them to use the money for direct care. Finally, we will close out the hearing with testimony from the industry's perspective.

In sum, this hearing today is about keeping the focus and pressure on doing better for the frail and elderly. It is extremely important and valuable to maintain a dialogue among nursing home care providers, regulatory agencies, Congress, and the all-important consumer about problems that persist.

I hope this hearing will help continue the dialogue and provide a road map along the way.

Senator Baucus?

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you very much, Mr. Chairman.

First, I want to recognize you, particularly, for your persistent efforts to improve health and quality and the life of elderly and disabled citizens.

I mean, as Chairman of the Aging Committee, and here as Chairman of the Finance Committee, you have done a super job. I deeply appreciate it and I know that a lot of seniors across our

country do as well. They should know all the good work that you are doing.

I also want to thank my good friend and colleague, Senator Bond, for his contributions in the general area. As more and more Senators get involved, the more likely that something is going to get done. So, I thank you very much, Senator, for your efforts.

I might add, too, that this hearing is an important follow-up to a hearing we held in the Finance Committee last year on elder justice. That hearing focused on the prevalence of elder abuse and neglect all across our society and on the lack of coordinated programs to respond to that abuse.

Senator Breaux, Senator Hatch, and I introduced legislation, S. 333, called the Elder Justice Act. The point of the bill was to address elder abuse and neglect in all its forms, including that which takes place in nursing homes. The bill improves identification of abuse and enforcement where abuse occurs. It attempts to address root causes.

One feature I particularly appreciate is its use of grants and other incentives to increase staffing in nursing homes. Many experts agree that nursing home quality and staffing rates are closely linked.

I am pleased that this committee is continuing to scrutinize those problems and institutions that serve our elderly and disabled, and I hope that we will some day mark up and pass that legislation.

Today, however, we are focused on a specific element of elder justice, that is, the quality of care received in our Nation's nursing homes. To be sure, we will hear some horror stories. Our hearts go out to these victims and their families. We will hear about unscrupulous or careless people who did not take care of our most vulnerable citizens.

But we will also hear about bright spots where innovation and hard work have resulted in quality improvements. I hope that all of our witnesses today agree on one thing, that the systems we use today to manage quality of nursing homes are not working the way they should.

State surveyors vary so much across States that the statistics they report can hardly be trusted. The GAO will tell us that the numbers may actually under report serious harms faced by nursing home residents.

Nursing home administrators often tell me that the numbers may overstate very small, tiny problems, like a broom out of place in a nursing home.

If we want to make improvements, we must understand the problems. Our assessment system simply does not work. CMS has not provided adequate guidance or oversight to ensure consistency in nursing home surveys.

In fact, the need for guidance here is so great that in my State, the State of Montana, the legislature recently passed a law asking Montana's Department of Public Health and Human Services to define the terms that surveyors rely on when they do nursing home inspections.

The legislature, lacking any Federal guidance, asked the agency to explain what "actual harm" means, and what "unavoidable"

means. Of course, a different State agency might reach a very different conclusion than that of the State of Montana.

How are we, CMS, or consumers supposed to interpret quality information when we cannot even agree on the meaning of common terms? There is so much uncertainty about what survey results mean, it is almost impossible for consumers to use information on web sites like that on CMS's Nursing Homes Compared.

We find ourselves awash in numbers and terms, like "deficiencies" and "immediate jeopardy," but the bottom line is that we cannot really tell what is going on in our nursing homes. That means that we cannot tell where to focus our efforts of enforcement.

Federal oversight. The survey process is weak. Recently, CMS has put a great deal of effort and money into a new initiative that relies on competition between nursing homes to improve overall quality.

I support the idea of competition and transparency, but this effort cannot come at the expense of improving the survey process. Competition works only when consumers have real choices.

In rural areas where there are very few nursing homes covering a very large area, consumers do not have many choices, that is, if they want to live near their loved ones.

So we must still rely on nursing home surveys to ensure minimum levels of quality. I am sure that everyone in this room would agree that nursing home quality can be improved with a more effective oversight system.

We should also admit that things could be worse. The administration's recent proposal to block grant the Medicaid program would give States the option to take a capped grant for Medicaid in exchange for eliminating virtually all Federal oversight in the Medicaid program.

States would have complete flexibility to monitor nursing home quality, or not, if State budget pressures are too tough. So I am concerned that such a proposal would leave our most vulnerable nursing home residents at great risk.

Thank you, Mr. Chairman, for holding this hearing. Nothing is more important than the security of our people, particularly those who are most vulnerable. I look forward to hearing from all witnesses.

The CHAIRMAN. Thank you.

Senator Bond is a co-requester of the report that will be issued today by the General Accounting Office. He has testified on this issue with me several times before.

I extend a warm welcome to you. Thank you, Senator Bond.

STATEMENT OF HON. CHRISTOPHER BOND, A U.S. SENATOR FROM MISSOURI

Senator BOND. Thank you very much, Chairman Grassley, Senator Baucus, for the invitation to be here today. We truly appreciate your tireless work and the leadership that you have shown on behalf of our Nation's seniors. I share your commitment to protect the health and safety of our Nation's frail and elderly nursing home residents.

As you indicated, I do chair the Aging Subcommittee of the Health Committee, and with my colleague Senator Mikulski, we intend to pursue this issue in that venue as well.

I know you have a busy schedule, and I have other commitments, so I will limit the portion of my remarks but ask that the full remarks be included in the record.

The CHAIRMAN. It will be included.

[The prepared statement of Senator Bond appears in the appendix.]

Senator BOND. Elderly nursing home residents are dying in Missouri and across the country due to failures to provide the most basic and fundamental elements of care. The GAO has amply documented years of death and neglect due to the poor quality of care in too many of our Nation's nursing homes.

In 1999, the GAO estimated that residents of 1 in 4 nursing homes in my State of Missouri suffered actual harm from the care they received. That is simply unacceptable. It is worse than unacceptable, it is a crime, in many cases literally, and it has to be stopped. It has to be corrected.

We simply cannot accept, in a modern and humane society such as ours, that elderly and vulnerable residents of nursing homes would suffer from harm instead of care.

In large part, societies are judged by how well they care for those who cannot care for themselves, the young and the old. Right now, we cannot avoid the rather harsh judgment imposed upon us by these cruel statistics. We can no longer look away from the statistics. We have to confront them and deal with them.

But, most important, there is a moral imperative that drives us to look at the human beings behind those statistics, our mothers, fathers, grandmothers, grandfathers, and some of us, probably, soon enough. We can no longer look away.

I have been monitoring reports of abuse and neglect in nursing homes since the summer of 1999, when reports from my constituents called into serious question the quality of care provided in some of Missouri's nursing homes.

Since then, I have personally met with families of victims in Missouri to hear first hand their reports of abuse and neglect. I have talked with these families, heard their stories.

I have seen pictures of the loved ones that haunt me to this day. As long as I live, I will never forget one woman who shared with me the heartbreaking story of finding her mother covered with ants. There can never be any excuse for this tragic lapse in care, so I am afraid that many stories, some we cannot repeat, are repeated a thousand-fold across the Nation.

Recently in St. Louis, there were heat-related deaths of four elderly women in the Leland Health Care Center in University City within a 48-hour period in April of 2001. The air conditioning was not working at the time. These four elderly women literally baked to death on the third floor of a three-story brick building as temperatures inside climbed to 95 degrees and higher.

The searing tragedy of the case is that it was so simply avoidable, and that many good people tried to raise the red flag on the conditions there but were ignored by a system that long ago broke down.

According to a report on the Leland incidents released by the Missouri Division of Aging, the facility had failed to maintain a safe and comfortable temperature inside the building for 4 days straight, despite repeated complaints from paramedics, the fire department, and other emergency workers, as well as family members of patients regarding the climbing temperature in the nursing home. The warning signs were there. People tried to intervene, but no action was taken and four innocent people died as a result.

Four people are dead, a clear case of negligence. No one was held accountable. The fines were reduced to $43,000, a little more than $10,000 per death.

Well, that is appalling, but sadly this is not a problem unique to Missouri. Abuse, neglect and homicide in nursing homes is truly a national problem. How many other Lelands are out there? How many other elderly patients right now, this summer, are baking in nursing homes somewhere else in this country?

As Chairman of the Subcommittee on Veterans Affairs, Housing, and Urban Development and Independent Agencies, I have also had an interest in veterans placed in community nursing homes.

December 31 last year, the VA OIG provided me a report that contains troubling information for veterans placed into private nursing homes when, for one reason or another, they cannot be placed in a VA facility.

The OIG found that veterans in these community nursing homes are vulnerable to incurring abuse, neglect, and financial exploitation. Sixty-three percent of the review teams interviewed by the OIG knew of veterans who reported abuse or neglect while residing in the CNHs.

Twenty-seven percent of the veterans sampled were placed in centers for which the CMS, Centers for Medicare and Medicaid Service, had placed the homes on watch lists, nursing homes cited for placing residents in harm's way or in immediate jeopardy.

Mr. Chairman, I request that the VA OIG report be placed in the record.

The CHAIRMAN. Yes.

[The information appears in the appendix.]

Senator BOND. Neglecting an elderly, frail individual is no different than neglecting a child. Both are defenseless and lack a strong voice. Both are vulnerable. Both suffer at the hands of those who are, in some instances, nothing more than cowards or criminals.

Abuse of the elderly should be treated no differently than abuse of children. That is why I am proud to be an original co-sponsor of the Elder Justice Act, as mentioned by Senator Baucus, introduced by Senator Breaux and supported by many members of this committee.

On a positive note, I have met with Secretary Thompson of Health and Human Services and discussed with him a new bedside technology that can easily and accurately record individual information about nursing home residents and the care they received.

Technology is designed to streamline recordkeeping, improve the quality of care, in addition to keeping the staff updated on patient status. This technology will help prevent errors in administering

medication and will provide real-time clinical warnings for caregivers.

The University of Missouri's award-winning QIPMO, Quality Improvement Program for Missouri, which presently provides all nursing homes in Missouri with reports about the quality of the care they deliver, stands ready to marry the bedside technology with its voluntary consultative services.

I believe QIPMO, if enhanced with bedside, real-time technology, providing real-time patient data, has the potential to erect an early-warning system with capacity to alert caregivers to life-threatening problems before they become widespread or have tragic consequences.

I am very pleased that Secretary Thompson enthusiastically supported the project and has provided $800,000 to fund a demonstration and evaluation process. Evaluation will center on whether the use of beside technology improves the collection of daily measures of patient care and improves the outcomes of care.

We urgently need a technological revolution in nursing home care that can save lives and spare our seniors unnecessary suffering. I am most appreciative of the work the Secretary has done.

I thank you, Mr. Chairman and Senator Baucus, for your attention, and look forward to sharing the information with you. I think it could be a tremendous help throughout the Nation.

I thank you for holding this important hearing and for giving me this opportunity, and we look forward to working with you on this issue.

The CHAIRMAN. Thank you, Senator Bond.

I have no questions. Do you have questions, Senator Baucus?

Senator BAUCUS. No.

The CHAIRMAN. We thank you and dismiss you. We appreciate very much your leadership in this area and look forward to working with you on any legislation that is in the jurisdiction of your subcommittee.

Senator BOND. Thank you, sir.

The CHAIRMAN. I have the opportunity to welcome two individuals who have experienced firsthand the devastating consequences of substandard nursing home care.

We have Sheila Albores and Jeanne Hodgson before the committee, our first panel. Sheila traveled from Oak Hill, Illinois. She will testify about her mother, Ana Carrasco, who died tragically in the spring of 2001 after five short days in an Illinois nursing home. Her mother was 57 years old.

She died because of a tube that was fit into her trachea that was not properly cared for. It is simple. This needs to be cleaned out from time to time and it was not cleaned out. Obviously, as a result of that, there was not enough oxygen and she was not able to breathe because of the accumulation of mucus and other fluid from time to time.

We are going to hear from Ms. Hodgson, who traveled here from Ransom, West Virginia. She will testify about her mother, Annie Boyd, an Alzheimer's patient who died in a West Virginian nursing home. The questionable circumstances surrounding the death of her mother are extremely troubling.

We thank you for not only honoring your family members who suffered, but most importantly, for coming here to testify and to be a living example above and beyond the statistics that I referred to.

We will start with you, Ms. Albores.

STATEMENT OF SHEILA ALBORES, DAUGHTER OF ANA CARRASCO, OAK HILL, ILLINOIS

Ms. ALBORES. Thank you. Good morning. I would like to thank you, Senator Grassley and members of the Senate Finance Committee, for the opportunity to travel here today and share my family's experience.

My name is Sheila Albores, and I would like to tell you about the neglect my mother, Ana Carrasco, suffered in a nursing home entrusted with her care.

In April 2001, my mother was admitted to the hospital with trouble breathing. Doctors placed her on a ventilator, but after a tracheotomy was performed my mother's condition gradually improved and she was soon able to breathe on her own.

Just 2 years earlier, my mother had been diagnosed with cancer and received chemotherapy and radiation treatments. When she was admitted to the hospital, our family had feared the worst. But after tests were performed, we soon received wonderful news: there was no cancer. My mother just needed to regain her strength, and the doctors recommended she be placed in a facility for short-term rehabilitation.

On a Thursday morning in April of 2001, my mother was transferred from the hospital to the nursing home closest to my home. While my mother was being transferred, my husband and I moved her belongings from her house to ours so we could care for her after what we expected would be just a brief stay at a nursing home.

We arrived at the nursing home approximately 8:00 p.m. that night to find my mother just lying in a bed, just lying there. Her oxygen had not been hooked up. She had not had any supplemental feedings which she should have been receiving through her NG, or nasogastric, tube.

She had been there for more than six hours and nothing had been taken care of. During the few days my mother resided in the nursing home, the pattern of neglect continued.

My mother was so upset, she pleaded with me to take her out of the facility. She told me she thought she was going to a facility for physical therapy, but instead she had been placed in a room with an elderly nursing home resident whose needs were also being ignored. The poor woman in my mother's room had bedsores all over her body.

That first night, my husband and I and my 4-year-old daughter stayed until 11:00 p.m., instructing the nurse on everything my mother needed. All my mother's instructions were written and sent over with her, so the nurses should have known what she needed.

But the nurse on duty said she started her shift after my mother arrived and assumed that my mother's needs had been taken care of by the previous nurse, but nothing had been done.

I returned to the nursing home approximately 8:30 the next morning. When I met with the director, she assured me that what had happened to my mother was unusual and that transferring out

of the facility would traumatize her more. The director reassured me that my mother would be given special care.

It was Friday morning, and I told the director that if I did not see improvements in my mother's care over the weekend, I would demand that she be released to my care. I had already called a home health care agency and they were scheduled to deliver the necessary equipment so I would be prepared to care for my mother at my home.

When I returned Friday afternoon, my mother still had not received any of her medication. When I complained to the nurse, she told me she had been too busy to get to it.

I returned to the nursing home early Saturday and spent the weekend taking care of my mother. She was warm and perspiring, but when she asked that her room be made cooler she was told it could not be done. I saw a thermostat on the wall and turned it down myself.

My mother also asked to be bathed, since she had not been bathed since she arrived. We were informed that the nursing home was short-staffed and that my mother would have to be put on a bath schedule, and she was not due for one.

She asked for some cold, wet rags so I could wipe her down. I was told I could not have any, so I took some small washcloths from a cart that I found in the hallway and did it myself.

One of the medications on my mother's chart was for extreme nausea she sometimes experienced. Her doctor had prescribed it because the tracheotomy put her in extreme risk if she had vomited. When my mother began complaining of nausea, I begged the nurse to please give her the medication. She assured me that she would.

My uncle went to visit my mother that evening and he was mortified by the lack of care. During his visit, no one had even come in to check on my mother. He had told me that they still had not given her the medication, so when I called the facility that night they told me she could not come to the phone because she, indeed, had vomited.

I called again and tried to calm my mother down. "I will be there first thing in the morning," I told her. When I arrived Sunday, my mother again begged me to take her home. She said she could not stand to be there one more moment. Her room was hot and she had not been bathed, and she had not received any therapy. Her medication had not been given to her on schedule.

I frantically pleaded with the nurses, please give my mother the medication. Please try to make her comfortable. It was Sunday, and I promised my mother, first thing Monday, I would call the social worker to prepare her transfer papers.

Early Monday, I arranged for my mom to be transferred out of the facility immediately. That night, my husband, my 4-year-old daughter and I were back at the nursing home.

My mother was so scared, but I promised her that the next morning the home health agency was delivering all the equipment to my house, a hospital bed, oxygen tanks, portable commode, and all the equipment we needed to take care of her. I told her, hang in there for just one more night.

Early Tuesday morning, the home health agency called to confirm our appointment. A nurse and a technician were on their way

to my house to set up the oxygen and give my mother breathing treatments. I called my mother right away to tell her everything was ready for her and that would be coming home, but my mother was not in her room.

I was put on hold several times, and a nurse finally came to the phone to inform me my mother had been transferred to a nearby hospital. "You must be mistaken, I told her. "My mother is coming home today." I thought my mother was being prepared for her transfer, but instead she was lying alone for hours in a nearby hospital emergency room. She died there.

My mother, Ana Carrasco, was 57 years old. She had been in a nursing home for 4 days. My mother died from a dirty, clogged tracheotomy tube. A contributing cause was the nursing home not giving her the medications prescribed by her doctors to help her breathe and thin her secretions.

When my mother's death was investigated, the nursing home was not cited for neglect, for violating my mother's rights, or for causing her death by neglecting to clean her tracheotomy tube.

Senator Grassley, members of the committee, I would like to thank you again for inviting me here today to tell my mother's story and to bear witness to the suffering she endured in a nursing home that provided substandard care.

Senators, I ask you, my mother, Ana Carrasco, was able to speak and voice her complaints and her concerns. She had her family by her bedside and in the nursing home. Yet, she still died of neglect.

My mother did not get her medicine. She did not receive physical therapy. She did not get the proper care she needed to keep her tracheotomy tube functioning properly. She could not even get a bath. This happened, despite my vigilance, my constant calls, my visits to the nursing home, my begging and pleading.

If this happened to my mother, what is happening to all those other nursing home residents, the ones without a voice, the ones that have no one to look out for them and protect them from harm?

The CHAIRMAN. And there are so many that do not have a voice like yours. We thank you for your testimony.

[The prepared statement of Ms. Albores appears in the appendix.]

The CHAIRMAN. Ms. Hodgson?

STATEMENT OF JEANNE HODGSON, DAUGHTER OF ANNIE BOYD, RANSOM, WV

Ms. HODGSON. Mr. Chairman, members of the finance committee, thank you for this opportunity to testify today and to tell you the story of my mother, Annie Boyd, whose untimely and shocking passing is the reason I am here before you today.

My name is Jeanne Hodgson and I am from Ransom, West Virginia.

In October of 2000, my brother, sister and I faced the most difficult decision we have ever faced in our lives, the decision to put our mother in a nursing home. We put off this decision for quite some time, but as our mother's Alzheimer condition quickly worsened, we felt like we had no choice.

It was clear to us that mom needed 24-hour care, that my sister, brother and I could not provide while holding down jobs, supporting our families, and dealing with our own health problems.

We began this journey by trying to find the best home we could for Mom. We chose a facility that looked nice and the admission staff boasted of their special Alzheimer's/Dementia Special Care Unit, which offered increased supervision and frequent resident/staff interactions.

You see, my mom had a tendency to wander and she loved to walk. She had fallen and hurt herself at home, so we needed a nursing home facility that could deal with that problem.

We thought this nursing home would provide Mom with a level of care beyond anything that we could give her. So on October 18, 2000, we moved Mom into the home.

Despite our hopes, it soon became apparent to us that she was not receiving the level of supervision promised to us. In fact, we began to realize that Mom spent most of her days wandering the nursing home halls without any proper help or supervision.

Although the nursing home had promised to engage her in special activities to help her with her Alzheimer's, they rarely provided them.

My sister and I would each visit my mom at least three times a week. During those visits, we began to realize that the nursing home was greatly understaffed.

During our individual visits, my sister and I both noticed there was not even enough staff to feed the patients, so on more than one occasion my sister and I fed patients in need of assistance.

During my sister's visits, she also noticed that lunch trays would often come without any liquids and that pills were lying around on the floor.

Within 2 years of mom moving into the facility, she had sustained over 30 falls and other unexplained injuries and accidents ranging from regular bruises, lost teeth, black eyes, to head lacerations requiring stitches, and a fractured left wrist.

Unfortunately, we did not know of many of these falls until after mom's passing because they were documented but not reported. As for the injuries we knew about, the staff claimed they had no idea what happened.

It was clear to me that they did not have adequate staffing to supervise my mom and simply could not keep her safe. We complained. We tried to work with the staff, but it did not change anything.

As the falls and injuries became more frequent, my family started to doubt our decision. The final straw occurred in October of 2002, when mom was admitted to Jefferson Memorial Hospital because she was suffering from severe dehydration.

At that point, we were certain the nursing home was doing a lot more harm than good, so we made the decision to move mom out of the facility and we began to consider other options. Unfortunately, our decision came too late. On November 20, 2002, around 11:15 p.m., I received a knock on the door.

When I opened my door, there on my front porch was an officer with the Charlestown Police Department. He told me that my mother had died at the nursing home. The nursing home never

even called to inform my family of my mom's passing or any of the surrounding events.

As to how she died, he told me that she had been hanged. My mother was found with a shower hose around her neck. It was considered a suspicious death and they were undertaking an investigation. Ultimately, it was an investigation that went nowhere. The police never determined how my mom died.

I cannot put into words how I felt at that moment, standing on the porch. The lingering feelings still haunt me today. I feel guilty for having put my mom in such a place. I feel outraged that they could allow this to happen to such a vulnerable person.

Unfortunately, I cannot bring our mother back. But what I can do is share the story with you. Based on our family's experience and what I have come to know about nursing homes and elderly care since that time, I know that nursing home neglect is much more commonplace than people realize.

Staff shortages at these facilities is an important problem that needs to be addressed at the national level. Rather than limit the rights of these elders through court reform, I would ask this body to get to the root cause of this neglect, look at how to solve the problem by addressing the staffing problems.

If, by giving this testimony, I can help save even one elderly person from suffering from nursing home neglect due to staff shortages and poorly trained workers, I will have done honor to the memory of my mom and all that she did for me and my family. Thank you.

[The prepared statement of Ms. Hodgson appears in the appendix.]

The CHAIRMAN. We thank you for sharing your stories with us and with the Nation. As sad as your stories are and the dread that it brought to your family, it seems to me your testifying here is a constant reminder of the inadequacy of some of the enforcement and the care.

So, we thank you for doing that. We thank you because we want to learn from your testimony. We want the people that are involved in enforcement of nursing home care to learn as well.

So I really only have one question of both of you, but a very basic question and something that we and the Nation ought to learn from you. In light of these experiences you have had, in light of the care I think each of you feel you took to make sure that your parents had adequate care, you found out that, regardless of how much care you took or what advice you took, what you relied on for the placement for a short period of time or a longer period of time in the nursing home, that things did not turn out the way that you had been led to believe or that you anticipated.

So my question is in regard to the advice that you would give people all across this country if they were in a situation like you, faced with placing a loved one in a nursing home, what you have learned considering all the care that you took. What advice would you give to the thousands of people that are probably in exactly the same position you were within the last couple of years?

Ms. Albores, would you start out?

Ms. ALBORES. I, first, would like to say that anyone facing the same decision I had, give as much attention as you can. But even

in my case and in Ms. Hodgson's case, it does not matter. So my advice, I guess, would be to look into any other avenues except putting your loved one in a nursing home.

The CHAIRMAN. Ms. Hodgson?

Ms. HODGSON. I pretty much feel the same way. Try everything you can before you have to do that. If it still comes to that point where you have to do it, maybe research more than we did. I wanted mom close to where I was so that we could go visit her.

What we did, is we would pop in at different times of the day so they would not know when we were coming. Sometimes I would go in the morning, sometimes I would go in the evenings, and then my sister would do the same. But it still did not really help as far as that goes, either.

So if I had it to do over again—I kept her at home for 5 years, as long as I could. I really think if I would have looked at other avenues I may have been able to do like she was going to do when her mom came home, someone to come in and take care of her. I wish I would have looked into that more than I did.

I mean, if it gets down to the point where there is nothing else you can do and you have to place them in a nursing home, I would just go there as often as I could and not be afraid to speak up about something you did not like, and take it higher if you have to.

The CHAIRMAN. I have never met one constituent who said, I am just dying to get into a nursing home. I hope that we have policies, public as well as private consideration, that have a continuum of care that leads us to the same point that both of you made, that we should keep people out of nursing homes as long as we can, not because of the quality of care that is an subject of this hearing, but just because people have a higher quality of life if they are in an environment that they choose as opposed to one they do not choose.

Ms. ALBORES. I agree.

The CHAIRMAN. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Ms. Albores and Ms. Hodgson, first, I want you to know that you have the condolences of myself, the Chairman, and all the members of this committee, and I am sure all members of the Senate, for the pain and suffering that you and your family have gone through.

It takes great courage for both of you to come before us today to share your pain, what you have been through, and I take my hat off to you. It is not easy to do this.

I also suspect that everybody listening to you is thinking back to his or her own family experiences. I know I am in mine. My mom was in a nursing home and I had to spend a lot of time personally making sure she was getting the care that she otherwise was not getting.

If I had to do it, I am sure that most everybody else has to do the same thing. Fortunately, my mother did not have the tragic outcome that occurred in both of your cases.

This is tough. I think part of the solution, as you have alluded to, is staffing. It just struck me, in the nursing home my mom was in, staffing is not great. There is a lot of turnover, a lot of shifts changing all the time, not enough follow-up, as you have mentioned in your cases. I found the same thing. I, too, had to go to the direc-

tor personally and say, hey, you are not taking care of Mom. My guess is, this is much more the rule rather than the exception.

We have got a real problem here, Mr. Chairman. I think we are going to have to press GAO and the Federal Government and just figure out what we can do, because it is a problem. We will work on it, rest assured we will. But thank you so very much for, again, your courage in coming before us and sharing your experiences with other Americans.

Ms. HODGSON. Can I say one thing?

Senator BAUCUS. Sure.

Ms. HODGSON. One time when I was in the nursing home visiting, I think it must have been on a holiday because I was off work. It was during the week, though. They knew that people were coming.

They were notified that whoever comes to do whatever they do, regulate them or check them out to make sure things are the way they are supposed to be, they know when they are coming so they are prepared. I do not think that is right. They should not know when someone is going to pop in, and then they would be more careful.

Senator BAUCUS. Right. Right. She is talking about unannounced inspections.

Ms. HODGSON. Right. Unannounced visits. Maybe there are some of those, but that one in particular, they were getting ready for it. They were moving things, and doing this and that. I asked what they were doing and they said, such and such is coming in. I just thought it was weird that they knew it.

Senator BAUCUS. Right.

Ms. HODGSON. And there were more people on duty that day and things were going differently that day.

Senator BAUCUS. Do you have any sense of how to get an ethic there among the personnel that really want to care for people? Any thought? Because my sense is, there is a lot of warehousing here.

Ms. HODGSON. A lot of what?

Senator BAUCUS. Warehousing.

Ms. HODGSON. Right.

Senator BAUCUS. How do you get people that work there to care?

Ms. ALBORES. I just think that administrators do not check into the backgrounds of the people that they have working there. I did notice, when I was at this particular nursing home, there was maybe one registered nurse per shift for two wings, and then maybe some agency, part-time nurses, candy stripers, just volunteers or people that were employed by minimum wage.

If you put those types of people in an environment like that, they just do not have the heart in it. They are not there because they chose that profession. They are just there because of the money, I guess. Maybe there is just not enough staffing.

Senator BAUCUS. Yes. Well, thank you very much. We appreciate it.

Ms. ALBORES. Thank you.

Ms. HODGSON. Thank you.

The CHAIRMAN. Thank you very much. We appreciate your testimony to the Senate, through this committee.

I rely on the General Accounting Office to do a lot of work in a lot of areas, but one place where I really found their work very outstanding is what they do on assessing health issues.

I have called on Dr. Bill Scanlon many times as Director of Health Financing and Public Health Issues to do General Accounting Office reports on the nursing home industry and quality of care.

So I call him now, and I call Dara Corrigan, who is Acting Principal Deputy for the Department of Health and Human Services.

Dr. Scanlon is going to testify on a report that I requested to reassess the extent of State and Federal progress made in improving nursing home care.

Ms. Corrigan is with the Inspector General's Office, which has historically provided valuable testimony to the committee. She recently assumed new responsibilities as Acting Deputy Inspector General. I look forward to your two testimonies.

I am going to start with Dr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Dr. SCANLON. Thank you very much, Mr. Chairman. I am very pleased to be here today as you once again spotlight the critical issue of assuring quality of care for vulnerable seniors and disabled persons in nursing homes.

Since 1997 when you began this effort, GAO has been very proud to assist you in examining the quality of nursing home care provided to Medicare and Medicaid beneficiaries and the State and Federal oversight and enforcement mechanisms to ensure that care meets minimum standards.

As you indicated, today our latest report is being released. It was completed at the request of yourself and Senator Bond and it discusses the recent trend and serious deficiencies, as well as the continuing weaknesses we identified in State and Federal nursing home oversight.

I would like to provide you some highlights from that report. The message today is mixed. On the one hand, there is distressing news. The survey inspections we reviewed still show that an unacceptable share of nursing homes, almost a fifth, had deficiencies involving harm to residents.

Tragically, the surveys document too many instances of harm that could be avoided through good care involving adequate nutrition, hydration, and more frequent repositioning.

The positive side, is that the proportion of homes with actual harm deficiencies is almost 9 percentage points smaller than when we last reviewed the survey results. That good news, however, is tempered by the reality that surveys understate the extent of current serious care problems.

In looking at a sample of surveys from homes with a history of harming residents but whose current surveys showed no such deficiencies, we found that a significant share had deficiencies that virtually everyone would agree involved actual harm, instances of avoidable pressure sores, serious weight loss, and repeated falls with broken bones and other injuries.

Both you and Senator Baucus indicated the problem we have with the data on nursing home deficiencies, and we agree that the data is not accurate in terms of reporting the level of deficiencies.

Unfortunately, all of the evidence points to the fact that in terms of serious deficiencies involving actual harm or immediate jeopardy to residents, the data is understated, they are not overstated.

We found, in preparing today's report, that a lack of clear and consistent CMS guidance on the definitions of actual harm and immediate jeopardy is an impediment for State surveyors in identifying these serious deficiencies.

Although CMS has been developing new surveyor guidance on investigating and categorizing quality problems since October of 2000, the first set of new guidance on pressure sores has not yet been released.

CMS has instituted a more systematic oversight of State survey, complaint, and enforcement activities, which is a positive move.

However, after its initial reviews, CMS officials acknowledge that their effectiveness could be improved. CMS has taken steps to improve the consistency of the reviews and needs to be attentive to ensuring that the collected information adequately identifies the extent and nature of any identified problems in order to guide needed interventions.

Let me point to one such area for needed improvement. CMS is not adequately monitoring the State's compliance with its October 2000 policy requiring that nursing homes that repeatedly harmed residents be sanctioned immediately.

In the past, no sanctions were implemented if a home took corrective action within a 90-day, so-called, grace period. For all practical purposes, this had resulted in repeat offender homes never facing sanctions.

Despite the new policy, we found that a significant share of homes with successive actual harm deficiencies were not referred for immediate sanctions as required, significantly undermining the deterrent effect of this policy.

Mr. Chairman, I would like to now step back from the findings in today's reports and offer some thoughts based upon my involvement in your efforts over the past six years.

First, we need some clarity about what should be our most immediate objective. No one would dispute the desirability of improving overall nursing home quality, but we must not confuse a wish to improve quality in all homes with the more pressing need to ensure a minimum quality of care in every home, to eliminate the possibility that nursing home residents can be at risk of harm due to woefully deficient care, a risk that our report indicates exists today for over 300,000 elderly and disabled individuals residing in about 3,500 nursing homes.

Laudably, the nursing home industry launched last year a Quality First initiative, a commitment to find means to improve care in all homes. Laudable as that is, and I sincerely hope it is extremely successful, it is not a substitute for strengthening the survey and enforcement process to ensure that deficient care resulting in harm to residents in too sizeable a minority of homes is eliminated.

In medicine, there is the concept of triage. When the number of patients seeking treatment exceeds capacity, medical professionals

focus first on those who cannot afford to wait and who can benefit most from immediate treatment.

We need to focus, first, on deficient care that is harming residents and ensure this critical, unacceptable problem is addressed to the best of our abilities.

There has also been discussion over the last six years about a need to change the nature of the survey and enforcement process or to reduce our reliance on it as a means of assuring nursing home quality.

It has been suggested that the process should be less regulatory, surveyors less like policemen. Some suggest surveyors should play more of a consultative role, assisting nursing homes in understanding how to comply with Federal standards.

I agree that surveyors should not be regarded as policemen. They should be perceived as consumer representatives, reviewing whether the care Medicare and Medicaid programs are purchasing on behalf of their beneficiaries meets standards of minimal quality, something no different than what a corporation might do to check whether the goods it ordered from a supplier were of acceptable quality.

The analogy is apt, because surveys are only done for homes that voluntarily want to sell care to Medicare or Medicaid beneficiaries. Homes that do not are not surveyed.

I do find it hard to understand the idea that the nursing homes would need the consultative help of government surveyors in order to avoid deficiencies. The types of deficiencies we have been talking about involve practices so egregious, so lacking, what one does not have to be a health professional to instantly understand their inadequacy.

In our reports in different hearings and in the examples that you have heard today, there have been cases of serious harm and other industry, and possibly death, when physicians' orders were ignored, when residents were allowed to deteriorate due to malnutrition or dehydration with any intervention, or because decubiti went undiagnosed, or even when diagnosed were not appropriately treated.

The nursing home industry is a $100 billion a year industry, employing tens of thousands of health professionals. It is incongruous to me to think that it needs the consultative assistance of a government surveyor to correct problems that every non-health professional in this room would instantly agree involved care that was simply and woefully lacking.

Most of us know from raising children about the basics required to sustain a human being, basics that some nursing home residents do not receive.

Some may say the survey and enforcement processes have proven inadequate to ensure nursing home quality, given the reports of continuing deficiencies over the last 6 years.

My perspection is different. I do not believe we have adequately implemented the survey and enforcement process as envisioned in OBRA 1987, and further defined by HCFA.

The execution of surveys and the enforcement actions that should follow them have been so lacking, we do not know how effective the process can be.

We and the OIG have identified a whole series of actions that could be taken that would provide the survey and enforcement processes a much better chance of being more effective in ensuring minimum quality.

On their face, the survey and enforcement processes have promise. We simply need to implement them adequately to discover how much of that promise can be realized and how much poor quality nursing home care can be eliminated.

Thank you very much, Mr. Chairman. I would be happy to answer any questions that you may have.

The CHAIRMAN. Thank you, Dr. Scanlon.

[The prepared statement of Dr. Scanlon appears in the appendix.]

The CHAIRMAN. I am going to go to Ms. Corrigan before we ask questions.

Proceed.

STATEMENT OF DARA CORRIGAN, ACTING PRINCIPAL DEPUTY INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Ms. CORRIGAN. Good morning, Mr. Chairman. I appreciate the opportunity to talk to you today about the quality of care in nursing homes.

This is an issue, as we have seen today, that potentially will affect everyone in this room in a way that is very personal and has nothing to do with dollars. It is a subject of intense and continuing interest at the Office of the Inspector General.

You asked us to provide our current assessment of the quality of care in nursing homes based upon our work over the past several years. I have gone through all of the reports, and I hope to talk to you about some of them today.

But as a summary, I would say, as many people have said already and I will echo a lot of what the GAO has said, we see glimmers of hope and progress, but overall we still have serious concerns about the quality of living conditions for residents at nursing homes.

As part of our study of nursing homes, we have looked at the data compiled by surveyors. We have looked at the complaints that residents have lodged with ombudsmen. We have talked to the surveyors. We have talked to operators of nursing homes.

We have gone into nursing homes and looked at the records of individual residents and we have had independent medical reviews of certain sampled residents at nursing homes. We also sent our own teams in to look at nursing homes to examine aspects of care.

As part of our preparation for this year, we looked at the GAO's reports and the GAO's results. We found that, while we have looked at different things, our information and factual data, analysis, and conclusions are very similar to the GAO's.

We have compared, for example, the deficiencies that we found across the country in 1996 to the year 2001, and we found that the deficiencies are still increasing. We found that more nursing homes have deficiencies.

But perhaps more important than the actual numbers of deficiencies, we have looked at the types of deficiencies that relate to quality of care, the ones that the earlier people testified about. We found that, unfortunately in that area, there has also been an increase in those types of deficiencies.

And we are not talking about minor deficiencies like hanging a sign wrong on the wall. I will give you two examples. One, was a case where a resident reported that a nurse aide had used a sheet around her neck that left red marks on her neck, and upon further investigation there were seven similar incidents of resident mistreatment in the records.

There was another deficiency cited where the resident had been having trouble drinking and eating and had signs of dehydration, yet that patient continued to receive diuretics while they were in a nursing home. They were later transferred to a hospital, where they subsequently died.

These are not minor deficiencies. They affect the quality of life for the residents in nursing homes, and it is something that we all have to be very concerned about.

There is one other area I would like to focus on, which is the resident assessment and care plans. Now, that sounds like a government, bureaucratic paper thing, but it is not.

What that type of assessment is, is when someone goes into a nursing home, they should have an interdisciplinary team that looks at them and figures out how to meet all of their needs, like dehydration, or if they have any problem with falling, or if they have dementia, or if they have any visual problems, so that a care plan can be drawn up that addresses all of those needs.

What we found, is that over time there have been more deficiencies in that area. What we are concerned about, is the lack of those plans is not just a paper problem. I can lead to actual harm or potential harm, in some cases. We looked at one particular nursing home where 7 out of 31 people did not have these comprehensive care plans.

What it means in real terms, is one person was not receiving pain medication for severe pain. For another person in the nursing home, they were not meeting their dietary needs and the person was losing weight, even though that was a concern from the beginning when they were admitted to the nursing home.

In addition to our concerns about the actual deficiencies, we share the GAO's concern and this committee's concern about the data that we are using and whether or not survey data can be relied upon.

We found in our studies that there are differences between the States, within the State, between Federal oversight in the States, and even sometimes within the same survey.

We consider this to be critically important because all enforcement tools are based upon that survey data, so if we do not have good enforcement data, the Federal Government cannot take appropriate enforcement action.

We have several explanations for the inconsistencies or variability in survey data. I think it can be explained by things like the surveyor's approach.

Some surveyors take much more of an enforcement approach versus an approach where they go in and try to consult with the nursing home. There are variable differences in the level of review that some surveys actually have before the survey results are finalized. There are difficulties in the way that they try and figure out what a deficiency is, based on the guidelines. There are some ambiguities there.

We just want to raise again the concern that those types of variabilities are going to cause enforcement problems and will affect quality of care at the nursing homes. In addition, I would just like to point out that, in reviewing the ombudsman reporting data, it corroborates much of what has been said here today.

The complaints by nursing home residents have increased over time. Again, these complaints are not about trivial things. They are about medications not being given and not having their requests for assistance answered. Unexplained bruising and a failure to bathe many residents was really high.

When I read about people complaining about not being bathed, it seems like such a basic quality of life issue. I find that type of complaint as disturbing as the other complaints, because if those things are not happening, you know the more serious medication and other type of care are not taking place either.

As the GAO has already stated, there are some positives in the data. Certainly, we have seen signs of improvement from CMS. There have been real strides to try and make things better. We found in our data that the number of repeat offenders, the people coming back time after time with the same deficiencies has been reduced.

But I think after reviewing all of the data in preparation for this hearing, the feeling that I am left with is mostly a feeling of disappointment, disappointment that it is not a lot better from several years ago.

So, I do not think this is a time to become complacent. Instead, I think it is a time to become innovative and to figure out new ways to attack this problem.

I do agree with the GAO that we really have to focus on which enforcement tools work best and making the survey and certification process better.

But I would like to do a study on what is making the best nursing homes work the way that they do, the nursing homes who have not had deficiencies for years. I would like to study where the money is going. Is it going to patient care?

Now, much has been done, but we can continue to do more. I want you to be assured that the Office of the Inspector General will be ready to do as much work as we possibly can. We hope that our contributions are constructive and we welcome your criticism, suggestions, and input.

[The prepared statement of Ms. Corrigan appears in the appendix.]

The CHAIRMAN. Could I ask you to pursue that study? I would be very interested in it and would like to have you pursue the study you just referred to. You said you would like to study.

Ms. CORRIGAN. Yes, Mr. Chairman.

The CHAIRMAN. Yes. I would make that request.

My first question would be to both of you. I often year that Medicaid is an inadequate payor. Is that true? Would you also comment on Medicare, maybe at the same time, Dr. Scanlon, then Ms. Corrigan?

Dr. SCANLON. Certainly there has been a lot of information about Medicare being an inadequate payor that has circulated in the media and in policy circles. I think, though, we need to take this with some perspective.

Until 1997, we had the Boren amendment to the Social Security Act that required that Medicaid programs had to pay rates to nursing homes that were sufficient to cover the costs of an economically and efficiently operated facility.

Prior to 1997, the nursing home industry was quite aggressive in terms of going to court and insisting that States do pay rates that were adequate to cover the cost of efficiently and economically operated facilities.

So I think at that point in time, using it as a benchmark, we can say that rates were reflecting the cost of those types of homes in virtually all States.

Subsequent to 1997 when that amendment was repealed, States were experiencing surpluses, and people that looked at Medicaid rates found that there had not been significant changes in payments, any kind of significant reduction in payments sort of immediately following the repeal of the Boren amendment.

Right now, at your request, we have been looking at what has been happening since States have undergone significant fiscal pressure with the recession and their reduced revenues. We have looked at 20 States, including those that reported the largest deficits in terms of having to balance their budgets in the last 2 years.

What we have found, is that in those 20 States there have been almost no reductions in Medicaid nursing home rates up through 2002. Right now, we are trying to update this for 2003 with the information from the legislative sessions that are just being completed right now.

What we found instead, was that the rate of increase in rates paid by Medicaid to nursing homes over the period from 1998 to 2002 was actually increasing faster than the rate of increase in inflation for nursing home inputs, labor, supplies, and other materials, as measured by the nursing home market basket that CMS puts together.

So the overall picture, from those perspectives, is quite positive. At the same time, I would emphasize that State Medicaid programs have been prudent about how they paid nursing homes.

They are interested in paying the cost of efficient and economical facilities. They are not interested in paying the cost of inefficient and uneconomical facilities. They do not pay all of the costs of very high-cost facilities.

Something also of interest, I think, to you, would be the fact that they do not typically give nursing homes payment in a lump sum. They take into account what nursing homes are spending in different areas, such as nursing, dietary costs, administration, the building and other facility costs, and they try to skew the payment toward the things that relate to resident care, things that would hopefully produce a higher quality of care.

With respect to Medicare, we issued a report last year which indicated that, under the new Medicare prospective payment system, there was quite generous margins that freestanding nursing homes were enjoying under the prospective payment system, at that time, somewhere between 15 and 20 percent margins.

As you know, since then, certain additional payments have expired. But MEDPAC, in its most recent report, estimates for this year the average margin for freestanding facilities will be about 13 percent.

One last comment. There has often been sort of a proposal that Medicare needs to compensate for inadequate payment on the part of Medicaid. There are two parts to the way we need to think about that.

One, is we need to address more directly the question of whether Medicaid payment is inadequate. Second, we need to think about whether Medicare is the right vehicle to compensate for any inadequacies in Medicaid payment.

If some States have inadequate Medicaid payments, to raise Medicare rates nationally would be a quite expensive way to solve the problem. Furthermore, the distribution of Medicare residents in homes is very different than the distribution of Medicaid residents.

Many homes do not serve many Medicare residents, but will serve many Medicaid residents. They are not going to benefit from increasing Medicare payment, and that is not going to help if their Medicaid rates are inadequate.

Thank you.

The CHAIRMAN. Ms. Corrigan?

Ms. CORRIGAN. Mr. Chairman, when we were preparing for this hearing I had discussions with my staff about this issue. It turns out that our office has not focused before on whether or not payment is appropriate and adequate to provide quality of care.

I think that we should be focusing on that issue, and we should also be focusing on where the money is going. What I can tell you is, while we have not studied it yet, we plan to study it in the future.

The CHAIRMAN. All right.

Dr. Scanlon, you spoke about understatement of surveys. I would like to have some examples of deficiencies that you believe should have been cited that give us concern about the level of actual harm.

Dr. SCANLON. Yes, Mr. Chairman. As I said, we took a sample of deficiencies from homes that had actual harm in the past, and in their current survey did not have actual harm. In our report, we listed the 39 percent of that sample that we regarded as involving actual harm.

Let me give you just a couple of them as this point. We have a resident that was admitted to a nursing home with a fractured hip and a gastrostomy tube inserted through the abdomen so that they could be fed directly into their stomach.

There was concern about the tube and the potential for infection. The physician's orders were to clean this tube site with soap and water and apply a dry sponge.

What the surveyors found was, the site of the tube insertion had become reddened, with thick, yellow-green discharge and had an odor, indicating signs of infection when the surveyor was there.

The family of the resident indicated that the dressing was rarely changed, and also there was no documentation to show that this tube site had been cleansed as ordered on 12 out of 16 different occasions.

There is another instance in terms of development of pressure sores that did not seem to have to have occurred. A resident was admitted with heart failure, high blood pressure, and a Stage II pressure sore on their back. Unfortunately, within several months, the pressure sore had been worsened to a Stage III. When the surveyor was there, the pressure sore was a Stage IV.

The physician had ordered that the resident be turned every hour, but the staff failed to turn the resident as directed. The surveyor, while they were there, observed the resident lying on her back for two or more hours.

The resident reported that frequently she was turned only twice in every eight hours. The charge nurse did not know that the physician had ordered the resident to be turned every hour, so that there was not appropriate supervisory accountability.

The CHAIRMAN. All right.

One more question of you, then one question for Ms. Corrigan. Do you believe that States are making progress in holding nursing homes accountable for meeting Federal quality standards? Are they receiving adequate Federal funding to meet all the demands placed on them?

Dr. SCANLON. I think if today were the first hearing on this subject, we would never believe that progress could have been made, given the negative aspects of what we have been talking about in terms of under-identification of problems, the fact that there is such a significant number of homes with serious problems.

At the same time, compared to where we were when we first reported in 1998, I think we should give the State some credit, and CMS some credit, in terms of having moved forward on a number of fronts.

One thing. In our last report, we indicate that Federal surveyors, when they do comparative surveys to assess the performance of the State surveyors, are finding that the States have missed fewer serious deficiencies. It is a positive move.

At the same time, the Federal surveyors are finding that there are 20 percent of facilities where a serious harm deficiency has been missed. That is totally unacceptable.

We are also doing a much better job in terms of the complaint system, which is one of the very critical early-warning safety valves for residents and families, whereas, when we first testified about the complaint system several years ago there was very little systematic review of whether complaints that were serious were being handled quickly. That type of review is occurring now.

We have not yet achieved perfection in terms of meeting the guidelines of investigating all immediate jeopardy claims in 2 days, or actual harm claims in 10 working days, but we have moved more positively in that direction and I think that is something to take into account.

The last thing I would mention in terms of our progress, is that when we first testified before you in 1998, 98 percent of facilities with serious harm deficiencies were not referred for sanction. Be-

cause of the policy now that facilities having successive surveys with immediate harm deficiencies be immediately referred for sanction, there has been a significant number of those facilities that have been sanctioned.

While we reported that almost 700, or slightly more than 700 had not been properly referred, there were about 4,000 that had been properly referred over a 2-year period. So, I think that is a positive move.

In terms of the adequacy of resources, I think we have some significant concerns. One of the things that we hear repeatedly in the States is that, in terms of trying to deal with complaints, both in terms of having to respond quickly, which is a new priority that they are focusing on today, as well as an increased volume of complaints, because frankly one of the other positive things that has come out of your efforts has been much more visibility to 1–800 numbers and other ways for residents and their families to express complaints.

States have reported that their ability to deal with the volume of surveys required by complaints, the volume of surveys that are needed to deal with the annual survey, that they are simply stretched too thin. I think we are hearing it from too many to be able to say that it is not necessarily genuine.

The other thing I worry about in terms of quality oversight, is that we have dealt not only with nursing home quality oversight, but with quality oversight in dialysis facilities, in home health agencies, in intermediate care facilities for people with mental retardation.

When we talk to CMS and we talk to the States, they all talk about it almost being a game of robbing Peter to pay Paul, that when you focus on one type of provider and trying to provide adequate oversight, it often means that another type of provider is not receiving adequate oversight.

The CHAIRMAN. Ms. Corrigan, one other question for you. That is, in light of this under reporting, what does this mean to the reliability and the integrity of the OSCAR data?

Ms. CORRIGAN. I think it means that it is a problem that we need to work on. The data there can certainly be used. The tendency to under report means that perhaps things should be different than they are, but what is there, I think we can use.

I think there needs to be some effort, though, to close the gaps on the four issues that I talked to you about, to figure out whether surveyors are going to be more in the enforcement mode or more in the consultative role, to figure out what type of review process we want for surveyors, to figure out a way to write the actual deficiencies more clearly.

I think if we start doing those types of things, we will try to have less variability in the system, which I think is what everybody is looking for. It is not there yet, but it is a very good start and it is a very good measure of really focusing on the problems of particular nursing homes. But it can be much better. Once it is better, it will be a better enforcement tool.

The CHAIRMAN. Thank you.

I am going to call on Senator Breaux. He is one that has worked with me over all these years on exactly this issue. Before he was

Chairman of the Aging Committee, he was also Ranking Member during my chairmanship. He continues to have this interest. I would call on you. I have no further questions. Then when you are done, I will call Mr. Scully.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. I thank Ms. Corrigan and Dr. Scanlon for their testimony. I apologize. We were in a mark-up in another committee and I could not be in two places at one time.

But this is an important hearing. I think that we, in our Aging Committee, have also looked at the quality of care in nursing homes.

We all know that many seniors would like to stay in their own home as long as they possibly can. But for many, there comes a time in their lives when 24-hour a day, 7-day a week care is absolutely essentially. That is the type of care that nursing homes do provide.

There are alternatives to nursing homes which I have encouraged our institutions to provide, particularly assisted living types of facilities, because that also is now going to be part of the mix in the future.

But I am delighted to hear that nursing home deficiencies, I think, are going down. I think things are getting better. But we still have a lot of work to do in order to have a system that we can all be completely comfortable with, and that is the goal of all of us.

I would just mention, Mr. Chairman, if I may, that this whole issue is one of the reasons why Senator Hatch and I introduced our legislation on the Elder Justice Act, S. 333, as part of that solution.

I think it goes a long way towards providing everyone the tools that they need in order to be able to make sure that everything possible is being done to protect those who are receiving care in our Nation's facilities.

The bill improves prevention and intervention by funding projects that are important in enhancing long-term care quality. It also enhances detection. It is a big problem. We found out that many times problems are never discovered until it is too late, and too often they are covered up so they, in fact, are never discovered. Our legislation would help address that.

It also tries to increase collaboration and coordination between all the various agencies that have something to do with this at the State, local and county level, as well as the Federal level. We need more coordination and cooperation. Our legislation would do that.

It also increases prosecution when it gets to the point, when that is necessary. In many cases, that is the final hammer that is needed to make sure that abuse and neglect does not continue to occur.

So, Mr. Chairman, we now have a significant number of sponsors of our legislation in the Congress and in the Senate, particularly, as well as the House. The leadership in the House has taken a lead role in this.

We have over 170 organizations nationwide that support this legislation and this effort. I think that hopefully we will reach a point when we may consider actually moving and acting on our Elder

Justice Act. We thank you for having this hearing. It fits right in with what we are trying to do with our legislation. Thank you very much.

The CHAIRMAN. I personally have not focused on your legislation as much as I should have. I know that I support the goals that you seek, and I know that my staff has been visiting with your staff about, not a lot of concerns, but some concerns that we have had about it. I would like to continue to work with you on that.

Senator BREAUX. I appreciate the Chairman. I would just mention, I did not know the number when I was making my initial comments. We have over 27 co-sponsors in the Senate now, 10 of which are on the Senate Finance Committee. So, we have been working hard to try and build up that momentum that I think would be very important.

The CHAIRMAN. Thank you, Senator Breaux.

I thank both of you for testifying.

It is my privilege now to call CMS Administrator Tom Scully, because he has significant responsibilities in this area because of CMS's important role. I want to thank him for coming.

Mr. Scully, I want to thank you for coming to testify before our committee, because you do have such an important role as Administrator here, of what is going right and what is going wrong in this regard to the quality of care at nursing homes.

I know that you can testify on strides that have been made and I presume that you are also aware of some inadequacies that I know you are concerned about as well.

Would you proceed?

Senator BREAUX. Is this the same Mr. Scully that was on the front page of the Wall Street Journal?

The CHAIRMAN. It happens to be the same Mr. Scully.

Go ahead.

STATEMENT OF HON. TOM SCULLY, ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. SCULLY. I apologize. I could have easily lived without that one. Thank you. Thank you, Mr. Chairman and Senator Breaux, for having me here again today. Thank you for many years of focus and persistence on these issues that have really created a positive environment in CMS, and I think in the States, to actually try and improve things.

If it was not for, Senator Grassley, your long work in the Aging Committee, and Senator Breaux's—we had a long way to go, as I will discuss—without your focus we would not be at least heading in the right direction.

I do not always agree, as Bill knows, with GAO reports. I am usually pretty good about telling him that I do not agree with all of them.

But in this particular case, I think this report, which I read all of last night, is excellent. I also think a lot of Bill's comments, which I will relate to, and his testimony are excellent.

We have huge challenges with nursing homes. We have roughly three million elderly and disabled people in 17,000 nursing homes.

About half of those people are in long-term care, and about half are in post-hospitalization rehabilitation.

As Bill mentioned, about 65 to 70 percent of the average nursing home patients are Medicaid patients, and about 10 to 15 percent are Medicare. I do not think there is any question that nursing home quality over the years has been spotty at best.

But, as Bill also mentioned and I will get into, the financing has been spotty as well. I think that quality and financing are tied together.

The GAO report has a lot of good news and bad news. I think I will start with the bad news, first. The first, to me, is that we still have 1 in 5 nursing homes in the country that have reports of actual harm or immediate jeopardy, and that is just unacceptable. Clearly, it is just a terrible outcome for patients.

We have a lot of inconsistency. If you look at the report, we have from 7 percent of the nursing home in Wisconsin that have significant problems—which I have not told Secretary Thompson, but he will be happy to know Wisconsin is the lowest—to Connecticut, where you have 50 percent of the homes that have some significant problems. That is a pretty wide variation and I think indicates a lot of the real disparity between the States and how they are working to solve these problems.

The bottom line is, as our witnesses said this morning, there are people being hurt, and in fact dying, in nursing homes and that is a real problem that we really need to spend a lot of time focusing on.

The good news in the GAO report, and I think there is some of that as well, is there has been significant improvement in recent years. I think if you look around page 11 of the report, you will see a fair amount of evidence of that.

There has been a decline since the late 1990's, from about 29 percent of the homes that had actual harm or immediate jeopardy to about 20 percent of homes, a pretty significant decline.

Seven States reported declines of 20 percent or more, and three-quarters of the States reported absolute declines in significant problems in nursing homes.

During the period 1997 to 2000, the previously measured period by GAO, you had 31 percent that had increasing levels of significant problems, and now you have three-quarters of the States since the year 2000 showing reduced problems.

But, still, we had five States around the country even in the most recent period that had a 5 percent increase in significant health care problems.

Again, the trends are correcting, but it varies by State. It varies all over the board, and we still have a lot of work to do.

GAO pointed out we could do the surveys better, we could clearly correlate—and we are trying to—the Federal surveys with the State surveys better.

Again, Bill mentioned in his testimony that in the previous period we found, when we checked on State surveys, that 34 percent of them, when they essentially reported a clean bill of health, actually had significant deficiencies. In the last period, that was down to 22 percent. Obviously, 22 percent wrong is not good, but it is an improvement over the previous period.

GAO made a lot of very legitimate criticisms, and I think a lot of very constructive suggestions. I will just point out four that we are in the process of working on.

One, is more rigorous surveys and methodology. We are on the way with a contract to do that. We hope we are going to have a more rigorous survey process prepared soon.

Second, is require the State quality assurance process to review lower levels of harm. We are in the process of doing that right now. We have a new data system, the ASPEN enforcement model, to detect trends in that area.

Third, is to finalize guidelines for State investigative processes. We agree, and again we are using something called the ASPEN Complaints Tracking System to standardize, correct, and improve our analysis of complaints.

Fourth, was to refine the actual State performance reviews to identify problems, analyze trends, and try to differentiate between serious problems and less serious problems. That is done.

We actually have a comparative result of the States. We are ready to brief the committee staff on that whenever they are ready, I think, in the next week. If the Chairman and the committee think it is appropriate, we are likely to put that out to the public shortly thereafter.

Again, we have a long way to go, but I think before I got here, under the end of the previous administration when you spent a lot of time focusing on these things, there are a couple of people in CMS—and I will go into a couple of comments as well.

But Steve Pelovitz is behind me, and Charlene Brown, who is out of our Philadelphia region and is now in Baltimore, really took the GAO interest and your interest to heart, and I think four or 5 years ago really started to enhance and turn around CMS's efforts.

We have a long way to go, but I can tell you that there are a lot more people focused in CMS on this issue. Those two individuals—I think the progress we have made, and again, we have a lot more progress to make—are largely responsible for institutionally getting CMS to change its real attitude on this, and I would like to thank them and congratulate them.

We have a long way to go on surveys, and surveys and hands-on review of individual nursing homes is clearly the key to changing nursing home performance.

But I also think, as you know, Secretary Thompson and I are totally committed to public measurements of quality performance and putting those out in the public venue.

Two years ago, we picked on nursing homes first because they had the worst problems, we perceived, and because we also had the best data in our MDS system to analyze nursing homes.

Again, we look at this as a supplement and a complement to the survey process that will basically enhance and improve performance.

Can I go a couple of more minutes, Mr. Chairman?

The CHAIRMAN. Yes, please do. Please proceed.

Mr. SCULLY. All right. I will be quick.

The nursing home quality initiative that we announced 2 years ago, I think, is one of the great successes that Secretary Thompson and I have had at CMS, for a couple of reasons.

When we first started talking to the AFL–CIO, the AARP, the National Consumer Coalition on Nursing Home Reform, which is NCCNHR, a patient group, the National Quality Forum, all of those groups have been involved in quality. The relations between the consumer groups, the unions, and the nursing homes, in my opinion, were not particularly good. They did not talk to each other.

We got them all in a room for about a year, pushed them very hard, at the National Quality Forum to come up with 11 quality performance measures initially in a six-State demonstration, which we rolled out in the spring of 2002. It was not an easy process, but we did come up with the measures.

We did a six-State demonstration, then last fall we rolled out a 50-State demonstration and we put 10 quality measures in every major newspaper in the country. Again, it does not replace surveys, but I think it has really enhanced the focus of nursing homes on improving quality, it has raised the public perception, it has put a lot of pressure on everybody to perform better, which we think quality measurements are all about, and I think it has worked.

If you look at the results from our demonstration program, we found that 88 percent of the nursing homes in the country were aware of it; 52 percent of them asked our Quality Improvement Organizations that we pay for through Medicare for help; 20 percent of those nursing homes are getting intense help on a day-to-day basis from the QIOs.

In fact, for instance in Iowa, 70 individual nursing homes in Iowa were engaged in the QIO to actually come in and review their performance and try to improve it.

Seventy-eight percent of the nursing homes said they changed their policies as a result. We also found the calls about nursing homes through our 1–800 Medicare number doubled in the States in the demonstration.

As a result of that, in the full one in all 50 States, in the last 6 months of the first half of this year we have had six million individual web site hits on our Nursing Home Compare website.

All of those are very positive supplemental developments to give people more information and focus more, both for consumers on defining nursing home quality, and on the nursing homes to put pressure on themselves, their boards, their employees, their nurses, their families to focus on the problems and improve them. So, we think we are making progress, but we obviously have a long way to go.

A couple of other issues I would like to just hit on quickly. I think Bill mentioned, and I attached to my testimony, our CMS report on the finances of nursing homes. We have big problems in nursing homes, and clearly huge quality problems. But they are tied hand in hand to financing. I think we have put out reports in every area.

I hired a couple of former Wall Street analysts. We put out analysis on all areas of health care, because I think it is important for us to know when the financing is adequate or inadequate, and where the problems are.

As a rough matter in Medicare, we do, in fact, overpay Medicare. I think Bill is right, it is a very sloppy, inappropriate way to try to make up for underpayment in Medicaid.

I think I attached to my testimony the various average State payments of Medicaid, and they are all over the board. On average, this year we will pay on a Medicare bed $268 a day; we will pay Medicaid $124 a day. That is up from $95 a day in 1998, so it is a little better.

But the bottom line is, in many States, nursing homes just flat-out are not covering their costs and they are relying on cost shifts from Medicare. I do not like that. I think MEDPAC is correct that we do overpay on Medicare, but I have to look at both programs. As a short-term matter, I am not sure we have a choice.

Nursing home margins are not great. I came out of the hospital sector, as you know. I do not know a lot of people who are nurses or hospital administrators that want to be in the nursing home business.

In the long term, if we are going to improve nursing homes, we have to be predictable, solid government contracting partners to draw quality capital, quality people, and people in it for the long term who are going to be focused on taking care of good patients.

So I think attracting good people who want to be in this business long term is extremely important, and I think making sure that we have consistency in our payment policy is important.

I do not like it any more than you do, Mr. Chairman. We have talked about the cross subsidy from Medicare to Medicaid. But until we can work with the States to make sure that—and some States are paying great rates, but in some States there are clearly problems. Medicare cross subsidy is not the right way to go in the long haul. In the short run, I am not sure we have another option.

A couple of things I would just like to mention quickly as far as alternatives. Long-term care insurance, which you have worked on, and President Bush has a number of proposals to increase that, is critical.

Secretary Thompson has been working aggressively with HUD to try to take on—I believe, one of the problems with pressure on the States and nursing homes is that there are many, many people in nursing homes, which is about a third of the Medicaid program, who are not low income. They are middle income and high income and they transfer their assets to get into a nursing home.

Every time we have a higher income person in a Medicaid bed, that takes away money from a poor person, takes away money from poor women and children in nursing homes, take away money from disabled people. I think we have to find ways around that.

We have 76 percent of seniors who have a paid-off mortgage of more than $100,000 a year. Many of them want to stay home and cannot. Before they look to transfer their assets to their kids and go in the nursing home, I think we need to find ways to give them access to the capital they build up in their houses to pay for home health nurses, to stay at home, and do other things. We are working aggressively on a program in that area.

We do not want to push anybody to do that, but I think many seniors, including my parents, would take that choice if they knew they had an easy way to access the capital they built up in their homes, to stay at home where they want to be and to get better care without being institutionalized. We think that is a great idea.

I do not mean to take credit for that. That was an AARP National Council on Aging idea. We have been working with them a lot. We hope we are going to have something before the end of the summer to roll out with HUD to use that.

Finally, I would mention what I think is a massively under-utilized program, especially for poor people, is the PACE program, which is a terrific program. We have had a very difficult time with States, getting them to sponsor PACE programs.

They are for low-income Medicaid beneficiaries. It gives them day care, home health care, keeps them out of nursing homes, gives them community day care. It is a fabulous program.

I have been in a bunch of them, Secretary Thompson has been in a bunch of them. We have had a very difficult time getting States, because it is a Medicare/Medicaid partnership, to do them.

I would hope the committee would focus on that, because every place I have been they work extremely well. Patients and their families love them. They are good for the Federal Government, they are good for patients, they are good for the State governments.

But for some reason which I have not figured out—I think I am the number-one PACE cheerleader—they have not been sprouting all over the country, and they should be.

But, anyway, Mr. Chairman, we have a long way to go. I am certainly not here to declare victory. I hope we have turned the corner. We are going in the right direction with your strong encouragement. But this is a major public health problem still and we have a lot of work to do. Thank you.

[The prepared statement of Mr. Scully appears in the appendix.]

The CHAIRMAN. Would the staff time me and the rest of us so we can have five-minute rounds?

I want to take off with my first question on the issue that you brought up about reimbursement. I have not talked to you about this, but I have talked to the Secretary about this.

I have talked to Senator Baucus about it, and I think he and I are on the same wavelength. That is in regard to the proposed rulemaking that could result in an additional $7 billion being provided to nursing homes out there.

I have proposed that those funds be directed to hands-on care of nursing home residents. I have suggested in all these years, back when Senator Breaux was Ranking Member and I was on the Aging Committee, that the problem is too much turnover at the nurse's aide or the hands-on type of aides for people in nursing homes.

If we can improve retention, if we can enhance the quality of care there with perhaps more care there, even more personnel, that that is the one thing to dramatically increase the quality of care in nursing homes.

So I guess my question to you is a very direct one. That money should not be given to nursing homes unless it is going to be used to improve the quality of care. Not to put you on the spot, but I hope you agree with me. That is my question to you.

Mr. SCULLY. No. I got your letter, and the Secretary's.

The CHAIRMAN. All right.

Mr. SCULLY. In fact, tomorrow I was going to call you about exactly this issue, so I hope we can get connected. I totally agree with

you. In the current statute, I am not sure I can connect it directly, but I am happy to work with you and your staff to find ways to make sure it works.

As you know, some of the expiring provisions in the old law, which tended to be temporary add-ons, were tied to nursing home staffing and quality. But I totally agree with you. The only reason we are doing this, to be perfectly honest, is my actuaries came to me early in the year. This is similar to what happened with the physician payments. You remember our problem last year.

We update every year on projections, not on real costs. My chief actuary, Rick Foster, came to me early in the year and said, essentially since the beginning of skilled nursing PPS 3 years ago, we have been updating our inflation updates off projections from two years before, not actual, real costs.

Their technical suggestion was that we basically should be updating everybody on our most recent data, not on a projection that is 2 years old, which I think was correct, and Rick convinced me was right. To be honest with you, I never thought OMB would agree. I took it to the Secretary. He thought it was substantively correct. To my amazement, OMB agreed.

It is not just skilled nursing. That is where the biggest differential has been. But because of this, it is a purely technical actual projection, we have underpaid over 3 years because we have been working off projections, not real inflation data, by about 3.26 percent cumulatively over the last 3 years.

The Secretary's suggestion is to fix that. We had a similar problem. We had three new PPS systems that came in after the 1997 bill, home health, outpatient PPS, and skilled nursing facilities. We are going to do the same in all three.

The biggest disparity was by far the nursing homes, and it is a significant amount of money. I think it is $450 million in the first year. I would be more than happy to work with you to come up with some regulations to try to make that incremental change.

But the other thing you mentioned in your letter, which I really want to totally, completely agree with you and focus on publicly, is what goes up can go down. We are making a technical change to change the way we do our inflation updates because we think it is more accurate, but it can very easily end up in a lower update next year and the year after.

It is much more technically accurate, but it may well end up the next year they get a lesser amount. So, it happens to be a temporary improvement and a bump-up this year. It could be less in future years, but it is a much more accurate way to update for inflation than we have been doing.

I think it is the right thing to do for technical, actuarial reasons, and that is why we have done it. But I think the nursing home industry should be on notice that they may be happy that we are fixing this quirk in the system now, but it could very easily go the other way next year and the year after.

The CHAIRMAN. I told the Secretary that I would not be able to support the rule if he would not see that money was directed that way. I have had an opportunity to visit with leaders of the industry and I think I have an understanding with them that the money would be used in that direction.

Mr. SCULLY. Absolutely.

The CHAIRMAN. On another point, in regard to the finding of the General Accounting Office, supported by HHS testimony, information that is being provided to the public regarding the quality of care in nursing homes is understated.

How would you let the public know that fact, and what actions could you take to correct what I consider a critical flaw?

Mr. SCULLY. It is a critical flaw. I think, again, we have a long way to go. I think we have been making significant effort in the last couple of years. Steve Pelovitz is here with us and has spent a lot of time trying to get much more consistent training, standards, and guidelines for State surveyors. These people all work for the States. We pay for the bulk of it, all of it in Medicare and most of it in Medicaid.

The issue is, you have a very subjective survey process. It is one of the reasons that I think our objective quality measures, while not substituting for the survey, will help give consumers more information. Because if you have 50 different State survey agencies with 50 different State sets of guidelines, we need to make them as consistent as we can.

But there are a lot of subjective judgments made when you try to make judgments made on scope, severity, and type of problems. There is always going to be a certain amount of subjective inconsistency.

One of the reasons I like the supplemental benefit of the objective quality standards we have come up with, is the information is much more objective. It is based on MDS data. It is not really left to subjective judgment.

I think if consumers and nursing homes and communities look at these things, they can use both to weigh them. But we have a lot of work to do to make sure that nursing home surveyors in Louisiana, Montana, and Iowa are using the same standards, the same judgments, and are trained the same way. We have made a lot of progress, but we have a long way to go.

The CHAIRMAN. Thank you.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Scully, we all know we have a lot further to go, and there are a lot of things we could do in the margin. In your judgment, what does this really come down to? I mean, just cutting through all the stuff, a lot of people here, lots of statistics, lots of acronyms. I know a lot of them mean a lot, because all of us are working around the edges trying to make something happen.

On the other hand, to some degree, it is kind of working around the edges. We have been at this question for a long time. We hope we are not still dealing with it as seriously in the not-too-distant-future.

That is, hopefully we found some kind of a, not silver bullet because I do not believe in silver bullets, but at least something so that we are not still addressing this, perhaps, wrapped around the axle.

What does it come down to to get the kind of quality care in homes? It does not have to be perfect, but good quality care in nursing homes. What does it come down to?

Mr. SCULLY. Well, we could spend hours on that, and I think we should.

Senator BAUCUS. No, just answer my question. Not hours.

Mr. SCULLY. Yes.

Senator BAUCUS. But in a couple sentences, what does it come down to?

Mr. SCULLY. Well, I think the first thing we need to do is focus on giving people options not to be in nursing homes, as the Chairman said. I think there are a lot of ways we can do that.

Senator BAUCUS. All right.

What else?

Mr. SCULLY. A lot of people are going to be in nursing homes, and I think we really need to come up with a lot more State consistency. States are under a lot of budget pressure.

Senator BAUCUS. State consistency.

What else?

Mr. SCULLY. To be honest, we spend, I think, $258 million a year on surveys. We discussed before, my administrative budget is $2.7 billion. My entitlement budget is over $600 billion. We tend to be very focused on the appropriations side of how you spend money. A $4 or 5 million change in my appropriated side of the budget is huge.

We make estimates of $2 to 3 billion a week sometimes in one direction on the entitlement side. So my point is, on the Medicare/Medicaid side, the money changes are huge, hundreds of millions of dollars and billions of dollars daily, and no one cares.

But when you are looking at what has basically been a flat survey and certification budget for the last six, 7 years, I think it is $258 million a year, which pays for the bulk of this, it has been flat. On the appropriations side, it is very, very hard to do that.

So my own view—and this probably would not have gotten through OMB clearance, is my guess—if you really wanted to look at it——

Senator BAUCUS. That is what I am asking, your own view.

Mr. SCULLY. Is that probably you should somehow tie the survey and certification both for Medicare and Medicaid, because they really are fundamental to the programs back into this committee's jurisdiction, because the reality is, when it is competing for resources on the Medicaid and Medicare side and appropriations, it is very hard to make big changes.

If you really want to make a big change in Medicaid quality or Medicare quality—I think you would save money, too. It is not cheap when you make mistakes. I mean, it is penny wise and pound foolish. If you are making mistakes and causing a lot of complications in hospitals and nursing homes, it costs the programs money. It is obviously not good for patients.

So I think to some degree the way we look at the funding for fraud and abuse is coming out of Medicare and Medicaid, which is the integrity program, it might be wise to start looking at survey and certification and some of the other fundamental programs that are really integral to Medicare and Medicaid, and as part of Medicaid and Medicare operations, not as part of appropriations, because the appropriations pot is very tough.

Again, I am former OMB. I am cheap and I do not like spending more money. But I think——

Senator BAUCUS. That Wall Street Journal pointed that out.

Mr. SCULLY. Yes, I am a cheap guy. But I am also worried about the fact that you cannot make big change if you do not make some investment.

Senator BAUCUS. That is right.

On another matter, as you know, we have a big, difficult issue ahead of us, and that is prescription drug benefits in conference. And there are strongly-held views on both sides, whether it is premium support, or fallback, or whatnot.

As you also know, Tom, major social legislation with major consequence, historically, has passed with a large vote, whether it is the Social Security Act, Medicare, Medicaid, the Civil Rights Act, and so forth.

I believe, and I hope the administration believes, that the only way we are going to get good, solid prescription drug benefits passed is if we were to get a strong bipartisan result.

That is, not try to push ideologically one side or the other, but just get a good, balanced compromise here, and therefore get a good vote, somewhat similar to the Senate solution and the Senate vote.

I know the administration agrees with me. I would just like to hear it from you that that is the administration's approach.

Mr. SCULLY. According to the paper yesterday, I am not quite ready to be fired yet, so I do not want to improve those chances any today. But we would not be here with——

Senator BAUCUS. The paper said you have great support.

Mr. SCULLY. I hope so.

Senator BAUCUS. The Secretary.

Mr. SCULLY. The Secretary and I are great friends and get along great.

We would not be here without you and Senator Breaux. There is no question about that. So, first, you are to be congratulated on your efforts. I have said many times publicly, 2 months ago I thought the odds of this are 1 in 4. They are a lot better than that because of the progress you have made.

I do not think it is productive for the administration to take sides between the House and Senate, and I do not think we will. The President has been very clear, including a number of times this week, that he wants to get a bill. I think we will get one done.

My own personal view, having been through a number of conferences that I think were further apart than this, including child care 10 years ago that Senator Breaux was involved in, people tend to jump in trenches and take positions on one-liners that do not always represent the substance.

In this case, my own view—and I have said this a lot this week—is that the rhetoric is probably worse than the substance. And rather than getting locked into what is in the House bill and the Senate bill, I think we need to look at some ways to get out of the existing trenches and work them out.

Senator BAUCUS. I am not asking the administration or you to take sides on one bill over the other. But I am asking, is it true that the administration wants a strong bipartisan bill?

Mr. SCULLY. Absolutely. The administration wants to get a bill done, and the President wants to be strongly supportive. You cannot legislate in Medicare or in any other social policy without a lot of strong, international support.

Senator BAUCUS. Strong bipartisan support.

Mr. SCULLY. But I also think, as Senator Breaux knows, we did not put premium support in our bill for reasons, obviously. But it used to be called Breaux-Frist. There are reasons why Senator Breaux and Senator Frist like it. Academically, it has a lot of merit.

But I think that we would really like to sit down and talk to them about the details of the substance before people get locked into things. I personally think, Senator, that we can work all these things out.

Senator BAUCUS. Can I get you to say you want strong bipartisan support? Can I get you to say that? Do you agree with that?

Mr. SCULLY. Yes. Absolutely.

Senator BAUCUS. That is great. Thank you very much.

Mr. SCULLY. As I said, bipartisan means a lot of people. Again, Senator Grassley left the room, but Chairman Grassley, you, and Senator Breaux should be congratulated. We have said publicly many times that we would not be here talking about a conference if it was not for your efforts, and we are very grateful for that.

Senator BAUCUS. Thank you. Thank you.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman.

I thank Tom for, as usual, eloquent testimony. Of course, bipartisanship means more than just a one-vote margin in the House and a one-vote margin in the Senate. It means a big number, is what we are going to try and get.

Because I tell you, a big number is going to be easier to get than a small number, because a small number may not be possible. What I mean by that, if we bring back a bill that people would say, well, we will get a one-vote margin in the Senate, that one-vote margin will not be able to be achieved. It will be easier to get 60 votes in the Senate than it will be to get 51.

You heard, Tom, I had mentioned while you were in the audience about the Elder Justice Act. It seems to me that what we are trying to do in that legislation—and I know that is not the topic of this hearing—it really helps address some of the concerns that Mr. Scanlon and you have expressed about the ability to get accurate information on the quality in our nursing homes.

I point out on a regular basis that we in the Federal Government have paid a great deal of attention to child abuse and to crimes against women. We have people in the Federal Government working specifically on those areas.

Yet, through our work in the Aging Committee and in other forums, we have not really been able to find a single Federal employee whose full-time work is geared towards looking after older Americans from a justice standpoint like we do with child abuse and crimes against women.

It seems to me that what we are trying to construct in the Elder Justice Act is a plan within the Federal Government to be able to find ways to increase collaboration between the various agencies,

State, Federal and local, to be able to enhance detection, which is incredibly important to improving prevention and intervention with our Nation's seniors who are being abused, and also to help in the area of prosecution.

Perhaps the administration, I take it, has not taken a position. Any personal thoughts about the direction we are trying to head in this? Is something like this positive or is it not needed? Can it be helpful? Do you have any general comments about it?

Mr. SCULLY. I do not think the administration has taken a position on it. I just looked at it last night. But I think everything you are trying to do, obviously, makes, to me, a lot of sense. I cannot make up an administration position here, but it certainly seems consistent to me.

And my guess would be, given how popular it is with all the other conferees, including the President, that this is probably something that could somehow be done this year, potentially, something along these lines.

Senator BREAUX. I appreciate that.

Did Dr. Scanlon say something—maybe, Bill, you can tell me about the differentials and the reimbursements among the various nursing homes under the Medicaid program versus Medicare. Tom, can you comment on that?

Mr. SCULLY. Yes. In fact, I think I attached the most recent State-by-State nursing home payment to my testimony. But it is about $124 a day this year, on average, for 2002, for Medicaid; it was about $268 for Medicare.

But, for example, in Louisiana——

Senator BREAUX. Yes. We are way at the bottom. What is it?

Mr. SCULLY. Yes. Last year it was $82.90 a day.

Senator BREAUX. How is that fee to the nursing homes calculated? What they will tell me in my State, with a reimbursement rate that is about half of the national average, is look, Senator, we would like to do more in prevention and hire better people, but with an $80 reimbursement rate we are not able to do that.

So do you know how we calculate? We calculate it in Washington. There is this huge differential. The question is, why? Is that supposed to reflect less cost of doing business in my State than the average in the country? How do we get that number?

Mr. SCULLY. No. It is a matching system. We pay our share and the State sets the rates.

Senator BREAUX. So the State is principally responsible for picking the rate, and then we just match it.

Mr. SCULLY. Totally responsible.

Senator BREAUX. So it is really a State decision.

Mr. SCULLY. State decision. We pay our matching rate.

Senator BREAUX. If Louisiana could come up with $100, then the Federal Government would match that?

Mr. SCULLY. Yes. For the $82.92 a day in Louisiana, I think the match is 74 percent, 40 percent federal, or something.

Senator BREAUX. Probably a 70/30 match.

Mr. SCULLY. If they came up and decided to pay more, we would pay our 70 whatever percent. Whatever their rate is, we match our percentage. But Louisiana is one of the lowest in the country.

Senator BREAUX. Yes. Well, I appreciate your testimony. I appreciate your work, too. Thank you. You are doing a terrific job.

Mr. SCULLY. Thank you.

The CHAIRMAN. I am going to have to submit a couple of questions for answer in writing because of the fact that we have to go on to the next panel now. We are kind of running out of time.

Thank you, Tom.

Mr. SCULLY. Thank you, Mr. Chairman. Thank you, Senators.

The CHAIRMAN. On the next panel we only have one person to come. We had anticipated Catherine Hawes, Professor, Department of Health Policy and Management at the School of Rural and Public Health, Texas A&M University to be with us, but she was hospitalized just very recently so she will not be able to come.

So it is my privilege then to call only our last witness. That is Mary Ousley, who is here on behalf of the American Health Care Association and Sun Bridge Health Care Center.

Ms. Ousley, I thank you very much for traveling to Washington to be with us. I know you have come from the State of New Mexico.

STATEMENT OF MARY OUSLEY, CHAIR, AMERICAN HEALTH CARE ASSOCIATION, SUN BRIDGE HEALTH CARE CENTER, ALBUQUERQUE, NM

Ms. OUSLEY. Yes, sir. Mr. Chairman and members of the committee, I appreciate the opportunity to be with you today.

I have been in this profession for almost three decades, having served as a registered nurse, a nursing home administrator, and now a senior executive. I must say that the stories that we have heard today, for someone who has devoted my career to caring for the elderly, are most disturbing.

The GAO report that is the subject of today's hearing finds nearly a 30 percent reduction in actual harm deficiencies in the last 18 months. I believe these results demonstrate actual quality improvement, but the GAO concludes that it may be due to an understatement of deficiencies.

Quite honestly, I do not know which one of us is correct. This points to a central problem in today's survey process, that it cannot distinguish between an oversight problem and quality improvement.

This does not mean that we view the survey process as irrelevant. We do not. The survey process is necessary and it is extremely important. The information that the process generates is used by many to define quality, but in reality it forms only one part of the picture.

We believe the indicator of quality is not deficiency rates, but patient outcomes and patient satisfaction. The way to achieve sustainable improvement in outcomes of care is through quality improvement programs.

We view quality improvement as an internal process, not an external process. Regulatory efforts are extremely important, but they will not lead to sustained improvements in quality because changes in culture, caregiving, and patient outcomes must come from a facility's own internal processes.

Yet, improving the accuracy and the consistency of the survey process and encouraging facilities to implement quality improvement programs are not mutually exclusive, they are compatible.

Quality improvement and associated systems must be resident centered. They must be based on solid policies and procedures and care protocols. It is through these systems that we can get widespread and sustained change in care delivery in our Nation's nursing homes.

Logically, this will result in fewer deficiencies and better compliance. I have had many experiences with quality improvement during my career, and most recently in taking over as new management of a company in Chapter 11 in mid-2001.

This company was more than challenged with its inability to achieve and sustain compliance. We implemented a comprehensive quality improvement program with new policies, new procedures, and care protocols. We have made steady progress during that period of time in improving clinical outcomes and, yes, in improving our survey results.

In my written testimony I have gone into some detail about how the profession, both independently and in partnership with HHS, is approaching quality measurement and improvement, and I just want to touch on a couple of points.

Secretary Thompson and Administrator Scully are to be commended for their commitment to quality and the implementation of the National Nursing Home Quality Initiative. It involves expert collaboration and public disclosure of outcomes of care.

The quality initiative, working with Quality Improvement Organizations, and the organizations working with individual facilities to implement quality improvement programs are absolutely the key to success.

Already we are hearing States reporting—Iowa being one, Florida being another—significant improvement in clinical outcomes for patients in these facilities that are working with the QIOs.

The principals embodied in the quality initiative are solid. I have seen them work throughout my career. They are principles that are proven effective in improving care, regardless of the measurement system one uses to look a them.

Equally important is the second and voluntary effort announced last year by our nursing home profession, the entire profession, Quality First. It is a profession-led program designed to advance quality of care. It builds on the National Nursing Home Quality Initiative. It also involves public reporting.

It will have a national commission of respected experts outside the profession to evaluate the quality and make recommendations on initiatives to improve quality.

Today, there is a much broader recognition of the importance of quality and a broader commitment to work to improve it. We, as providers, know that we must lead in increasing trust and customer satisfaction.

The Nursing Home Quality Initiative and Quality First are two innovative programs that I believe have the potential of taking nursing home quality where we all want it to be.

But of course, as many have said today, to be truly effective our profession needs economic and workforce stability that the government has a vital role in providing.

We have seen the devastating results with the cuts of BBA and the positive impact of the relief provided in BBRA. We must modulate this see-saw and provide adequate funding so that we can all continue to focus on quality.

I would like to conclude, sir, by saying that I am extremely proud of what I do every day, and I am very proud of the over one million caregivers that get up every morning and walk into the nursing homes in this Nation, and touch the hands and provide the care of those individuals that need it. I am proud to represent them in front of you and this committee today. Thank you.

[The prepared statement of Ms. Ousley appears in the appendix.]

The CHAIRMAN. We thank you very much for your testimony. We appreciate very much your devotion to your duty, and probably speaking for a vast majority of the people that administer, as well as work in nursing homes.

I have never found anybody in my State of Iowa that was not sincerely devoted to the work that they do in the many nursing homes that I visited in my State. So, I think I can sense that among people in my State.

I have one question. This is something you touched on, so I am just asking you maybe to repeat and be a little more specific. This is from officials of the association who were recently quoted as stating that "the association is seeking a review system that moves away from the current method of nursing home surveys to one that measures clinical outcomes."

I believe that the current system uses clinical outcomes as a focal point for review, so how would the association's proposed system differ?

Ms. OUSLEY. Well, sir, as I said, we do very much continue to support the survey system. The survey system does need to continue to improve, as Administrator Scully said. But we do not envision that the survey system is going to go away.

We do believe that Quality First, set forth on this platform of continuous quality improvement, are really taking all of the requirements of participation and making it a customer-focused, resident-centered, can improve the processes that are going on in facilities every single day so that we do not have to worry about a survey.

It is just what we do every day. We do it for the customers that we serve. That is the way we need to manage our facilities, and that needs to be the philosophy, that we all drive better and improved care.

That is how we envision Quality First working, being on a continuous quality improvement platform, but also working with, again, the outside experts, the national commission that can look at the outcomes and evaluate and analyze, are these the right things that are happening, and work with us to set new standards and greater expectations.

The CHAIRMAN. Senator Breaux?

Senator BREAUX. Well, thank you very much, Ms. Ousley, again, for traveling all the way to Washington to be with us.

You have said it very eloquently as far as what your industry does every day and every night, 24 hours a day, 7 days a week. Without your industry, I am not sure where we would be for the literally thousands of Americans who need that 24-hour a day, 7-day a week care.

It is not easy. It is very difficult treating the most vulnerable of our fellow citizens among us who are generally the oldest and, in many cases, the sickest. That is not an easy job, whether you are an administrator or whether you are right at the bottom of the chain of authority in a nursing home. It is very difficult work, and extremely important work. Thank goodness for your industry being there.

Like any other industry, there is always going to be some bad actors. Of course, the whole idea of the committee, CMS, and GAO is to make sure that the good players are not damaged by the bad players and to make sure that they are treated accordingly and action is taken against them.

That is the whole purpose of what we are trying to do. I think that there are improvements. Things are encouraging. There is still more room for improvement, as there is in everything. But I just wanted to say thanks for putting a positive face on the industry you represent. Thank you.

The CHAIRMAN. I want to say a few things here at the closing before we adjourn. But, first of all, I need to thank you and the other witnesses for coming long distances and telling your points of view. It is very necessary for the process that we go through.

Once again, I think it is important, first and foremost, to make sure that there is continued and sustained Federal and State effort to follow through and address the problems that we have heard about today.

I know I say probably at every hearing on this subject, we have to be diligent, not only with the money, but to make sure the money is spent wisely. That is where the leadership is so important.

I have made it clear, as I stated to Mr. Scully, when I said to Secretary Thompson that if nursing homes are going to receive roughly $7 billion more through changes in formula, I expect them to use the money to improve patient care. That means not using the money to increase profits.

More money should result in better care. Coming out of this hearing, I will see to it that we have a plan of action to address those problems. That plan of action will include continued efforts to oversee the administration's implementation of initiatives to improve quality.

As a general matter, I want to monitoring nursing home quality aggressively by continuing to work with the General Accounting Office and the IG of HHS. In addition, my Finance Committee staff will continue their independent investigations.

Previously, I have said CMS must also maintain its efforts to fully and effectively implement recommendations made by the General Accounting Office.I am going to demand a time line from CMS and see to it that we move forward to make necessary improvements.

I am also going to formally request that the General Accounting Office design a survey instrument so that we get on top of this under-reporting problem. We need to ask probing questions of current and past surveyors to get to the bottom of that issue.

We rely on survey information too much, and it is too important to allow misleading information to get into consumers' hands so that they cannot make a good judgment on where to place one of their loved ones.

CMS should also take every available step to ensure that the information on its website is valid, reliable, and accurate.

To accomplish that goal, I believe CMS should eliminate inconsistencies in the survey process. With respect to MDS data, CMS must be more aggressive to ensure that self-reported information is accurate.

In light of the apparent problems in the survey process, I want to request the General Accounting Office to look into adequacies of Federal funding for State surveys and certification activities, not just for nursing homes, but other providers such as home health care.

In addition, the testimony of Ms. Hodgson raises some serious questions that need to be investigated. As I mentioned, I think the IG of HHS needs to get involved in these types of tragic deaths that seem to go under everyone's radar screen.

I think it is important, too, that where nursing homes are found to have a pattern of harming residents, CMS must ensure that State survey agencies refer those cases for immediate sanctions. This type of critical reporting failure on the State level is simply unacceptable and CMS must address that.

Finally, CMS must reexamine its resident assessment procedures to ensure that residents receive reliable assessments and corresponding care plans where appropriate, and take action to carry out those plans.

I know that is quite a list, and by no means a complete list. We have problems, even considering improvements, that we have to work on. I am aware, however, that every step, no matter how small, will help get us towards the goal of better quality of care for our frail and vulnerable.

I want to note that the hearing record will remain open for 3 weeks for further comments and questions. So if you or anybody else on other panels get questions in writing, we would appreciate responses in writing, because so many members had other obligations and could not be here.

Thank you all very much.

[The prepared statement of Dr. Hawes appears in the appendix.]

The CHAIRMAN. The meeting is adjourned.

[Whereupon, at 12:15 p.m., the hearing was concluded.]

APPENDIX

TESTIMONY OF SHEILA E. ALBORES

THURSDAY, JULY 17, 2003

U.S. SENATE, COMMITTEE ON FINANCE
Washington, DC
Room 215, Dirksen Senate Office Building

I would like to start by thanking Senator Grassley and the members of the Finance Committee for the opportunity to share my family's experience with a nursing home and the quality of care provided to my mother.

On April 9, 2001, my mother, Ana Carrasco, went into a hospital ER due to several reasons. My mother Ana was 57 years old and went into the hospital because she was having difficulty breathing. Her condition was critical and guarded. She was admitted to the intensive care unit and was placed on a ventilator. She needed a tracheotomy tube placed for breathing. Her condition gradually improved and she was able to breathe on her own. She had head and neck cancer that was treated with chemotherapy and radiation just 2 years before. Tests were done and my family received the best possible news. No cancer! Her voice box was damaged from the anti-cancer treatments, but the doctors could do something in the future. My mother first needed to regain her strength and a course of short-term rehabilitation was recommended.

The social worker from the hospital spoke to me and my family and recommended, along with attending physicians at the hospital, that my mother be placed in a short-term facility for instructions on how to change and clean her tracheotomy. The social worker recommended a few facilities nearby. We chose the closest to my home. The social worker made the arrangements with the director of the facility for my mother's transfer with tracheotomy care instructions.

On Thursday, April 26, 2001, my mother was released at approximately 1:30 p.m. from the hospital en route to the rehabilitation/nursing home. She was transferred to the nursing home after spending 25 days in the hospital. She arrived at approximately 2:00 p.m. Her treatment plan included physical therapy and she was to then go to my home with services. That same day, my husband and I were moving my mother's belongings from her home to my home, for she would be staying with us temporarily. My husband and I arrived at the nursing home approximately at 8:00 pm after we were finished with the move.

My mother, Ana was admitted to Room 104a. When we arrived, I observed my mom was just lying in a bed and no oxygen was hooked up, which was supposed to have been taken care of. She had a G-tube and was supposed to be receiving supplemental feedings through her G-tube. Nothing had been taken care of. She was just lying there. My mother told me she had been placed in the room by the ambulance technicians, and nothing further had been done for her since her arrival six hours prior. She was visibly upset and pleaded with me to take her out of the facility. She told me she thought she was going to a facility for rehabilitation, and now she was placed in a room with an

elderly patient with many needs that were unmet. A poor elderly women in my mother's room had bedsores all over her side.

My mother Ana was visibly nervous because she had just arrived from a hospital where she had made such an improvement in her health and didn't want to worsen her condition. I summoned the head nurse on duty, and had asked for her assistance several times before she finally came. I expressed my outrage and concern for my mother's care. My husband, my four-year-old daughter and I were there until 11:00 p.m. Instructing the nurse on everything my mother needed. All my mother's instructions were written and sent over with her, so the nurse should have known what was needed for here care. However, the nurse on duty said she had started her shift after my mother arrived and assumed my mother's needs had been met by the previous nurse. However, nothing had been done. Finally, when I had gotten my mother, Ana, semi-comfortable, I called my sister in California because it was her birthday and my mother wanted to speak with her.

I explained my mother's needs and her medication requirements to the staff. I was assured by the head nurse that she and the staff would take care of my mother's needs and that I should take my complaints up with the Director of the facility the next day when she was at work.

The following morning, I arrived at approximately 8:30 a.m. And was told by the receptionist to take a seat because the Director was in a meeting and would see me when she was done. Shortly after, I was summoned into the Director's office. The social worker of the facility was also there. They were discussing my mother's needs and the problems during her admittance.

I told them that I was outraged at the care given to my mother and wanted her released immediately. I had been given a list of other facilities in the area and wanted to have my mother transferred. Since I was already working on having my mother moved to my home with in-home nurses and other necessary help, the Director assured me that this was not an everyday occurrence and that moving her to another facility would just traumatize and upset my mother even more. I expressed my mother's fears of being placed in a home and again both the Director and the social worker assured me that extra care was going to be taken with the handling of my mother.

They assured me they were going to summon the resident physician for a complete evaluation. Her therapy would start immediately, and they asked me to please give them a week to work with her and her therapy. I responded, "Today is Friday. I am going to call a home health agency my mother is already using and ask them to have my home set up with the necessary equipment to care for my mother at home. You have the weekend for me to see any type of improvement. If by then, my mother, Ana and I are not satisfied with the care and therapy she should be receiving, I want a referral made for her immediate release to my home."

The social worker seemed compassionate and accompanied me to speak with my mother and try to calm her. She also took all the information for the home health agency for

future transfer. We went to see my mother and the social worker apologized for the previous night and told her that her care would be handled differently from that point on.

I came back later that afternoon. My mother's medication was supposed to have been given at approximately 4:00 p.m. She still had not received her medication and again I complained to the nurse who told me she was very busy and had not had a chance to get to her. I stayed until she received her medication and was comfortable.

On Friday, April 27, 2001 I spoke to the attending physician. I explained to him the account of my mother's first day, the meeting with the director, social worker, and head nurse. Even after all those discussions and meetings, my mother's care had not improved. Nothing had changed. He said he understood, spoke to my mother, put in orders for her medications and said therapy was not to start on the weekend, but because all that had happened, she would receive therapy Saturday and Sunday. He had no explanation as to the lack of proper care for my mother at that point.

On Saturday, April 28, 2001, when I arrived, my mother was complaining that she was warm and perspiring. She requested that her room be a little cooler. They said it could not be. I noticed the thermostat on the wall and turned it down myself. My mother also asked if she could be bathed since she had not received a bath since her arrival on Thursday. We were informed that they were short staffed and she would be put on a bath schedule and she wasn't due for one yet. My mother then asked if she could have some cold wet rags so I could wipe her down. I was told she couldn't have those. So I took some small washcloths I found on a cart sitting in the hallway and did it myself. I did that along with some other grooming my mother had asked for. She also complained of severe nausea. I asked that she be given Prevocid, a medication to help control nausea, which was also on her chart. Without this medication she could become very ill and vomit. I strongly urged the nurse's staff to please get that medication to her because considering she had a tracheotomy, vomiting was not an option for her. They assured me they would contact the attending physician and get it to her. In the meantime, they felt the over the counter medication Pepcid would do the same for her. The nurse told me to leave and they would take care of the situation. I only did so because my uncle was coming to visit my mother.

When my uncle arrived, he also observed that my mother Ana was in a state of panic. She again complained of nausea and excessive heat. She told him that I had requested that she be given a medication to help combat the nausea and still had not received anything. Her room was also very warm. He left and went to the closet store and brought her back and portable fan and Chapstick because her lips were extremely dry and chapped. As he left the facility, he called me from his cell phone to tell me how mortified he was with the condition of her care. He also stated that he was there for over and hour and no one had come by to check on her. I called the facility around 8:45 p.m. and asked to speak to my mother and was told I could not because she had vomited. They told me they had given her Pepcid and that she was doing much better. I waited about a half an hour and called again to speak to my mother, Ana Carrasco. I was paying for her to have a phone in her room but the phone never worked. Whenever I

would call to speak with her, the staff would have to find another phone and bring in it to her. My mother at this point was so upset because she had vomited and was concerned about the tracheotomy. She was very nervous and was very warm. I tried to calm her down and said I would be there first thing in the morning. Again, she confirmed they did not give her the medication that was requested and prescribed Prevocid.

When I arrived on Sunday afternoon, my mother, Ana seemed extremely agitated and again was very warm to the touch. Her room again was very warm. Once again, I asked that the temperature in her room be made cooler. When it was not, I myself turned the thermometer down. My mother again asked me to get some cool washcloths to cool her down because she again was not given a bath. She also had not received therapy that day. In addition, she complained of not being able to breathe well. She begged me to take her out of the facility; she did not want to spend another moment there. I told her first thing in the morning I would speak to the social worker of the facility to prepare the transfer papers. Again I noticed her medication had not been given to her on schedule and pleaded with the nurses and staff to assist her and try to make her comfortable. I also told them she was extremely nervous and had been for the last couple of days. She had a prescription to help her with panic/anxiety attacks. For an hour the nurse and I went back and forth trying to get this medication for her. While this was going on, my husband was sitting next to the nurse's station and overheard the head nurse say "I don't need this bullshit. I am a registered nurse and shouldn't have to deal with these patients' relatives." She had no idea my husband overheard her comment.

Finally, the nurse got an Ativan, crushed it and put it in a small cup of applesauce. Together we went to my mother's room. I watched as she instructed my mother to swallow the sauce with the crushed medication in it. My mother and I both told her that she never swallowed her meds but they were always administered through her G-tube. The nurse said to try and swallow it because it would get absorbed into her system quicker this way. In desperation to feel better, my mother did as told.

On Monday morning I called and spoke to the social worker of the nursing home and informed her I wanted my mother transferred out of the facility immediately. I was told that my mother could not be released to me but to another facility or agency. I then gave the social worker all the information to the at-home health agency that my mother was already using, and asked that the process for transfer begin ASAP. We spoke at least five times on that Monday regarding her transfer out of the nursing home to my home with the assistance of the home health agency and about my request for necessities to help care for my mother.

I went to see my mother, Ana again that evening accompanied by my husband and my daughter. My mother seemed greatly distressed. She was clammy and she was very warm, extremely nervous; and at this point, she said she was just plain scared. I told her that this would be her last night there and that she would be leaving the nursing home tomorrow and coming to my home. I told her that I had already spoken to the home health agency and already had her hospital bed, oxygen tanks, portable commode, and other equipment to assist her arriving the next morning. She begged me to take her out at

that moment, but the equipment could not be set up until the next day. I said, "just hang in there one more night."

The next morning I was busy speaking to the home health agency. They called to confirm our appointment for that day and that they were sending a nurse and a technician to set up oxygen and give breathing treatments to my mother. I called the nursing home to speak to my mom to let her know everything was ready for her arrival and if there was anything else she needed for her stay with me. When I called the nursing home I was first told she was not in her room. I asked where she was and was told by whomever answered the phone that she might be in therapy. I then informed this person she was not due for therapy because she was being transferred that day. I was put on hold several times until a nurse came on the phone to inform me that my mother was transferred to a nearby hospital with no further explanation. I then told the nurse she must have been mistaken and that I would be on my way to clear up any misunderstandings. The nurse told me not to come to the nursing home but that I should go to the hospital because there had been a problem with my mother. She then went on to tell me that some time early that morning she was making her rounds when she passed my mother's room and observed she was using the commode so the nurse continued on to the next patient. A nurse's aid summoned her back to my mother's room and told her" your patient doesn't look well." That is when the nurse said she observed that my mother Ana was seizing and laid back and was unresponsive. They said they started CPR, called the doctor, then called paramedics and my mother was then taken to a nearby hospital. I never received any calls from the nursing prior to this to inform me of what happened. My mother lay in the emergency room for hours while I thought she was being prepared for her transfer. By the time I arrived at the emergency room, it was too late. I was told my mother was unresponsive.

Instead of going home, my mother died. From the time of her admission till the time she was brought to the hospital by the paramedics on May 1, 2002; the nursing home let Ana & my family down. They didn't provide her with the treatment and services she was sent to the nursing home to receive. Ana didn't get her medicines; she didn't receive therapy, didn't receive the necessary services to keep her tracheotomy tube functioning properly, shed didn't even receive a bath. This happened despite my vigilance; my constant calls, my visits to the home, my begging and pleading. It all fell on deaf ears.

Members of the Committee, I again would like to thank you for the opportunity to tell about my family's unfortunate ordeal to help you understand the great need for better health care in nursing homes today. I conclude today's testimony with this statement; My mother, Ana Carrasco, was fifty-seven years old, able to voice her complaints and concerns, and had the support of family by her side at the nursing home, and yet still faced a fatal end. If this could happen to my mother, I ask who is watching those patients who are not able to voice their complaints or do not have relatives for support. What does fate hold for them?

PREPARED STATEMENT OF HON. MAX BAUCUS

Thank you, Chairman Grassley. I want to recognize your persistent efforts to improve the health and quality of life of elderly and disabled citizens who reside in our nation's nursing homes. You have been an outspoken advocate for their interests, and I applaud you for your leadershiin this area. I also want to recognize my colleague, Senator Bond, and thank him for testifying today.

This hearing is an important follow up to a hearing we held in the Finance Committee last year on "Elder Justice." That hearing focused on the prevalence of elder abuse and neglect across our society, and on the lack of coordinated programs to respond to the abuse crisis.

Shortly after the hearing, Senator Breaux, Senator Hatch and I announced the introduction of S. 333, the Elder Justice Act. The bill addresses elder abuse and neglect in all of its forms, including when it takes place in nursing homes. It improves identification of abuse and enforcement when abuse occurs. And it attempts to address root causes. One feature of the bill I particularly appreciate is its use of grants and other incentives to increase staffing in nursing homes. Many experts agree that nursing home quality and staffing rates are closely linked. I am pleased that this Committee is continuing to scrutinize the programs and institutions that serve our elderly and disabled citizens, and I hope that we will someday mark up and pass the Elder Justice Act.

Today, we will focus on a specific element of "Elder Justice"—the quality of care received in our nation's nursing homes. To be sure, we will hear some horror stories. Our hearts go out to these victims and their families. We will hear about unscrupulous or careless people who did not take care of our most vulnerable citizens. But we will also hear about bright spots where innovation and hard work have resulted in quality improvements.

I hope that all of our witnesses today agree on one thing: the systems that we use today to measure quality in nursing homes are not working the way they should. State surveyors vary so much across states that the statistics they report can hardly be trusted. The GAO will tell us that the numbers may underreport serious harms faced by nursing home residents. Nursing home administrators often tell me that the numbers overstate tiny problems, like a broom out of place in a nursing home.

If we want to make improvements, we must understand the problems. And our assessment system does not work. CMS has not provided adequate guidance or oversight to ensure consistency in nursing home surveys. In fact, the need for guidance in this area is so great that the Montana legislature recently passed a law asking Montana's Department of Public Health and Human Services to define the very terms that surveyors rely on when they do nursing home inspections. The legislature, lacking any federal guidance, asked the agency to explain what "actual harm" means. And what "unavoidable" means.

Of course, a different state agency might reach a very different conclusion from Montana. How are we, or CMS, or consumers supposed to interpret quality information when we can't even agree on the meaning of common terms? With so much uncertainty about what survey results mean, it is almost impossible for consumers to use information on websites like CMS's "Nursing Home Compare." We find ourselves awash in numbers and terms like "deficiencies" and "immediate jeopardy," but the bottom line is that we can't really tell what's going on in our nursing homes. And that means that we can't tell where to focus our efforts and enforcement.

Federal oversight of the survey process is weak. Recently, CMS has put a great deal of effort and money into a new initiative that relies on competition between nursing homes to improve overall quality. I support the idea of competition and transparency. But this effort cannot come at the expense of improving the survey process. Competition works only when consumers have real choices. In rural areas, where there are very few nursing homes covering a very large area, consumers don't have many choices if they want to live near their loved ones. So we must still rely on nursing home surveys to ensure minimum levels of quality.

I am sure that everyone in this room could agree that nursing home quality could be improved with a more effective oversight system. But we should also admit that things could be worse. The Administration's recent proposal to block grant the Medicaid program would give states the option to take a capped grant for Medicaid in exchange for eliminating virtually all federal oversight in the Medicaid program. States would have complete flexibility to monitor nursing home quality—or not, if state budget pressures were too tough. I am concerned that such a proposal would leave our most vulnerable nursing home residents at great risk.

So thank you, Mr. Chairman, for holding this hearing. Nothing is more important than the security of our people, particularly those who are vulnerable. I look forward to hearing from all of our witnesses.

NURSING HOME QUALITY REVISISTED: THE GOOD, THE BAD, AND THE UGLY

THURSDAY, JULY 17, 2003

U.S. SENATE, COMMITTEE ON FINANCE
Washington, DC
Room 215, Dirksen Senate Office Building

TESTIMONY OF SENATOR KIT BOND

Chairman Grassley, Ranking Member Baucus thank you for the invitation to be here today. I appreciate your tireless work and the leadership you have shown on behalf of our nation's seniors. I share your commitment to protect the health and safety of our nation's frail and elderly nursing-home residents.

Elderly nursing-home residents are dying in Missouri and across the country due to failures to provide the most basic and fundamental elements of care. The General Accounting Office (GAO) has amply documented years of death and neglect due to the poor quality of care in too many of our nation's nursing homes. In 1999, the GAO estimated that residents of one in four nursing homes in my state of Missouri suffered actual harm for the care they received. And that is simply unacceptable. It is worse than unacceptable. It is a crime. In many cases, literally and it must be stopped and corrected. We simply cannot accept in a modern and humane society such as ours that elderly and vulnerable residents of nursing homes suffer from harm instead of care. In large part, societies are judged by how well they care for those who cannot care for themselves—the young and the old. And right now we cannot avoid the rather harsh judgment imposed upon us by these cruel statistics. We can no longer look away from the statistics. We have to confront them and deal with them. But most importantly there is a moral imperative that drives us to look at the human beings behind those statistics—our mothers, fathers, grandmothers and grandfathers. We can no longer look away.

I have been monitoring reports of abuse and neglect in nursing homes since the summer of 1999, when reports from my constituents called into serious question the quality of care provided in Missouri nursing homes. Since then, I have met personally with families of victims in Missouri to hear first hand reports of abuse and neglect. I have talked with these families, I have heard their heart breaking stories and I have seen pictures of their loved ones that haunt me to this day. As long as I live I will never forget one woman who shared with me the heartbreaking story of finding her mother covered with ants. There can never be any excuse for this tragic lapse in care. And, I am so afraid that the many stories—horrific stories, some that I cannot repeat—are repeated a thousand fold across this nation.

More recently in St. Louis we experienced a terrible collapse in care. We suffered the heat related deaths of 4 elderly women in Leland Health Care Center in University City, Missouri within a 48 hour period in April of 2001. The air conditioning was not

working at the time and these four elderly women literally baked to death on the third floor of a three story brick building as temperatures inside climbed to 95 degrees and higher. The searing tragedy of this case is that it was so simply avoidable and that many good people tried to raise the red flag on the conditions there, but were ignored by a system that long ago broke down.

According to a report of the Leland incidents released by the Missouri Division of Aging, this facility had failed to maintain a safe and comfortable temperature inside the building for four days straight despite repeated complaints from the paramedics, the fire department, and other emergency workers as well as family members of patients regarding the climbing temperature in the nursing home. The warning signs were there. People tried to intervene but no action was taken and four innocent people died as a result.

The record is undeniable. This facility placed patients under their care in immediate jeopardy and presented an imminent danger to the health, safety, and welfare of all their residents. Four people are dead. A clear case of negligence and no one was held accountable. The fines were reduced to $43,000—that is little more than $10,000 for each death. It is as if we, as a society, have forgotten that the elderly are still people—deserving the full range of legal and medical protection that we are all guaranteed. Something is very wrong with a system that allows four elderly women to die in the State of Missouri and holds no one accountable. It is simply appalling that this matter has been dismissed with only $43,000 in fines. As the Leland tragedy has shown, seniors are not just suffering, they are dying from neglect.

But sadly, this is not a problem unique to Missouri; abuse, neglect and homicide in nursing homes is truly a national problem. How many other Lelands are out there? How many other elderly patients right now –this summer—are baking in nursing homes somewhere else in this country? It is time to admit that the perils of abuse and neglect in nursing homes have been apparent for too long, with too little action and with tragic consequences.

As Chairman of the Subcommittee on Veterans Affairs, Housing and Urban Development and Independent Agencies I also had an interest in veterans being placed in community nursing homes (CNHs). On December 31, 2002, the VA Office of Inspector General (OIG) provided to me a report that contains troubling information for veterans placed into private nursing homes when for one reason or another they cannot be placed in a VA facility. The VA OIG found that veterans in CNHs are vulnerable to incurring abuse, neglect, and financial exploitation. 63% of CNH review teams interviewed by the OIG knew of veterans who reported abuse or neglect while residing in CNHs. The OIG found incidents of abuse, neglect or financial exploitation of veterans and non veterans in the 25 CNHs visited. 27% of the veterans sampled were placed in Centers for Medicare and Medicaid Services (CMS) watch-list homes (nursing homes cited for placing residents in harms way or in immediate jeopardy). Accordingly, I request that the OIG report be placed into the record.

Neglecting an elderly, frail individual is no different that neglecting a child. Both are defenseless and lack a strong voice. Both are vulnerable and both suffer at the hands of those who are nothing more than cowards and criminals. Abuse of the elderly should be treated no differently than abuse of children.

That is why I am an original cosponsor of the Elder Justice Act, legislation introduced by Senator Breaux and supported by many members of this Committee. This bill is the first comprehensive federal effort to address the issue of elder abuse. This bill combines law enforcement and public health to study, detect, treat, prosecute and prevent elder abuse, neglect and exploitation. It is a successful approach that has been applied to combat child abuse and violence against women. This bill creates federal leadership and resources to assist families, communities and states in the fight against elder abuse; coordinates federal, state and local elder abuse prevention efforts; establishes new programs to assist victims; provides grants for education and training of law enforcement and facilitates criminal background checks for elder-care employees.

The tragic toll of nursing home deaths in Missouri is so compelling that I have also sought new ways to approach this seemingly intractable problem. I have met with Secretary Thompson and discussed with him a new bedside technology that can easily and accurately record individual information about nursing-home residents and the care they receive. This new technology is designed to streamline record keeping and improve the quality of patient care. In addition to keeping staff updated on a patient's status, this technology will help prevent errors in administering medication and will provide real-time clinical warnings for caregivers.

The University of Missouri's award winning QIPMO (Quality Improvement Program from Missouri) program, which presently provides all nursing homes in Missouri with reports about the quality of care they deliver, stands ready to marry bedside technology with its voluntary, consultative services. I believe QIPMO, if enhanced with bedside real-time technology providing real-time patient data, has the potential to erect an early warning system with the capacity to alert care givers to life threatening problems before they become widespread or have tragic consequences. Secretary Thompson has been enthusiastic in his support for propelling nursing home facilities into the technology revolution and has provided $800,000 this year to fund a demonstration and evaluation project in Missouri. The University of Missouri will conduct a two-year test in as many as six nursing homes in Missouri. Researchers will then compare results from the use of bedside technology to different systems used in other nursing homes to improve care. Evaluation will center on whether the use of bedside technology improves the collection of daily measures of patient care, whether it improves the outcomes of care, and whether paring bedside technology with clinical on-site consultation enhances patient outcomes.

We urgently need a technological revolution in nursing-home care that can save lives and spare our seniors unnecessary suffering. I thank Secretary Thompson for working with me and for offering his enthusiastic support and commitment to make this project a reality for nursing-home patients in Missouri. I look forward to sharing with

you, Mr. Chairman, and this Committee the outcome of this very promising demonstration project.

Missouri's elderly nursing-home residents and their families have suffered and been victimized by problem nursing homes for far too long. Thank you for holding this important hearing and for all your work to ensure the highest quality of nursing-home care for our seniors. Unfortunately, I need to depart for another event but I would be happy to address questions in writing from any members of the Committee.

Thank you.

Finance Committee

***Nursing Home Quality Revisited* Hearing**

OPENING STATEMENT
of
SENATOR BREAUX

July 17, 2003

Good morning. I would like to thank the Chairman and the Ranking Member for today's important hearing. Mr. Chairman, I must commend you for your extensive body of work on improving the quality of nursing home care. Truly you are a leader in this area. Today's hearing addresses a subject that Senator Grassley and I have worked on very closely together when we were on the Special Committee on Aging. Also, I must recognize the leadership of both Senator Grassley and Senator Baucus on this subject while on the Finance Committee.

Today's report by the GAO is in direct response to inquiries initiated back in 1997 when Chairman Grassley and I headed the Committee on Aging. Concurrent with a Committee hearing the following year which focused on deficiencies in quality of care, the Administration announced a series of initiatives in an effort to address many of the weaknesses identified by the GAO at that time. Today we will be hearing about what the effect of these initiatives has been. Mr. Chairman, you championed the issue of protecting the health and welfare of our nation's nursing home residents back in 1997 when we first delved into this area, and once again I commend yor leadership in ensuring that such efforts were not all for naught. This is an area where we as a Congress will continue to strive for improvements - our nation's seniors deserve that.

As you know, Mr. Chairman, older Americans are one of our most valuable resources. Yet recently, I've focused on aegism in our health care system. Too often, the health care system writes off the elderly as simply too old or assumes that their illnesses are simply a natural part of aging. I've often said that the good news is that seniors are living longer; the bad news is that seniors are living long. With 77 million Baby Boomers advancing in age, we are faced with unprecedented numbers

and unprecedented challenges ahead. It is essential that we begin to put in place the infrastructure to understand and address the myriad of issues facing older Americans, such as health care, retirement security, long-term care, and transportation. And, we must ensure an environment where seniors are protected from abuse, neglect and exploitation.

Today, we will examine the status of quality care in our Nation's nursing homes. Mr. Chairman, you and I can recognize there are many fine nursing homes in this country that provide quality care that is safe from abuse. Indeed, the GAO report released today shows improvement in the quality of care. Although I am a proponent of maintaining the independence of seniors in their homes as long as that is possible, we all must recognize that there may come a time in many lives where nursing home care is essential. The question that remains is how we can consistently ensure that all older Americans are safe in our institutions. Moreover, we must ensure that older Americans are safe in their homes and free from all types of abuse: physical, sexual, financial and neglect.

Mr. Chairman, these are among the several reasons, why Senator Hatch and I offered the Elder Justice Act, S. 333, as part of that solution. I am pleased to say we have 27 co-sponsors in the Senate and a companion bill introduced in the House. Ten of the Senate co-sponsors are members of this Committee.

Congress has passed comprehensive bills to address the ugly truth of two other types of abuse - child abuse and crimes against women. These bills placed both issues into the national consciousness and addressed the abuses at a national level. Yet, despite dozens of congressional hearings over the past two decades on the devastating effects of elder abuse, neglect and exploitation, interest in the subject has waxed and waned, and to date, no federal law has been enacted to address elder abuse in a comprehensive manner.

The time has come for Congress to provide seniors a set of fundamental protections. Nursing homes are regulated at both the federal and state levels. Yet, abuses still occur. The larger percentage - approximately 80% - of our older population is cared for in homes, not nursing homes and other institutions. We are ill-equipped on both public health and law enforcement levels to address these abuses of our seniors now, and I submit we will be far less equipped to prevent abuses in the near future as 77 million Baby Boomers advance in age. The Elder

Justice Act will elevate elder abuse, neglect and exploitation to the national stage in a lasting way. We want to ensure federal leadership to provide resources for services, prevention and enforcement efforts to those on the front lines in the states.

The Elder Justice Act addresses elder abuse in a comprehensive manner in homes and in institutions. It seeks to jump-start research and promising projects and improve the quality, quantity and accessibility of information. In addition, the bill seeks to develop forensic capacity to assist in the detection of elder abuse and train individuals to combat abuse by recognizing the signs. Also Mr. Chairman, I would like to mention just a few of the provisions of the bill that I believe are particularly relevant to the long-term care institutions and to this hearing today.

- The bill **improves prevention and intervention** by funding projects to enhance long-term care staffing.
- The bill **enhances detection** by creating forensic centers and developing to enhance detection of the abuse.
- The bill **bolsters treatment** by funding efforts to find better ways to mitigate the devastating consequences of elder mistreatment.
- The bill **increases collaboration** by requiring ongoing coordination at the federal level, among federal, state and local private entities, law enforcement, long-term care facilities, consumer advocates and families.
- The bill **aids prosecution** by assisting law enforcement and prosecutors to ensure that those who abuse our nation's frail elderly will be held accountable, wherever the crime occurs and whoever the victim.

Finally, Mr. Chairman, even more specific to long-term care facilities, the bill provides the following requirements:

- Prompt reporting of crimes to local law enforcement;
- Criminal background checks for all long-term care workers;
- Enhancements in long-term care staffing;
- Information about long-term care for consumers through a consumer clearinghouse; and
- Accountability through a new federal law to prosecute abuse and neglect in nursing homes.

The cost of elder abuse and neglect is high by any measure. The price of this

abuse is paid in needless human suffering, inflated healthcare costs, depleted public resources, and the loss of one of our greatest national assets - the wisdom and experience of our elders. With scientific advances and the graying of millions of Baby Boomers, the number of the elderly on the planet passed the number of children for the first time last year. Although we have made great strides in promoting independence, productivity and quality of life, old age still brings inadequate health care, isolation, impoverishment, abuse and neglect for far too many Americans.

I believe the Elder Justice Act can provide many of the solutions we seek today with regard to long-term institutions. The bill has broad support across diverse segments of the populations and across party lines. It is supported by a coalition of more than 170 organizations nationwide.

I thank you, Mr. Chairman, for providing me the opportunity to make these comments for the record, and again, thank you for all your efforts to improve the quality of life for older Americans.

Testimony

Before Senate Finance Committee

United States Senate

"Quality of Care in Nursing Homes Nationwide"

Testimony of Dara Corrigan
Acting Principal Deputy Inspector General

July 17, 2003
10:00 a.m.
215 Dirksen Senate Office Building

Office of Inspector General
Department of Health and Human Services

Statement of Dara Corrigan
Acting Principal Deputy Inspector General
U. S. Department of Health and Human Services
Before the
Senate Finance Committee
July 17, 2003

Good morning Mr. Chairman and Members of the Committee. I am pleased to have this opportunity to speak to you about quality of nursing home care -- a subject of intense, continuing interest to the Office of Inspector General.

As you know, we have been working in this field for a number of years, covering all aspects of Medicare and Medicaid nursing home services, focusing our audits, evaluations, investigations, and legal attention on issues relating to funding, access, and quality oversight. In fact, it was almost exactly four years ago (March, 1999) our office testified before you, Mr. Chairman, and other members of the Senate Aging Committee, advising you of our concerns about deficiencies in nursing home care and weaknesses in the survey and certification process. We made numerous recommendations to improve nursing home care, which addressed the survey and certification system, the ombudsman program, resident abuse safeguards, care guidelines, and access to information for family members of nursing home residents.

Since that hearing, we have continued our work, completing studies on resident assessments, services for seriously mentally ill persons residing in nursing homes, the use of psychotropic drugs as chemical restraints, standards for nurse aid training, the efficacy of quality oversight committees, the role of medical directors, and adequacy of psychosocial services. Most recently, we repeated the earlier study of the survey and certification process and of trends in nursing home deficiency rates, which served as a general barometer for the measurement of care, as discussed in our earlier testimony.

You have asked for our current assessment of nursing homes, based on the entire body of our work. In response, I would say that while we see glimmers of progress, we still have serious concerns about the quality of living conditions and care in nursing homes.

Following is a more detailed description of our findings, recommendations, and enforcement actions. We have divided our analysis into two broad sections: conditions in nursing homes, and oversight and quality assurance systems.

CONDITIONS IN NURSING HOMES

Much of the information we have about conditions in nursing homes is derived from oversight, care planning, and protection systems that are discussed in the second half of this testimony. Among them are the survey and certification system (the state-based quality oversight mechanism for nursing homes based on on-site visits by independent, professional teams, the Minimum Data Set (MDS) (used in connection with assessments

of the care needs of individual nursing home residents), and the ombudsman complaint system, one of several venues through which residents or their families can register their concerns about the safety and quality of conditions in the facilities and receive assistance from an independent advocate to get their problems resolved.

We used several approaches to analyze this information. First, we examined data from *all* of these systems, assessing the consistency among them. Second, we emphasized *trends* rather then absolute values so we could assess general directions over time. Finally, we sought other, corroborating evidence, such as complaints received by long-term care ombudsmen and opinions of survey and certification officials who are in a position to know what is going on and whose judgment is informed by their experience and expertise.

We also based our evaluation on our in-depth studies of assessment systems used to identify the needs of and develop plans of care for nursing home residents. On a selected basis, we sampled residents' records and assessments and subjected them to independent review by medical experts. We also sent our own teams to nursing homes to examine specific aspects of care.

In addition, we compared our data and findings to those obtained by the General Accounting Office (GAO), which are also being presented at this hearing. Our information and analysis is consistent with GAO's. We supplemented their findings by identifying those factors that lead to the kinds of critical care problems identified in their report and attempted to identify steps that can be taken to avoid the occurrence of these problems. Here is what we found.

Overall Increase in Nursing Home Deficiencies

General Rates of Increase. All Medicare and/or Medicaid participating nursing homes must be certified as meeting certain Federal requirements. Certification is achieved through routine facility surveys, which the Centers for Medicaid and Medicaid Services (CMS) contracts with States to perform. Nursing homes are subject to unannounced standard surveys no later than 15 months after the date of the previous standard survey. If, during the standard survey, a nursing home is found to have provided substandard quality of care, an additional extended survey is conducted within two weeks. Nursing home surveys are typically conducted by a team of surveyors, with a team leader assigned to manage the process while on site. The survey team also conducts various pre-survey tasks, such as reviewing existing program data, before going to the facility.

When a nursing home fails to meet a specific requirement, the facility receives a deficiency citation. These deficiencies are categorized into 1 of 17 major areas, such as quality of care and physical environment. A total of 190 deficiencies with different tag numbers can be cited. Surveyors also determine a scope and severity level for each deficiency. Scope indicates how widespread the deficiency is, while severity indicates potential for harm. Survey data are entered into the Online Survey and Certification Reporting System.

We compared the deficiencies cited by surveyors in 2001 and compared them to the citations in 1998. We found that the overall number of survey and certification deficiencies went up, both in the aggregate and in the number of deficiencies per nursing home.

Quality of Care. We found that 78 percent of nursing homes received at least one deficiency in three categories related to quality of care. This is an 8-percentage point increase since 1998. These categories of deficiencies are – Quality of Care (covering 25 deficiencies), Quality of Life (covering 19 deficiencies), and Resident Behavior and Facility Practices (covering six deficiencies). Deficiencies in each of these categories rose 9.1, 9.0, and 5.3 percent respectively. Some examples of deficiencies in these categories that we found in the survey and certification reports we reviewed are:

- A resident reported that a nurse aide tied a sheet around the resident's neck and kept pulling it tighter; this resident had redness around his neck as a result. A review of the aide's file indicated that she had seven prior incidents of resident mistreatment.

- Two residents were admitted to a nursing home each with stage II or III pressure sores. Each developed stage IV pressure sores -- one within 24 hours.

- One resident who did not eat or drink and showed signs of dehydration continued to receive diuretics for 10 days. This resident was transferred to a hospital where he died.

Resident Assessments and Care Plans. Of particular concern is the category that showed the greatest overall increase--resident assessment. Resident assessments are required to be conducted by inter-disciplinary teams comprised of nursing home staff when individuals first enter the facilities and at other prescribed intervals. These routine assessments may trigger additional, more specific assessment protocols depending on clinical and functional conditions observed. Such protocols in turn provide the framework for developing care plans to address the needs of the residents. These protocols relate to such things as pressure ulcers, dehydration and fluid maintenance, delirium, dementia, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, behavior symptoms, falls, nutrition, feeding tubes, dental care, psychotropic drug use, physical restraints, visual function, communication, and functional abilities for activities of daily living. If resident assessments are not done or are not performed correctly, residents with conditions such as these may not receive the care they need.

In 2001, 50.1 percent of nursing homes had at least one deficiency related to resident assessments. This is an increase of 11.6 percentage points since 1998. This is significant because the resident assessment is the foundation for care planning for residents. Without reliable assessments, residents' needs cannot be appropriately addressed and they may therefore not get the care they need.

In reviewing survey reports for our inspection work, we have noted a number of resident assessment deficiencies that have resulted in actual or potential harm. For example, a large, suburban California nursing home failed to develop comprehensive care plans for 7 of 31 sampled residents. One resident suffered with severe pain, but had no pain management plan; another at risk for weight loss actually lost weight because diet was not addressed in the plan; and the plan for a third resident with a history of falling did not identify approaches to prevent further falls. Other examples of resident assessment deficiencies include a Down's syndrome resident with a history of wandering and resistance to care; the staff simply acknowledged that these behaviors were ongoing problems, but they were not addressed in the care plan. At another facility, a resident whose care plan did not address his violent behavior had to be transferred to another facility after he assaulted another resident.

Our inspection reports note vulnerabilities in the resident assessment process. In 2001, we released a report on the nursing home resident assessment processes, including the use of the Minimum Data Set. In this inspection, we sampled medical records and had them reviewed by medical experts to assess the accuracy of the resident assessments and the appropriateness of additional assessment protocols required by conditions found in the initial review. They found that 17 percent of assessment data fields contained errors and 25 percent of the additional assessment protocols triggered by the initial assessments were questionable. Furthermore, 25 percent of the protocols which were completed did not have associated care plans.

In that same year, we examined the independent physical and mental evaluations that are required for Medicaid beneficiaries with serious mental illnesses who were in nursing homes. We focused on younger patients, those under 65. We found that only 41 percent of the required evaluations were conducted, as were only 29 percent of required re-assessments.

Additionally, in March of this year we released a report on psychosocial services in nursing homes. In it we reported that 10 percent of residents missed one or more required assessments and that 39 percent of residents with psychosocial needs had inadequate care plans. Furthermore, we found that 46 percent of those with care plans did not receive all planned services.

Further evidence of shortcomings in resident assessment comes from the state ombudsman reporting system whose data show a 70 percent increase since 1996 in complaints related to care plans and assessments.

Other Deficiencies. Deficiencies in other categories also increased. These include pharmacy services (21.1 percent of nursing homes had at least one deficiency in this category in 2001, an increase of 7.9 percentage points since 1998), infection control (20.7 percent, up 5.1 percentage points), physical environment (25.8 percent, up 5.1 percentage points), and residents' rights (29 percent, up 3.7 percentage points).

Decrease in Consecutive Deficiencies. We did find some signs of improvement. One indicator of nursing home care is whether a nursing home has "actual harm" or "immediate jeopardy" deficiencies in consecutive standard surveys. In 2001, 7 percent of the nursing homes had repeat deficiencies of this severity. We analyzed deficiency data going back to 1998 and found that this represents a decline from 11.5 percent in 1999.

Other Evidence Corroborating Deficiency Trends

Ombudsman Complaints. Data from the National Ombudsman Reporting System show that between 1996 and 2000 the total number of complaints have risen 28 percent to 186,000. This translates to 102 complaints per 1,000 beds -- a 30 percent increase.

The characteristics of these complaints, however, did not change significantly over time. The top 12 categories, which account for one-third of all complaints, remained the same. Accidents and request for assistance remained the top two most common complaints. In addition, personal hygiene, medication administration and symptoms unattended, complaints categorized under resident care, also remained in the top 12 categories between 1996 and 2000. These types of complaints may include unexplained bruises, unanswered requests for assistance, a resident not bathed in a timely manner, medications not given, and failure to provide services to a resident's changed condition. Staff turnover, while not one of the top 12, did show the greatest increase at over 200 percent.

State Survey Staff. To gain further insight into the state of care in nursing homes, we surveyed all State Survey and Certification Directors in all States and the District of Columbia, and interviewed a purposive sample of 32 surveyors. With regard to the trend in the quality of care, 45 percent of Directors believe it has remained the same, but 27 percent believe it has in fact declined over the past 3 years. Similarly, 34 percent of front line surveyors believe quality of care has remained the same, while the same number believes quality has declined. On the other hand, 19 of 32 of nursing home administrators we interviewed reported that the quality of care has improved over the past 3 years. The others believe it has remained the same or declined.

OVERSIGHT AND QUALITY ASSURANCE SYSTEMS

As noted in the previous section on conditions in nursing homes, most of the data we use to monitor the quality of life and care is derived from systems whose primary purpose is to provide oversight and enforce compliance with quality of life and care requirements, to plan and care for residents, and to protect them when things go wrong. The following is a discussion of the major oversight and quality assurance systems.

Survey and Certification Process

Inconsistencies in the Citing of Deficiencies. We found many inconsistencies in the citation of deficiencies at all levels -- among States, between Federal and State reviews, and even among individual survey reports. Such inconsistencies can weaken the efficacy of the survey and certification process. Residents receiving inadequate care or living in

substandard conditions may not be protected as a result of the failure to cite the deficiencies.

The inconsistencies could also open deficiency citations to legal challenges. This in turn might make surveyors and State administrators wary of citing deficiencies even when they are clearly justified. As a result, the entire process can be encumbered with administrative delays and expenses resulting from preparing and responding to appeals, remedies delayed or foregone, and residents' needs untended.

In our most recent study of survey and certification deficiencies, we found wide variance in individual State-level deficiency data. In 2001, for example, one-third of the nursing homes in Virginia were deficiency-free while none in Nevada were. In five States almost a quarter or more of homes were deficiency-free; in 12 other States, 5 percent or less were. The national average for deficiency-free nursing homes was 11 percent in 2001. The rate of deficiencies per nursing home also varied. This ranged from a high of 11.2 deficiencies per nursing home in California to a low of 2.9 in Vermont. Nationally, the average deficiency rate in 2001 was 6.2 deficiencies per nursing home.

Differences Between Federal and State Surveys. Federal oversight surveys, conducted by the Centers for Medicare and Medicaid Services on a sample of State surveys, provide additional evidence of the inconsistency in the application of deficiency standards. Furthermore, the inconsistency between Federal and State surveys runs overwhelmingly in one direction—Federal survey teams find larger numbers of, and more serious, deficiencies than State teams. In 166 comparative surveys conducted in 2002, Federal surveyors found 1303 deficiencies compared to 851 identified by State surveyors. Federal surveyors found deficiencies involving actual harm or immediate jeopardy to residents in 24 percent of facilities, while for State surveyors, this number was only 13 percent. Overall, Federal and State surveyors cited the same deficiency only 124 times.

Reasons for Inconsistencies. There are many possible explanations for these inconsistencies. Presumably, they reflect variations in the conditions of nursing homes. However, a greater number of citations may also reflect more intense efforts to identify and correct deficiencies rather than a greater incidence of them. Or, they may reflect longstanding practices that have varied from State to State or region to region over many years. In order to gain a greater understanding of the underlying causes, we reviewed documentation for 310 different deficiencies from 135 survey reports. We also interviewed 32 surveyors in eight States, and gathered information from all 50 State agency directors and the District of Columbia concerning the way each conduct surveys. Based on our review, we identified four factors that contribute to variability in citing deficiencies across States.

Differences in Focus. We found considerable variation in the overall focus of State surveys. For example, the degree to which surveys emphasize enforcement aspects of the survey versus consultative aspects varies among States and from year to year. Thirty-six State agency directors said that their State's survey process is only somewhat consistent

in this regard, acknowledging that the difference between enforcement and consultative focus affects the scope of the review.

During our on-site visits to the six sample States, we observed such differences in focus by survey teams. In one State, surveyors used a more consultative approach in making specific recommendations to the nursing home staff about treatment protocols for an individual resident. This approach contrasted with a more enforcement approach we observed in another State survey, where very little dialogue occurred between the survey team and nursing home staff.

Regarding the consultative approach, both GAO and our office note instances where surveyors fail to cite deficiencies. In five of the six surveys we observed, we noted that surveyors did not always cite deficiencies for problems they identified. This would occur, for example, if the nursing home said they were aware of the problem and were addressing it.

The 51 State agency directors we surveyed also cited several other factors affecting the focus of nursing home surveys. These included the political climate, the strength of the nursing home lobby, and changing Federal and State regulations.

Lastly, 21 States have their own specific criteria governing nursing home surveys that may affect the focus of their Federal surveys. These State criteria most commonly include nursing home staffing ratios and State life safety codes. In 14 of these States, the criteria have changed over the past 3 years. Differences in these criteria among the States also accounts for some of the inconsistencies we found.

Lack of Clarity in Guidelines. We found that surveyors occasionally had difficulty interpreting deficiency guidelines. Twenty-three State agency directors and 17 of 32 sampled surveyors reported that some groups of deficiencies are inherently more vulnerable to inconsistent citation than others. They said deficiencies that are categorized under "quality of life" are most vulnerable due to the lack of clarity in and complexity of the Federal guidelines. They believe this fosters a subjective interpretation, thereby contributing to inconsistent citation among surveyors.

We reviewed the State Operations Manual's "quality of life" and "quality of care" categories and found some of the guidance to be confusing. For example, guidance for tag F250 (social services) offers 14 examples of medically related social services, six types of unmet needs, and 10 conditions to which the nursing home must respond with social services. Some of the definitions for these tags are general and subjective. While the guidance does offer numerous examples of specific scenarios that can be cited under each deficiency tag, in some cases the broad range of examples can be confusing. We also noted that for certain deficiencies, surveyors are directed to refer to more than one deficiency category or tag for the same issue, without explicit direction as to whether to cite under multiple tags when the facility is found to be out of compliance.

Differences in the Way Draft Survey Reports Are Processed. States use different review processes for draft survey reports. In 42 States, all draft survey reports had supervisory reviews in 2001, but not in the remaining eight. Only 18 States conducted reviews when reports changed significantly from draft to final. Thirty-one States had internal quality assurance teams and two States developed continuous quality improvement teams, while17 States had both.

These inconsistencies in States' review processes are reflected in the wide variation in revisions made to draft deficiency reports. State agencies report that an average of 5 percent of deficiencies are removed from draft survey reports before they become final. However, this removal rate ranges from 25 percent in one State to 0 percent in three other States. Further, State agencies report that an average of 6 percent of scope and severity determinations are downgraded from draft surveyors' reports before they become final. This ranges from 38 percent of deficiencies downgraded in one State to 0 downgraded in two other States. In addition, the States with lower deficiency rates removed more deficiencies, on average, from draft survey reports than States with higher rates.

Turnover of Surveyor Staff. We also learned that staff turnover influences survey results. Virtually every State survey director reported that it is very or somewhat difficult to replace survey staff when they leave. Thirty-one said that registered nurses are the most difficult to replace. Based on our survey data, we determined that nationally, surveyors work an average of only 6.5 years for the State agency and that State survey directors have held their jobs on average for only 6.4 years.

On all our visits to the six States, surveyors told us that finding and retaining staff was problematic. They also expressed concern that high staff turnover impacts the consistency of the survey process, since a high proportion of newer staff detracts from the continuity of surveyors' experience. In fact, in one nursing home that we visited the survey team members all had less that two years experience, and two had been on the job for only a few months. We observed that these surveyors were uncertain about what problems to cite and spent several hours debating which deficiency tags to cite.

Based on our study, we recommended that the Centers for Medicare and Medicaid Services continue to improve its guidance to State agencies on citing deficiencies by providing guidelines that are both clear and explicit, and work with the States to develop a common review process for draft survey reports.

The Federal False Claims Act As An Enforcement Tool

The survey and certification process provides several mechanisms for enforcement of nursing home standards. These include corrective action plans, civil monetary penalties, suspension of intake of new Medicare and Medicaid patients, required changes in management, and even de-certification. In some cases, the quality of care is so deficient that remedies under the survey and certification process are not sufficient. If resident care is so poor that it effectively represents a failure to provide care, the Federal False Claims Act can be invoked. In essence, this would amount to a charge that the Federal

Government had been billed for services not rendered. More than 20 nursing home cases have been settled based on the False Claims Act since 1996.

A hallmark of all of these settlements is the imposition of substantial quality of care obligations upon the facilities and the requirement the facilities pay for independent monitors. Depending upon the jurisdiction in which the case arose, these requirements are contained either in the body of the settlement agreement or in separate corporate integrity agreements with the OIG. Following are some recent examples of settled cases.

- **Poor Care and Abrupt Closure.** A nursing home company agreed to resolve its liability under the False Claims Act in a case involving allegations that two nursing homes owned by the company had failed to provide adequate nutrition, hydration, pressure ulcer prevention and treatment, dental care, and safety monitoring to its residents. During the course of the government's investigation, both nursing homes closed abruptly and all of the residents were transferred to other facilities with little advance notice. As part of the settlement, the company agreed to fund a study of the effect of transfer trauma on residents.

- **Infection, Pressure Ulcers, and More.** A nursing home agreed to implement specific protocols, standards of care and compliance policies to resolve its liability for failing to provide appropriate care to one of its residents. The resident developed an infection and pressure ulcer due to a lack of care. The investigation also revealed facility-wide problems with respect to staffing, nutrition monitoring, pressure ulcer care, and treatment planning. The settlement required the facility to pay for an outside monitor selected by the government and to fund special "quality of care/quality of life" projects.

- **Death and Cover-up.** The allegations in this case involved deficiencies with respect to admission assessments, pressure ulcer care, monitoring of residents' hydration, medication administration, and pain management. The investigative focus of the case was on the facility's failure to properly treat one particular resident that died as a result of medication errors that were then covered-up. The nursing home agreed to implement specific protocols, standards of care and compliance policies to resolve its liability. The nursing home also agreed to pay for an outside monitor selected by the government. A nurse, who falsified records in the cover-up attempt, pled guilty to making false Statements and received a 10-month prison sentence.

- **Infested Wounds.** Another nursing home agreed to enter into a 3-year comprehensive corporate integrity agreement that included the appointment of a monitor. The allegations involved multiple findings of residents with maggot infested wounds, substandard catheter care, and significant staffing shortages. The damage aspect of the case focused on two patients whose care was particularly egregious.

Perspectives on Using the False Claims Act for Nursing Home Cases. As the terms o these particular settlement agreements reflect, our first priority is to ensure nursing home residents receive the care they need. We work closely with the Department of Justice on these settlements in order to achieve a balance between recovering a fair amount of dollars for restitution and damages, and establishing systematic changes in the way the nursing homes provide care. It is a very difficult balance because we do not want to take dollars away from the nursing home that would otherwise be spent on patient care. As part of that collaboration, last year the OIG sponsored a 1 1/2 day conference on nursing home quality of care. During the conference, nearly 100 Federal prosecutors and investigators explored ways to effectively use our enforcement tools, including the False Claims Act, corporate integrity agreements, and program exclusions, to improve the quality of care residents receive.

We will continue to investigate cases of care failure and resident harm for which application of the False Claims Act may be appropriate and to work with the Department of Justice, CMS, State officials, and others to resolve them expeditiously.

Resident Assessment Needs to Be Performed and Improved

I have already described inadequacies of the assessment processes related to the Minimum Data Set and stemming from special requirements for residents with serious mental illness and psychosocial service needs. Several additional Office of Inspector General reports shed more light on this subject. They are listed in an attachment to this testimony and can be readily accessed on the Internet.

In our reports on this topic, we have recommended that the Centers for Medicare and Medicaid Services more clearly define the MDS elements; work with the nursing home industry to enhance MDS training; and focus on psychosocial services as part of resident assessment oversight. With regard to Medicaid, we recommended they ensure the completion of the required assessments for residents with severe mental illness and require State Medicaid agencies to work with State mental health agencies on community based treatment alternatives.

Quality Assurance Programs Also Need Attention

Through our studies, the Office of Inspector General has also examined other systems mandated by the Omnibus Reconciliation Act of 1987 to assure that residents receive appropriate care in nursing homes. Our reports cover such topics as training requirements for nurse aides; the role of medical directors; and the efficacy of quality assurance committees. In general, we found that the most fundamental requirements were being met: aides were receiving the required training; medical directors were assigned to nursing homes and were working to provide general oversight of residents' medical care; quality assurance committees were appointed and met regularly to advise on nursing home conditions and care; and psychotropic drugs were generally not being used as chemical restraints.

However, all of these programs could benefit from improvements. Training standards need to be modernized; the practice of medical directors would be enhanced if more specific standards and clearer expectations were developed for them; quality assurance committees could make better use of available information to inform their deliberations; and psychotropic drugs may still be over-utilized and need to be subjected to stronger drug utilization review procedures. The relevant reports and their Internet addresses are listed in the attachment.

LOOKING AHEAD

In light of the findings cited above and based on our work over the last several years, I recommend a three-pronged strategy to improve the quality of living conditions and care in nursing homes:

- Strengthen the enforcement system, especially the survey and certification process. This includes improving the reliability of deficiency citations though clearer definition and report processing standards; following up on repeat offenders; and working to investigate, and resolve complaints expeditiously.

- Make sure that patient assessments are performed, that they are accurate, and that care plans are prepared and followed.

- Establish continuous improvement programs for quality assurance infrastructures such as those relating to nurse aide training, medial directors, drug utilization review, quality assurance committees, long-term care ombudsmen, and quality of care information for residents and their families.

CMS has already taken steps in this regard. I refer to their initiatives over the last several years related to such things as the scheduling and conduct of surveys, resident assessment, performance measures, and publication on the Internet of information about quality of care in each and every nursing home. It is critical for CMS to follow through on its plans to improve all these systems in a timely manner.

Improving nursing home services will also require the combined efforts, over many years, of all stakeholders -- the residents and their families, the nursing home industry, health care professionals, Medicare and Medicaid program administrators, and State quality assurance organizations.

CONCLUSION

Much has been done, but much still remains to improve conditions in nursing homes and guarantee that the improvements take hold. The Office of Inspector General will continue to do its part through its evaluations, audits, investigations, and legal services. We hope our contributions are constructive.

Selected Nursing Home Reports

U.S. Department of Health and Human Services
Office of Inspector General
July 2003

Recently Completed Work

Nursing Home Deficiency Trends and Survey and Certification Process Consistency
http://oig.hhs.gov/oei/reports/oei-02-01-00600.pdf

Nurse Aide Training
http://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf

Quality Assurance Committees in Nursing Homes
http://oig.hhs.gov/oei/reports/oei-01-01-00090.pdf

Nursing Home Medical Directors
http://oig.hhs.gov/oei/reports/oei-06-99-00300.pdf

Psychosocial Services in Skilled Nursing Facilities
http://oig.hhs.gov/oei/reports/oei-02-01-00610.pdf

Prior Work

Nursing Home Survey and Certification: Deficiency Trends
http://oig.hhs.gov/oei/reports/oei-02-98-00331.pdf

Nursing Home Survey and Certification: Overall Capacity
http://oig.hhs.gov/oei/reports/oei-02-98-00330.pdf

Nursing Home Resident Assessment: Quality of Care
http://oig.hhs.gov/oei/reports/oei-02-99-00040.pdf

Psychotropic Drug Use in Nursing Homes
http://oig.hhs.gov/oei/reports/oei-02-00-00490.pdf

Younger Nursing Facility Residents with Mental Illness: Preadmission Screening and Resident Review (PASRR) Implementation and Oversight
http://oig.hhs.gov/oei/reports/oei-05-99-00700.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 5 2003

The Honorable Charles E. Grassley
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This is in response to your letter dated August 14, 2003 in which you asked me to respond to three questions as a follow-up to my testimony at the Senate Finance Committee hearing of July 17, 2003 regarding nursing home quality of care. Thank you for the opportunity to provide additional information to you on this important topic.

Question 1. Based on the cumulative work of the OIG in this area, where do we go from here?

Answer. In recent months, the Office of Inspector General (OIG) has issued several reports addressing various aspects of resident care. We have additional projects underway, as outlined in our current work plan and plan to undertake a number of new projects that will be identified in the soon-to-be released Fiscal Year 2004 OIG Work Plan. These projects will cover a broad spectrum of nursing home issues, including quality of care, with studies on nursing home quality-of-care sanctions, accuracy of minimum data set reporting and nursing home compliance with dietary services.

In addition, it is my expectation to work with your committee to learn more a about effective practices being used in those nursing homes that are providing excellent, high-quality care and to measure, to the extent possible, the impact of reimbursement levels on quality of care.

Question 2. You report that States are following the CMS survey protocols and that variation across States in deficiencies is not due to inconsistent protocol application. Is it not a violation of CMS protocols when States take a "consultative" approach rather than citing deficiencies during a survey? How do you square your conclusion that States are following CMS protocols regarding the timing of surveys with GAO's conclusion that 34 percent of current State surveys were predictable?

Answer. We did find that the surveyors were following the prescribed protocol for conducting the survey. However, we identified four other factors that may contribute to variability in how States cite deficiencies – differences in focus, lack of clarity in guidelines, differences in the way draft reports are processed, and turnover of surveyor staff. With regard to the focus of surveys, some States take a more consultative approach

and others a stronger enforcement approach. In its guidance to States, the Centers for Medicare & Medicaid Services (CMS) encourages information exchange between surveyors and nursing home staff. Specifically, CMS guidelines state that "This information exchange is not a consultation with the facility, but a means of disseminating information that may be of assistance to the facility." Finally, we did not examine the predictability of surveys. Our finding was that States completed their surveys within the required 9 to 15 months timeframe.

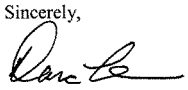
Question 3. How could it be that the death that occurred under questionable circumstances at the West Virginia nursing home was not found during the audit of the facility by your office? We would like your office to review further the circumstances of the West Virginia death.

Answer. The main focus of this particular OIG audit was to review the staffing levels of nursing facilities. For this study, we chose a sample of facilities to review. The nursing home in question was part of the sample. As part of our audit work, we reviewed the facility's annual survey report, which focused on a 2-week period of time during the year. The patient's death did not occur during the 2-week period that was within the scope of our review. However, in the course of our work, we obtained additional documentation for further analysis, where we found the information about the death. When we learned of this event, we contacted the State and confirmed the death was properly reported, although the State identified deficiencies related to the death. Facilities follow a specific process in reporting the death of a patient, but we did not review the process at that time of our audit because it was not within the scope of the review.

My office is planning follow-up work with regard to the circumstances surrounding the death and will provide more information to you about how we will proceed in this matter in the next few weeks.

I commend your commitment to these and other important health care issues affecting the quality of care of Medicare and Medicaid beneficiaries and look forward to continuing our joint initiatives with your committee. If you would like to discuss this matter further, please contact me or have your staff call George Grob, Deputy Inspector General for Management and Policy, at (202) 619-2482.

Sincerely,



Dara Corrigan
Acting Principal Deputy Inspector General

PREPARED STATEMENT OF HON. CHARLES E. GRASSLEY

Good morning. I thank everybody for coming. As chairman of the Finance Committee, I'm particularly pleased that this morning's hearing will follow up on the extensive work we did when I chaired the Special Committee on Aging. As everyone knows, the Finance Committee has had plenty on its plate this session, and I'm proud of our accomplishments with the tax and drug bills that we moved out of the committee and successfully voted out of the Senate. At the same time, my staff and I have continued with my longstanding commitment to ensure that more is done to protect the frail and elderly who live in nursing homes across the country. Today greater numbers of Americans are blessed with longevity and thus able to enjoy more time with their family and loved ones. Take it from me, it's a treasure to watch your grandchildren grow up and incredible to congratulate a granddaughter on the birth of her own child. But as Americans break new age barriers, society must cope with the changing needs of an aging and expanding population. This hearing is an opportunity to revisit and assess the quality of care in America's nursing homes. Today we'll hear that there's still much to be done—at the state level, at the federal level, and by the nursing home industry. I think it's fair to say that some progress has been made, although it remains difficult to say how much. We do know, however, that we can and must do more to protect vulnerable nursing home residents.

Some have said that this hearing is about nothing new. I disagree. I believe this hearing is another wake-up call to America. It's a reminder that the oldest and neediest among us deserve to live their final years on earth with dignity. The people assembled here today—the tireless advocates and family members, the members of the media and nursing home industry, the government regulators and elected policymakers—many of us are dedicated to keeping this issue a front-burner priority. We must always keep in mind the goal simply put, it is improving the quality of care in nursing homes. It's important to note that our primary concern in this regard is about genuinely poor care to residents. We're talking about preventing basic, but lifethreatening problems, such as dehydration, malnutrition and injury prevention, including the prevention of pressure sores, falls and other serious injuries that result from substandard care. We need to target the bad actors among nursing homes, who do a disservice to all the good homes out there. And I want to emphasize that the majority of nursing homes are greatly concerned about providing quality care. For instance, in anticipation of this hearing, I received a letter from the United Presbyterian Home in Iowa. This is an awardwinning home and was found deficiency-free on its last inspection. I applaud this nursing home and the efforts of its staff. I'd like to believe that all nursing homes are as diligent with their responsibilities. However, we know that there are too many bad homes where abuse, neglect and life-threatening problems exist. We should always keep in mind that any death due to substandard care is one death too many.

I believe that too often we here in Congress get bogged down in data and statistics. It's easy to forget that there are human lives and untold stories behind those statistics. That's why we'll hear this morning from a panel of everyday Americans. They are family members dealing with the tragic consequences of substandard care. In many respects, they are heroes for agreeing to tell us their stories. We must listen to them becausewhat they'll tell us is truly tragic and all too common. Each has come before this committee today to remind us that quality care in nursing homes isn't about numbers. It's about life and too frequently, tragic death. I've longchampioned the idea that sunshine is the best disinfectant. I believe openness in any system helps to cleanse impurities, educate the public and hold people accountable. American consumers are growing increasingly accustomedto a "right to know" when it comes to purchasing products, choosing services and even when buying groceries. When it comes to finding high-quality care for a loved one, they have a right to know about the standards of care provided at their local nursing home. Everyone should know that there's a huge gap in quality among nursing homes across America; there are homes where tremendous care and compassion is provided, and then there are homes where horrendous neglect, abuse and preventable death exist. I've been working on nursing home quality for almost eight years now, and at my request the General Accounting Office has issued a series of reports documenting severe problems in too many nursing homes. Today we'll learn about the GAO's most recent findings. I welcome back Dr. Bill Scanlon, who has testified numerous times about nursing home quality since the Nursing Home Initiative began in the summer of 1998. He will testify about the latest in a series of several important GAO reports. I look forward to hearing about the GAO's findings, as well as its new recommendations about how to improve the quality of care.

In addition, we will welcome before the Committee and hear testimony from Senator Bond, Chairman of the Aging Subcommittee for the Committee on Health, Education, Labor, and Pensions. Also, the Department of Health and Human Services, Office of Inspector General, will be hereto discuss the OIG's work on nursing home quality. As always, we have invited CMS Administrator Tom Scully to be with us, too. CMS's federal role in overseeing nursing homes and implementing initiatives to improve care is of paramount importance, and we look forward to his testimony. One of the positive policy initiatives to emerge from CMS was the launch of a national on-line database. The "Nursing Home Compare" Web site offers American consumers a comprehensive, user-friendly resource to assist with the difficult decision of choosing a nursing home for a loved one. I am keeping close tabs on this Web site because, as we'll learn today, flaws and gaps still exist in some of the information. I continue to say that consumers need to be aware that this is one resource among many. As President Reagan was fond of saying when he was in office, "Trust but verify."

As always, we'll also talk about money today—the federal government pays vast sums to provide for quality care and for oversight and enforcement of that care. Over the past couple months I've been working to ensure that a proposed $6.9 billion dollar federal windfall to the nursing home industry over the next 10 years should be directed to improve patient care. We must ensure that the nursing home industry doesn't line its pockets with this money. I expect the industry to use that money for the direct care of residents. And finally, we'll close out the hearing with testimony from the industry's perspective. In sum, this hearing today is about keeping the focus and pressure on doing better for the frail and elderly in nursing homes. It's extremely important and valuable to maintain a dialogue among nursing home care providers, regulatory agencies, Congress and consumers about the problems that persist. I hope this hearing will help continue that dialogue and provide a road map for all that still needs to be done.

Nursing Home Quality: Problems, Causes, And Cures

Written Testimony

Testimony Before The U.S. Senate Committee on Finance

Catherine Hawes, Ph.D.
Professor
Department of Health Policy and Management
Director, Southwest Rural Health Research Center
School of Rural Public Health
Texas A&M University System Health Science Center
College Station, Texas

July 17, 2003

The testimony presented here represents my views, opinions, and interpretation of data. These views do not necessarily represent the views of any of the agencies that funded the research mentioned or of the Texas A&M University System Health Science Center.

For more information on any of the studies cited here, please contact the researchers mentioned, using the information provided in the reference section, or contact me at the School of Rural Public Health at (979) 458-0081 or through the Center's main number at (979) 458-0654.

Good morning Senator Grassley and members of the Committee. Thank you for the opportunity to be here and address this important topic.

My name is Catherine Hawes. I am a Professor of Health Policy and Management and Director of the Southwest Rural Health Research Center at the School of Rural Public Health at Texas A&M.

In my testimony today, I intend to make three basic arguments:

- First, quality improved post-OBRA but serious problems remain, and indeed, substantial evidence suggests that quality has declined over the last decade.
- Second, many factors have contributed to these quality problems, including inadequate regulatory processes, perverse reimbursement incentives, and so on. However, all the key stakeholders agree that inadequate staffing is the major cause of poor nursing home quality.
- Third, solving the staffing problem has been impeded by disagreements among key stakeholders. However, the time has come – indeed is long past – for resolving these differences and improving staffing levels and staff training.

*****

Quality improved immediately after the implementation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). The most notable improvement was in the huge reductions in the use of physical restraints, where use nationwide dropped from nearly 40% of residents restrained pre-OBRA to fewer than 10% by 2000 (Phillips, Hawes & Leyk-Williams, 2003; Hawes et al. 1997; Kane et al 1994). Moreover, research identified several other areas of process quality and resident outcomes that improved during the early years of OBRA implementation (Garrard et al., 1995; Hawes et al., 1997; Marek et al., 1996; Mor et al., 1997; Phillips et al., 1997; Teno et al., 1997; U.S. Senate - Aging, 1995; Vladeck, 1995).

However, even with the early improvements, some quality problems remained. Moreover, the initial pace of improvement post-OBRA was not maintained and, indeed, there is substantial evidence suggesting that quality has deteriorated over the last decade. Evidence of this can be seen in recent academic studies, reports by ombudsmen, testimony before the U.S. Senate Special Committee on Aging, and Congressional audits and include such problems as increased complaints about abuse and neglect, malnutrition and dehydration, inadequate treatment of pain, improper care for pressure ulcers, inadequate care to maximize physical functioning in activities of daily living (ADLs), and lack of adequate supervision to prevent accidents. (AOA, 2000; Bernabei et al., 1998; Blaum et al., 1995; Fries et al., 1997; Hawes, 1997; Johnson & Kramer, 1998; Kayser-Jones, 1997; Kayser-Jones and Schelle, 1997; US-DHHS OIG 1999; US GAO 1998; 1999).

There are many explanations for the seeming intractability of quality problems in nursing homes. These include such factors as inadequate staffing in facilities, perverse quality

incentives in Medicare and Medicaid payment systems, and flaws in the regulatory process -- including the survey, nursing home complaint investigation, and enforcement processes (Edelman, 1997; 1998; Hawes Blevins and Shanley 2001; Hawes 2002; Harrington & Carrillo 1999; US OIG, 1999; US DHHS, 1998; US GAO, 1998; US GAO1999a, b, c, d). They also include the difficulty of implementing and sustaining quality interventions in nursing homes, the challenge of culture change even among willing facilities, and the politics of long-term care. However, the most significant problem -- and one that must be addressed before we can expect to even approach adequate quality of care for the nation's elderly -- is inadequate staffing.

The evidence is overwhelming that the most significant causes of poor quality, including abuse and neglect, are low staffing levels and inadequate staff training in nursing homes.

A discussion of "staffing" and "ratios" sounds technical. However, CNAs are eloquent about what it means to work short-staffed. What gets ignored first, out of necessity, according to CNAs, is range of motion exercises – which leads to contractures. Next, staff report, they are unable to provide sufficient help with eating and drinking. Undernutrition, malnutrition, and dehydration inevitably follow such neglect, with the concomitant sequelae of skin breakdown, pressure ulcers, poor healing of wounds, and premature mortality - - not to mention the daily misery of being hungry and thirsty. CNAs also report they can't change residents more than once a shift if they are short-staffed, so residents sit or lie in wet clothing and bedding, an assault on dignity as well as skin integrity. What staffing adequacy really means is whether there are sufficient people on duty so that nation's grandparents receive enough help eating so that they don't slowly starve, so that day after day they don't suffer from unquenched thirst. It means that there are enough trained and caring people that our mothers are helped to use the bathroom before they wet themselves in desperation and despair.

Support for the argument that low staffing is the most significant impediment to adequate quality comes from the informed opinion of key stakeholders. As part of several studies, my colleagues and I surveyed staff in all the state survey agencies and all the state nursing home ombudsmen. We also conducted focus group interviews with Certified Nursing Assistants (CNAs) from more than 20 states. In addition, we interviewed administrators and directors of nursing (DONs) in facilities that focused on dementia care and conducted focus group interviews with state survey agency directors. Finally, we interviewed families of residents. All of these stakeholders identified staffing as critical to nursing home quality (Hawes, Blevins & Shanley 2001; Hawes & Greene 199; Hawes and Bowers, 2002).

- For a CMS-funded study of the Nurse Aide Registries, my staff and I interviewed state survey agency staff. As shown in Exhibit 1, 85% of the state survey agency staff cited low staffing levels as a main cause of abuse and neglect in nursing homes.

- In focus group interviews, CNAs asserted that short staffing was the main cause of neglect and a substantial cause of abuse (Hawes, Blevins & Shanley, 2001).

- In facilities that had been identified as providing exemplary care to people with Alzheimer's disease , DONs, nursing home administrators, and CNAs argued that staff-to-resident ratios of one CNA to six or eight residents were optimal (Hawes & Greene, 1998).

- For the Nurse Aide Registry study we interviewed the state long-term care ombudsmen in 2000. More than 90% of the respondents argued that inadequate staffing levels were the most significant cause of abuse and neglect. This was consistent with a 1999 survey in which 81% of the state and local ombudsmen responded that inadequate staffing had limited the effect of the OBRA '87 nursing home reforms (Hawes & Durand, 2000).

Exhibit 1: State Agency Views on Main Causes of Abuse and Neglect

Cited Cause	Percent*
Staffing shortages, too few staff, bad staff to resident ratios	85%
Staffing shortages & difficulty hiring qualified staff	71%
Poor training	61%
Poor supervision, management	51%
Staff turnover	63%
Low wages	78%
Combative residents	56%
Vulnerable consumers/residents	29%

**Multiple responses were allowed*

Source: Exhibit 5.1 in Hawes, C., Blevins, D. and Shanley, L. (2001). *Preventing Abuse And Neglect In Nursing Homes: The Role of The Nurse Aide Registries.* Report to the Centers for Medicare and Medicaid Services. College Station, Texas: School of Rural Public Health, Texas A&M University System Health Science Center.

Other studies have found similar results. For example:

- In 10 States surveyed by the DHHS OIG, the survey and certification staff, State and local ombudsmen, and directors of State Units on Aging identified inadequate staffing levels as one of the major problems in nursing homes. The OIG report also concluded that the type of deficiencies commonly cited "suggest that nursing home staffing levels are inadequate" (OIG, 1999a).

The findings are essentially the same in terms of the inadequacy of staff training. CNAs argued that after short staffing, inadequate training was the most significant contributor to resident abuse (Hawes, Blevins & Shanley, 2001). Other informed stakeholders who were interviewed in the Nurse Aide Registry study agreed.

- 61 percent of the aide registry directors argued that poor training was a significant factor causing abuse;

- 58 percent of the ombudsmen identified inadequate training of CNAs as a major obstacle to quality of care in nursing homes.

- CNAs noted that inadequate training of staff is particularly problematic in terms of their ability to meet the needs of residents with Alzheimer's disease. A failure by staff to understand the impact of this disease on the behavior and needs of residents is a major factor in abuse and rough treatment of residents (Hawes, Blevins & Shanley, 2001).

It does not take much to see the sense behind this argument that staff training is inadequate. In Texas, for example, a manicurist cannot be licensed unless he or she has completed 600 hours of approved training and passed a state test (http://www.state.tx.us/professionals). Of course, such manicurists are prohibited from treating or removing calluses, soft calluses, or ingrown nails. By contrast, CNAs provide daily hands-on care in settings where the typical resident suffers from between three and four chronic diseases, is incontinent, has some form of significant cognitive impairment, and needs help with more than four basic activities of daily living, including bathing, dressing, locomotion and using the toilet. Many exhibit challenging behaviors. Yet to be certified, a nursing assistant is required to complete only 75 hours of training. The majority of states follow this federal requirement, with only seven states requiring 120 to 150 hours of training for certification (personal communication from Charlene Harrington).

Additional evidence about the importance of staffing comes from a host of prior studies and reports on the association between staffing type, staff training, and quality (e.g., Nyman 1988; Spector & Takada, 1991). Such prior studies have been cited in several studies by the Institute of Medicine (e.g., IOM, 1986; Wunderlich & Kohler, 2000). More recent research also emphasize the importance of staffing levels -- including a study led by Charlene Harrington (Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J. and Beutel, P., 2000), another by Jack Schnelle (Schnelle et al. 2003), and, most significantly, the Phase I staffing report to Congress from the Centers for Medicare & Medicaid Services (CMS) (see US-DHHS/CMS 2001).

Unfortunately, the evidence suggests that staffing has gotten worse, not better over the last several years, particularly if one considers staffing in relation to apparent increases in the complexity and intensity of residents' care needs (Harrington et al. 1999; Phillips et al. 1997). There was some improvement in the average licensed nurse staffing (RNs and LPNs) but essentially none in CNA staffing during the mid-1990s Harrington et al., 1999; US-DHHS/CMS, 2001). However, there has been no change from 1996 to 2002. Indeed, just completed analyses of staffing data by Dr. Charlene Harrington and her colleagues shows that licensed nurse staffing declined after the implementation of the nursing home prospective payment system in the Medicare program (Harrington, Carillo, Wellin & Shemirani, 2003). In 37 of the states and the District of Columbia, the average reported licensed nurse staffing was lower in 2002 than it was during one or more of the preceding six years. In most states, the highest licensed nurse staffing occurred in 1998 or 1999 and declined from the high point. A slight increase in CNA staffing in some states helped overcome the decrease in licensed nurse staffing so that total nurse staffing remained essentially static between 1997 and 2002. And all the evidence indicates that these levels for CNAs and licensed nurses are woefully inadequate.

The fundamental question that remains about staffing is why there has been no action at the federal level. As a member of the original IOM Committee on Nursing Home Regulation – whose recommendations were largely embodied in the OBRA '87 reforms – I can only plead temporary insanity. We largely focused in changes in process and outcome quality and, sadly, ignored the key role played by structural elements such as CNA staffing levels. And while our recommendation for a federal CNA training requirement represented progress, it is too little, particularly as the tasks expected of staff have become more demanding with the increase in resident case mix intensity.

Since then, several factors have contributed to our failure to address staffing issues. First, and probably most significantly, there is disagreement about whether or not it will take more Medicare and Medicaid funding to increase staffing levels. One side argues essentially what the head of Medicaid rate setting program asserted to us in an on-going CMS-funded study. In a state with very low payment rates, he noted that most homes were making a "healthy profit." Thus, while he recognized that there were some significant quality problems in the state's nursing homes, he saw no reason to give those facilities higher Medicaid rates. The other side argues that without increases in government payment, there can be no government requirement for additional staffing, for increased staff training, or for a living wage for staff.

I probably fall into the second camp for practical reasons. Some states have rates that probably don't support adequate quality of care. But more significantly, I've seen little evidence that policymakers are willing to explicitly limit the profit made by some nursing homes and redirect what might be viewed as the "excess" profit into paying for better quality. Certainly, it is technically feasible to do this. There have been reimbursement systems in place that more effectively directed funds to increased spending on food and staffing and limited "profit" to efficiency incentives available only on spending not associated with direct resident care (e.g., administrative and general services spending). There have also been policies that provided additional Medicaid funding to increase staffing that have been successful – and ones that have been abused. The experience we have had with these various ways of addressing reimbursement policy and staffing suggests that some policies that are technically feasible are not necessarily politically feasible. In reality, it will prove easier to direct new funds to increased staffing than to redirect existing expenditures, much less profits. The failure to face this reality contributes to no action on improving staffing.

Second, some argue that imposing minimum staffing requirements will lead many facilities to aim for and achieve only that minimum. These critics are probably correct, but my response is that this will still represent an improvement for most facilities. Moreover, future adjustments for case mix intensity and to reflect improvements in clinical practice can be built into any system of new staffing requirements.

Third, some people argue that the survey process can address the problem of inadequate staffing. However, the reality is that the survey process fails to detect and cite many deficiencies, including cases of actual harm. Moreover, even when a deficiency is cited that is related to inadequate staffing, survey agencies often fail to

require increased staffing levels as part of the facilities' plan of correction. Indeed, this was a striking failure in the abuse and neglect complaint investigation process. Although the survey agency was charged with investigating the facilities' role in any substantiated case of abuse or neglect, most survey agency staff either could not estimate how often they looked at such issues as whether inadequate staffing levels played a role in cases of abuse or neglect or reported they investigated the facilities role in fewer than 10% of the cases (Hawes, Blevins & Shanley, 2001). Moreover, there is some evidence that suggests that if surveyors believe a nursing home is receiving an inadequate Medicaid payment rate, some will not cite deficiencies for problems whose solution would apparently require additional funds. Finally, the enforcement process and use of federal remedies is flawed, as several recent studies and Congressional audits by the General Accounting Office (GAO) have found (e.g., Edelman, 1997a and b; 1997-98; 1008; Harrington and Carrillo, 1999; Harrington, Mullan & Carrillo, 2001; Hawes, 2002). Thus, the survey and enforcement processes – at least at present – are weak reeds upon which to rely for improvements in facility staffing.

I would also note that we do not, in general, provide sufficient funds for survey and certification activities. In the last two Administrations, we have seen proposed budgets for survey and certification activities at CMS that represented decreases in resources for their activities and oversight, as well as for research activities that would support its ability to improve the survey and enforcement process. Only pressure generated by the Grassley hearings before the U.S. Senate Special Committee on Aging and the GAO reports and monitoring of the CMS quality initiatives required by the Committee have staved off total disaster. It is unrealistic to expect more of CMS or the state survey agencies without adequate funding for these essential activities. This is especially true given the budget cuts many states are experiencing.

Fourth, some argue that harnessing market forces can improve staffing and advocate public reporting facility staffing data as a way to inform consumers and pressure facilities to improve their performance. This position ignores a host of facts about how the elderly and their families choose facilities, about the time pressure they face when making such choices, about the lack of alternative options and competition, particularly in rural areas, about the ability of consumers to process information and use it to make decisions, and about the ability of facilities to recognize and correctly interpret any action by consumers (see Castle, 2003; Phillips, Hawes & Leyk, 2002). It is important to improve the quality of information available and to educate consumers, but it is no substitute for adequate staffing standards.

> *"As a society, we need to respect our disabled/elderly . . . enough to want to care for them and, in addition, to foster caring in the staff, for example, with career ladders, proper pay, decent work loads."*
>
> Aide Registry Director
> (Quoted in Hawes, Blevins & Shanley, 2001)

Finally, some argue that the total cost of increasing staffing levels, much less paying CNAs a living wage, is too high. And the truth is, there is never a particularly good time to expand funding, particularly not with the budget process Congress faces. But it is also true that 1.6 million nursing home residents don't have that much time to wait.

REFERENCES

Bernabei, R., Giovanni, G., Lapane, K., Landi, F., Gatsonis, C., Dunlop, R., Lipsitz, L., Steel, K., & Mor, V. (1998). Management of pain in elderly patients with cancer. *Journal of the American Medical Association, 279* (23), 1877-1882.

Blaum, C.S., Fries, B.E., & Fiatarone, M.A. (1995). Factors associated with low body mass index and weight loss in nursing home residents. *Journal of Gerontology: Medical Sciences, 50A* (3), M162-M168.

Castle, N. (2003). Searching for and selecting a nursing facility. *Medical Care Research and Review. 60* (2): 223-147.

Edelman, T. (1997a). Health Care Financing Administration retreats from regulatory role. *Clearinghouse Review, 31*: 236.

Edelman, T. (1997b). An Unpromising Picture: Implementation of Reform Law's Enforcement Provisions Troubles Advocates. *Quality Care Advocate*. March.

Edelman, T. (1997-98, Winter). The politics of long-term care at the federal level and implications for quality. *Generations, 21* (4), 37-41.

Edelman, T. 1998. What Happened to Enforcement? *Nursing Home Law Letter.* 1-2:1-46.

Fries, B., Hawes, C., Morris, J., Phillips, C. Mor, V., and Park, P. (1997). Effect of the national resident assessment instrument on selected health conditions and problems. *Journal of the American Geriatrics Society 45*(8): 994-1001.

Garrard, J., Chen, V., & Dowd, B. (1995). The impact of the 1987 federal regulations on the use of psychotropic drugs in Minnesota nursing homes. *American Journal of Public Health, 85*(6), 771-76.

Harrington, C, Carrillo, H, Wellin, V. and Shemirani, B. (2003). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1996 Through 2002.* San Francisco, CA: Department of Social and Behavioral Sciences, University of California at San Francisco.

Dr. Harrington can be reached at **chas@itsa.uscf.edu** or (415) 476-4030.

Harrington, C., Mullan, J. & Carrillo, H. (2001, June). *State nursing home enforcement systems.* A report prepared for the Kaiser Commission on Medicaid and the Uninsured. San Francisco, CA: University of California, Department of Social and Behavioral Sciences.

Harrington, C., Zimmerman, D., Karon, S.L., Robinson, J. and Beutel, P. (2000). Nursing Home Staffing and Its Relationship to Deficiencies. *Journal of Gerontology: Social Sciences.* 55B (5):S278-S287.

Harrington, C., Carrillo, H., Thollaug, S., Summers, P., & Wellin, V. (2000). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1993-99.* Report prepared for the Health Care Financing Administration. San Francisco, CA: Univ. of California. Available: http://www.hcfa.gov/medicaid/nursingfac/nursfac99.pdf.

Harrington, C. & Carrillo, H. (1999). The regulation and enforcement of federal nursing home standards. *Medical Care Research and Review, 56* (4), 471-494.

Harrington, C., Carrillo, H., Thollaug, S., & Summers, P.(1999). *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-97.* Report prepared for the Health Care Financing Administration and Agency for Health Care Policy and Research. San Francisco, CA: Univ. of California.

Hawes, C. (Aprl 2002). *Assuring Quality in Nursing Homes: The Role of Enforcement.* Final Report to the Retirement Research Foundation. College Staton TX: The Program on Aging, Disability and Long-Term Care Policy, The School of Rural Public Health at Texas A&M Unversty System Health Science Center.

Hawes, C., Blevins, D. and Shanley, L. (2001). Preventing abuse and neglect in nursing homes: The role of the nurse aide registries. Report to the Centers for Medicare and Medicaid Services (formerly HCFA). College Station, Texas: School of Rural Public Health, Texas A&M University System Health Science Center.

Hawes, C. and Greene, A. (1998). *Final Report: Training and "Dementia-Capable" Care for Residents In Assisted Living Facilities and Nursing Homes.* Report to the Alzheimer's Association. Research Triangle Park: Research Triangle Institute.

Hawes, C. "Prevalence and Causes of Potential Under-nutrition Among Nursing Home Residents." Testimony before the U.S. Senate Special Committee on Aging, *Forum on Risk of Malnutrition in Nursing Homes.* Washington, DC: October 22, 1997.

Hawes, C., Phillips, C.D., Morris, J.N., Mor, V., Fries, B.E., Steele-Freidlob, E., Greene, A. & Nennsteil, M. (1997). The impact of OBRA-87 and the RAI on indicators of process quality in nursing homes. *Journal of the American Geriatrics Society, 45* (8), 977-985.

Institute of Medicine. (1986). *Improving The Quality Of Care In Nursing Homes.* Washington, DC: National Academy of Sciences Press.

Johnson, M.F. & Kramer, A. (1998). *Quality of care problems persist in nursing homes despite improvements since the nursing home reform act.* Paper prepared for the Institute of Medicine Committee on Quality on Long-Term Care. Denver, CO: University of Colorado Health Sciences Center.

Kane, R.L., Williams, C.C., Williams, T.F. & Kane, R.A. (1993). Restraining restraints: Changes in a standard of care. *Annual Review of Public Health, 14*, 545-584.

Kayser-Jones, J. & Schell, E. (1997). The effect of staffing on the quality of care at mealtime. *Nursing Outlook, 45* (2), 64-72.

Marek, K.D., Rantz, M.J., Fagin, C.M.& Krejci, J.W. (1996). OBRA '87: Has it resulted in positive change in nursing homes? *Journal of Gerontological Nursing, 22* (12), 32-40.

Mor, V., Intrator, O., Hiris, J., Fries, B., Phillips, C., Hawes, C., Teno, J., & Morris, J. (1997). Impact of the MDS on changes in nursing home discharge rates and destinations. *Journal of the American Geriatrics Society 45*(8), 1002-1010.

Phillips, C, Hawes, C & Leyk-Williams, M (2003). *Nursing Homes in Rural and Urban Areas, 2000.* College Station, TX: Southwest Rural Health Research Center, School of Rural Public Health, Texas A&M University System Health Science Center.

Dr. Phillips can be reached at **phillipscd@srph.tamushsc.edu** or at (979) 458-0080.

Phillips, C., Morris, Hawes, C., J., Mor, V., Fries, B., Murphy, K., Iannacchione, V., & Nennsteil, M. (1997). The impact of the RAI on ADLs, continence, communication, cognition, and psychosocial well-being. *Journal of the American Geriatrics Society 45*(8): 986-993.

Schnelle, JF, Simmons, SF, Harrington, C., Cadogan, M, Garcia, E. & Bates-Jensen, B. (2003). Nursing home staffing information: does it reflect differences in quality of care? Working paper. Los Angeles: University of California, Department of Medicine, Division of Geriatrics.

Teno, J., Branco, K., Mor, V., Phillips, C.D., Hawes, C., Morris, J., & Fries, B.E. (1997). The early impact of the patient self-determination act in long-term care facilities: Results from a 10 state sample. *Journal of the American Geriatrics Society, 45* (8), 939-944.

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (2001). *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes.* (http://www.cms.hhs.gov/medicaid/reports/rp700hmp.asp)

U.S. Department of Health and Human Services, Office of the Inspector-General (OIG) (1999a). *Quality of Care in Nursing Homes: An Overview.* Washington, DC: (March).

U.S. Department of Health and Human Services, Office of the Inspector-General (OIG) (1999b). *Abuse Complaints of Nursing Home Residents.* Washington, DC: (May): Office of Evaluation and Inspections (OEI-06-98-00340).

U.S. Senate, Special Committee on Aging. *Medicaid Reform: Quality Of Care In Nursing Homes At Risk?* (1995, October 26) (Testimony by: Ellen T. Reap, President, Association of Health Facility Survey Agencies; John Willis, Texas State Long-Term Care Ombudsman; Scott Severens, President, National Citizens Coalition for Nursing Home Reform; William M. Russell, M.D., Medical Director, St. Elizabeth Home, Baltimore, MD).

Vladeck, B.C. (1995, December). Testimony at a Congressional Staff and Press Briefing, Sponsored by Senators David Pryor and Jay Rockefeller and the Democratic Members of the U.S. Senate Special Committee on Aging, by Bruce Vladeck, Administrator, Health Care Financing Administration in Washington, DC.

Wunderlich, G.S. and Kohler, P., Eds., Institute of Medicine (IOM). (2000). *Improving the Quality of Long-Term Care.* Washington, DC: National Academy of Sciences, IOM.

STATEMENT OF JEANNE M. HODGSON BEFORE THE UNITED STATES SENATE COMMITTEE ON FINANCE

Mr. Chairman, members of the Senate Finance Committee, thank you for this opportunity to testify today and to tell you the story of my mother, Annie Boyd, whose untimely and shocking passing is the reason I am here before you today.

My name is Jeanne Hodgson. I'm from Ranson, West Virginia. In October of 2000, my brother, sister and I faced the most difficult decision we have ever faced in our lives: the decision to put our mother in a nursing home. We put off this decision for quite some time. But, as our mother's Alzheimers condition quickly worsened, we felt like we had no choice. It was clear to us that Mom needed 24-hour care; care that my sister, brother, and I could not provide while holding down jobs, supporting our families and dealing with our own health problems.

We began this journey by trying to find the best home we could for mom. We chose a facility that looked nice, and the admissions staff boasted of their special Alzheimer/Dementia Special Care Unit, which offered increased supervision and frequent resident/staff interactions. You see my mom had a tendency to wander -- she loved to walk. And she had fallen and her hurt herself at home, so we needed a nursing home facility that could deal with that problem.

We thought this nursing home would provide Mom with a level of care beyond anything we could give her. So, on October 12, 2000, we moved Mom into the Home.

Despite our hopes, it soon became apparent to us that she was not receiving the level of supervision promised to us. In fact, we began to realize that Mom spent most of her days wandering the nursing home halls without any proper help or supervision. Although the nursing home had promised to engage her in special activities to help with her Alzheimers, they rarely

provided them. My sister and I would each visit my Mom at least three times a week, and during those visits we began to realize the nursing home was gravely understaffed. During our individual visits, my sister and I both noticed there was not enough staff to even feed the patients. So, on more than one occasion my sister and I fed patients in need of help. During my sister's visits, she noticed that lunch trays would often come without liquids, and that pills were lying on the floor.

Within two years of Mom moving into the facility, she had sustained over 30 falls and other unexplained injuries and accidents, ranging from a regular bruises, lost teeth, and black eyes---to head lacerations requiring stitches, and a fractured left wrist. Unfortunately, we didn't know of many of these falls until after Mom's passing because they were documented, but not reported. As for the injuries we knew about, the staff claimed they had no idea what happened. It was clear to me that they didn't have adequate staffing to supervise my mom and simply could not keep her safe. We complained, we tried to work with the staff, but it didn't change anything.

As the falls and injuries became more frequent, my family started to doubt our decision. The final straw occurred in October of 2002 when Mom was admitted to Jefferson Memorial Hospital because she was suffering from severe dehydration. At that point, we were certain that the nursing home was doing a lot more harm than good. So, we made the decision to move Mom out of the facility, and we began to consider other options.

Unfortunately, our decision came too late. On November 20, 2002, around 11:15 pm, I received a knock on the door. When I opened my door, there on my front porch, was an Officer with the Charleston Police Department. He told me that my mother had died at the nursing

home. The nursing home never even called to inform my family of my mom's passing or any of the surrounding events.

As to how she died, he told me she had been hanged. My mother was found with a shower hose around her neck. It was considered a suspicious death and they were undertaking an investigation. Ultimately it was an investigation that went nowhere. The police never determined how my Mom died.

I cannot put into words how I felt at that moment, standing on the porch. The lingering feelings still haunt me today. I felt guilty for having to put my mom in such a place. I felt outrage that they could allow this to happen to such vulnerable person. Unfortunately, I can't bring our mother back, but what I can do is share this story with you. Based on our family's experience, and what I have come to know about nursing homes and elderly care since that time, I know that nursing home neglect is much more commonplace then people realize. Staff shortages at these facilities is an important problem that needs to be addressed at the national level. Rather than limit the rights of these elders through tort reform, I would ask this body to get to the root cause of this neglect. Look at how to solve the problem by addressing the staffing problems.

If by giving this testimony, I can help save even one elderly person from suffering from nursing home neglect due to staff shortages and poorly trained workers, I will have done honor to the memory of my Mom and all that she did for me and my family. Thank you

WRITTEN TESTIMONY
OF
Mary K. Ousley
Chairman
American Health Care Association

U.S. Senate Finance Committee
Thursday, July 17, 2003

1201 L Street, NW, Washington, DC 20005

Good morning Senator Grassley, and members of the Committee. I appreciate the opportunity to be with you here today -- and to provide you with perspective on the progress we are making in regard to improving the quality of long term care we provide to more than 1.5 million elderly and disabled Americans annually.

My name is Mary Ousley -- and I am the Chairman of the American Health Care Association. I speak today on behalf of all members of the American Health Care Association (AHCA). We are a national organization representing some 12,000 providers of long term care that employ more than 1.5 million caregivers.

I have been in the care giving profession for nearly three decades. I am a senior executive with a multifacility corporation, a registered nurse and a licensed nursing home administrator. I am intimately familiar with the challenges of being on the front lines of care giving -- and acutely aware that providing quality care to our seniors, necessarily, is a collective and collaborative effort.

I have worked formally and informally with the Centers for Medicare and Medicaid Services (CMS) and its predecessor, the Health Care Financing Administration (HCFA), over several decades, in various capacities, and on many issues representing the long term care profession -- a profession that is facing economic uncertainties. We are struggling in an environment of Medicare cuts, critical reductions to Medicaid programs in many states and skyrocketing liability costs. Despite the fact that the profession is under severe financial pressures, skilled nursing facilities are dedicated to maintaining the highest quality of care and services for the frail elderly and disabled of America.

I'd like to thank you Mr. Chairman for calling this important hearing. You are providing stakeholders a valuable opportunity to discuss in detail our commitment to the quality of long term care services, and you are fostering an environment in which we can continue to work successfully together.

In addition to you, Chairman Grassley, it is also important to recognize President Bush, HHS Secretary Tommy Thompson and CMS Administrator Tom Scully for their commitment to ensuring America's seniors receive the highest quality health care our great nation has to offer.

Measuring, Communicating and Improving Care Quality: Charting a New Course

We feel nothing but compassion for those who appeared first before this Committee -- their stories and unfortunate experiences will remain with us all long after today's hearing. It is, however, critically important to emphasize these incidents are the exception, and the efforts of all of us here today are dedicated toward eliminating such occurrences. Mr. Chairman, we must understand that bad outcomes are not the norm and we are committed to working with the government to improve substandard providers or get them out of our profession. The positive long term care

experiences of millions of America's seniors do not garner headlines, nor, really should they - because quality care is expected, and must be the norm.

But I'm not here today to say the state of affairs regarding quality is optimal -- the process of health care delivery is dynamic and must never remain static -- we must always seek to improve the norm of performance -- we can never feel complacent or satisfied with incremental progress; achieving progressively higher levels of care quality is an ongoing effort - as is the progressive effort to measure, assess and evaluate quality care itself.

We understand that the GAO report that is the subject of today's hearing finds an almost 30% reduction in actual harm deficiencies over an 18 month period that ended in 2002. Perhaps this is an indication of actual quality improvement, or as the GAO concludes, this is due to an understatement of deficiencies. This points to the central problem in today's survey process - that it cannot distinguish between an oversight problem and quality improvement.

In fact, Mr. Chairman, you addressed this very issue in the September 2000 hearing when you asked GAO Inspector General Scanlon, and I quote, whether "the quality of the surveys and the information in the OSCAR data base is reliable enough to make judgments about the level of quality provided in the nation's nursing homes."

Mr. Scanlon's answer was, "Mr. Chairman, I am afraid it is not."

This, of course, does not mean we view the survey process as defunct and irrelevant by any means. We do not. The survey procedure for long term care facilities' is a necessary and important process that Congress has directed CMS to use to determine facilities' compliance with regulations and certify facilities as Medicare and Medicaid providers. The statistical information (OSCAR data) that the process generates is used by many to define quality. However, this information forms only one part of the picture of quality.

Yes, Mr. Chairman, it is but one tool - and we believe the true barometer of quality is not deficiency rates but patient outcomes. The clinical outcomes achieved by residents receiving care in our nation's nursing facilities -- and the satisfaction of the patients, their families and staff -- hold the most reliable information on the quality of care provided by facilities.

We have, Mr. Chairman, set upon a new course with quality as our guide and compass. We view quality improvement as essentially an internal process - not an external process. Regulatory efforts are important, but they will not necessarily lead to sustained improvements in quality because changes in care giving and patient outcomes must come from internal processes. Yet, improving the accuracy and consistency of the survey process, and encouraging facilities to adopt quality

assessment and improvement systems are not mutually exclusive - they are compatible.

Internal quality improvement and quality management systems must be customer centered. These systems must be based on solid, well-understood policies and procedures and resident care protocols. The policies, procedures and protocols then will enable the facility interdisciplinary team to monitor not only the multiple clinical conditions but also the processes of care that lead to improved outcomes for residents. It is in this way that quality is measured, communicated, and improved. It is only through these systems that sustained and system wide improvements in quality of care and patient outcomes can be maintained. Logically, these results will lead to fewer deficiencies and overall improved compliance with federal and state regulatory expectations.

I have had this experience first hand – when I became part of the new management team that assumed the leadership of my current company in mid-2001. The company was in Chapter 11 and was very challenged in its ability to achieve and sustain regulatory compliance with the requirements of participation. In addition to a comprehensive set of policies and procedures, we developed and implemented an array of quality management tools including the Resident Care Management Systems ("RCMS"). RCMS presents "best practice" procedures for significant clinical areas within specialized modules. The modules outline procedures, responsibilities, and documentation requirements specific to respective patient conditions. These systems provide for quality and consistency in care and outcomes as reflected in the RCMS Quarterly Audit and our company's Standards Report. This unique approach is just one of many 'Foundations for Improvement' initiatives within our company, which fosters a patient-centered focus in contrast to the facility survey focus of the past.

Since that implementation of these initiatives, the company has realized steady improvement in the areas detailed in the following list:

- Quality Indicators Profile percentiles have improved, which are indicative of improved resident outcomes.
- Average number of deficiencies has decreased.
- Average number of facilities found to be deficiency free on annual survey has increased.
- Average level of severity of deficiencies have decreased.
- Facilities meeting regulatory care standards have increased.

- Imposition of remedies including denial of payment and monetary penalties has decreased.

While our company needs to continue its ongoing quality management and quality improvement efforts -- the emphasis on understanding the importance of the regulatory framework for long term care facilities – complemented by the resident-centered quality improvement efforts of our management teams at all levels of the corporation have demonstrated that change can occur and reap rewards for both residents and staff.

While there are some nursing homes that need closer regulatory oversight, there also needs to be an emphasis on working with facilities to address their systems of care and culture that involves the facility staff. Creating an environment that promotes sharing of best practices between nursing homes -- and that focuses on systems of care - are critically important to complement the current regulatory approach.

The total number of deficiencies as a proxy for quality is a false choice, and it is our common sense contention that there is no single measure of quality - there are multiple measures. The multiplicity and confluence of indices represents the new course of quality evaluation that benefits patients, policymakers, caregivers and consumers alike.

Just as competition spurs choice, productivity and product innovation in the economic marketplace, competing of quality assessment outcomes will provide similar benefits in the health care marketplace.

The many innovations and improvements in healthcare we've seen just in the past two decades has been extraordinary, and we fully expect and hope additional means to measure quality will emerge. We are excited about the pace of changes we see occurring in long term care, and we look forward to working collaboratively with all stakeholders to determine, on an ongoing basis, what constitutes quality, and how we can best measure it.

In regard to the GAO report that is one of the focal points of today's hearing, there are obviously some aspects of the report that trouble us - they cannot be discounted. Yet there is also evidence that improvements have been made, at least from the standpoint of the existing survey process, which, as we indicated, is just one way to go about evaluating quality.

One time progress, though, is not good enough. We need to keep working together to improve care quality across the board. The joint HHS/CMS Nursing Home Quality Initiative (NHQI) and our own Quality First initiative are the ways we are working to do so.

The NHQI: More Accountability, Increased Disclosure, More Competition

The NHQI, like our Quality First initiative, has helped place us on the course necessary to ensure care quality improves and evolves in a manner that best serves patient needs. It focuses upon:

- Resident centered care;
- Care outcomes;
- Public Disclosure;
- Increased collaboration; and
- Accountability and dissemination of best practices models of care delivery.

The Nursing Home Quality Initiative -- introduced by HHS and CMS in 2002 -- requires all nursing facilities in all states to participate in the program. It was implemented nationally last year, and our profession endorsed it from its introduction, and committed to the government to help make it succeed. The goal of this initiative is to identify care areas that may need improvement within a facility, publicly report nursing facility quality measures to assist consumers in making nursing home choices, and to improve patient care outcomes.

The public reporting of nursing home quality measures is done via the CMS Nursing Home Compare web site. Eight standardized measures that are intended to capture meaningful aspects of nursing care outcomes are reported. The measures are posted and updated quarterly on the CMS Web site. An additional component of the NHQI is the reporting of "statewide averages" for the measures so consumers can compare results to other facilities in the state where the facility is located.

Preliminary results of the NHQI indicate that it has been successful in promoting quality improvement activities among nursing homes. The initiative is only 8 months into its national implementation, but we are already witnessing change. According to CMS, analysis has shown that over three-quarters of nursing homes (78%) reported making quality improvement changes during the NHQI pilot and 77% indicated that the NHQI was, in part, responsible for their decision to undertake these activities. Other evaluations have confirmed that within the first five months of the NHQI, more than half of the nursing homes (52%) in the six pilot states requested quality improvement technical assistance from the Quality Improvement Organizations (QIO).

In an effort to inform consumers about the NHQI and the availability of the quality measures, CMS placed one-time-only newspaper ads in many news markets to

promote consumer awareness of its web site. CMS' studies also indicate that consumers are using the information available to them at the Nursing Home Compare website. In fact, 70% of the web users rated the information as "clear, easy to understand, easy to search and valuable."

Even in this system there are limitations that are related to inadequacies in the clinical data assessment tool and clinical information system currently used in long term care and from which the quality measures are derived. However, we are excited about the recent announcement by the Secretary of HHS, Tommy Thompson, concerning the department's efforts to standardize medical/clinical terminology. The new and recommended terminology and classification system, called SNOMED (Standardized Nomenclature of Medical Diagnoses), is far more advanced than what is currently used in long term care and supports clinical decision-making needed to achieve quality care and outcome measures.

An extremely important component of the NHQI is that it uses a collaboration and partnership model to leverage knowledge and resources. The NHQI introduced the involvement of state Quality Improvement Organizations (QIOs) to assist nursing home providers in implementing continual, community-based quality improvement programs designed for nursing homes to improve their quality of care.

A nursing home in Florida, which was one of the six pilot states, discovered that 21% of its patients were reported as suffering from chronic, unresolved pain. They did not know this fact prior to the reporting effort and they began working with Florida Medical Quality Assurance, Inc. (the QIO). FMQAI helped them analyze the system they were using to assess and manage residents' pain. They reviewed some patient charts and worked with staff to analyze where their current system was breaking down. Rather than trying to invent an entirely new system -- the FMQAI was able to identify and fix weak spots in the facility system and teach the staff how to continuously monitor their own improvement.

By November of last year, when the Quality Initiative was launched nationally, this facility's reported number for chronic pain was down to 6.6%. As of the latest round of reports (last month), their number is down to 3.25%.

In Iowa, the partnership between the individual nursing facilities and the state's QIO, the Iowa Foundation for Medical Care, has already delivered impressive results. The percentage of residents with pain dropped from 12.5% in the second quarter of 2002, to 9.1% in the fourth quarter for those facilities working with the QIO. Other quality measures, including rates of infection and residents with a loss of ability in basic daily tasks have been reported by the QIO to have significantly improved. One important reason for the improvement is the partnership between the facility and the QIO - both parties acknowledge there are problems and work together to improve the situation. In fact, a nursing facility nurse involved in the Iowa NHQI project

stated that, "the NHQI process, while it is just the beginning, has brought a collaborative effort of sharing ideas for quality improvements among the health care profession which is only improving the quality of care we provide to our residents."

A further affirmative example is a facility in the Salt Lake City area that prior to NHQI did not have any programs or processes in place regarding the assessment of residents with pain. After working with Utah's QIO, *HealthInsight*, the facility has learned best practices and implemented a process where the nurses assess residents for pain every shift when they are giving medications. The changes have been easy to implement, have decreased the amount of time it takes for documenting pain on the required assessments, and have led to better patient pain management.

Another example of how the NHQI has fostered positive relationships is evident in Mississippi. The Mississippi Health Care Association representing 190 nursing homes and long term care facilities is working in concert with the state QIO and the long term care ombudsman to educate consumers on what to look for in a nursing home through a series of statewide forums.

CMS, stakeholders, members of Congress, researchers and consumers recognize the value of quality assessment and improvement methods and their effectiveness in measuring, promoting and rewarding quality outcomes in nursing facilities. The increasing complexity of the long term care environment in recent years and the growing demands and expectations on the regulatory process offer both an opportunity and a need to creatively incorporate methods into the equation of providing and regulating long term care.

Patient, family and staff satisfaction should, officially, be a key measurement of quality. We recommend that Congress allow CMS to use measures in addition to the survey process to assess patient outcomes and their satisfaction. CMS will then have the requisite legal latitude and authority to develop better measures of quality of care in skilled nursing facilities so the process can begin to design appropriate payment incentives.

Quality First Initiative: Proactive, Profession-Wide Partnership to Advance Quality Care

Providers have also learned that we must lead in the area of improving public trust and customer satisfaction. Like quality, these areas can best be improved by providers themselves rather than by regulators, Congress or others. So we in the long term care profession have made this one of our primary missions. In July of 2002, the American Health Care Association, the Alliance for Quality Nursing Home Care, and the American Association of Homes and Services of the Aging, joined together to establish a proactive, profession-wide partnership to advance the quality of care and services for older persons and persons with disabilities.

This signifies a turning point in the empowerment and shared mission of providing quality long term care to today's and tomorrow's seniors. We are proud that long term care providers have taken this step to improve quality through increasing accountability and disclosure - a voluntary initiative that no other health care provider group has taken.

The Quality First Covenant, as it is known, is based upon seven principles that cultivate and nourish an environment of continuous quality improvement, openness and leadership. These include:

- Continuous Quality Assurance and Quality Improvement;
- Public Disclosure and Accountability;
- Patient/Resident and Family Rights;
- Workforce Excellence;
- Public Input and Community Involvement;
- Ethical Practices; and
- Financial Stewardship.

Quality First supports and builds upon CMS's Nursing Home Quality Initiative -- and is based on the concept that reliably measuring nursing home quality and making the results available to the public is in the best interest of consumer and caregiver alike.

Within Quality First there are six expected outcomes for assessing the quality in the profession. By 2006, we are working to achieve the following benchmarks:

- Continued improvement in compliance with federal regulations;
- Demonstrable progress in promoting financial integrity and preventing occurrences of fraud;
- Demonstrable progress in the quality of clinical outcomes and prevention of confirmed abuse and neglect;
- Measurable improvements in all Centers for Medicare and Medicaid Services Continuous Quality Improvement measures;
- High rates on consumer satisfaction surveys that will indicate improved consumer satisfaction with services; and
- Demonstrable improvement in employee retention and turnover rates.

It is noteworthy, Mr. Chairman, these outcomes incorporate measures from key regulatory bodies, as well as incorporating the voices of staff, residents and families. Our research demonstrates that staff and residents are important arbiters of quality. This provides the impetus for targeted systems improvement, which, as I previously noted, is an important mechanism for boosting quality. Since Quality First has been announced, providers who have made this pledge are beginning to work to catalogue their progress, identify shortfalls, and make necessary improvements.

Quality First is born from the profession and the implementation of Quality First must reside inside the profession. But of equal, if not greater importance, Quality First must be supported by those outside of the profession who are able to provide unbiased analysis. Therefore Quality First will provide for the establishment of a National Commission to advise and monitor performance and the need for improvement. While the profession supports the establishment of this Commission, it also recognizes that to be effective and credible the Commission must be independent of the profession.

The National Commission will be a private sector, non-partisan panel composed of nationally respected health care and quality improvement experts, consumer representatives, former government officials, and business leaders.

As part of its work, the Commission will evaluate the current state of long term care performance, identify key factors influencing the ability of providers to achieve meaningful quality improvement, and make recommendations on national initiatives that will lead to sustainable quality improvement.

An area of great progress has been the evolution of quality programs at the state level.

Supplementing CMS's introduction of QIOs, AHCA affiliates are collaborating within their states to implement activities and programs that foster performance improvement. Models of particular note are those in Georgia, Ohio, Minnesota and Florida.

Working in concert, the Georgia Nursing Home Association, the Department of Community Health, the Alzheimer's Association and InnerView consultants developed *The Evidence-based Quality Improvement Program for Georgia Nursing Homes* to improve the quality of life for patients in nursing homes. The program provides long term care facility managers with the knowledge and skills necessary to implement an effective continuous quality improvement program, and consumers with informational resources including nursing home quality profiles and family and employee satisfaction surveys.

In Ohio, our state affiliate was instrumental in securing legislation that funds ongoing customer satisfaction surveys of nursing facility patients and families. The most recent results indicate an average satisfaction score of 89.1 out of 100 for families and 91.8 for patients. Because Ohio nursing facility providers recognize the importance of weighing customer satisfaction when measuring quality, the Ohio Health Care Association currently is urging the legislature to continue to fund the surveys.

In addition to these state programs, AHCA has committed significant resources to the tools and programs that will support providers in quality improvement. Efforts have included development of the *How to Be A Nurse Assistant* curriculum that effectively trains nurse assistants to deliver top-quality care, and the creation of *Radiating Excellence: The Senior Nurse Leader Self-Assessment* -- a unique program that delivers leadership and management education. Additionally, we have produced the AHCA Model Consumers Guide, which promotes the value of providing customer focused information and provides resources for long term care providers to assess customer satisfaction.

Mr. Chairman, I'd like to thank you again for providing us the opportunity to share our views about how we can continue to work together to improve the quality of long term care, and to do so in a manner that helps us best measure both progress as well as shortcomings. To be effective, our profession needs economic and workforce stability that the government has a role in providing. We saw the devastating result of BBA cuts and the impact of BBRA relief. We must modulate this seesaw with adequate funding.

As I noted, improving care quality is a continuous, dynamic, ongoing enterprise - and I can say from all my years in long term care that there has never been a broader recognition of the importance of quality, or a broader commitment to ensure it keeps improving.

Let us all commit today to ensure the systems and methods used in the 20th century to help assess and measure care quality are improved upon by new, evolving systems and methods that, in the 21st century, we are just now beginning to explore. We are committed to achieving demonstrable, measurable quality improvements on every front, and we look forward to maintaining a successful working partnership with you, Mr. Chairman, and with everyone here today.

August 29, 2003

The Honorable Charles Grassley, Chairman
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Grassley:

I am pleased to have the opportunity to respond to your questions that follow up to the July 17th Senate Finance Committee hearing examining the state of nursing home care quality in America. We appreciate having been invited to testify about quality improvement in nursing facilities, and wish there had been additional time to discuss the many initiatives we are taking to both improve quality and reduce deficiencies. I am proud of the tremendous progress we have made together in the past 24 months, and your questions will afford me the opportunity to briefly enumerate several of these initiatives.

The American Health Care Association takes very seriously any instance of poor care, and it is central to our mission that we help all providers better measure, communicate, and continuously improve their level of care quality provided to patients.

Question #1: "As an association that represents the for-profit nursing industry, what ideas do you have to address the 3,500 nursing homes that are not doing their job? I am sure that you will agree that these homes give all nursing homes a bad name."

First, it is essential to note for the record that AHCA represents both non-profit and for-profit nursing homes that provide care to more than one million beneficiaries. Our membership is approximately 20% not-for-profit. These ownership designations, however, do not in any way impact or alter the missions of the providers we represent who, despite many systemic challenges, strive to provide consistently excellent care to our nation's elderly and disabled.

We believe that it is inappropriate to conclude that a facility, as an entity, is necessarily not doing its job if it receives a single citation during a single inspection for an isolated deficiency. In a perfect world, no caregivers would ever make any mistakes, but with tens of millions of hours of care given everyday, occasional mistakes are inevitable. We don't believe that it is the intent of the survey system for a citation to be an indictment of an entire facility, its caregivers and their treatment of all patients.

Nevertheless, we do believe that facilities and states associations and we, as their national representatives, should do everything possible to avoid errors or deficient facility practice and that a consistent focus should be fostering internal quality improvement mechanisms at the patient level. This has been a prime mission of AHCA for many years, and we continue to develop new and exciting means to deliver the highest quality long term care. We have a number of ongoing programs and new ideas regarding how to improve care at the facility level. I detailed several in my testimony, and others are listed in response to your second question below. Most importantly, many of them are showing results. The

most successful are those that employ a collaborative approach to problem solving, such as the government's Nursing Home Quality Initiative (NHQI) partnership, which leverages knowledge and resources to improve patient care. We look forward to working with you to continue making progress when it comes to both decreasing deficiencies and increasing patient satisfaction. Overall, as a national association, we believe it is important to continually provide our members with information and materials that can assist them in providing the highest quality care. In addition, we believe the public disclosure of clinical indicators of outcomes of care in all nursing facilities through the NHQI will be helpful. The NHQI program adds an incentive for facilities to implement programs and systems that identify and continuously improve areas needing attention. This is one of the reasons that we were supporters of this program from its inception, and continue to be.

Question #2: "While acknowledging AHCA's development of a quality assurance program for nursing homes, what is AHCA doing to identify and help the 20 percent of facilities that harm patients, particularly those homes that have a history of harming residents?"

AHCA is working daily on scores of issues and programs - each dedicated to ensuring our member caregivers have the resources, staff, technical and clinical knowledge they need to provide high-quality care, and to continuously improve their quality. Existing survey data can be used to identify facilities at any level of deficiencies. In addition, as our Quality First program is developed, we expect that it will be able to identify those facilities whose performance is lower than their peers.

As the largest national association representing long term care providers, AHCA has both longstanding and new programs and tools to measure, communicate and improve quality, training and staffing. These efforts include:

- Our ongoing partnership with state Quality Improvement Organizations that has taken on new relevance with the NHQI; in Iowa the partnership has already delivered impressive results with marked improvement in quality measures including pain, rates of infection, and residents with a loss of ability in basic daily tasks;
- Our profession-wide Quality First initiative that involves measuring and reporting to the public, Congress and other governmental agencies about progress on specific and identified goals;
- Development of the preeminent nurse aide training curricula and texts, *How to be a Nurse Assistant*; this AHCA-created program, released just a few months ago, is the best of its type and emphasizes "Mindfulness" as a mindset where individual resident needs are preeminent and emphasized over automatic or routine actions;
- Creation and support of the National Commission on the Long Term Care Workforce to bring together educators, caregiver representatives, providers, labor organizations, and other stakeholders across the long term care spectrum to build consensus on the challenges and solutions to address the growing shortage in the long term care workforce;

- Development of a pioneering set of competencies and training for nurse leadership through a program we call *Radiating Excellence*; this program recognizes that senior nurses have ample opportunities to develop clinical expertise, but no similar opportunity for guidance and cultivation of management competencies; the program offers opportunities for development of such expertise;
- Taking a leadership role in leading other associations to become the first profession to work with OSHA to develop comprehensive, industry-specific voluntary guidelines to reduce ergonomic injuries;
- Working toward broad system-wide improvements such as developing an adequate and stable workforce; AHCA's partnership with the Department of Labor resulted in www.carecareers.net, which provides a free mechanism for linking caregivers and employers;
- Pioneering and leading the profession in giving an active and preeminent voice to customers and their families. AHCA developed the first profession-wide customer satisfaction assessment questionnaires with the Gallup organizations in the mid 1990's, has championed and provided direction in developing model consumer guides at the state level, and recently published a manual for providers on how to conduct satisfaction surveys;
- Implementation of the AHCA/NCAL Quality Award Program. Initiated in 1996 this three-level program integrates all of the Malcolm Baldrige national Quality award attributes and customized to long term care;
- Development and delivery of high quality educational programming at an annual convention and at other forums, serving as the direction and training for participants as well as a model of what our state affiliates develop;
- Nurse scholarship program; over years, AHCA has offered nearly $200,000 in scholarships to more than 350 students working toward nurse licensing;
- Striving for more stable and appropriate funding mechanisms; and,
- Improving the oversight system so that it communicates quality measures that are of value to consumers.

Mr. Chairman, we are cognizant of the fact that improving care quality is a permanent, ongoing mission, and that we have work to do. Nevertheless, we are firm in our belief that efforts emphasizing patient outcomes and programs focused on improving from within a facility must be undertaken if we are to consistently improve levels of care quality. We look forward to continuing our work with you and your staff and all long term care stakeholders to ensure our frail, elderly and disabled receive the highest level of care our nation has to offer.

Sincerely yours,

Mary K. Ousley

Mary Ousley, Chairman
American Health Care Association

United States General Accounting Office

GAO

Testimony
Before the Committee on Finance,
U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, July 17, 2003

NURSING HOMES

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

Statement of William J. Scanlon
Director—Health Care Issues

GAO-03-1016T

July 17, 2003

GAO
Accountability · Integrity · Reliability

Highlights

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

NURSING HOMES

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

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*	
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*	
	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.

*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.

Nursing Homes: Quality of Care More Related to Staffing than Spending. GAO-02-431R. Washington, D.C.: June 13, 2002.

Nursing Homes: More Can Be Done to Protect Residents from Abuse. GAO-02-312. Washington, D.C.: March 1, 2002.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities. GAO-02-279. Washington, D.C.: February 15, 2002.

VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening. GAO-01-768. Washington, D.C.: July 27, 2001.

Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment. GAO/T-HEHS-00-209. Washington, D.C.: September 28, 2000.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6. Washington, D.C.: November 4, 1999.

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality of Care. GAO/T-HEHS-00-27. Washington, D.C.: November 4, 1999.

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. GAO/HEHS-99-154R. Washington, D.C.: August 13, 1999.

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment. GAO/T-HEHS-99-155. Washington, D.C.: June 30, 1999.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157. Washington, D.C.: June 30, 1999.

Nursing Homes: Complaint Investigation Processes in Maryland. GAO/T-HEHS-99-146. Washington, D.C.: June 15, 1999.

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. GAO/HEHS-99-80. Washington, D.C.: March 22, 1999.

Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care. GAO/T-HEHS-99-89. Washington, D.C.: March 22, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. Washington, D.C.: March 18, 1999.

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Problems. GAO/T-HEHS-98-219. Washington, D.C.: July 28, 1998.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

GAO's Mission

The General Accounting Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through the Internet. GAO's Web site (www.gao.gov) contains abstracts and full-text files of current reports and testimony and an expanding archive of older products. The Web site features a search engine to help you locate documents using key words and phrases. You can print these documents in their entirety, including charts and other graphics.

Each day, GAO issues a list of newly released reports, testimony, and correspondence. GAO posts this list, known as "Today's Reports," on its Web site daily. The list contains links to the full-text document files. To have GAO e-mail this list to you every afternoon, go to www.gao.gov and select "Subscribe to e-mail alerts" under the "Order GAO Products" heading.

Order by Mail or Phone

The first copy of each printed report is free. Additional copies are $2 each. A check or money order should be made out to the Superintendent of Documents. GAO also accepts VISA and Mastercard. Orders for 100 or more copies mailed to a single address are discounted 25 percent. Orders should be sent to:

U.S. General Accounting Office
441 G Street NW, Room LM
Washington, D.C. 20548

To order by Phone: Voice: (202) 512-6000
TDD: (202) 512-2537
Fax: (202) 512-6061

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Public Affairs

Jeff Nelligan, Managing Director, NelliganJ@gao.gov (202) 512-4800
U.S. General Accounting Office, 441 G Street NW, Room 7149
Washington, D.C. 20548

United States General Accounting Office
GAO
Report to Congressional Requesters

July 2003

NURSING HOME QUALITY

Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight

G A O
Accountability * Integrity * Reliability

GAO-03-561

July 2003

GAO
Accountability · Integrity · Reliability

Highlights

Highlights of GAO-03-561, a report to congressional requesters

NURSING HOME QUALITY

Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight

Why GAO Did This Study

Since July 1998, GAO has reported numerous times on nursing home quality-of-care issues and identified significant weaknesses in federal and state oversight. GAO was asked to assess the extent of the progress made in improving the quality of care provided by nursing homes to vulnerable elderly and disabled individuals, including (1) trends in measured nursing home quality, (2) state responses to previously identified weaknesses in their survey, complaint, and enforcement activities, and (3) the status of oversight and quality improvement efforts by the Centers for Medicare & Medicaid Services (CMS).

What GAO Recommends

GAO is making several recommendations to the Administrator of CMS to (1) strengthen the nursing home survey process, (2) ensure that state survey and complaint activities adequately assess quality-of-care problems, and (3) improve CMS oversight of state survey activities. CMS concurred with the report's recommendations, but its comments on intended actions were not fully responsive to all of the recommendations. Eleven states provided comments that most often focused on the resource constraints states face in meeting federal standards for oversight of nursing homes.

www.gao.gov/cgi-bin/getrpt?GAO-03-561.

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

What GAO Found

The proportion of nursing homes with serious quality problems remains unacceptably high, despite a decline in the incidence of such reported problems. Actual harm or more serious deficiencies were cited for 20 percent or about 3,500 nursing homes during an 18-month period ending January 2002, compared to 29 percent for an earlier period. Fewer discrepancies between federal and state surveys of the same homes suggests that state surveyors are doing a better job of documenting serious deficiencies and that the decline in serious quality problems is potentially real. Despite these improvements, the continuing prevalence of and state surveyor understatement of actual harm deficiencies is disturbing. For example, 39 percent of 76 state surveys from homes with a history of quality-of-care problems—but whose current survey found no actual harm deficiencies—had documented problems that should have been classified as actual harm or higher, such as serious, avoidable pressure sores.

Weaknesses persist in state survey, complaint, and enforcement activities. According to CMS and states, several factors contribute to the understatement of serious quality problems, including poor investigation and documentation of deficiencies, limited quality assurance systems, and a large number of inexperienced surveyors in some states. In addition, GAO found that about one-third of the most recent state surveys nationwide remained predictable in their timing, allowing homes to conceal problems if they chose to do so. Considerable state variation remains regarding the ease of filing a complaint, the appropriateness of the investigation priorities, and the timeliness of investigations. Some states attributed timeliness problems to inadequate staff and an increase in the number of complaints. Although the agency strengthened enforcement policy by requiring states to refer for immediate sanction homes that had repeatedly harmed residents, GAO found that states failed to refer a substantial number of such homes, significantly undermining the policy's intended deterrent effect.

CMS oversight of state survey activities has improved but requires continued attention to help ensure compliance with federal requirements. While CMS strengthened oversight by initiating annual state performance reviews, officials acknowledged that the reviews' effectiveness could be improved. For the initial fiscal year 2001 review, officials said they lacked the capability to systematically distinguish between minor lapses and more serious problems that required intervention. CMS oversight is also hampered by continuing database limitations, the inability of some CMS regions to use available data to monitor state activities, and inadequate oversight in areas such as survey predictability and state referral of homes for enforcement. Three key CMS initiatives have been significantly delayed—strengthening the survey methodology, improving surveyor guidance for determining the scope and severity of deficiencies, and producing greater standardization in state complaint processes. These initiatives are critical to reducing the subjectivity evident in current state survey and complaint activities.

Contents

Figure

Abbreviations

ACTS	ASPEN Complaint Tracking System
CMS	Centers for Medicare & Medicaid Services
CMP	civil money penalties
HCFA	Health Care Financing Administration
MDS	minimum data set
OSCAR	On-Line Survey, Certification, and Reporting system
RN	registered nurse

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

July 15, 2003

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Christopher S. Bond
United States Senate

A number of congressional hearings since July 1998 have focused considerable attention on the need to improve the quality of care for the nation's 1.7 million nursing home residents, a highly vulnerable population of elderly and disabled individuals. As we previously reported, poor quality of care at about 15 percent of the nation's approximately 17,000 nursing homes—an unacceptably high proportion—had repeatedly caused actual harm to residents, such as worsening pressure sores or untreated weight loss, or had placed them at risk of death or serious injury.[1] Significant weaknesses in federal and state nursing home oversight that we identified in a series of reports and testimonies since 1998 included (1) periodic state inspections, known as surveys, that understated the extent of serious care problems due to procedural weaknesses, (2) considerable state delays in investigating public complaints alleging harm to residents, (3) federal enforcement policies that did not ensure deficiencies were addressed and remained corrected, and (4) federal oversight of state survey activities that was limited in scope and effectiveness.[2]

In July 1998, the Health Care Financing Administration (HCFA)—the federal agency with responsibility for managing Medicare and Medicaid and overseeing compliance with federal nursing home quality standards—launched a series of actions intended to address many of the weaknesses we identified.[3] Since 1998, the agency has worked to strengthen surveyors'

[1]See U.S. General Accounting Office, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, GAO/HEHS-99-157 (Washington, D.C.: June 30, 1999).

[2]A list of related GAO products is at the end of this report.

[3]Effective July 1, 2001, HCFA's name changed to the Centers for Medicare & Medicaid Services (CMS). In this report we continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

ability to detect quality-of-care deficiencies; required states to investigate complaints alleging resident harm within 10 days; mandated immediate sanctions for nursing homes with a pattern of harming residents;[4] and begun measuring state compliance with federal survey requirements and reviewing data on the results of state surveys to help pinpoint shortcomings in state survey activities.

To evaluate the extent of the progress made in improving the quality of nursing home care since we last addressed this issue in September 2000, you asked us to assess:

- trends in measured nursing home quality;
- state responses to previously identified weaknesses in their survey, complaint, and enforcement activities; and
- the status of key federal efforts to oversee state survey agency performance and improve quality.

To assess recent trends in measured nursing home quality, we analyzed survey results for the period July 11, 2000, through January 31, 2002, and compared them to survey results for two earlier 18-month periods: (1) January 1, 1997, through June 30, 1998, and (2) January 1, 1999, through July 10, 2000. Our analysis relied on data from the Centers for Medicare & Medicaid Services' (CMS) On-Line Survey, Certification, and Reporting (OSCAR) system, which compiles the results of all state nursing home surveys nationwide. To better understand the trends identified through our OSCAR analysis, we analyzed the results of federal comparative surveys, conducted at recently surveyed nursing homes to assess the adequacy of the state surveys, for two time periods—October 1998 through May 2000 and June 2000 through February 2002. We also reviewed 76 survey reports from homes with a history of actual harm deficiencies but whose most recent survey found no such deficiencies in states where the percentage of homes cited for actual harm had declined to below the national average since mid-2000. Our review of deficiencies from these survey reports focused on the types of quality-of-care deficiencies most frequently cited nationwide.

[4]The term used in the law and regulations to describe a nursing home penalty for noncompliance is "remedy." Throughout this report, we use a more common term, "sanction," to refer to such penalties. Sanctions include actions such as fines, denial of payment for new admissions, and termination from the Medicare and Medicaid programs.

To assess state survey activities as well as federal oversight, we analyzed the conduct and results of fiscal year 2001 state survey agency performance reviews during which CMS regional offices determined state compliance with seven federal standards; we focused on the five standards related to statutory survey intervals, survey documentation, complaint activities, enforcement requirements, and OSCAR data entry. We conducted structured interviews with officials from CMS, CMS's 10 regional offices, and 16 state survey agencies to discuss trends in survey deficiencies, the underlying causes of problems identified during the performance reviews, and state and federal efforts to address these problems.[5] We also discussed these issues with officials from 10 additional states during a governing board meeting of the Association of Health Facility Survey Agencies. We selected the 16 states with the goal of including states that (1) were from diverse geographic areas, (2) had shown either increases or decreases in the percentage of homes cited for actual harm, (3) had been contacted in our prior work, and (4) represented a mixture of strong and weak performance based on the results of federal performance reviews of state survey activities. We also obtained data from most state survey agencies on staffing issues such as nursing home surveyor experience and vacancies. To assess enforcement actions, we analyzed data in CMS's enforcement database and compared homes identified in OSCAR as requiring immediate sanctions with those actually referred to CMS for sanctions by state survey agencies. See appendix I for a more detailed description of our scope and methodology. Our work was performed from January 2002 through June 2003 in accordance with generally accepted government auditing standards.

Results in Brief

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. Compared to the prior 18-month period, the percentage of nursing homes cited for actual harm or immediate jeopardy from July 2000 through January 2002 declined by about one-third—from 29 percent (about 5,000 homes) to 20 percent (about 3,500 homes). Consistent with this reported improvement in quality, federal comparative surveys completed during a recent 20-month period found actual harm or higher-level deficiencies in 22 percent of

[5]We contacted officials in Alabama, California, Colorado, Connecticut, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New York, Oklahoma, Pennsylvania, Tennessee, Washington, and Virginia.

homes where state surveyors found no such deficiencies, compared to 34 percent in an earlier period. Fewer discrepancies between federal and state surveys suggest that state surveyors' performance in documenting serious deficiencies has improved and that the decline in serious quality problems nationwide is potentially real. Despite this improvement, however, the magnitude of understatement of actual harm deficiencies remains a cause for concern. Federal surveyors found examples of actual harm deficiencies in about one-fifth of homes that states had judged to be deficiency free. Moreover, 39 percent of 76 surveys we reviewed from homes with a history of quality-of-care problems—but whose current survey indicated no actual harm deficiencies—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.

Weaknesses persist in state survey, complaint investigation, and enforcement activities. Several factors at the state level contribute to the understatement of serious quality-of-care problems. Poor investigation and documentation of deficiencies identified during nursing home surveys preclude a determination of the seriousness of some deficiencies. According to some state officials, the large number of inexperienced surveyors due to high attrition and hiring limitations has also had a negative impact on the quality of surveys. While most of the 16 states we contacted had a quality assurance process in place to review deficiencies cited at the actual harm level and higher, half did not have such a process to help ensure that the scope and severity of less serious deficiencies were not understated. The continued predictability of the occurrence of standard surveys also likely contributes to the understatement of deficiencies. Our analysis of OSCAR data indicated that about one-third of the most recent state surveys nationwide occurred on a predictable schedule, allowing homes to conceal problems if they chose to do so. In addition, many states' complaint investigation policies and procedures were still inadequate to provide intended protections. For example, 15 states did not provide toll-free hotlines to facilitate the filing of complaints, the majority of states lacked adequate systems for managing complaints, and one or more states in most of CMS's 10 regions did not correctly determine the investigation priority for complaints. Moreover, most states did not investigate all complaints involving actual harm within 10 days, as required. Some states attributed the timeliness problem to insufficient staff and an increase in the number of complaints. Although HCFA strengthened its enforcement policy by requiring state survey agencies, beginning in January 2000, to refer for immediate sanction homes that had a pattern of harming residents, we found that states failed to refer a

substantial number of such homes, significantly undermining the intended deterrent effect of this policy.

While CMS has increased its oversight of state survey and complaint activities, continued attention is required to help ensure compliance with federal requirements. In October 2000, HCFA 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. We also found inconsistencies in how CMS regions conducted their reviews, raising questions about the validity and fairness of the results. 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. Implementation has been significantly delayed for three other federal initiatives that are critical to reducing the subjectivity evident in the state survey process for identifying 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.

We are recommending that the Administrator of CMS strengthen survey, complaint, enforcement, and oversight processes by (1) finishing the development of a more rigorous survey methodology, (2) requiring states to implement a quality assurance process to test the validity of cited deficiencies for surveys that include deficiencies below the actual harm level, (3) developing guidance for states that addresses key weaknesses in their complaint investigation processes, and (4) improving the ability of federal oversight of state survey activities to distinguish between systemic and less serious state survey performance problems. Although CMS concurred with our recommendations, its comments did not fully address our concerns about the status of the initiative intended to improve the effectiveness of the survey process or the recommendation regarding state quality assurance systems. Eleven states provided comments that most often focused on the resource constraints states face in meeting federal standards for oversight of nursing homes.

Background

Combined Medicare and Medicaid payments to nursing homes for care provided to vulnerable elderly and disabled beneficiaries were expected to total about $63 billion in 2002, with a federal share of approximately $42 billion. Oversight of nursing homes is a shared federal-state responsibility. Based on statutory requirements, CMS defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. A range of statutorily defined sanctions is available to help ensure that homes maintain compliance with federal quality requirements. CMS is also responsible for monitoring the adequacy of state survey activities.

Standard Surveys

Every nursing home receiving Medicare or Medicaid payment must undergo a standard survey not less than once every 15 months, and the statewide average interval for these surveys must not exceed 12 months.[6] A standard survey entails a team of state surveyors, including registered nurses (RN), spending several days in the nursing home to assess compliance with federal long-term care facility requirements, particularly whether care and services provided meet the assessed needs of the residents and whether the home is providing adequate quality care, such as preventing avoidable pressure sores, weight loss, or accidents. Based on our earlier work indicating that facilities could mask certain deficiencies, such as routinely having too few staff to care for residents, if they could predict the survey timing, HCFA directed states in 1999 to (1) avoid scheduling a home's survey for the same month of the year as the home's previous standard survey and (2) begin at least 10 percent of standard surveys outside the normal workday (either on weekends, early in the morning, or late in the evening).

State surveyors' assessment of the quality of care provided to a sample of residents during the standard survey serves as the basis for evaluating nursing homes' compliance with federal requirements. CMS establishes specific investigative protocols for state surveyors to use in conducting these comprehensive surveys. These procedural instructions are intended to make the on-site surveys thorough and consistent across states. In response to our earlier recommendations concerning the need to better ensure that surveyors do not miss significant care problems, HCFA

[6]CMS generally interprets these requirements to permit a statewide average interval of 12.9 months and a maximum interval of 15.9 months for each home.

planned a two-phase revision of the survey process. In phase one, HCFA instructed states in 1999 to (1) begin using a series of new investigative protocols covering pressure sores, weight loss, dehydration, and other key quality areas, (2) increase the sample of residents reviewed with conditions related to these areas, and (3) review "quality indicator" information on the care provided to a home's residents, before actually visiting the home, to help guide survey activities. Quality indicators are essentially numeric warning signs of the prevalence of care problems such as greater-than-expected instances of weight loss, dehydration, or pressures sores.[7] They are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in the state.[8] By using the quality indicators to select a preliminary sample of residents before the on-site review, surveyors are better prepared to identify potential care problems. Surveyors augment this preliminary sample with additional resident cases once they arrive in the home. To address remaining problems with sampling and the investigative protocols, CMS is planning a second set of revisions to its survey methodology. The focus of phase two is (1) improving the on-site augmentation of the preliminary sample selected off-site using the quality indicators and (2) strengthening the protocols used by surveyors to ensure more rigor in their on-site investigations.

Complaint Investigations

Complaint investigations provide an opportunity for state surveyors to intervene promptly if quality-of-care problems arise between standard surveys. Within certain federal guidelines and time frames, surveyors generally follow state procedures when investigating complaints filed against a home by a resident, the resident's family, or nursing home employees, and typically target a single area in response to the complaint.

[7]Quality indicators were the result of a HCFA-funded project at the University of Wisconsin. The developers based their work on nursing home resident assessment information, known as the minimum data set (MDS)—data on each resident that homes are required to report to CMS. See Center for Health Systems Research and Analysis, *Facility Guide for the Nursing Home Quality Indicators* (University of Wisconsin-Madison: Sept. 1999).

[8]Because resident assessment data are used by CMS and states to calculate quality indicators and to determine the level of nursing homes' payments for Medicare (and for Medicaid in some states), ensuring accuracy at the facility level is critical. We have made earlier recommendations to CMS on ways to improve the accuracy of these data. See U.S. General Accounting Office, *Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities*, GAO-02-279 (Washington, D.C.: Feb. 15, 2002).

Historically, HCFA had played a minimal role in providing states with guidance and oversight of complaint investigations. Until 1999, federal guidelines were limited to requiring the investigation of complaints alleging immediate jeopardy conditions within 2 workdays. In March 1999, HCFA acted to strengthen state complaint procedures by instructing states to investigate any complaint alleging harm to a nursing home resident within 10 workdays. Additional guidance provided to states in late 1999 specified that, as with immediate jeopardy complaints, investigations should generally be conducted on-site at the nursing home. This guidance also identified techniques to help states identify complaints having a higher level of actual harm. As part of a complaint improvement project, also initiated in late 1999, HCFA plans to issue more detailed guidance to states, such as identifying model programs or practices to increase the effectiveness of complaint investigations.

Deficiency Reporting

Quality-of-care deficiencies identified during either standard surveys or complaint investigations are classified in 1of 12 categories according to their scope (i.e., the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). States are required to enter information about surveys and complaint investigations, including the scope and severity of deficiencies identified, in CMS's OSCAR database.

Table 1: Scope and Severity of Deficiencies Identified During Nursing Home Surveys

	Scope		
Severity	**Isolated**	**Pattern**	**Widespread**
Immediate jeopardy[a]	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm[b]	A	B	C

Source: CMS.

[a]Actual or potential for death/serious injury.

[b]Nursing home is considered to be in "substantial compliance."

The importance of accurate and timely reporting of nursing home deficiency data has increased with the public reporting of survey deficiencies, which HCFA initiated in 1998 on its Nursing Home Compare Web site.[9] The public reporting of deficiency data is intended to assist individuals in differentiating among nursing homes. In November 2002, CMS augmented the deficiency data available on its Web site with 10 clinical indicators of quality, such as the percentage of residents with pressure sores, in nursing homes nationwide. While the intent of this new initiative is worthwhile, CMS had not resolved several important issues that we raised prior to moving from a six-state pilot to nationwide implementation.[10] These issues included: (1) the ability of the new information to accurately identify differences in nursing home quality, (2) the accuracy of the underlying data used to calculate the quality indicators, and (3) the potential for public confusion over the available data.

Enforcement Policy

Ensuring that documented deficiencies are corrected is a shared federal-state responsibility. CMS imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification on the basis of state referrals.[11] CMS normally accepts a state's recommendation for sanctions but can modify it. The scope and severity of a deficiency determine the applicable sanctions that can involve, among other things, requiring training for staff providing care to residents, imposing monetary fines, denying the home Medicare and Medicaid payments for new admissions, and terminating the home from participation in these programs. Before a sanction is imposed, federal policy generally gives nursing homes a grace period of 30 to 60 days to correct the deficiency. We earlier reported, however, that the threat of federal sanctions did not prevent nursing homes from cycling in and out of compliance because they were able to avoid sanctions by returning to compliance within the grace period, even when they had been

[9]http://www.medicare.gov/NHCompare/home.asp.

[10]U.S. General Accounting Office, *Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature*, GAO-03-187 (Washington, D.C.: Oct. 31, 2002).

[11]States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of homes. They may use the federal sanctions or rely on their own state licensure authority and nursing home sanctions. States are responsible for ensuring that homes that have a pattern of harming residents are immediately sanctioned.

cited for actual harm on successive surveys.[12] In 1998, HCFA began a two-stage phase-in of a new enforcement policy. In the first stage, effective September 1998, HCFA required states to refer for immediate sanction homes found to have a pattern of harming residents or exposing them to actual or potential death or serious injury (H-level deficiencies and above on CMS's scope and severity grid). Effective January 14, 2000, HCFA expanded this policy to also require referral of homes found to have harmed one or a small number of residents (G-level deficiencies) on successive standard surveys.[13]

CMS Oversight

CMS is responsible for overseeing each state survey agency's performance in ensuring quality of care in state nursing homes. Its primary oversight tools are statutorily required federal monitoring surveys conducted annually in 5 percent of the nation's certified Medicare and Medicaid nursing homes, on-site annual state performance reviews instituted during fiscal year 2001, and analysis of periodic oversight reports that have been produced since 2000. 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. State performance reviews, implemented in October 2000, measure state performance against seven standards, including statutory requirements regarding survey frequency, requirements for documenting deficiencies, timeliness of complaint investigations, and timely and accurate entry of deficiencies into OSCAR. These reviews replaced state self-reporting of their compliance with federal requirements. In October 2000, HCFA also began to produce 19 periodic reports to monitor both state and regional office performance. The reports are based on OSCAR and other CMS databases. Examples of reports that track state activities include pending nursing home terminations (weekly), data entry

[12]U. S. General Accounting Office, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, GAO/HEHS-99-46 (Washington, D.C.: Mar.18, 1999).

[13]States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G-L on CMS's scope and severity grid) in each of two successive surveys within a survey cycle. A survey cycle is two successive standard surveys and any intervening survey, such as a complaint investigation.

timeliness (quarterly), tallies of state surveys that find homes deficiency free (semiannually), and analyses of the most frequently cited deficiencies by states (annually). These reports, in a standard format, enable comparisons within and across states and regions and are intended to help identify problems and the need for intervention. Certain reports—such as the timeliness of state survey activities—are used to monitor compliance with state performance standards.

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

The magnitude of the problems uncovered during standard nursing home surveys remains a cause for concern even though OSCAR deficiency data indicate that state surveyors are finding fewer serious quality problems. Compared to an earlier period, the percentage of homes nationwide cited since mid-2000 for actual harm or immediate jeopardy has decreased in over three-quarters of states—with seven states reporting a drop of 20 percentage points or more. State surveys conducted since about mid-2000 showed less variance from federal comparative surveys, suggesting that (1) state surveyors' performance in documenting serious deficiencies has improved and (2) the decline in serious nursing home quality problems is potentially real. However, federal comparative surveys, as well as our review of a sample of survey reports from homes with a history of quality-of-care problems, continued to find understatement of actual harm deficiencies.

Proportion of Nursing Homes with Documented Actual Harm or Immediate Jeopardy Care Problems Has Declined since 2000

Compared to the preceding 18-month period, the proportion of nursing homes cited for actual harm or immediate jeopardy has declined nationally from 29 percent to 20 percent since mid-2000.[14] In contrast, from early 1997 through mid-2000, the percentage of homes cited for such serious deficiencies was either relatively stable or increased in 31 states.[15] From July 2000 through January 2002, 40 states cited a smaller percentage of homes with such serious deficiencies, while only 9 states and the District of Columbia cited a larger proportion of homes with such deficiencies.[16] Despite these changes, there is still considerable variation in the proportion of homes cited for serious deficiencies, ranging from about 7 percent in Wisconsin to about 50 percent in Connecticut. Appendix II provides trend data on the percentage of nursing homes cited for serious deficiencies for all 50 states and the District of Columbia.

Table 2 shows the recent change in actual harm and immediate jeopardy deficiencies for states that surveyed at least 100 nursing homes.[17] Specifically:

- Twenty-five states had a 5 percentage point or greater decrease in the proportion of homes identified with actual harm or immediate jeopardy. For over two-thirds of these states, the decrease in serious deficiencies was greater than 10 percentage points. Seven states—Arizona, Alabama,

[14]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. See app. I for our complete scope and methodology. Our analysis considered only standard surveys. In commenting on a draft of this report, Missouri stated that our findings would have shown that quality had remained "fairly stable" had we included actual harm and immediate jeopardy deficiencies identified during complaint investigations in our analysis in table 2. However, we found that both nationally and in Missouri, the proportion of homes cited for actual harm or immediate jeopardy showed a similar decline even when complaint surveys were considered.

[15]The two earlier time periods we analyzed are for surveys conducted from January 1, 1997, through June 30, 1998, and from January 1, 1999, through July 10, 2000. See U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: Sept. 28, 2000).

[16]The proportion of nursing homes in Utah cited with serious deficiencies remained the same between the two time periods.

[17]We excluded Alaska, Delaware, the District of Columbia, Hawaii, Idaho, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, Utah, Vermont, and Wyoming from this analysis because fewer than 100 homes were surveyed and even a small increase or decrease in the number of homes with serious deficiencies in such states produces a relatively large percentage point change.

California, Michigan, Indiana, Pennsylvania, and Washington—experienced declines of 15 percentage points or more.

- Two states, South Dakota and Colorado, experienced an increase of 5 percentage points or greater in the proportion of homes with actual harm or immediate jeopardy deficiencies (6.6 and 10.8, respectively).
- The remaining 11 states were relatively stable—experiencing approximately a 4 percentage point change or less.

Table 2: Change in the Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during State Standard Surveys between the periods January 1, 1999, through July 10, 2000, and July 11, 2000, through January 31, 2002, by State

State[a]	Number of homes surveyed (7/00-1/02)	Percentage of homes with actual harm or immediate jeopardy deficiencies 1/99-7/00	7/00-1/02	Percentage point difference[b]
Decrease of 5 percentage points or greater				
Arizona	147	33.8	8.8	-25.0
Alabama	228	42.2	18.4	-23.8
Pennsylvania	764	32.2	11.6	-20.6
California	1,348	29.1	9.3	-19.9
Indiana	573	45.3	26.2	-19.1
Michigan	441	42.1	24.7	-17.4
Washington	275	54.1	38.5	-15.6
Oregon	152	47.5	33.6	-13.9
Illinois	881	29.3	15.4	-13.9
Mississippi	219	33.2	19.6	-13.5
Minnesota	431	31.7	18.8	-12.9
Montana	103	37.5	25.2	-12.3
Missouri	569	22.3	10.2	-12.1
South Carolina	180	28.7	17.8	-10.9
North Carolina	419	40.8	30.1	-10.7
Arkansas	267	37.7	27.3	-10.4
Massachusetts	512	33.0	22.9	-10.2
Iowa	494	19.3	9.9	-9.4
Tennessee	377	26.0	16.7	-9.3
Nation	**17,149**	**29.3**	**20.5**	**-8.8**
Virginia	285	19.9	11.6	-8.3
Kansas	400	37.1	29.0	-8.1
Nebraska	243	26.0	18.9	-7.1
Wisconsin	421	14.0	7.1	-6.9
Maryland	248	25.6	20.2	-5.5
Ohio	1,029	29.0	23.7	-5.3
Change of less than 5 percentage points				
Kentucky	306	28.8	25.2	-3.7

State[a]	Number of homes surveyed (7/00-1/02)	Percentage of homes with actual harm or immediate jeopardy deficiencies 1/99-7/00	7/00-1/02	Percentage point difference[b]
New Jersey	366	24.5	22.4	-2.1
Georgia	370	22.6	20.5	-2.0
West Virginia	143	15.6	14.0	-1.7
Texas	1,275	26.9	25.5	-1.5
Florida	742	20.8	20.1	-0.8
Maine	124	10.3	9.7	-0.6
New York	671	32.2	32.3	0.2
Connecticut	259	48.5	49.4	0.9
Louisiana	367	19.9	23.4	3.5
Oklahoma	394	16.7	20.6	3.9
Increase of 5 percentage points or greater				
South Dakota	114	24.1	30.7	6.6
Colorado	225	15.4	26.2	10.8

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

[a]Includes only those states in which 100 or more homes were surveyed since July 2000.

[b]Differences are based on numbers before rounding.

States offered several explanations for the declines in actual harm and immediate jeopardy deficiencies, including (1) changing guidance from CMS regional offices as to what constitutes actual harm, (2) hiring additional staff, and (3) surveyors failing to properly identify actual harm deficiencies.

Federal Comparative Surveys Show Decreased Variance with State Survey Findings, but Understatement of Actual Harm Deficiencies Continued

Our analysis of federal comparative surveys conducted nationwide prior to and since June 2000 showed a decreased variance between federal and state survey findings (see app. I for a description of our scope and methodology). For comparative surveys completed from October 1998 through May 2000, federal surveyors found actual harm or higher-level deficiencies in 34 percent of homes where state surveyors had found no such deficiencies, compared to 22 percent for comparative surveys completed from June 2000 through February 2002. In addition, while federal surveyors found more serious care problems than state surveyors on 70 percent of the earlier comparative surveys, this percentage declined to 60 percent for the more recent surveys.

Despite the decline in understatement of actual harm deficiencies from 34 percent to 22 percent, the magnitude of the state surveyors'

understatement of quality problems remains an issue. For example, from June 2000 through February 2002, federal surveyors found at least one actual harm or immediate jeopardy quality-of-care deficiency in 16 of the 85 homes (19 percent) that the states had found to be free of deficiencies. For example, federal surveyors found that 1 of the 16 homes 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. The federal surveyors who conducted the comparative survey of this nursing home noted in the file that a lack of consistent monitoring of pressure sores existed at the home during the time of the state's survey and that the state surveyors should have found the deficiency.

Several states that reviewed a draft of this report questioned the value of federal comparative surveys because of their timing. Arizona noted that comparative surveys do not have to begin until up to 2 months after the state's survey, and Iowa and Virginia officials said they might occur so long after the state's survey that conditions in the home may have significantly changed. Although legislation requires comparative surveys to begin within 2 months of the state's survey, CMS is continuing to make progress in reducing the timeframe between the state and the comparative survey. Based on our earlier recommendation that comparative surveys begin as soon after the state's survey as possible, CMS instructed the regions to begin these surveys no later than one month following the state's survey, and the average time between surveys nationally has decreased from 33 calendar days in 1999 to about 26 calendar days for surveys conducted from June 2000 through February 2002.[18]

Quality-of-Care Problems Were Understated in Homes with a History of Problems

Even with the reported decline in serious deficiencies, an unacceptably high number of nursing homes—one in five nationwide—still had actual harm or immediate jeopardy deficiencies. Moreover, we found widespread understatement of actual harm deficiencies in a sample of surveys we reviewed that were conducted since July 2000 at homes with a history of harming residents (see app. I for a description of our methodology in selecting this sample). In 39 percent of the 76 survey reports we reviewed, we found sufficient evidence to conclude that deficiencies cited at a lower level (generally, potential for more than minimal harm, D or E) should

[18]U.S. General Accounting Office, *Nursing Homes: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, GAO/HEHS-00-6 (Washington, D.C.: Nov. 4, 1999).

have been cited at the level of actual harm or higher (G level or higher on CMS's scope and severity grid). 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 the investigations conducted by surveyors and in the adequacy with which they documented those deficiencies.

Of the surveys we reviewed, 30 (39 percent) contained sufficient evidence for us to conclude that deficiencies cited at the D and E level should have been cited as at least actual harm because a deficient practice was identified and linked to documented actual harm involving at least one resident (see table 3). These 30 survey reports depicted examples of actual harm, including serious, avoidable pressure sores; severe weight loss; and multiple falls resulting in broken bones and other injuries (see app. III for abstracts of these 30 survey reports). The following example illustrates understated actual harm involving the failure to provide necessary care and services. A nurse at one facility noted a large area of bruising and swelling on an 89-year-old resident's chest. Nothing further was done to explore this injury until 11 days later when the resident began to experience shortness of breath and diminished breath sounds. Then a chest x ray was taken, revealing that the resident had sustained two fractured ribs and fluid had accumulated in the resident's left lung. A facility investigation determined that the resident had been injured by a lift used to transfer the resident to and from the bed. It was clear from the surveyor's information that the facility failed to take appropriate action to assess and provide the necessary care until the resident developed serious symptoms of chest trauma. Nevertheless, the surveyor concluded that there was no actual harm and cited a D-level deficiency—potential for more than minimal harm.

Table 3: Incidence of Underreported Actual Harm Deficiencies in Surveys GAO Reviewed

State	Number of surveys from state	Number of surveys in which GAO identified G-level deficiencies	Number of G-level deficiencies GAO identified
Alabama	6	2	2
Arizona	3	1	2
California	22	13	17
Iowa	7	5	7
Maryland	3	1	1
Minnesota	5	0	0
Mississippi	1	0	0
Missouri	4	1	1
Nebraska	4	2	2
Pennsylvania	11	2	3
South Carolina	1	0	0
Virginia	7	3	4
West Virginia	1	0	0
Wisconsin	1	0	0
Total	**76**	**30**	**39**

Source: GAO analysis of state surveys.

Note: We reviewed surveys where state surveyors had cited deficiencies at the D or E level (potential for more than minimal harm) in one or more of four quality-of-care areas (see app. I, table 6). We reviewed all such deficiencies to determine if, in our judgment, the deficiencies should have been cited at the G level or higher (actual harm).

State survey agency officials in Alabama, California, Iowa, and Nebraska told us that surveyors had originally cited G-level deficiencies in 10 of the surveys we reviewed, but that the deficiencies had been reduced to the D level during the states' reviews because of inadequate surveyor documentation. We concluded that 5 of the 10 surveys did contain adequate documentation to support actual harm because there was a clear link between the deficient facility practice and the documented harm to a resident. For example, the survey managers in one state changed a G- to a D-level deficiency because the surveyor only cited one source of evidence to support the deficiency—nurses' notes in the residents' medical records.[19] According to the surveyor, a resident with dementia, experiencing long- and short-term memory problems, fell 11 times and

[19]Instructions from the state's CMS regional office suggest, but do not require, the use of more than one source of information to support a deficiency.

sustained a fractured wrist, three fractured ribs, and numerous bruises, abrasions, and skin tears. According to the notes of facility nurses, a personal alarm unit was in place as a safety device to prevent falls. The surveyor found that the facility had (1) failed to provide adequate interventions to prevent accidents and (2) continued to use the alarm unit even though it did not prevent any of the falls. The medical record documentation of these events was extensive and, in our judgment, was sufficient evidence of a deficiency that resulted in actual harm to the resident.

In many of the 76 surveys we reviewed, including surveys in which we found no D- or E-level deficiencies that would appear to meet the criteria for actual harm deficiencies, we identified serious investigation or documentation weaknesses that could further contribute to the understatement of serious deficiencies in nursing homes. In some cases, the survey did not clearly describe the elements of the deficient practice, such as whether the resident developed a pressure sore in the facility or what the facility did to prevent the development of a facility-acquired pressure sore. In other cases, the survey omitted critical facts, such as whether a pressure sore had worsened or the size of the pressure sore.

Weaknesses Persist in State Survey, Complaint, and Enforcement Activities

Widespread weaknesses persist in state survey, complaint investigation, and enforcement activities despite increased attention to these issues in recent years. Several factors at the state level contribute to the understatement of serious quality-of-care problems, including poor investigation and documentation of deficiencies, the absence of adequate quality assurance processes, and a large number of inexperienced surveyors in some states due to high attrition or hiring limitations. In addition, our analysis of OSCAR data indicated that the timing of a significant proportion of state surveys remained predictable, allowing homes to conceal problems if they choose to do so. Many states' complaint investigation policies and procedures were still inadequate to provide intended protections. For example, many states do not investigate all complaints identified as alleging actual harm in a timely manner, a problem some states attributed to insufficient staff and an increase in the number of complaints. Although HCFA strengthened its enforcement policy by requiring state survey agencies, beginning in January 2000, 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 a substantial number of homes for sanction, significantly undermining the policy's intended deterrent effect.

Investigation Weaknesses and Other Factors Contribute to Underreporting of Care Problems

CMS and state officials identified several factors that they believe contribute to state surveys continuing to miss significant care problems. These weaknesses persist, in part, because many states lack adequate quality assurance processes to ensure that deficiencies identified by surveyors are appropriately classified. According to officials we interviewed, the large number of inexperienced surveyors in some states due to high attrition has also had a negative impact on the quality of state surveys and investigations. Our analysis of OSCAR data also indicated that nursing homes could conceal problems if they choose to do so because a significant proportion of current state surveys remain predictable.

Investigation and Documentation Weaknesses

Consistent with the investigation and documentation weaknesses we found in our review of a sample of survey reports from homes with a history of actual harm deficiencies, CMS officials told us that their own activities had identified similar problems that could contribute to an understatement of serious deficiencies at nursing homes.

- CMS reviews of state survey reports during fiscal year 2001 demonstrated weaknesses in a majority of states, including: (1) inadequate investigation and documentation of a poor outcome, such as reviewing available records to help identify when a pressure sore was first observed and how it changed over time, (2) failure to specifically identify the deficient practice that contributed to a poor outcome, or (3) understatement of the seriousness of a deficiency, such as citing a deficiency at the D level (potential for actual harm) when there was sufficient evidence in the survey report to cite the deficiency at the G level (actual harm).
- State survey agency officials expressed confusion about the definition of "actual harm" and "immediate jeopardy," suggesting that such confusion contributes to the variability in state deficiency trends. For example, officials in one state told us that, in their view, residents must experience functional impairment for state surveyors to cite an actual harm deficiency, an interpretation that CMS officials told us was incorrect. Under such a definition, repeated falls that resulted in bruises, cuts, and painful skin tears would not be cited as actual harm, even if the facility failed to assess the resident for measures to prevent falls.
- CMS officials also told us that, contrary to federal guidance, state surveyors in at least one state did not cite all identified deficiencies but rather brought them to the homes' attention with the expectation that the deficiencies would be corrected. CMS officials told us that they identified the problem by asking state officials about the unusually high number of homes with no deficiencies on their standard surveys.

Inadequate Quality Assurance Processes

Some state officials told us that considerable staff resources are devoted to scrutinizing the support for actual harm and higher-level deficiencies that could lead to the imposition of a sanction. While most of the 16 states we contacted had quality assurance processes to review deficiencies cited at the actual harm level and higher, half did not have such processes to help ensure that the scope and severity of less serious deficiencies were not understated.[20] State officials generally told us that they lacked the staff and time to review deficiencies that did not involve actual harm or immediate jeopardy, but some states have established such programs. For example, Maryland established a technical assistance unit in early 2001 to review a sample of survey reports; the review looks at all deficiencies—not just those involving actual harm or immediate jeopardy. A Maryland official told us that she had the resources to do so because the state legislature authorized a substantial increase in the number of surveyors in 1999. However, staff cutbacks in late 2002 due to the state's budget crisis have resulted in the reviews being less systematic than originally planned. In Colorado, two long-term-care supervisors reviewed all 1,351 deficiencies cited in fiscal year 2001. Maryland and Colorado officials told us that the reviews have identified shortcomings in the investigation and documentation of deficiencies, such as the failure to interview residents or the classification of deficiencies as process issues when they actually involved quality of care. The reviews, we were told, provide an opportunity for surveyor feedback or training that improves the quality and consistency of future surveys.

Inexperienced State Surveyors

State officials cited the limited experience level of state surveyors as a factor contributing to the variability in citing actual harm or higher-level deficiencies and the understatement of such deficiencies. Data we obtained from 42 state survey agencies in July 2002 revealed the magnitude of the problem: in 11 states, 50 percent or more of surveyors had 2-years' experience or less; in another 13 states, from 30 percent to 48 percent of surveyors had similarly limited experience (see app. IV). For example, Alabama's and Louisiana's recent annual attrition rates were 29 percent and 18 percent, respectively, and, as a result, almost half of the surveyors in both states had been on the job for 2 years or less. In California and Maryland—states that hired a significant number of new surveyors since 2000—52 percent and 70 percent of surveyors,

[20]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.

respectively, had less than 2 years of on-the-job experience.[21] According to CMS regional office and state officials, the first year for a new surveyor is essentially a period of training and low productivity, and it takes as long as 3 years for a surveyor to gain sufficient knowledge, experience, and confidence to perform the job well. High staff turnover was attributed, in part, to low salaries for RN surveyors—salaries that may not be competitive with other employment opportunities for nurses. Overall, 29 of the 42 states that responded to our inquiry indicated that they believed nurse surveyor salaries were not competitive (see app. IV). Officials in several states also told us that the combination of low starting salaries and a highly competitive market forced them to hire less qualified candidates with less breadth of experience.

Predictable Surveys

Even though HCFA directed states, beginning January 1, 1999, to avoid scheduling a nursing home's survey for the same month of the year as its previous survey, over one-third of state surveys remain predictable. Our analysis demonstrated little change in the proportion of predictable nursing home surveys. Predictable surveys can allow quality-of-care problems to go undetected because homes, if they choose to do so, may conceal problems.[22] We recommended in 1998 that HCFA segment the standard survey into more than one review throughout the year, simultaneously increasing state surveyor presence in nursing homes and decreasing survey predictability. Although HCFA disagreed with segmenting the survey, it did recognize the need to reduce predictability.

Our analysis of OSCAR data demonstrated that, on average, the timing of 34 percent of current surveys nationwide could have been predicted by nursing homes, a slight reduction from the prior surveys when about 38 percent of all surveys were predictable. The predictability of current surveys ranged from 83 percent in Alabama to 10 percent in Michigan (see app. V for data on all 50 states and the District of Columbia). In 34 states, 25 percent to 50 percent of current surveys were predictable, as shown in

[21] As of July 2002, both states had vacant surveyor positions and a surveyor hiring freeze.

[22] In commenting on a draft of this report, Arizona disagreed with the significance we attribute to survey predictability, questioning whether poor homes would, or even could, hide problems if they knew a survey was imminent. However, advocates and family members have told us that a home that operates with too few staff could temporarily augment its staff during the expected period of a survey in order to mask an otherwise serious deficiency—a common practice based on advocates' own observations.

table 4. In 9 states, more than 50 percent of current surveys were predictable.[23]

Table 4: Predictability of Nursing Home Surveys

Percentage of predictable surveys[a]	Number of states[b]
More than 50 percent	9
25 percent to 50 percent	34
Less than 25 percent	8

Source: GAO analysis of OSCAR data as of April 9, 2002.

[a]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys, or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys.

[b]Includes the District of Columbia.

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

Most state agencies did not investigate serious complaints filed against nursing homes within required time frames, and practices for investigating complaints in many states may not be as effective as they could be. A CMS review of states' timeliness in investigating complaints alleging harm to residents revealed that most states did not investigate all such complaints within 10 days, as CMS requires. Additionally, a CMS-sponsored study of complaint practices in 47 states raised concerns about state approaches to accepting and investigating complaints.

Until March 1999, states could set their own complaint investigation time frames, except that they were required to investigate within 2 workdays all complaints alleging immediate jeopardy conditions. In March 1999, we reported that inadequate complaint intake and investigation practices in states we reviewed had too often resulted in extensive delays in investigating serious complaints.[24] As a result of our findings, HCFA began requiring states to investigate complaints that allege actual harm, but do

[23]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys (13 percent of homes, nationally) or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys (21 percent of homes, nationally). Because homes know the maximum allowable interval between surveys, those whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

[24]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).

not rise to the level of immediate jeopardy, within 10 workdays.[25] CMS's 2001 review of a sample of complaints in all states demonstrated that many states were not complying with these requirements. Specifically, 12 states were not investigating all immediate jeopardy complaints within the required 2 workdays, and 42 states were not complying with the requirement to investigate actual harm complaints within 10 days.[26] The agency also found that the triaging of complaints to determine how quickly each complaint should be investigated was inadequate in many states.

The extent to which states did not meet the 2-day and 10-day investigation requirements varied considerably. Officials from 12 of the 16 states we contacted indicated that they were unable to investigate complaints on time because of staff shortages. Oklahoma investigated only 3 of the 21 immediate jeopardy complaints that CMS sampled within the required 2-day period and none of 14 sampled actual harm complaints in 10 days. Oklahoma officials attributed this timeliness problem to staff shortages and a surge in the number of complaints received in 2000, from about 5 per day to about 35. The rising volume of complaints is a particular problem for California, which receives about 10,000 complaints annually, and had a 20 percent increase in complaints from January 2001 through July 2002. State officials told us that California law requires all complaints alleging immediate jeopardy to a resident to be investigated within 24 hours and all others to be investigated within 10 days, and that the increase in the number of complaints requires an additional 32 surveyor positions.[27] CMS regional officials told us that the vast majority of California complaints were investigated within 10 days. However, the 2001 review also showed that about 9 percent of the state's standard surveys were conducted late.[28] Both CMS and California officials indicated that the priority the state attaches to investigating complaints affected survey timeliness. Officials

[25]In some states, the 10-day requirement significantly compressed the time frame in which complaints alleging potential actual harm must be investigated. For instance, prior to HCFA's change, such complaints were supposed to be investigated within 30 days in Michigan and 60 days in Tennessee.

[26]Staff from each of CMS's regional offices reviewed a 10 percent random sample of complaint files (maximum of 40 files) in each state.

[27]According to a state official, a hiring freeze precluded increasing the number of surveyors.

[28]Because CMS based its analysis of timeliness only on nursing homes that actually were surveyed during fiscal year 2001---and not on all homes in the state---the 9 percent figure is understated. Our analysis of all homes indicated that about 12 percent of the state's homes were not surveyed within the required time frame.

from Washington told us that their practice of investigating facility self-reported incidents led to their not meeting the 10-day requirement on all complaints that CMS reviewed. Washington investigated 18 of 20 sampled actual harm complaints on time—missing the 10-day requirement for the other two by 2 days and 4 days, respectively. Washington officials pointed out that the two complaints not investigated within 10 days were facility self-reported incidents and commented that many other states do not even require investigation of such incidents. Thus, in these other states, such incidents would not even have been included in CMS's review.

In its review of state complaint files, CMS also evaluated whether states had appropriately triaged complaints—that is, determined how quickly each complaint should be investigated. Most of the regions told us that one or more of their states had difficulty determining the investigation priority for complaints. In an extreme case, a regional office discovered that one of its states was prioritizing its complaints on the basis of staff availability rather than on the seriousness of the complaints. Several regions indicated that some states improperly assigned complaints to categories that permitted longer investigation time frames, and one region indicated that triaging difficulties involved state personnel not collecting enough information from the complainant to make a proper decision. Officials from some of the 16 state survey agencies we contacted indicated that HCFA's 1999 guidance to states on what constitutes an actual harm complaint was unclear and confusing.

In an effort to improve state responsiveness to complaints, HCFA hired a contractor in 1999 to assess and recommend improvements to state complaint practices. The study identified significant problems with states' complaint processes, including complaint intake activities, investigation procedures, and complaint substantiation practices.[29] For example, the report noted that 15 states did not have toll-free hotlines for the public to file complaints. In our earlier reports, we noted that the process of filing a complaint should not place an unnecessary burden on a complainant and that an easy-to-use complaint process should include a toll-free number that permits the complainant to leave a recorded message when state staff

[29]Center for Health Systems Research and Analysis at the University of Wisconsin, Madison, *Final Report: Complaint Improvement Project*, prepared for CMS, June 3, 2002. The report is based on a questionnaire sent to the 50 states, the District of Columbia, Puerto Rico, and CMS's 10 regional offices. Three states did not respond to the questionnaire. The report treated the District of Columbia and Puerto Rico as states.

are unavailable.[30] Table 5 summarizes major findings from the contractor's report to CMS.

Table 5: Key Findings of Report to CMS on State Complaint Investigation Processes

Finding	Description
States vary in the ease with which the public can file a complaint.	Thirty-four states indicated that they provide toll-free hotlines for the public to file complaints. Twenty-nine of the 34 states indicated that they operate their hotlines 24 hours a day, 7 days a week, and 5 said their hotlines were answered during business hours. Nineteen states had no provisions or plans to handle non-English speaking complainants.
States need to improve their complaint intake and triaging systems.	States need to better triage their complaints and decide which complaints should be referred to other agencies for investigation. They should also improve procedures for merging complaints with ongoing survey activities at a nursing home. More consistency is needed in handling facility self-reported incidents.
State survey staffs that conduct complaint intake and investigation often have additional duties.	States should use staff dedicated to investigating complaints to improve the quality of investigations. This might include assigning responsibility for a state's total complaint system to a single complaint supervisor or coordinator and also may require more careful hiring standards with specific job qualifications.
Investigation procedures vary across states.	States do not use all available data when preparing for a complaint investigation. There is little agreement among states regarding how many resident records should be sampled during a complaint investigation.*
Complaint investigation training is needed.	Specialized complaint training and periodic refresher training on complaint intake, triaging, and investigation techniques are needed to improve the quality of complaint investigations.
Resolution of complaints is inconsistent across states.	States have developed varying criteria for determining what constitutes a substantiated complaint and varying practices for communicating the results of investigations to complainants. Twenty-two states could not indicate how long it takes them to provide the results of an investigation to the complainant, and at least four states do not inform the complainant of the results.
Not all states have comprehensive complaint tracking systems, and CMS tracking systems are not up-to-date or user friendly.*	Twenty states indicated that they could track the status of complaints and produce summary reports.

Source: CMS.

[30]See GAO/HEHS-99-80 and U.S. General Accounting Office, *Medicare Home Health Agencies: Weaknesses in Federal and State Oversight Mask Potential Quality Issues*, GAO-02-382 (Washington, D.C.: July 19, 2002).

Note: GAO analysis of information from Center for Health Systems Research and Analysis at the University of Wisconsin, Madison, *Final Report: Complaint Improvement Project*, prepared for CMS, June 3, 2002.

[a]In 1999, we reported that HCFA had not provided states with guidance on when to expand a complaint review beyond the residents who were the subject of the original complaint. See GAO/HEHS-99-80.

[b]CMS is planning to implement a new complaint tracking system nationwide that should address this shortcoming.

States Did Not Refer a Substantial Number of Nursing Homes to CMS for Immediate Sanctions

State survey agencies did not refer 711 cases in which nursing homes were found to have a pattern of harming residents to CMS for immediate sanction as required by CMS policy.[31] 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.[32] In response, the agency required that homes found to have harmed residents on successive standard surveys be referred to it for immediate sanction.[33] Most states did not refer at least some cases that should have been referred under this policy.[34] Figure 1 shows the results of our analysis for the four states—Massachusetts, New York, Pennsylvania, and Texas—with the greatest numbers of cases that should have been

[31]Using CMS data, we identified 1,334 cases that appeared to meet the criteria for immediate sanctions but that did not appear to have been referred to CMS by states. (See app. I for a description of our methodology.) We use the term "cases" rather than "nursing homes" because some nursing homes had multiple referrals for immediate sanctions. At our request, CMS reviewed most of these cases and determined that 711 (62 percent of those CMS reviewed) should have been—but were not—referred for immediate sanction. CMS did not analyze 155 of the cases we asked it to examine and was unable to determine the status of an additional 30 cases.

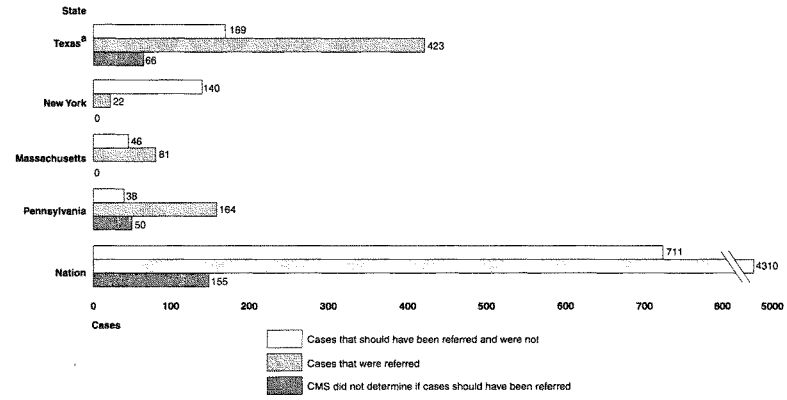
[32]See GAO/HEHS-99-46.

[33]This policy was implemented in two stages, and our analysis focused on implementation of the second stage in January 2000. Beginning in 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 (H-level deficiencies and above on CMS's scope and severity grid). Effective January 14, 2000, HCFA expanded this policy by requiring state survey agencies to refer for immediate sanction homes that had harmed residents—G-level deficiencies on the agency's scope and severity grid—on successive surveys. States are now required to deny a grace period to homes that are assessed one or more deficiencies at the actual harm level or above (G-L on CMS's scope and severity grid) 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.

[34]We found that states did refer 4,310 cases over a 27-month period. See app. VI for a summary of all sanctions that were implemented, including the amount of civil money penalties (CMPs) by state.

referred and for the nation (see app. VII for information on all states). These four states accounted for 55 percent of the 711 cases.

Figure 1: Four States with the Greatest Number of Cases that Should Have Been Referred for Immediate Sanctions, January 14, 2000, through March 28, 2002



Source: GAO and CMS analysis of OSCAR and enforcement data.

Note: Analysis includes cases entered in CMS's enforcement database by March 28, 2002.

[a]According to a Dallas regional office official, Texas referred most of the 423 cases because the nursing homes had a "poor enforcement history," not because of repeat harm level deficiencies. However, based on other information, the region coded these cases as requiring immediate sanction.

State and CMS officials identified several reasons why state agencies failed to forward cases to CMS for immediate sanction, including (1) an initial misunderstanding of the policy on the part of some states and regions, (2) poor state systems for monitoring the survey history of homes to identify those meeting the criteria for referral for immediate sanction, and (3) actions, by two states, that were at variance with CMS policy. First, officials from some states—and some CMS regional officials as well—told

us that they did not initially fully understand the criteria for referring homes for immediate sanction.[35] For example, several states and CMS regional offices reported that they did not understand that CMS required states to look back before the January 2000 policy implementation date to determine if there was an earlier survey with an actual-harm-level deficiency. The look-back requirement was specifically addressed in a February 10, 2000, CMS policy clarification specifying that state agencies were to consider the home's survey history before the January 14, 2000, implementation date in determining if a home met the criteria for immediate referral for sanction. However, officials in one region told us that they had instructed three of four states not to look back before the January 2000 implementation date of the policy. Two other regional offices told us that CMS policy did not require the state to look back before January 2000 for earlier surveys. Officials at another regional office did not recall the look-back policy at the time we talked to them in mid-2002, and were not sure what advice they had given their states when the policy was first implemented.

Second, some state survey agencies told us that their managers responsible for enforcement did not have an adequate methodology for checking the survey history of homes to identify those meeting the criteria. Some states said that their managers relied on manual systems, which are less accurate and sometimes failed to identify cases that should have been referred. Officials in one state told us that its district offices had no consistent procedure for checking the survey history of homes. An official in another state told us that some cases were not referred because time lags in reporting some surveys meant that an earlier survey—such as a complaint survey—with an actual harm deficiency might not have been entered in the state's tracking system until after a later survey that also found harm-level deficiencies.

Third, two states did not implement CMS's expanded policy on immediate sanctions. New York was in direct conflict with CMS policy. Although CMS policy calls for state referrals to CMS regardless of the type of deficiency,

[35]Arizona's comments on a draft of this report indicated that eight of the nine cases not referred for immediate sanction were during the period January through October 2000 when the state was struggling with various interpretations of CMS's new requirement. Similarly, Missouri officials indicated in their comments that the majority of cases they did not refer occurred during the initial stages of the new policy, which Missouri believes was "complicated, at best." Missouri officials added that the number of missed cases significantly declined as the state gained a better understanding of the policy.

a state agency official told us that the state only referred a home to CMS for immediate sanction if both actual harm citations were for the exact same deficiency.[36] A CMS official indicated that New York began complying with the policy in September 2002.[37] Texas, the second state, did not implement the CMS policy statewide until July 2002, when it received our inquiry about the cases not referred for immediate sanction. In the interim from January 2000 through July 2002, three of Texas's 11 district offices specifically requested from state survey agency officials, and were granted, permission to implement the policy.

CMS Oversight of State Survey Activities Requires Further Strengthening

While CMS has increased its oversight of state survey and complaint activities and instituted a more systematic oversight process by initiating annual state performance reviews, CMS officials acknowledged that the effectiveness of the reviews could be improved. In particular, CMS officials told us that for the initial state performance review in fiscal year 2001, they lacked the capability to systematically distinguish between minor lapses identified during the reviews and more serious problems that require intervention. CMS oversight is also hampered by continuing limitations in OSCAR data, the inability or reluctance of some CMS regions to use such data to monitor state activities, and inadequate oversight of certain areas, such as survey predictability and state referral of homes for immediate enforcement actions. CMS has restructured regional office responsibilities to improve the consistency of federal oversight and plans to further strengthen oversight by increasing the number of federal comparative surveys. However, three federal initiatives critical to reducing the subjectivity evident in the current survey process and the investigation of complaints have been delayed.

[36]This New York state official told us that the state believed it was in compliance with CMS's policy because it imposed one of two minor federal sanctions and a state civil money penalty on all consecutive G-level cases. This state official also indicated that state fines were imposed in place of federal civil money penalties in all cases. (The maximum state fine is $2,000 per violation, lower than the federal maximum of $10,000 per instance or per day of noncompliance.) However, when we discussed this explanation with officials in the CMS central office, they disagreed that the state was in compliance.

[37]In commenting on a draft of our report, New York officials indicated that their initial failure to refer nursing homes for immediate sanctions was based on their misinterpretation of the new policy and not on a deliberate refusal to implement it. They also indicated that their procedures are now consistent with the federal policy.

CMS Reviews of State Performance Have Identified Areas for Improvement

In the first of what is planned as an annual process, CMS's 10 regional offices reviewed states' fiscal year 2001 performance for seven standards to determine how well states met their nursing home survey responsibilities (see app. VIII for a description of the seven standards).[38] This enhanced oversight of state survey agency performance responds to our prior recommendations. In 1999, we reported that HCFA's oversight of state efforts had limitations preventing it from developing accurate and reliable assessments of state performance.[39] HCFA regional office policies, practices, and oversight had been inconsistent, a reflection of coordination problems between HCFA's central office and its regional staffs. In important areas, such as the adequacy of surveyors' findings and complaint investigations, HCFA relied on states to evaluate their own performance and report their findings to HCFA. Although OSCAR data were available to HCFA for monitoring state performance, they were infrequently used, and neither the states nor HCFA's regional offices were held accountable for failing to meet or enforce established performance standards.

To promote consistent application of the standards across the 10 regions, the agency developed detailed guidance for measuring each standard, including the method of evaluation, the data sources to be used, and the criteria for determining whether a state met a standard. Only two states met each of the five standards we reviewed and many did not meet several standards. Appendix IX identifies the standards we analyzed and the results of CMS's review of these standards. During the 2001 review, CMS elected not to impose the most serious sanctions available for inadequate state performance, including reducing federal payments to the state or initiating action to terminate the state's agreement, but advised the states that annual reviews in subsequent years will serve as the basis for such actions. While imposing no sanctions during the 2001 review, CMS did require several states to prepare corrective action plans. Each year, CMS plans to update and improve the standards based on experience gained in prior years.

[38]The CMS regions assessed each state's performance by (1) reviewing a set of standardized reports drawn from information contained in CMS's databases and (2) visiting states to review procedures and to examine a sample of records, such as complaint investigation files. Some reviews, such as assessing state complaint investigation timeliness, were performed semiannually, enabling regional office staff to provide midpoint feedback intended to correct any deficiencies identified.

[39]GAO/HEHS-00-6.

CMS's State Performance Standards and Review Had Shortcomings

Characterizing its fiscal year 2001 state performance review as a "shakeout cruise," CMS is working to address several weaknesses identified during the reviews, including difficulty in determining if identified problems were isolated incidents or systemic problems, flawed criteria for evaluating a critical standard, and inconsistencies in how regional offices conducted the reviews. In our discussions of the results of the performance reviews with officials of CMS's regional offices, it was evident that some regions had a much better appreciation of the strengths and weaknesses of survey activities in their respective states than was reflected in the state performance reports. However, this information was not readily available to CMS's central office. In addition, CMS has not released a summary of the review to permit easy comparison of the results. For subsequent reviews, CMS plans to more centrally manage the process to improve consistency and help ensure that future reviews distinguish serious from minor problems.

Distinctions in State Performance Were Hard to Identify

CMS officials acknowledged that the first performance review did not provide adequate information regarding the seriousness of identified problems. The agency indicated that it had since revised the performance standards to enable it to determine the seriousness of the problems identified. Some regional office summary reports provided insufficient information to determine whether a state did not meet a particular standard by a wide or a narrow margin. For example, although California did not meet the standard to investigate all complaints alleging actual harm within 10 days, the regional office summary provided no details about the results. Regional officials told us that they found very few California complaints that were not investigated within the 10-day deadline and those that were not were generally investigated by the 13th day.[40] Conversely, although the report for Oregon shows that the state met the 10-day requirement, our discussions with regional officials revealed that serious shortcomings nevertheless existed in the state's complaint investigation practices. [41] Officials in the Seattle region told us that for many years Oregon had contracted out investigations of complaints to local government entities not under the control of the state agency and, as

[40]According to CMS regional officials, California state law requires that all complaints other than those alleging immediate jeopardy be investigated within 10 days, irrespective of the seriousness of the allegation.

[41]CMS's database showed that Oregon conducted only 14 on-site complaint investigations during fiscal year 2001. Because of this low number, the region reviewed the entire universe of complaints (instead of a sample), but did not identify the number reviewed in its report.

a result, exercised little control over the roughly 2,000 complaints the state receives against nursing homes each year. For instance, under this arrangement, information about complaint investigations, including deficiencies identified, was not entered into CMS's database. Regional officials told us that the Oregon state agency recently assumed responsibility for investigating complaints filed by the public, but that the local government entities continue to investigate facility self-reported incidents.

CMS's Standard for Measuring States' Documentation of Deficiencies Was Flawed

CMS's standard for measuring how well states document deficiencies identified during standard surveys was flawed because it mixed major and minor issues, blurring the significance of findings. CMS's protocol required assessment of 33 items, ranging from the important issue of whether state surveyors cited deficiencies at the correct scope and severity level to the less significant issue of whether they used active voice when writing deficiencies. Because of the complexity of the criteria and concerns about the consistency of regional office reviews of states' documentation practices, CMS decided not to report the results for this standard for 2001. For the 2002 review, CMS reduced the number of criteria to be assessed from 33 to 7.[42] Based on the available evidence of the understatement of actual harm deficiencies, we believe that successful implementation of the documentation standard in 2002 and future years is critical to help ensure that deficiencies are cited at the appropriate scope and severity level.

CMS Regions' Reviews Were Inconsistent

CMS's regional offices were sometimes inconsistent in how they conducted their reviews, raising questions about the validity and fairness of the results. For example:

- Although the guidelines for the review indicated that the regional offices were to assess the timeliness of complaint investigations based on the state's prioritization of the complaint, officials from one region told us that they judged timeliness based on their opinion of how the complaint should have been prioritized.

[42]CMS's criteria for evaluating the documentation standard in 2002 are (1) the proper regulation is cited for each deficiency, (2) evidence supports the cited area of noncompliance, (3) several components required by the relevant regulation for each deficiency, such as identifying the citation number, are included, (4) the deficient practice is identified, (5) the cited severity of each deficiency is accurate, (6) the cited scope of each deficiency is accurate, and (7) the sources and identifiers in the deficient practice statement match the sources and identifiers in the findings.

- Two regional offices acknowledged that they did not use clinicians to review complaint triaging. Officials from two states questioned the credibility of reviews not conducted by clinicians.
- Although one objective of the reviews was to review some immediate jeopardy complaints in every state, the random samples selected in some states did not yield such complaints. In such cases, one region indicated that it specifically selected a few immediate jeopardy complaints outside the sample while another region did not. To eliminate this inconsistency in future years, CMS has instructed the regions to expand their sample to ensure that at least two immediate jeopardy complaints are reviewed in each state.
- While some regions examined more than the required number of complaints to assess overall timeliness, one region felt that additional reviews were unnecessary. For instance, surveyors reviewing California, which receives thousands of complaints per year, expanded the number of complaints reviewed beyond the minimum number required because they felt that the required random sample of 40 complaints did not provide sufficient information about overall timeliness in the state. To assess overall timeliness, they visited all but 1 of the state's 17 district offices to review complaints. However, surveyors from another CMS region reviewed only 3 or 4 of the roughly 18 complaints a state received and told us that additional reviews were unnecessary because the state had already failed the timeliness criterion based on the few complaints reviewed. Although the review of 3 or 4 complaints technically met CMS's sampling requirement, we believe examination of most or all of the relatively few remaining complaints would have provided a more complete picture of the state's overall timeliness.

Performance Standards Excluded Some Important Areas

While CMS has addressed some of the weaknesses in its 2001 state performance review by revising the standards and guidance for the 2002 review, including simplifying the criteria for assessing documentation and requiring regions to assess states' complaint prioritization efforts separately from the timeliness issue, the performance standards do not yet address certain issues that are important for assessing state performance and that would further strengthen CMS oversight of state survey activities. These issues include:

- **Assessing the predictability of state surveys.** Although CMS monitored compliance with its requirement for state survey agencies to initiate at least 10 percent of their standard surveys outside normal working hours to reduce predictability, it did not examine compliance with its 1999 instructions for states to avoid scheduling a home's survey during the same month each year. As shown in app. V, our analysis of CMS data found that from 10 percent to 31 percent of surveys in 31 states were

predictable because they were initiated within 15 days of the 1-year anniversary of the prior survey.

- **Evaluating states' compliance with the requirement to refer nursing homes that have a pattern of harming residents for immediate sanctions**. CMS officials confirmed that there was no consistent oversight of state agencies' implementation of this policy. Several CMS regional offices generally did not know, for example, how their states were monitoring homes' survey history to detect cases that should be referred for immediate sanction. CMS could have used the enforcement database to determine that New York was not adhering to the agency's immediate sanctions policy. During calendar years 2000 and 2001, New York cited actual harm at a relatively high proportion of its nursing homes but only referred 19 cases for immediate sanction. Over a comparable period, New Jersey, a state with far fewer homes and citations, referred almost three times as many cases.[43]
- **Developing better measures of the quality of state performance, in addition to process measures**. Several CMS regional officials believed that the scope of the state performance standards should address additional areas of performance, including assessing the adequacy of nursing homes' plans of correction submitted in response to deficiencies and the appropriateness of states' recommended enforcement remedies. In particular, several regions noted that rather than focusing only on the timeliness of complaint investigations, regions should also assess the adequacy of the investigation itself, including whether the complaint should have been substantiated. The introduction of a new CMS complaint tracking database, discussed below, should enable regions to automate the review of complaint timeliness, thereby allowing them to focus more attention on such issues.

Data Limitations and Inconsistent Use of Periodic Reports Hamper Oversight

CMS's oversight of state survey activities is further hampered by limitations in the data used to develop the 19 periodic reports intended to assist the regions in monitoring state performance and by the regions' inconsistent use of the reports.[44] For instance, CMS's current complaint database does not provide key information about the number of

[43]While cases referred by states were typically recorded in CMS's enforcement database, a New York regional official indicated that because of the departure of key staff members, the region had not entered all cases into the database.

[44]CMS's central office and the regions have jointly produced the reports since they were created in 2000. As CMS's systems become more user-friendly, the regions will be able to produce them independently.

complaints each state receives (including facility self-reported incidents) or the time frame in which each complaint is investigated.[45] In addition, officials from one region emphasized to us that information about complaints provided in the reports did not correspond with CMS's required complaint investigation time frames. The reports identify the number of state on-site complaint investigations that took place in three different time periods—3 days, from 4 to 14 days, and 15 days or more; however, required time frames for complaint investigations are 2 days for complaints alleging immediate jeopardy and 10 days for those alleging harm. Additionally, a regional official pointed out that investigations shown in one of the reports as taking place within 3 days do not necessarily represent complaints that the state prioritized as immediate jeopardy. Despite the problems with these data, however, several regional offices indicated that the reports could at least serve as a starting point for discussions with states about their complaint programs and often lead to a better understanding of state complaint activities. CMS indicated that the deficiencies in complaint data should be addressed by the new automated complaint tracking system that it is developing for use by all states as part of the redesign of OSCAR.[46]

Officials from several regions also told us that the value of some of the 19 periodic reports was unclear, and officials in three regions said they either lacked the staff expertise or the time to use the reports routinely to oversee state activities. For example, officials in one region told us that

[45]As we reported previously, although HCFA standards require states to report information about complaints, the process for collecting it results in inaccurate and incomplete information. For example, the form CMS requires states to use to record the results of complaint investigations was created to record information about a single complaint, but many states investigate multiple complaints at a nursing home during one on-site visit. As a result, the timeliness, prioritization, and other important tracking information related to multiple complaints is reported as though it applies to one complaint. See GAO/HEHS-99-80.

[46]CMS planned to implement the new system, known as the ASPEN Complaint Tracking System, or ACTS, nationwide in October 2002. However, implementation was delayed because of several issues that surfaced during pilot testing: (1) states have different policies regarding the treatment of self-reported facility incidents, (2) complaints filed with some states may be investigated by entities other than the state survey agency (for instance, the Board of Nursing), and (3) 8 to 10 states have indicated that their current state complaint tracking systems have superior capability to ACTS and they do not wish to discontinue using their own system or maintain separate systems. CMS plans to evaluate this last issue during the extended pilot test. As of July 2003, nationwide implementation had been further delayed by the need to obtain approval from the Office of Management and Budget for publication of a notice in the *Federal Register*, a procedure that applies to establishing a system of federal records.

they used one of the reports about complaints to ask states questions about their prioritization practices. But a different region appeared unaware that the reports showed that two of its states might be outliers in terms of the percentage of complaints they prioritized as actual harm or immediate jeopardy. Additionally, because the periodic reports do not include trend data, many regional offices were unaware of the trends in the percentage of homes cited in their states for actual harm or immediate jeopardy. We believe that such data could be useful to CMS's regions in identifying significant trends in their states.

CMS indicated that it is continuing to make progress in redesigning the OSCAR reporting system. In 1999, we recommended that the agency develop an improved management information system that would help it track the status and history of deficiencies, integrate the results of complaint investigations, and monitor enforcement actions.[47] Another objective of the OSCAR redesign is to make it easier to analyze the data it contains, addressing the problem that generating analytical reports from OSCAR was difficult and most regions lacked the expertise to do so. The redesigned system, called the Quality Improvement and Evaluation System, would also eliminate the need for duplicate data entry, which should reduce the potential for data entry errors to which OSCAR is susceptible.[48] CMS has faced some problems in the implementation of the new system, such as inadvertent modifications of survey data results when data are transferred from the old OSCAR database into the new system, but the agency indicated that its target date for completing the redesign is 2005.

CMS Is Making Progress but Also Encountering Delays in Several Key Efforts

CMS has taken, or is undertaking, several other efforts to improve federal oversight and survey procedures, including making structural changes to the regional offices to improve coordination, expanding the number of comparative surveys conducted each year, improving the survey methodology, developing clearer guidance for surveyors, and developing additional guidance to states for investigating complaints. As of April 2003, only the effort to restructure the regional offices had been completed. The

[47]GAO/HEHS-99-46.

[48]Until recently, states had to manually enter data into a computerized system that generated survey reports and then manually reenter much of the same data into OSCAR. This duplicative data entry process increased the chances for errors in OSCAR.

other efforts critical to reducing the subjectivity evident in the current survey process and the investigation of complaints have been delayed.

CMS Is Taking Additional Steps to Address Inconsistencies in Regional Office Performance and Improve Federal Oversight

In December 2002, CMS reduced the number of regional managers in charge of survey activities from 10 (1 per region) to 5, a change intended to provide more management attention to survey matters and to improve accountability, direction, and leadership. Our prior and current work found that regional offices' policies, practices, and oversight were often inconsistent. For example, in 1999 we reported that regional offices used different criteria for selecting and conducting comparative surveys. The 5 regional managers will be responsible only for survey and certification activities, while in the past many of the 10 were also responsible for managing their regions' Medicaid programs.

In response to our prior recommendations, CMS plans to more than double the number of federal comparative surveys in which federal surveyors resurvey a nursing home within 2 months of the state survey to assess state performance. We noted in 1999 that, although insufficient in number, comparative surveys were the most effective technique for assessing state agencies' abilities to identify serious deficiencies in nursing homes because they constitute an independent evaluation of the state survey. CMS plans to hire a contractor to perform approximately 170 additional comparative surveys per year, bringing the annual total of comparative surveys performed by both CMS surveyors and the contractor to about 330. Although CMS had intended to award a contract and begin surveys by spring 2003, as of July 2003, it was still in the process of identifying qualified contractors. CMS officials stated that using a contractor would provide CMS flexibility because if it suspects that a state or region is having problems with surveys, it can quickly have the contractor conduct several comparative surveys there. Being able to direct the contractor to quickly focus on states or regions where state surveys may be problematic could represent a significant improvement in CMS's oversight of state survey agencies.

Key Initiatives to Improve Survey Consistency and Complaint Investigations Have Been Delayed

CMS's implementation schedules have slipped for three critical initiatives intended to enhance the consistency and accuracy of state surveys and complaint investigations, delaying the introduction of improved methodologies or guidance until 2003 or 2004. Because surveyors often missed significant care problems due to weaknesses in the survey process, HCFA took some initial steps to strengthen the survey methodology, with the goal of introducing an improved survey process in 2000. In July 1999, the agency introduced quality indicators to help surveyors do a better job of selecting a resident sample, instructed states to increase the sample size

in areas of particular concern, and required the use of investigative protocols in certain areas, such as pressures sores and nutrition, to help make the survey process more systematic.[49] However, HCFA recognized that additional steps were required to ensure that surveyors thoroughly and systematically identify and assess care problems.

To address remaining problems with sampling and the investigative protocols, CMS contracted for the development of a revised survey methodology. The contractor has proposed a two-phase survey process.[50] In the first phase, surveyors would initially identify potential care problems using quality indicators generated off-site prior to the start of the survey and additional, standardized information collected on-site, from a sample of as many as 70 residents. During the second phase, surveyors would conduct an investigation to confirm and document the care deficiencies initially identified.[51] According to CMS officials, this process differs from the current methodology because it would more systematically target potential problems at a home and give surveyors new tools to more adequately document care outcomes and conduct on-site investigations. Use of the new methodology could result in survey findings that more accurately identify the quality of care provided by a nursing home to all of its residents.[52] Initial testing to evaluate the proposed methodology focused primarily on the first phase and was completed in

[49]Quality indicators are derived from nursing homes' assessments of residents and rank a facility in 24 areas compared with other nursing homes in a state. By using the quality indicators to select a preliminary sample of residents before the on-site review, surveyors are better prepared to identify potential care problems.

[50]The agency is committed to implementing only those portions of the new methodology that are proven to be significantly more effective than the current survey methodology. CMS officials said the new process must be manageable and easy to use, add no additional time to surveys, and require limited additional training resources. Given the high turnover among surveyors and state budget constraints, the agency is particularly concerned about imposing new training requirements that would interfere with the conduct of mandatory surveys.

[51]A minimum of three residents would be included in the sample for each of the care problems identified in phase one, which covers as many as 33-35 resident-care areas.

[52]The goals of the new survey methodology are to (1) ensure that all areas of care are addressed, (2) make the survey process more data-driven and less reliant on surveyor judgment, thus reducing variability in the citation of serious deficiencies, (3) focus surveyors' attention more on nursing homes with poor quality and less on better performing homes, (4) more reliably determine the scope of deficiencies at nursing homes, that is, the number of residents potentially or actually affected, and (5) produce better documented and defensible survey deficiencies.

three states during 2002. As of April 2003, a CMS official told us that the agency lacked adequate funding to conduct further testing that more fully incorporates phase two. As a result, it is not clear when changes to survey methodology will be implemented. We continue to believe that redesign of the survey methodology, under way since 1998, is necessary for CMS to fully respond to our past recommendation to improve the ability of surveys to effectively identify the existence and extent of deficiencies. While CMS's goal of not adding additional time to surveys is an important consideration, it should not take priority over the goal of ensuring that surveys are as effective as possible in identifying the quality of care provided to residents.

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. The areas originally targeted for this initiative included deficiencies related to pressure sores, urinary catheters and incontinence, activities programming, safe food handling, and nutrition. Delays have occurred because CMS is committed to incorporating the work of multiple expert panels and two rounds of public comments for each deficiency. The project has been further delayed because the approach used to identify resident harm shifted during the course of work. The process should proceed more quickly, however, now that CMS has developed its approach. CMS expected to release the first new guidance, addressing pressure sores, in early 2003, but officials were unable to tell us how many of the 190 federal nursing home requirements will ultimately receive new guidance or a specific time line for when this initiative will be completed.[53] As discussed earlier, CMS's state performance reviews include an assessment of state surveyors' documentation of the scope and severity of a sample of deficiencies cited, which should provide CMS with an opportunity to assess the effectiveness of the new guidance.

Finally, despite initiation of a complaint improvement project in 1999, CMS has not yet developed detailed guidance for states to help improve their complaint systems. Effective complaint procedures are critical

[53]As of July 2003, the guidance had not yet been released.

because complaints offer an opportunity to assess nursing home care between standard surveys, which can be as long as 15 months apart. In 1999, HCFA commissioned a contractor to assess and recommend improvements to state complaint practices. CMS received the contractor's final report in June 2002, and indicated agreement with the contractor that reforming the complaint system is urgently needed to achieve a more standardized, consistent, and effective process. The study identified serious weaknesses in state complaint processes (see table 5) and made numerous recommendations to CMS for strengthening them. Key recommendations were that CMS increase direction and oversight of states' complaint processes and establish mechanisms to monitor states' performance. CMS indicated that it has already taken steps to address these recommendations by initiating annual performance reviews that include evaluating the timeliness of state complaint investigations and the accuracy of states' complaint triaging decisions, and by developing the new ASPEN complaint tracking system, which should provide more complete data about complaint activities than the current system. The contractor also recommended that CMS (1) expand outreach for the initiation of complaints, such as use of billboards or media advertising, (2) enhance complaint intake processes by using professional intake staff, (3) improve investigation and resolution processes by using available data about the home being investigated and establishing uniform definitions and criteria for substantiating complaints, (4) make the process more responsive by conducting timely investigations and allowing the complainant to track the progress of the investigation, and (5) establish a higher priority for complaint investigations in the state survey agency. CMS noted that some of these recommendations are beyond the agency's purview and will require the support of all stakeholders to accomplish. 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 reported decline in the percentage of homes cited for serious deficiencies that harm residents is consistent with the concerted congressional, federal, and state attention focused on addressing quality-of-care problems. More active and data-driven oversight is increasing CMS's understanding of the nature and extent of weaknesses in state survey activities. Despite these efforts, however, the proportion of homes reported to have harmed residents is still unacceptably high. It is therefore essential that CMS fully implement

key initiatives to improve the rigor and consistency of state survey, complaint investigation, and enforcement processes.

The seriousness of the challenge confronting CMS in ensuring consistency in state survey activities is also becoming more apparent. Our work, as well as that of CMS, demonstrates the persistence of several long-standing problems and also provides insights on factors that may be contributing to these shortcomings:

- state surveyors continue to understate serious deficiencies that caused actual harm or placed residents in immediate jeopardy;
- deficiencies are often poorly investigated and documented, making it difficult to determine the appropriate severity category;
- states focus considerable effort on reviewing proposed actual harm deficiencies, but many have no quality assurance processes in place to determine if less serious deficiencies are understated or have investigation and documentation problems;
- the timing of too many surveys remains predictable, allowing problems to go undetected if a home chooses to conceal deficiencies;
- numerous weaknesses persist in many states' complaint processes, including the lack of consumer toll-free hotlines in many states, confusion over prioritization of complaints, inconsistent complaint investigation procedures, and the failure of most states to investigate all complaints alleging actual harm within 10 days, as required; and
- states did not refer a substantial number of homes that had a pattern of harming residents to CMS for immediate sanctions.

Over the past several years, CMS has taken numerous steps to improve its oversight of state survey agencies, but needs to continue its efforts to help better ensure consistent compliance with federal requirements. Several areas that require CMS's ongoing attention include (1) the newly established standard performance reviews to ensure that critical elements of the review, such as assessing states' ability to properly document deficiencies, are successfully implemented, (2) the successful modernization of CMS's data system by 2005 to support the survey process and provide key information for monitoring state survey activities, (3) the planned expansion of comparative surveys to improve federal oversight of the state survey process, (4) the survey methodology redesign intended to make the survey process more systematic, (5) the development of more structured guidance for surveyors to address inconsistencies in how the scope and severity of deficiencies are cited across states, and (6) the provision of detailed guidance to states to ensure thorough and consistent complaint investigations. Some of these efforts have been under way for

several years, and CMS has consistently extended their estimated completion and implementation dates. We believe that effective implementation of planned improvements in each of these six areas is critical to ensuring better quality care for the nation's 1.7 million nursing home residents.

Recommendations for Executive Action

To strengthen the ability of the nursing home survey process to identify and address problems that affect the quality of care, we recommend that the Administrator of CMS

- finalize the development, testing, and implementation of a more rigorous survey methodology, including guidance for surveyors in documenting deficiencies at the appropriate level of scope and severity.

To better ensure that state survey and complaint activities adequately address quality-of-care problems, we recommend that the Administrator

- require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality-of-care problems.
- finalize the development of guidance to states for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to residents; the handling of facility self-reported incidents; and the use of appropriate complaint investigation practices.

To better ensure that states comply with statutory, regulatory, and other CMS nursing home requirements designed to protect resident health and safety, we recommend that the Administrator

- further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.

Agency and State Comments and Our Evaluation

We provided a draft of this report to CMS and the 22 states we contacted during the course of our review. (CMS's comments are reproduced in app. X.) CMS concurred with our findings and recommendations, stating that it already had initiatives under way to improve the effectiveness of the survey process, address the understatement of serious deficiencies, provide better data on state complaint activities, and improve the annual federal performance reviews of state survey activities. Although CMS concurred with our recommendations, its comments on intended actions did not fully address our concerns about the status of the initiative to improve the effectiveness of the survey process or the recommendation regarding state quality assurance systems. Eleven of the 22 states also commented on our draft report.[54] CMS and state comments generally covered five areas: survey methodology, state quality assurance systems, definition of actual harm, survey predictability, and resource constraints.

Survey Methodology Redesign

In response to our recommendation that the agency finalize the development, testing, and implementation of a more rigorous nursing home survey methodology, under way since 1998, CMS commented that it had already taken steps to improve the effectiveness of the survey process, such as the development of surveyor guidance on a series of clinical issues.[55] However, the agency did not specifically comment on any actions it would take to finalize and implement its new survey methodology, which is broader than the actions CMS described. Our draft report noted that, earlier this year, CMS said it lacked adequate funding for the additional field testing needed to implement the new survey methodology. Through September 2003, CMS will have committed $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 additional field testing could jeopardize the entire initiative, in which a substantial investment has already been made. We continue to believe that CMS should implement a revised survey methodology to address our 1998

[54]States that commented included Alabama, Arizona, California, Connecticut, Iowa, Missouri, Nebraska, New York, Pennsylvania, Tennessee, and Virginia.

[55]Our draft report discussed the problems CMS encountered in developing this guidance and pointed out that the guidance on the first clinical issue to be addressed, pressure sores, was expected in early 2003. As of July 2003, the guidance had not yet been released.

finding that state surveyors often missed significant care problems due to weaknesses in the survey process.

State Quality Assurance Systems

We recommended that CMS require states to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm to help reduce instances of understated quality-of-care problems. CMS commented on the importance of this concept and noted it had already incorporated such reviews into CMS regional offices' reviews of the state performance standards. However, the agency did not indicate whether it would require states to initiate an ongoing process that would evaluate the appropriateness of the scope and severity of documented deficiencies, as we recommended. While federal oversight is critical, the annual performance reviews conducted by federal surveyors examine only a small, random sample of state survey reports and should not be considered a substitute for appropriate and ongoing state quality assurance mechanisms. In its comments, New York stated that, in April 2003, it had implemented a process consistent with our recommendation and it had already realized positive results. New York is using the results of these reviews to provide surveyor feedback and expects that instances where deficiencies may be understated will decrease. California also commented that it fully supports this recommendation but indicated that a new requirement could not be implemented without additional resources.

State Resource Constraints

Officials from five states indicated that resource shortages are a challenge in meeting federal standards for oversight of nursing homes. Alabama commented that there is a relationship among (1) the scheduling of nursing home standard surveys, (2) the number and timing of complaint surveys, (3) the tasks that must be accomplished during each survey, and (4) the resources that are available to state agencies. According to Alabama, the funding provided by CMS is insufficient to meet all of the CMS workload demands, and many of the serious problems identified in our draft report were attributable to insufficient funding for state agencies to hire and retain the staff necessary to do the required surveys. For example, Alabama indicated that the inability of some states to meet survey time frames—maintaining a 12-month average between standard surveys and investigating complaints alleging actual harm within 10 days—is almost always the result of states not having enough surveyors to accomplish the required workload.

Comments from other states echoed Alabama's concerns about the adequacy of funding provided by CMS. Arizona said that, in order to hire and retain qualified surveyors, it increased surveyor salaries in 2001. Because CMS did not increase the state's survey and certification budget to accommodate these increases, the state left surveyor positions unfilled and curtailed training to make up for the funding shortfall. Arizona also observed that CMS's priorities sometimes conflict, further complicating effective resource use. CMS's performance standards require states to investigate all complaints alleging immediate jeopardy or actual harm in 2 and 10 days, respectively. For budgeting purposes, however, CMS ranks complaint investigations as a lower priority than annual surveys and instructs states to ensure that annual surveys will be completed before beginning work on complaints. California and Connecticut officials said that the growing volume of complaints in their states, combined with limited resources, is a concern. California officials observed that the growth in the number of complaints, coupled with the lack of significant funding increase from CMS, has made it impossible to meet all federal and state standards. They added that they received a 3-percent increase in survey funding from fiscal years 2000 through 2003, but documented the need for a 24-percent increase over this period. As noted in our draft report, the higher priority California attaches to investigating complaints affected survey timeliness—about 12 percent of the state's homes were not surveyed within the required 15 months. Connecticut indicated that 90 percent of the complaints it receives allege actual harm and require investigation within 10 days, but that with fairly stagnant budget allocations from CMS, its ability to initiate investigations of so many complaints within 10 days was limited. CMS's fiscal year 2001 state performance review found that Connecticut did not investigate about 30 percent of the sampled actual harm complaints in a timely manner. Although not specifically mentioning resources, New York noted that the increasing volume of complaints was a concern and indicated that any assistance CMS could provide would be welcome.

Definition of Actual Harm

Comments from four states on our analysis of a sample of survey deficiencies from homes with a history of harming residents revealed state confusion about CMS's definition of actual harm and immediate jeopardy, a situation that contributes to the variability in state deficiency trends shown in table 2. CMS's written comments did not address our review of these deficiencies; however, during an interview to follow up on state comments, CMS officials told us that they agreed with our determinations of actual harm as detailed in appendix III.

Arizona and California agreed that some of the deficiencies we reviewed for nursing homes in their states should have been cited at the level of actual harm. However, their disagreement regarding others stemmed from differing interpretations of CMS guidance, particularly the language on the extent of the consequences to a resident resulting from a deficiency.[56] For example, Arizona stated that one of the two deficiencies we reviewed could not be supported at the actual harm level because the injuries from multiple falls—including skin tears and lacerations of the extremities and head requiring suturing—did not compromise the residents' ability to function at their highest optimal level (table 8, Arizona 3). In these cases, it was documented that nursing home staff had failed to implement plans of care intended to prevent such falls. In contrast, California agreed with us that state surveyors should have cited actual harm for similar injuries resulting from falls—head lacerations and a minimal impaction fracture of the hip—due to the inappropriate use of bed side rails (table 8, California 9). CMS officials noted that the definition of actual harm uses the term "well-being" rather than function because harm can be psychological as well as physical. Moreover, they indicated that whether the consequence was small or large was irrelevant to determining harm. CMS central office officials acknowledged that the language linking actual harm to practices that have "limited consequences" for a resident has created confusion for state surveyors and that this reference will be eliminated in an upcoming revision of the guidance.

Regarding preventable stage II pressure sores, California stated that guidance received from CMS's San Francisco regional office in November 2000 precluded citing actual harm unless the pressure sores had an impact on residents' ability to function.[57] According to a California official, this and similar guidance on weight loss was the CMS regional office's reaction to the growing volume of appeals by nursing homes of actual harm

[56]CMS guidance to states in the *Medicare State Operations Manual* defines actual harm as "noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident."

[57]Stages of pressure sore formation are I—skin of involved area is reddened; II—upper layer of skin is involved and blistered or abraded; III—skin has an open sore and involves all layers of skin down to underlying connective tissue; and IV—tissue surrounding the sore has died and may extend to muscle and bone and involve infection.

citations as well as a reaction to administrative law hearing decisions.[58] Prior to this written guidance, which California received in late 2000, it routinely cited preventable stage II pressure sores as actual harm. The guidance noted that small stage II pressure sores seldom cause actual harm because they have the potential to heal relatively quickly and are usually of limited consequence to the resident's ability to function. We discussed the San Francisco regional office guidance with another regional office as well as with CMS central office officials, who agreed that the San Francisco region's pressure sore guidance was inconsistent with CMS's definition of harm, which judges the impact of a deficiency on a resident's "well-being" rather than functioning. Moreover, central office officials indicated that the regional office's guidance should have been submitted to CMS's Policy Clearinghouse for approval. This entity was created in June 2000 to ensure that regional directives to states are consistent with national policy. San Francisco regional office officials indicated that the individual responsible for the guidance provided to California had since left the agency.

California also disagreed with our assessment that state surveyors should have cited immediate jeopardy for a resident who repeatedly wandered (eloped) outside the facility near a busy intersection. According to state officials, California's policy on immediate jeopardy requires the surveyor to witness the incident. A San Francisco regional office official told us that surveyors did not have to witness an elopement to cite immediate jeopardy. An official from a different regional office agreed and noted that repeated elopements suggested the existence of a systemic problem that warranted citation of immediate jeopardy.

Although Iowa and Nebraska did not comment specifically on the deficiencies in their surveys that we determined to be actual harm, they did address the definition of harm and the role of surveyor judgment in classifying deficiencies. Iowa officials indicated that a more precise definition of harm is needed because of varying emphasis over the last several years on the degree of harm—harm that has a small consequence for the resident or serious harm. Nebraska commented that we may have based our conclusion that two deficiencies in its surveys should have been cited at the actual harm level on insufficient information because citing

[58]Nursing homes can appeal civil money penalties imposed by CMS when they are found to have serious deficiencies. The appeals are decided by the Department of Health and Human Service's Departmental Appeals Board.

actual harm is a judgment call that varies among state and federal surveyors based on experience and expertise. As noted in our draft report, we found sufficient evidence in the surveys we reviewed to conclude that some deficiencies should have been cited as actual harm because a deficient practice was identified and linked to documented actual harm.

Survey Predictability

CMS, Arizona, and Iowa commented that nursing home surveys, as currently structured, are inherently predictable because of the statutory requirement to survey nursing homes on average every 12 months with a maximum interval of 15 months between each home's survey. We agree but believe that survey predictability could be further mitigated by segmenting the surveys into more than one visit, a recommendation we made in 1998 but that CMS has not implemented.[59] Currently, surveys are comprehensive reviews that can last several days and entail examining not only a home's compliance with resident care standards but also with administrative and housekeeping standards. Dividing the survey into segments performed over several visits, particularly for those homes with a history of serious deficiencies, would increase the presence of surveyors in these homes and provide an opportunity for surveyors to initiate broader reviews when warranted. With a segmented set of inspections, homes would be less able to predict their next scheduled visit and adjust the care they provide in anticipation of such visits.

CMS also commented that our report captures only the number of days since the prior survey and does not take into account other predictors, for example the time of day or day of the week. Rather than segmenting standard surveys as we earlier recommended, the agency instructed states to reduce survey predictability by starting at least 10 percent of surveys outside the normal workday—either on weekends, in the early morning, or in the evening. It also instructed states to avoid, if possible, scheduling a home's survey for the same month as its previous standard survey. Though varying the starting time of surveys may be beneficial, this initiative is too limited in reducing survey predictability, as evidenced by our finding that 34 percent of current surveys were predictable. Arizona commented that it was unaware of any CMS guidance to avoid scheduling a home's survey for the same month of the year as the home's previous standard survey

[59]U.S. General Accounting Office, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, GAO/HEHS-98-202 (Washington, D.C.: July 27, 1998).

and indicated the state will now incorporate the requirement into its scheduling process.

Comments from CMS and Arizona stated that the window of time for a survey to be unpredictable was limited and, as a result, little could be done to reduce predictability. CMS's technical comments noted that many states have annual state licensing inspection requirements that would limit the window available to conduct surveys to 9 to 12 months after the prior survey, particularly since most inspections are done in conjunction with the federal survey to maximize available resources. CMS, however, was unable to provide a list of such states. None of the 10 states we subsequently contacted had state licensure inspection requirements that would explain their high levels of survey predictability.[60] Arizona commented that the state's licensing inspections are triggered by facilities applying to renew their licenses 60-120 days before their annual license expires. Due to budgetary constraints, Arizona conducts both this state and the federal survey at the same time. While not a requirement, the state strives to complete surveys during this 60-120 day period of time. Thus, nursing homes in Arizona may have some level of control over when federal surveys are conducted, particularly when the state begins complying with CMS guidance to avoid scheduling a home's survey for the same month as its previous survey. As we reported in September 2000, Tennessee also had an annual licensing inspection requirement that contributed to survey predictability, but the state modified its law to permit homes to be surveyed at a maximum interval of 15 months.[61] Since then, the proportion of predictable surveys in Tennessee decreased from about 56 percent to 29 percent. Arizona also stated that surveys had to be conducted within a 45-day window after the 1-year anniversary of the prior survey to be considered unpredictable.[62] Arizona's comments erroneously assume that a survey cannot take place before the 1-year anniversary of the prior survey. There is no prohibition on resurveying a home prior to the 1-year anniversary of its last survey, and many states do so. In fact,

[60]We contacted 10 states that were included in our review and that had a significant percentage of predictable surveys—Alabama, California, Connecticut, Maryland, Nebraska, New York, Oklahoma, Tennessee, Virginia, and Washington. As shown in table 10 (see app. V), the proportion of predictable surveys in these states ranged from 29 percent to 83 percent.

[61]See GAO/HEHS-00-197.

[62]We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior surveys or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys.

from October 1, 2000 through September 30, 2001, Arizona conducted 23 percent of its surveys before the 1-year anniversary.

CMS provided several technical comments that we incorporated as appropriate.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services and appropriate congressional committees. We also will make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

Please contact me at (202) 512-7118 or Walter Ochinko, Assistant Director at (202) 512-7157 if you or your staffs have any questions. GAO staff acknowledgments are listed in appendix XI.

Kathryn G. Allen

Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Scope and Methodology

This appendix describes our scope and methodology following the order that findings appear in the report.

Nursing home deficiency trends. To identify trends in the proportion of nursing homes cited for actual harm or immediate jeopardy, we analyzed data from CMS's OSCAR system. We compared standard survey results for three approximately 18-month periods: (1) January 1, 1997, through June 30, 1998, (2) January 1, 1999, through July 10, 2000, and (3) July 11, 2000, through January 31, 2002. Because surveys are to be conducted at least once every 15 months (with a required 12-month state average), it is possible that a facility was surveyed more than once in a time period. To avoid double counting of facilities, we included only the most recent survey of a facility from each of the time periods. The data from the two earliest time periods were included in our September 2000 report.[1] We updated our earlier analysis of surveys conducted from January 1, 1999, through July 10, 2000, because it excluded approximately 300 surveys that had been conducted but not entered into OSCAR at the time we conducted our analysis in July 2000.

Sample of state survey reports. To assess the trends in actual harm and immediate jeopardy deficiencies discussed above, we (1) identified 14 states in which the percentage of homes cited for actual harm had declined to below the national average since mid-2000 or was consistently below that average and (2) reviewed 76 survey reports from homes that had G-level or higher quality-of-care deficiencies on prior surveys but whose current survey had quality-of-care deficiencies at the D or E level, suggesting that the homes had improved.[2] All the surveys we reviewed were conducted from July 2000 through April 2002. Our review focused on four quality-of-care requirements that are the most frequently cited nursing home deficiencies nationwide (see table 6). According to OSCAR data, 99 surveys in the 14 states conducted on or after July 2000 documented a D- or E-level deficiency in at least one of these four quality-of-care requirements. We reviewed all such deficiencies in surveys from 13 states but randomly selected 22 surveys from California, which cited the majority (45) of these deficiencies. In reviewing the surveys, we looked for a description of the resident's diagnoses, any assessment of special problems, and a description of the care plan and physician orders

[1]GAO/HEHS-00-197.

[2]The 14 states are Alabama, Arizona, California, Iowa, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, Virginia, West Virginia, and Wisconsin.

connected with the deficiency identified. We also looked for a clear statement of the home's deficient practice and the relationship between the deficiency and the care outcome.

Table 6: Quality of Care Requirements Reviewed in a Sample of State Survey Reports

Nursing home quality of care requirements	Description
Necessary care and services	Facility must provide the necessary care and services for each resident to attain or maintain the highest practicable well-being.
Pressure sores	Facility must ensure residents entering facility without pressure sores do not develop sores, unless the individual's clinical condition indicates the pressure sores were unavoidable, and that residents with sores receive necessary treatment to promote healing, prevent infection, and prevent new sores.
Prevention of accidents	Facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents.
Maintenance of nutrition	Facility must ensure each resident maintains acceptable parameters of nutritional status, such as body weight.

Source: CMS's *Medicare State Operations Manual.*

Federal comparative surveys. In September 2000, we reported on the results of 157 comparative surveys completed from October 1998 through May 2000.[3] To update our analysis, we asked each CMS region to provide the results of more recent comparative surveys, including data on the corresponding state survey. The regions identified and provided information on the deficiencies identified in 277 comparative surveys that were completed from June 2000 through February 2002.[4]

Survey predictability. In order to determine the predictability of nursing home surveys, we analyzed data from CMS's OSCAR database. We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior survey or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys. Consistent with CMS's interpretation, we used 15.9 months as the maximum allowable interval between surveys. Because homes know the maximum allowable interval between surveys, those

[3]See GAO/HEHS-00-197.

[4]One of the comparative surveys in our updated analysis was completed in May 2000.

whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

Complaints. We analyzed the results of CMS's state performance review for fiscal year 2001 to determine states' success in investigating both immediate jeopardy complaints and actual harm complaints within time frames required either by statute or by CMS instructions. To better understand the results of state performance as determined by CMS's review, we interviewed officials from CMS's 10 regional offices and 16 state survey agencies (see state performance standards below for a description of how these states were chosen).[5] We also reviewed the report submitted to CMS by its contractor, which was intended to assess and recommend ways to strengthen state complaint practices.[6] Finally, to assess the implementation of CMS's new automated system for tracking information about complaints, we reviewed CMS guidance materials and interviewed CMS officials and state survey agency officials from our 16 sample states.

Enforcement. To determine if states had consistently applied the expanded immediate sanction policy, we analyzed state surveys in OSCAR that were conducted before April 9, 2002, and identified homes that met the criteria for referral for immediate sanction. We included surveys conducted prior to the implementation of the expanded immediate sanction policy because actual harm deficiencies identified in such surveys were to be considered by states in recommending a home for immediate sanction beginning in January 2000. To be affected by CMS's expanded policy, a home with actual harm on two surveys must have an intervening period of compliance between the two surveys. Because OSCAR is not structured to consistently record the date a home with deficiencies returned to compliance, we had to estimate compliance dates using revisit dates as a proxy. We compared the results of our analysis to CMS's enforcement database to determine if CMS had opened enforcement cases for the homes we identified. Our analysis compared the survey date in OSCAR to the survey date in CMS's enforcement database. We considered any survey date in the enforcement database within 30 days of the OSCAR survey date to be a match. CMS officials reviewed and

[5]We contacted officials in Alabama, California, Colorado, Connecticut, Iowa, Louisiana, Maryland, Michigan, Missouri, Nebraska, New York, Oklahoma, Pennsylvania, Tennessee, Washington, and Virginia.

[6]Center for Health Systems Research and Analysis at the University of Wisconsin, Madison.

concurred with our methodology. We then asked CMS to analyze the resulting 1,334 unmatched cases to determine if a referral should have been made.[7]

State performance standards. To assess state survey activities as well as federal oversight of state performance, we analyzed the conduct and results of fiscal year 2001 state survey agency performance reviews during which the CMS regional offices determined compliance with seven federal standards; we focused on the five standards related to statutory survey intervals, deficiency documentation, complaint activities, enforcement requirements, and OSCAR data entry. Because some regional office summary reports on the results of their reviews for each state did not provide detailed information about the results, we also obtained and reviewed regions' worksheets on which the summary reports were based. In addition, we conducted structured interviews with officials from CMS, CMS's 10 regional offices, and 16 state survey agencies to discuss nursing home deficiency trends, the underlying causes of problems identified during the performance reviews, and state and federal efforts to address these problems. We also discussed these issues with officials from 10 additional states during a governing board meeting of the Association of Health Facility Survey Agencies. We selected the 16 states with the goal of including states that (1) were from diverse geographic areas, (2) had shown either an increase or a decrease in the percentage of homes cited for actual harm, (3) had been contacted in our prior work, and (4) represented a mixture of results from federal performance reviews of state survey activities. We also obtained data from 42 state survey agencies on surveyor experience, vacancies, and related staffing issues.

[7]CMS determined that for 438 of the 1,334 cases we asked it to examine, the state had indeed made a referral to CMS. In some of these 438 instances, there was no corresponding case in the enforcement database because OSCAR had a different survey date. The "survey date" variable in OSCAR is the latter of the health survey date and the life-safety code survey, while the corresponding date in the enforcement database is usually the health survey date. For others, an enforcement case was already open for the home at the time of the referral, and CMS officials did not open an additional case. There was also a small number of cases where the state agency referred the home for immediate sanction, and CMS chose not to accept the state's recommendation. States failed to refer 711 cases that met CMS criteria for immediate referral. In addition, CMS did not analyze 155 other cases and was unable to determine the status of 30 cases.

Appendix II: Trends in The Proportion of Nursing Homes Cited for Actual Harm or Immediate Jeopardy Deficiencies, 1997-2002

Nationwide, the proportion of nursing homes cited for actual harm or immediate jeopardy during state standard surveys declined from 29 percent in mid-2000 to 20 percent in January 2002. From July 2000 through January 2002, 40 states cited a smaller percentage of homes with such serious deficiencies while only 9 states and the District of Columbia cited a larger proportion of homes with such deficiencies.[1] In contrast, from early 1997 through mid-2000, the percentage of homes cited for such serious deficiencies was either relatively stable or increased in 31 states.

To identify these trends, we analyzed data from CMS's OSCAR system. We compared results for three approximately 18-month periods: (1) January 1, 1997, through June 30, 1998, (2) January 1, 1999, through July 10, 2000, and (3) July 11, 2000, through January 31, 2002 (see table 7). Because surveys are to be conducted at least once every 15 months (with a required 12-month state average), it is possible that a facility was surveyed more than once in a time period. To avoid double counting of facilities, we included only the most recent survey from each of the time periods. Some of the data in table 7 were included in our September 2000 report.[2] However, we updated our analysis of surveys conducted from January 1, 1999, through July 10, 2000, because it excluded approximately 300 surveys that had been conducted but not entered into OSCAR at the time we conducted our analysis in July 2000.

[1]The proportion of nursing homes in Utah cited with serious deficiencies remained the same between the two time periods.

[2]GAO/HEHS-00-197.

Table 7: Trends in the Percentage of Nursing Homes Cited for Actual Harm or Immediate Jeopardy during State Standard Surveys, by State

	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference*	
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

	Number of homes surveyed			Percentage of homes cited for actual harm or immediate jeopardy			Percentage point difference*	
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
Pennsylvania	811	788	764	29.3	32.2	11.6	2.9	-20.6
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.

*Differences are based on numbers before rounding.

Appendix III: Abstracts of Nursing Home Survey Reports That Understated Quality-of-Care Problems

Our analysis of a sample of 76 nursing home survey reports demonstrated a substantial understatement of quality-of-care problems. Our sample was selected from 14 states in which the percentage of homes cited for actual harm had declined to below the national average since mid-2000 or was consistently below that average. We identified survey reports in these states from homes that had G-level or higher quality-of-care deficiencies (see table 1) on prior surveys but whose current survey had quality-of-care deficiencies at the D or E level, suggesting that the homes had improved. All the surveys we reviewed were conducted from July 2000 through April 2002. Our review focused on four quality-of-care requirements that are the most frequently cited nursing home deficiencies nationwide (see table 6).[1]

In our judgment, 30 of the 76 surveys (39 percent) from 9 of the 14 states had one or more deficiencies that documented actual harm to residents—G-level deficiencies—and 1 survey contained a deficiency that could have been cited at the immediate jeopardy level. While state surveyors classified these deficiencies as less severe, we believe that the survey reports document that poor care provided to and injuries sustained by these residents constituted at least actual harm. Table 8 provides abstracts of the 39 deficiencies that understated quality problems.

[1]According to OSCAR data, 99 surveys in the 14 states conducted on or after July 2000 documented a D- or E-level deficiency in at least one of the quality-of-care requirements we selected. We reviewed all such deficiencies in surveys from 13 states but randomly selected 22 of the 45 California surveys. The 14 states are Alabama, Arizona, California, Iowa, Maryland, Minnesota, Mississippi, Missouri, Nebraska, Pennsylvania, South Carolina, Virginia, West Virginia, and Wisconsin.

Table 8: Abstracts of the 39 Nursing Home Deficiencies that Understated Actual Harm from a Sample of 76 Nursing Home Survey Reports

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Alabama-1 November 2001	Provide necessary care and services: D	Resident admitted to facility 5/15/01with a fractured hip; a gastrostomy tube was inserted through the abdomen into the stomach to maintain feeding. On 10/9/01, resident was hospitalized for abdominal pain and signs of infection related to the gastrostomy tube. On return to facility, physician orders state, "clean G tube site with soap and water, apply a drain sponge."	Site of gastrostomy tube insertion became reddened with thick yellow-green drainage, and had an odor, indicating signs of infection, on 11/7/01.	Facility failed to provide proper care and services: daily cleaning and application of a drain sponge around the gastrostomy tube. Family indicated no one changed the dressing. There is no documentation to show resident's gastrostomy tube site was cleansed as ordered 12 out of 16 opportunities.
Alabama-5 March 2001	Provide supervision and devices to prevent accidents: D	Resident 1 admitted to facility 11/6/00 with diagnoses of stroke, pressure sores, and kidney failure. On 11/16/00, resident was noted to have abrasions and bruises.	Resident 1 sustained four skin tears on right arm and leg and multiple bruises to both legs from 1/16/01 to 3/21/01.	The facility failed to consistently reassess for preventive measures to address the problem of skin tears and bruises for both residents. Staff were unable to provide documentation of preventive interventions.
		Resident 2 was admitted to the facility 11/23/98 with anemia, depression, urinary incontinence, and a history of falls. She was identified as having a problem with skin tears and bruising.[c]	Resident 2 sustained seven skin tears and bruises to legs from 12/29/99 to 10/9/00.	

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Arizona-3 July 2000	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 08/24/99 with heart failure, high blood pressure, paraplegia, and a stage II pressure sore on lower back.[d] Pressure sore remained a stage II until May 2000, when wound was documented to be a stage III.	On 7/5/00, it was noted that the resident had developed a stage IV pressure sore.	The necessary services and care to promote healing and prevent worsening of existing pressure sore were not provided. Even after the pressure sore progressed to stage IV and a physician ordered that the resident be turned every hour, the staff failed to turn the resident as directed. Surveyor observed resident lying on her back for 2 or more hours. Resident stated that frequently she was turned only twice in 8 hours. Charge nurse did not know physician had ordered resident to be turned every hour.
Arizona-3 July 2000	Ensure adequate supervision to prevent accidents: D	Resident 1 admitted to the facility 4/7/00 with diabetes, partial paralysis of left side, and inability to speak. Resident also had a history of spinal fractures, and a fall prevention plan was developed on 4/15/00.	Resident 1 fell four times and sustained skin tears, abrasions, and lacerations.	Facility staff failed to implement a plan of care that called for identifying resident as a fall risk by placing a star on his door by his name. No other preventive measures were identified, and surveyor observed no star next to resident's name outside his door.
		Resident 2 admitted to the facility 12/10/97 with dementia, painful joints, and visual problems. A 7/13/00 assessment indicated resident was cognitively impaired and had a mental function that varied throughout the day. She was also identified as a wanderer.	Resident sustained 12 falls from 2/18 to 7/8/00 with lacerations of extremities and head requiring suturing and with other cuts and bruises.	Although resident was identified as at risk for falls in a care plan of 4/22/00, the facility staff failed to develop approaches to prevent falls even though the resident continued to fall and injure herself.
California-2 September 2000	Ensure prevention and healing of pressure sores: D	Resident 1 with leg contractures (permanent tightening of muscle, tendons, ligaments, or skin that prevents normal movement) was noted to have a small reddened area on left lower back on 9/20/00.	Resident 1 developed a reddened open area .3 cm. in diameter, (stage II pressure sore) on left lower back by 9/23/00.	The surveyor found that the facility did not identify, document, or provide intervention to prevent this facility-acquired pressure sore. The reddened area noted was not documented in the medical record 9/20-9/22/00.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
		Resident 2 was admitted to facility on 2/2/00. Family identified resident as having a "skin problem" on 9/17/00.	Resident 2 developed a stage II pressure sore.	The facility developed a nursing care plan for prevention of pressure sores and turning the resident every 2 hours on 9/8/00. The family identified a stage II pressure sore on 9/17/00. The surveyor found no evidence that the care plan was implemented at time of survey.
		Resident 3 admitted to facility 9/20/00 with diagnoses of multiple sclerosis, bilateral fractures of the femur, and obesity. Resident was unable to turn herself in bed; physician documented resident had no areas of skin breakdown and ordered resident to be up in a wheel chair two to three times a day.	Seven days after admission, resident 3 was noted to have four stage II pressure sores on right and left shoulder blades and right buttock and three stage I pressure sores on the left buttock.	The facility failed to prevent a rapid decline in resident's condition and occurrence of facility-acquired pressure sores. Staff said they were unable to turn resident (a larger bed and mattress were not provided, which would have facilitated turning). No pressure-relieving devices and staff assistance in getting out of bed were provided. In the 7 days after admission, the resident was out of bed only once, at which time the pressure sores were discovered.
California-2 September 2000	Maintain nutritional status: D	Resident admitted to facility 7/7/00 with a diagnosis of failure to thrive and a recorded weight of 89 pounds.	Resident's weight was recorded as 77 pounds 1 month after admission. Resident sustained a severe loss of 12 pounds (13 percent) between July and August.	Facility failed to provide a comprehensive nutritional assessment to meet resident's nutritional needs in order to maintain body weight.
California-5 February 2001	Provide supervision and devices to prevent accidents: D	Resident was identified as at high risk for falls in 5/00.	Resident fell while walking unassisted on 6/21/00 and again on 2/22/01, fracturing his right hip each time.	Facility failed to develop and implement a fall prevention plan when resident was identified as being a high risk for falls and after the first hip fracture.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-6 May 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility on 2/12/01with dizziness, fainting, poor vision, and cognitive impairment. Care plan of 2/20/01 identified resident as a wanderer and at risk for falls. Interventions suggested were visual checks every 2 hours and involvement of resident in facility activities. On 2/20/01 at 9:30 pm resident was found wandering outside on the patio and had fallen and sustained abrasions.	Resident wandered to an area 100 yards from facility near two busy intersections on 3/26/01 and again on 5/19/01. According to CMS, the failure of a facility to provide supervision of a cognitively impaired individual with known risk for wandering is considered failure to prevent neglect and places the resident in immediate jeopardy for death or serious injury during such an incident.	Facility failed to provide supervision and devices to prevent accidents even after resident was found wandering outside the facility on 2/20/01. The facility did not immediately implement procedures cited in the care plan to supervise the resident and prevent accidents and wandering, nor did the facility implement existing facility policies to prevent wandering and injury.
California-8 June 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility in 1996 with stroke, paralysis of lower right side, and senile dementia. Physician orders of 4/5/01 called for an air mattress. Assessment of 4/24/01 noted resident had a stage IV pressure sore on the right outer ankle. On 5/17/01, physician ordered cleansing of the wound with saline and an anti-infective solution, dressing it with soft protective gauze.	Resident sustained a facility-acquired stage IV pressure sore of the right ankle measuring 7 cm. by 5 cm.	Facility failed to ensure necessary treatment and service to promote healing and prevent infection of the pressure sore. Surveyor observed on 6/20 and 6/21/01 that there was no air mattress on resident's bed and on 6/20/01 that inappropriate technique was used in changing the dressing on the resident's ankle.
California-8 June 2001	Ensure maintenance of nutritional status: D	Resident admitted to facility in 1990 with a diagnosis of stroke and inability to speak. A 3/7/01 assessment noted erosive gastritis, anemia, and weight of 111 lbs. The county was the conservator and requested maximum treatment. Resident was placed on an enriched pureed diet with supplemental feedings three times daily.	Resident weighed 98.4 lbs and experienced a severe weight loss of 13 pounds (12 percent) in 3 months.	Facility failed to ensure that the resident maintained adequate nutrition. It did not monitor the amount of nutritional supplements consumed by the resident and inconsistently recorded weights, often without associated dates. It did not notify the physician of the resident's weight loss.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-9 December 2000	Provide supervision and devices to prevent accidents: B[c]	Resident 1, 48 years old, admitted to facility after a stroke with incontinence, inability to speak, right-side paralysis, and functional use of his left side. Resident communicated by signs and sounds.	Resident fell when trying to climb over side rails, sustaining a laceration to his head.	The facility failed to supervise the resident and prevent accidents from occurring: staff failed to accurately assess resident's safety needs and inappropriately assumed resident needed full side rails on the bed.
		Resident 2 had a history of a right hip fracture, chronic weakness in both legs, and dementia. Resident had a physician's order (9/16/99) for soft belt restraints when in wheelchair to prevent resident from getting up from wheelchair without assistance.	On 3/29/00, resident climbed over the bed side rails and was found on the floor at the foot of his bed with both side rails in the up position. Seven hours later, an x ray was taken and found that resident had a "minimal impaction fracture" of the left hip. Because restraints, including side rails, can pose a serious health and safety risk to nursing home residents if used improperly, CMS requires that restraints should only be used when other, less severe alternatives fail to address a resident's medical needs, and the benefits outweigh the potential risks. In such cases, the nursing home must ensure that any restraints are used safely and properly.	The facility failed to provide supervision and appropriate interventions to prevent this resident's fall. According to the surveyor, there were no orders for restraints in bed and no indication that all reasonable efforts had been made to safeguard the resident from additional injuries.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-9 December 2000	Ensure maintenance of nutritional status: D	Resident was readmitted (6/11/00) to facility following the removal of a hip prosthesis and a surgical incision that became infected with a fungus, resulting in a large gaping wound. Resident was unable to swallow following a stroke and was fed via a nasogastric tube.	A stage IV pressure sore on right heel was noted on 7/27/00.	Facility was slow to implement the dietician's recommendations of 6/15/00 for caloric, protein, and water intake necessary for wound healing. Diet ordered on 6/20/00. On 6/24/00 resident was admitted to the hospital for care of gastrointestinal bleeding and found to need nutritional supplements to address gastrointestinal bleeding and promote wound healing. Resident was readmitted to facility on 6/29/00. Following readmission, the facility also failed to implement both the hospital's and its own dietician's recommendations for increased protein, calories, and water to encourage wound healing.
California-10 May 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility with diagnoses of dementia and Alzheimer's disease and a history of falls, confusion, and unsteady gait. Resident identified as high risk for falls and had a physician's order for a restraining belt when in bed.	Resident fell while attempting to get out of bed and lacerated left elbow.	Facility failed to provide supervision and devices to prevent accidents. Specifically, resident was put to bed without a restraining belt.
California-11 May 2001	Provide necessary care and services: D	Resident admitted to the facility in 1999 with dementia and neurological disorders. Resident was receiving an antipsychotic medication that has a side effect of constipation. Care plan of 1/04/01 called for (1) providing liquids, roughage, and exercise, (2) monitoring for abdominal distention, pain, cramps, nausea, and vomiting, and (3) checking for impaction every 3 days.	Resident admitted to hospital for "several days" to relieve a fecal impaction.	Staff failed to implement the care plan. On 5/23/01 the surveyor noted the resident crying out, moaning, grimacing, and moving her arms and legs about. Last bowel movement recorded was on 5/19/01. The charge nurse administered Tylenol with codeine for what she believed was an earache at 10 a.m. Resident continued to cry out and the charge nurse called the physician who had the resident transferred to a hospital emergency room.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-11	Provide supervision and devices to prevent accidents: E	Resident was admitted 4/25/01 with acute kidney failure and emphysema and was one of five residents identified as being at risk for skin tears; all five developed skin tears. A care plan for potential for skin breakdown and treatment of the skin tears was developed.	Resident sustained a 9 cm. skin tear to the lower left leg on 4/28/01 and two 3 cm. skin tears below the left knee on 5/3/01. Four other residents also sustained multiple skin tears to their extremities and hip.	Facility failed to develop skin tear prevention plans. Staff did not fully investigate causes of the tears and did not know how to prevent skin tears. The staff development director stated that she had never provided instruction for the certified nurse aides on prevention of skin tears.
California-14 March 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 1/26/01 following a stroke, with inability to swallow, a gastric tube in place for feedings, and a stage I pressure sore on right hip.	Resident's pressure sore progressed to a stage II by 2/28/01 and a stage III on 3/7/01.	Facility staff failed to promote healing or prevent worsening of pressure sore by failing to employ the appropriate sheets that are used in conjunction with the low-air-loss, pressure sore mattress, thereby negating the pressure-relieving benefits of the mattress.
California-16 April 2001	Ensure prevention and healing of pressure sores: D	Resident admitted to facility 11/16/98 with dementia, anemia, irregular heartbeat, diabetes, high blood pressure, and difficulty in swallowing.	Resident developed a new stage II pressure sore on 4/26/01.	Facility staff did not prevent the development of a facility-acquired pressure sore. Specifically, the surveyor observed on 4/24/01 that the staff did not turn resident every 2 hours as directed by the care plan, and left her in the same position for as long as 8 hours.
California-18 April 2001	Provide necessary care and services: E	Resident admitted to the facility with a steel plate implanted in her back following a fracture. Nursing care plan called for comfort measures for back pain, such as heat/cold application, therapeutic touch, and staying with resident when she was in distress. Resident also had an order for Methadone 20 mg. that had been reduced to 2.5 mg.	Resident was observed screaming and writhing in unrelieved pain for greater than an hour.	Facility staff failed to assess the resident's pain levels after decreasing her Methadone. They did not do an in-depth pain assessment at any time after admission. The surveyor observed the staff ignoring the resident's cries for help and relief, which continued until the surveyor intervened.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
California-19 June 2001	Provide necessary care and services: D	Resident admitted to facility on 3/97 with stroke, one-sided paralysis, and moderate contractures of upper and lower extremities. Resident took Tylenol four times a day since 2/98 for pain. As his pain worsened, he began to refuse the splinting of his contracted extremities because it was too painful.	As a result of the facility's failure to address the resident's pain, the resident refused the splints used to control the contractures and the contractures worsened, leading to greater pain.	Facility staff did not reassess this resident's pain level and need for stronger pain relief.
California-20 January 2001	Provide supervision and devices to prevent accidents: D	Resident was admitted to facility on 3/6/00 and identified as a high risk for falls on 12/6/00 because of resident's failure to remember warnings about personal safety and poor safety awareness.	Resident fell and sustained abrasions to her right flank and hip on 12/24/00 and again on 1/7/01, sustaining a scalp laceration on the back of her head.	Facility failed to implement care plan of 12/19/00 that called for safety assessment and rehabilitation screening related to falls. In addition, facility failed to reassess resident's safety needs and alternative preventive measures after the two falls, as called for by facility policy and the care plan. Physical therapy staff did not assess resident for safety needs either. There was no documented evidence that a plan was implemented to prevent future falls.
California-22 October 2000	Provide supervision and devices to prevent accidents: D	Resident had diagnoses of diabetes, bipolar disease, and high blood pressure. Resident was assessed as at risk for falls.	Resident fell 17 documented times from 4/21 to 10/14/00, when she sustained a bruising of the right eye, and a bruise and an abrasion to her forehead.	Facility failed to provide supervision and prevent accidents. Specifically, facility staff did not provide a self-releasing seat belt or pressure sensitive alarm on resident's wheelchair as recommended by the facility's fall/risk committee. Although the MDS assessment of 9/4/00 indicated that the resident had no falls for 180 days, the resident's medical record indicated that the resident fell at least six times in this period.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Iowa-1 June 2001	Ensure prevention and healing of pressure sores: D	Resident 1 had diagnoses that included renal failure, diabetes, and dementia. Resident's record noted the presence of two pressure sores, one on 1/9/01 and the second on 4/1/01, between the buttocks and on the lower right back, respectively.	Resident's stage II pressure sores healed and then reopened repeatedly from 1/9/01 to 6/20/01.	Facility staff failed to provide appropriate treatment to prevent reoccurrence of pressure sores, resulting in the reappearance of pressure sores after they had resolved. Specifically, the facility did not reassess the current plan of treatment and did not modify the care plan to meet the needs of the resident.
		Resident 2 had a history of stroke and dementia. A 4/20/01 assessment note indicated that the resident had no ulcers, skin problems, or lesions. On 4/22/01, the resident fell, was admitted to the hospital for treatment of a fracture of the right wrist, and was readmitted to nursing home on 4/27/01 with a cast on the right arm, including the lower half of the hand and thumb.	Resident developed an infected stage II pressure ulcer at the base of the right thumb.	Facility staff failed to prevent an avoidable pressure sore. After the resident was readmitted with the cast on his arm, the staff did not assess whether the skin around the cast was intact for 18 days (4/27-5/14/01), at which time the nurse noted a foul odor and a reddened thumb.
Iowa-2 March 2002	(1) Ensure prevention and healing of pressure sores: D	On 2/25/02, surveyor observed resident being transferred using a mechanical lift and noted an open stage II pressure sore on the lower back. A record review revealed a history of healing and reoccurrence of a lower-back pressure sore on several occasions from 7/8/01 through 2/26/02.	Resident developed a stage II pressure sore that persisted and reopened after resolving.	Facility staff failed to ensure that a resident with a pressure sore received necessary treatment to promote healing and to prevent new sores from developing. Specifically, the record lacked evidence of assessment of potential causal factors and interventions to prevent the reoccurring pressure sore.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
	(2) Provide supervision and devices to prevent accidents: D	During the above cited observation of the same resident on the mechanical lift, the surveyor also noted bilateral purple bruises on the resident's lower legs and later checked the resident more fully and noted a total of five bruises and a scrape to the legs. A review of the resident's record revealed multiple bruises, abrasions, and skin tears going back 1 year. The surveyor observed that there was no padding on the mechanical lift.	Resident sustained multiple bruises, skin tears, and scrapes.	Facility failed to prevent bruises and skin tear injuries. The staff did not assess the cause of the injuries or implement protective devices, such as padding of the lift and wheelchair. On 2/26/02, a staff member stated that the probable cause of the bruises was the resident's hitting the mechanical Hoyer lift during transfers and that the lift should be padded.
Iowa-4 February 2001	Provide necessary care and services: E	Resident with a diagnosis of multiple sclerosis required extensive assistance with transfers, walking, and other activities of daily living. Care plan of 1/19/01 directed staff to monitor and record all skin changes. Surveyor noted multiple bruises on resident's legs.	Surveyor noted bruises on resident's legs and saw how resident's legs and feet were twisted between the wheelchair pedals and dragged and bumped against the wheelchair on 1/30 and 1/31/01. Resident sustained multiple bruises on both lower legs.	Facility staff failed to provide the necessary care and services in accordance with the plan of care. Staff failed to assess for risk of skin injury from wheelchair transfers and to protect resident from harm during transfers. Staff also failed to document resident's bruises.
Iowa-5 March 2001	Provide necessary care and services: D	Resident admitted to facility on 7/6/99 with Alzheimer's disease, high blood pressure, and anemia. Resident was receiving a diuretic to reduce blood pressure and an antihistamine for itching. Both drugs can reduce blood pressure below normal levels, causing dizziness or a drop in blood pressure when rising to stand (orthostatic hypotension). Resident's plan of care called for staff to monitor blood pressure on a weekly basis.	Resident fell five documented times, sustaining abrasions to the forehead, a bloody nose and mouth, a bump to the forehead, a broken tooth, a carpet burn of the knees, and a broken nose.	Facility failed to properly assess and monitor after the resident fell, striking her head on all five occasions. There was no documentation of weekly monitoring of blood pressure or for neurological status after resident struck her head.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Iowa-7 August 2001	Provide necessary care and services: D	Resident 1 admitted to facility on 3/2/01 with history of stroke, heart failure, and poor circulation, with related rash of the legs and feet. Assessment revealed a small scab on the left ankle that healed by 5/01. Resident developed a scabbed area on right foot. The physician ordered skin and heel protectors to be worn at night on 5/29/01.	Resident developed two stage II ulcers of the foot and ankle, one on 6/18/01 and the other on 6/26/01, which were still present, unhealed, on 8/7/01.	Facility staff did not consistently follow the orders and provide the necessary care for the resident. According to the surveyor, the skin and heel protectors were left off and the wheelchair was not padded and was causing additional erosion of the ankle lesions.
		Resident 2 was admitted with lung cancer, degenerative arthritis, osteoporosis, and anxiety. Physician's note of 5/16/01 indicated that resident was dying and would need to be assessed for pain relief as the disease progressed and that stronger, more effective pain relievers would be considered. As the resident began to experience increasing pain, he was given Tylenol even when pain appeared severe and unrelieved.	Resident 2 experienced severe unrelieved pain.	Facility staff failed to provide the necessary care for this resident to maintain comfort measures and avoid pain. The care plan of 5/21 and 6/13/01 did not include pain management. The staff did not assess the resident's complaints of pain and need for effective pain relief.
Iowa-7 August 2001	Provide supervision and devices to prevent accidents: D	Resident 1 has diagnoses of dementia and depression with long- and short-term memory deficits. Surveyor noted resident had fallen frequently from 2/23/01 through 7/23/01 and sustained serious injuries. Personal safety alarms selected for resident were ineffective in preventing falls.	Resident 1 fell 11 times and sustained a fractured wrist, three fractured ribs, bruises, abrasions, and a skin tear, plus pain associated with all these falls and injuries.	The facility failed to provide adequate interventions to prevent accidents. The personal alarm system was the only safety device employed, and there is no evidence that the staff evaluated its effectiveness and selected other measures.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
		Resident 2 was admitted to facility on 8/8/00 with renal failure and impaired mobility. On 4/3/01, he was assessed as being mentally confused at times. Surveyor noted the resident's record stated that resident fell frequently. The care plan and monthly summary for April identify the personal alarm unit as the safety device in use during this time (initiated 3/25/01). The resident frequently removed the unit or put it in his pocket.	Resident 2 fell 21 times from 1/6/01 to 6/26/01 and sustained multiple skin tears, two lacerations to the head and elbow requiring emergency room or clinic visits for sutures, multiple bruises and abrasions, and head injuries.	The facility failed to provide adequate interventions to prevent accidents. The personal alarm unit in use for this resident did not prevent his falls from occurring and there is no indication that other safety options were considered.
Maryland-1 August 2001	Provide supervision and devices to prevent accidents: D	Resident admitted to facility with multiple diagnoses including congestive heart failure, high blood pressure, and obesity. Resident suffered from shortness of breath and required oxygen at 3 liters per minute. She also had a history of falls and was considered a high risk for falls. Resident had a physician order for a quick-release belt while in wheelchair for safety.	Resident fell out of the wheelchair, was bleeding from nose and mouth, and was in acute respiratory distress. Staff did not intervene to address respiratory distress until resident stopped breathing and her pulse stopped. At this time the staff began to administer cardiopulmonary resuscitation (CPR).	The facility failed to provide supervision and devices to prevent accidents by not placing safety belt around resident while she was in the wheelchair. Staff also did not provide the resident with oxygen as ordered while she was in the wheelchair. Staff did not respond in a timely and appropriate manner to resident's onset of respiratory distress following the fall from the wheelchair. Staff did not initiate CPR until resident was no longer breathing and her pulse stopped.
Missouri-3 May 2001	Ensure adequate nutritional status: D	Resident had diagnoses of peptic ulcer disease, aspiration pneumonia, and a penicillin-resistant infection requiring long-term antibiotic treatment. From 11/00 through 2/01, resident sustained a severe weight loss of 10 to 12 percent.	Resident experienced another severe weight loss, dropping from 126 lbs in 3/01 to 116.9 lbs in 4/01, a loss of 7.2 percent in 1 month.	The facility failed to ensure adequate nutritional status. After noting resident's weight loss in 2/01, no care plan was developed to address the weight loss. In March, the dietician recommended a dietary supplement, which did not begin for a month.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Nebraska-1 September 2000	Provide necessary care and services: D	Resident 1 readmitted to facility from hospital with a diagnosis of insulin-dependent diabetes. Physician orders stated that the physician was to be called when resident's blood sugar fell below 40 or rose above 350 (normal range is 70 to 110). Resident received insulin on a sliding scale (insulin dose based on most recent blood sugar), and a variety of dietary interventions.	Over a period of 9 months, resident's blood sugar fluctuated, including frequent episodes of symptomatic hypoglycemia (low blood sugar between 48 and 60) and loss of consciousness.	Facility failed to provide the necessary care and services required to manage resident's diabetes. Specifically, (1) the staff infrequently called the physician about blood sugars below 40, the frequent blood sugar fluctuations, or the resident's episodes of symptomatic hypoglycemia, (2) fluctuating blood sugars were not identified as a problem in the care plan, and (3) there was no assessment of the resident's diabetes, appropriate diet, treatment effectiveness of hypoglycemic episodes, and administration of insulin on a sliding scale.
		Resident 2 with diagnoses of emphysema, Parkinson's disease, and osteoarthritis was receiving hospice services. Resident experienced increasing pain on a daily basis, unrelieved by regular Tylenol, a tranquilizer, and an antipsychotic drug specific for schizophrenia and mania. Resident obtained short-term (2.5 hours) relief from Tylox (Tylenol and oxycodone for pain relief and sedation).	This terminally ill resident suffered with unrelieved pain for at least 4 months.	Facility staff did not provide the necessary care and services to this resident. The staff did not assess or respond to the resident's continuing complaints of pain and noted in the record that the resident was demanding and manipulative. Nor did they monitor the effectiveness of the medications administered, resulting (according to the surveyor) in the resident's voicing thoughts of suicide.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Nebraska-3 September 2001	Ensure prevention and healing of pressure sores: D	Resident was readmitted to facility 5/24/01 with diagnoses of stroke, diabetes, and one stage II pressure sore of the lower back and one stage I pressure sore between the buttocks. Resident was totally dependent on staff for bed mobility because of a right-sided paralysis and developed pressure sores of both heels that were noted on 6/3/01 and identified as stage II on 7/24/01. A pressure-reducing mattress was added to the care plan on 9/4/01.	Resident developed a stage III pressure sore on the right heel with thick green drainage and foul odor.	Facility failed to ensure that a resident did not develop a pressure sore in the facility. Specifically, the facility staff failed to recognize the challenge the resident had in moving in bed because of the right-sided paralysis. In addition, they were slow to use a pressure-reducing mattress. When the mattress was placed on the bed the staff did not discontinue use of the fleece-lined protection booties and continued use for 3 weeks, which negated the pressure-reducing effects of the mattress.
Pennsylvania-3 May 2001	Ensure prevention and healing of pressure sores: D	Resident had a left hip fracture and was identified as high risk for skin breakdown on 12/18/00. A stage I pressure sore of the left heel was noted on 3/7/01 and by 3/14/01 it had progressed to stage II. A special boot to keep left heel elevated was not applied until 3/21/01 and was then left on continuously. A second stage II pressure sore was noted on the left outer foot 4/10/01. The boot was discontinued on 4/11/01. A nutrition assessment on 3/27/01 indicated resident's skin was intact and recommended no increase in protein in the diet.	In addition to the stage II pressure sore of the foot, resident developed a second stage II facility-acquired pressure sore on 4/10/01.	Facility failed to prevent the development of pressure sores. Specifically, the boot, which was left on continuously, contributed to the development of the pressure sore identified on 4/10/01. In addition, the dietician did not note the existing original pressure sore and wrongly assumed the resident had no extra need for protein. The need for additional protein in the diet was confirmed by laboratory tests indicating the resident's protein levels were below the normal range.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Pennsylvania-3 May 2001	Provide supervision and devices to prevent accidents: E	Resident had piriformis syndrome (compression of the sciatic nerve by the piriformis muscle) with a physician's order for physical therapy using stretching exercises and heat application. Physical therapy used a hydrocollator pack to provide moist heat treatments.[c]	Resident developed a second-degree burn of the right buttock, which blistered and was still healing after a month.	Facility staff failed to provide supervision and prevent injury. During a routine check on 1/9/01, the facility found that the temperature on the hydrocollator pack was 11 degrees above the manufacturer's recommended temperature. On 4/16/01 the hydrocollator pack was applied to the resident's right buttock. Resident said that he told the therapy staff that the pack was getting too hot and the pack was removed. Facility staff did not check the water temperature after the incident.
		Resident 2 had diagnoses that included dementia, poor vision, and Parkinson's disease and was assessed as a moderate risk for falls on 12/29/00. The MDS significant change assessment of 1/24/01 and the 4/9/01 quarterly review noted a history of falls, impaired decision making, and the need for assistance for transferring and walking. The records noted interventions found to be ineffective continued to be used.	Resident 2 fell nine documented times and, as a result of these falls, sustained a skin tear, a laceration requiring transfer to the hospital for treatment, and a dislocated hip requiring another hospital visit.	The facility failed to ensure adequate supervision and assistance devices to prevent accidents. According to the surveyor, there was no evidence that the facility had implemented effective interventions to avoid the risk of such accidents for the resident. The surveyor noted that this at-risk resident's room was too far from the nurses' station, making observation difficult.
Pennsylvania-9 May 2001	Provide supervision and devices to prevent accidents: D	A dependent resident with cognitive impairment was assessed as at risk for falls and skin tears. Interventions to prevent falls listed in the care plan included use of personal alarms, protective sleeves, and padded side rails.	Resident sustained eight skin tears on 6/27/00, 7/24/00, 7/31/00, 8/16/00, 9/20/00, 10/24/00, 1/8/01, and 1/27/01.	Surveyor stated that the facility failed to ensure that the necessary safety measures and/or devices were implemented and failed to adequately assess the ongoing use of these devices given their ineffectiveness in preventing falls and skin tears.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-1 August 2000	Provide necessary care and services: D	Resident admitted to facility for pain management associated with spread of cancer to the spine. Resident had physician orders for Oxycontin every 12 hours for long-term pain relief, as needed, and Percocet every 4 hours for any additional pain, as needed. Staff noted resident lay very still in bed and seldom asked for pain medication but that it was obvious he was in a lot of pain whenever he was turned or touched. Resident's daughter said her father was in constant pain and was depressed.	This resident suffered with severe pain that was incompletely relieved by the use of Percocet. The longer acting Oxycontin was never used.	The facility did not provide necessary care and services to manage this resident's pain. Resident did not receive any of the longer-acting Oxycontin and received only 10 doses of the Percocet during the 6 days he was in the facility. He was not offered pain relief in the morning when he was being turned and bathed. Monitoring of medication effectiveness was incomplete. Percocet was given, on average, once a day.
Virginia-2 March 2001	Provide necessary care and services: D	Resident was admitted to facility 11/4/97, with diagnoses of stroke, depression, and delusions. An MDS of 11/9/00 indicated the resident was cognitively impaired and required lift transfer. On 12/27/00 the nurse noted a large area of bruising on the left chest and left underarm with swelling around the rib cage. On 1/6/01 resident began to experience shallow breathing. Physician ordered a chest x ray if resident's breathing difficulties continued.	Resident sustained fractures of the eighth and ninth ribs with fluid in the left lower lobe of the lung demonstrated by x ray.	The facility failed to provide the necessary care and services to provide prompt treatment of the resident's chest injury. Specifically, the facility failed to take appropriate action to assess and provide the necessary care for this resident's injury for 11 days. The results of an investigation implicated the lift used to transfer the resident to and from the bed.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-2 March 2001	Ensure prevention and healing of pressure sores: D	Resident 1 admitted to the facility with diagnoses of Alzheimer's disease, anemia, depression, and joint pain. No pressure sores were noted on the admission assessment form. The care plan on 2/22/00 noted the resident was incontinent of bowel and bladder and at risk for pressure sores. Resident's blood protein was low. The most recent MDS (2/23/01) indicated no pressure sores but noted the resident was losing weight, 5 percent or more in the past 30 days (1/24/01- 2/23/01).	Resident developed three open pressure sores of the buttocks, evident 2 days after the MDS assessment. One of the pressure sores was a stage III.	The facility failed to prevent the development of facility-acquired pressure sores. The staff did not obtain timely alternative treatments and interventions to promote healing of early pressure sores.
		Resident 2 admitted to facility on 12/24/00 with diabetes, stroke, prostate cancer, requiring limited assistance for activities of daily living, and incontinent of bowel and bladder. As of 12/31/00 resident had an unhealed surgical wound of the back, two stage IV pressure sores of the right and left heels, and an excoriated (stage I) buttock. After a brief hospitalization, resident was readmitted to facility and the clinical record on 2/26/00 described the buttock sore as a stage II pressure sore. Treatment with a sealed dressing continued.	Resident developed an open stage III pressure sore with yellow drainage.	Staff failed to obtain timely alternative treatments and interventions to promote healing upon worsening of these sores from1/18/01 through 3/1/01. Specifically, the staff continued to treat the pressure sores without evaluating the effectiveness of the treatment.

State and date of survey[a]	Requirement and scope and severity cited	Resident description and relevant diagnoses[b]	Actual harm to resident documented by surveyor	Deficiencies in care cited by surveyor
Virginia-4 March 2001	Provide necessary care and services: D	Resident was an 81-year-old admitted to the facility on 8/17/90 with psychoses and hypothyroidism. Recent assessment (1/22/01) indicated long- and short-term memory loss and moderate dependency for activities of daily living. Care plan identified resident as at risk for falls. A list of preventive measures was provided. On 9/14/00 at 7:30 p.m., resident fell and complained of pain all over.	Resident sustained a nondisplaced fracture of the left wrist and suffered unnecessary pain.	Facility failed to provide necessary care and services. The facility failed to assess and investigate the source of the resident's pain. Nurses' notes indicate no apparent injury after fall. On 9/15/00 at 6:30 p.m., resident complained of pain in left arm. There was bruising on wrist and thumb, and the arm was swollen and tender to touch. According to the surveyor, there was a delay in seeking more aggressive treatment or service, as evidenced by the fact that an x-ray was not obtained until 37 hours after the resident's fall.

Source: State nursing home survey reports.

[a]To more easily distinguish among multiple surveys from the same state, we assigned consecutive numbers to each state's surveys.

[b]The resident description and relevant diagnoses are limited to the information provided by the surveyor. In some of the surveys, no background or diagnostic information was provided.

[c]Skin tears and multiple bruises are serious and painful injuries for older individuals and should not be considered in the same context as cuts and bruises sustained by healthy and younger adults. A skin tear is a traumatic wound occurring principally on the extremities of older adults as a result of friction alone or shearing and friction forces that separate the top layer of skin from the underlying layer or both layers from the underlying structures. A skin tear is a painful but preventable injury. Individuals most at risk for skin tears are those with (1) fragile skin, (2) advanced age, (3) assistance devices (wheelchairs, lifts, walkers), (4) cognitive and sensory impairment, (5) history of skin tears, and (6) total dependence for care. In addition, treatment of bruises and skin tears for elderly residents of a nursing home is frequently complicated by diabetes, poor circulation, poor nutrition, and medications with blood thinning effects. See Sharon Baranoski, "Skin Tears: Staying on Guard Against the Enemy of Frail Skin," *Nursing 2000*, vol. 30, no. 9, 2000.

[d]Stages of pressure sore formation are I—skin of involved area is reddened, II—upper layer of skin is involved and blistered or abraded, III—skin has an open sore and involves all layers of skin down to underlying connective tissue, and IV—tissue surrounding the sore has died and may extend to muscle and bone and involve infection.

[e]The following two resident incidents were cited at the B level for scope and severity, which means the surveyor found that both injuries were unavoidable and that the nursing home was in substantial compliance with the requirements.

[f]These two citations involve two residents, one cognitively competent and the other with dementia, who were injured because side rails were in place on their beds. Numerous reports have cited the danger of side rails. Residents trying to get out of bed over the rails have injured themselves by falling. Other individuals have been caught between the bed rails and the mattress or have caught their heads in the rails. Some of these injuries resulted in death.

[5]A hydrocollator pack is a canvas bag containing a silicone gel paste that absorbs an amount of water 10 times its weight. The pack is placed in a heated water container, set at a temperature above 150° F. When ready, it is placed in a protective dry terrycloth wrap and applied on top of the area where the individual is experiencing pain. Lying or sitting on the pack negates the insulating effect of the terrycloth and the individual may be burned.

Appendix IV: Information on State Nursing Home Surveyor Staffing

Table 9 summarizes state survey agencies' responses to our July 2002 questions about nursing home surveyor experience, vacancies, hiring freezes, competitiveness of salaries, and minimum required experience.

Table 9: State Survey Agency Responses to Questions about Surveyor Experience, Vacancies, Hiring Freezes, Competitiveness of Salaries, and Minimum Required Experience

State[a]	Surveyors with 2 years or less experience (percent)	Surveyor positions vacant (percent)	Surveyor hiring freeze in effect as of mid-2002	RN surveyor salaries are competitive	Minimum required experience for RN surveyors (years)
Maryland	70	9	Yes	Yes	0 to 2
Oklahoma	67	4	Yes	Yes	0 to1
New Hampshire	60	12	Yes	No	2
Florida	55	8	No	No	0
Idaho	54	0	Yes	No	1
Washington	54	0	No	No	2
California	52	6	Yes	Yes	1
Georgia	51	14	No	No	3
Kentucky	51	17	No	Yes	4
District of Columbia	50	9	Yes	Yes	3
Utah	50	8	No	No	2
Louisiana	48	6	Yes	No	2 to 3
Alabama	48	10	No	No	0
Tennessee	45	18	No	No	3
Maine	42	9	Yes	No	5
Hawaii	40	17	No	No	2-½
New York	40	4	Yes	No	1 to 2
Missouri	36	11	No	No	2
Oregon	34	12	Yes	No	5
Arkansas	33	20	No	No	2
North Carolina	33	18	No	No	4
Texas	32	20[b]	No[b]	No	1
New Mexico	30	34	No	No	3
New Jersey	30	23	Yes	No	3
Nebraska	29	6	No	No	1 to 2
Connecticut	29	1	Yes	Yes	4
Alaska	29	22	No	No	2
Wisconsin	25	15	No	No	0
Colorado	24	17	No	No	1
Virginia	21	5	No	No	0
Indiana	20	18	No	No	1
Arizona	20	24	Yes	No	2
South Dakota	18	0	No	Yes	2
Ohio	17	5	No	Yes	0

State[a]	Surveyors with 2 years or less experience (percent)	Surveyor positions vacant (percent)	Surveyor hiring freeze in effect as of mid-2002	RN surveyor salaries are competitive	Minimum required experience for RN surveyors (years)
Michigan	17	5	Yes	No	0
Kansas	17	4	No	No	[c]
Massachusetts	16	14	Yes	Yes	1 to 3
Pennsylvania	15	7	No	Yes	1
Rhode Island	9	13	No	Yes	1
Illinois	5	5	Yes	Yes	2 to 3
Iowa	4	0	Yes	No	5
Minnesota	0	17	Yes	No	3

Source: State survey agency responses to July 2002 GAO questions.

[a]Nine states did not respond to our inquiry—Delaware, Mississippi, Montana, Nevada, North Dakota, South Carolina, Vermont, West Virginia, and Wyoming.

[b]Texas indicated that although there was no hiring freeze or layoffs, the survey staff was reduced by 107 positions through attrition from September 1, 2001, through June 1, 2002, in light of state funding changes and agency cuts. As of mid-2002, Texas was authorized 215 nurse surveyors and had 42 positions vacant.

[c]Kansas requires independent experience in professional health care, but does not specify a time period for that experience.

Appendix V: Predictability of Standard Nursing Home Surveys

Our analysis found that 34 percent of current nursing home surveys were predictable, allowing nursing homes to conceal deficiencies if they choose to do so. In order to determine the predictability of nursing home surveys, we analyzed data from CMS's OSCAR database (see table 10). We considered surveys to be predictable if (1) homes were surveyed within 15 days of the 1-year anniversary of their prior survey or (2) homes were surveyed within 1 month of the maximum 15-month interval between standard surveys. Consistent with CMS's interpretation, we used 15.9 months as the maximum allowable interval between surveys. Because homes know the maximum allowable interval between surveys, those whose prior surveys were conducted 14 or 15 months earlier are aware that they are likely to be surveyed soon.

Table 10: Predictability of Current Nursing Home Surveys, by State

State	Number of active homes with a current and prior survey	Predictable surveys (percent)	Homes surveyed within 15 days of 1-year anniversary of prior survey (percent)	Homes surveyed within 1 month of 15-month maximum interval of prior survey (percent)
Alabama	225	82.7	5.8	76.9
Oklahoma	354	71.5	0.6	70.9
South Carolina	174	67.8	6.9	60.9
Nebraska	226	59.7	3.1	56.6
Utah	91	52.7	1.1	51.6
Montana	103	52.4	8.7	43.7
Georgia	357	52.4	0.6	51.8
Hawaii	44	52.3	13.6	38.6
New York	663	52.0	14.8	37.3
Idaho	84	50.0	4.8	45.2
New Mexico	80	43.8	13.8	30.0
Delaware	42	42.9	31.0	11.9
California	1,324	41.2	9.5	31.7
Nevada	45	40.0	24.4	15.6
Arizona	138	39.9	21.0	18.8
New Jersey	359	39.0	18.7	20.3
Oregon	142	38.0	14.1	23.9
Maryland	246	37.0	20.7	16.3
Massachusetts	497	36.2	17.3	18.9
Arkansas	239	35.6	27.6	7.9
Virginia	275	35.3	30.5	4.7
Iowa	457	34.6	31.1	3.5
Nation	**16,332**	**34.0**	**13.0**	**21.0**
Kentucky	303	33.7	10.6	23.1
Ohio	973	33.6	3.0	30.6
North Dakota	85	32.9	28.2	4.7
Vermont	43	32.6	11.6	20.9
New Hampshire	83	32.5	12.0	20.5
South Dakota	111	32.4	18.9	13.5
Wisconsin	404	32.4	19.6	12.9
Washington	268	32.1	22.4	9.7
Florida	718	32.0	9.3	22.7
Mississippi	187	31.6	2.1	29.4
Rhode Island	96	31.3	12.5	18.8
Connecticut	253	30.8	15.8	15.0
Wyoming	39	30.8	10.3	20.5
Indiana	550	30.7	14.4	16.4
Tennessee	324	29.0	6.2	22.8
Louisiana	315	28.6	19.0	9.5
Texas	1,122	27.2	15.7	11.5

State	Number of active homes with a current and prior survey	Predictable surveys (percent)	Homes surveyed within 15 days of 1-year anniversary of prior survey (percent)	Homes surveyed within 1 month of 15-month maximum interval of prior survey (percent)
Colorado	222	26.1	9.0	17.1
Pennsylvania	757	26.0	24.0	2.0
Kansas	369	25.2	13.6	11.7
Missouri	531	25.0	11.9	13.2
Maine	121	24.8	8.3	16.5
Minnesota	427	20.4	4.4	15.9
Alaska	15	20.0	6.7	13.3
District of Columbia	20	20.0	15.0	5.0
North Carolina	411	17.3	13.9	3.4
Illinois	849	15.2	9.7	5.5
West Virginia	138	10.9	8.7	2.2
Michigan	433	10.2	8.8	1.4

Source: GAO analysis of OSCAR data as of April 9, 2002.

Appendix VI: Immediate Sanctions Implemented Under CMS's Expanded Immediate Sanctions Policy

From January 2000 through March 2002, states referred 4,310 cases to CMS under its expanded immediate sanctions policy when nursing homes were found to have a pattern of harming residents.[1] Because some homes had more than one sanction or may have had multiple referrals for sanctions, 4,860 sanctions were implemented (see table 11). Table 12 summarizes the amounts of federal civil money penalties (CMP) implemented against nursing homes referred for immediate sanction. Although these monetary sanctions were implemented, CMS's enforcement database does not track collections. In addition, states may have imposed other sanctions under their own licensure authority, such as state monetary sanctions, in addition to or in lieu of federal sanctions. Such state sanctions are not recorded in CMS's enforcement database.

Table 11: Federal Sanctions Implemented against Nursing Homes Referred for Immediate Sanction, January 14, 2000, through March 28, 2002

Type of sanction*	Number implemented
CMP	2,933
Denial of payment for new admissions	1,232
Directed in-service training	345
State monitoring	192
Directed plan of correction	77
CMS approved alternative or additional state sanction	48
Termination from the Medicare and Medicaid programs	26
Temporary management	4
Denial of payment for all residents	2
Transfer of residents and closure of facility	1
Total	**4,860**

Source: CMS enforcement database as of March 28, 2002.

*We excluded sanctions that were not implemented either because they were pending as of March 28, 2002, the date of our extract of CMS's enforcement database, or because CMS withdrew them after imposition.

[1]We use the term "cases" because some homes had multiple referrals for immediate sanctions.

Table 12: Federal CMPs Implemented under CMS's Immediate Sanctions Policy, January 2000 through March 2002

State	CMP amount
Alabama	$375,627.50
Alaska	0.00
Arizona	350,652.50
Arkansas	1,571,654.04
California	1,681,813.50
Colorado	1,489,100.00
Connecticut	696,350.00
Delaware	214,342.50
District of Columbia	20,000.00
Florida	1,975,375.00
Georgia	487,050.00
Hawaii	20,000.00
Idaho	37,350.00
Illinois	2,801,656.50
Indiana	1,977,685.50
Iowa	175,945.00
Kansas	415,400.00
Kentucky	1,195,177.50
Louisiana	20,000.00
Maine	184,920.00
Maryland	290,270.00
Massachusetts	1,031,445.00
Michigan	1,035,815.00
Minnesota	66,307.50
Mississippi	186,977.50
Missouri	467,157.50
Montana	0.00
Nebraska	11,207.50
Nevada	429,500.00
New Hampshire	93,350.00
New Jersey	1,543,007.50
New Mexico	222,430.00
New York	0.00
North Carolina	2,171,013.75
North Dakota	15,730.00
Ohio	3,104,870.00
Oklahoma	1,075,036.50
Oregon	15,225.00
Pennsylvania	1,250,417.00
Rhode Island	9,425.00
South Carolina	29,250.00

State	CMP amount
South Dakota	0.00
Tennessee	381,432.50
Texas	7,677,219.58
Utah	37,157.00
Vermont	11,550.00
Virginia	934,425.00
Washington	0.00
West Virginia	112,160.00
Wisconsin	901,960.50
Wyoming	0.00
Total	**$38,794,439.37**

Source: CMS enforcement database.

Appendix VII: Cases States Did Not Refer to CMS for Immediate Sanction

State survey agencies did not refer to CMS for immediate sanction a substantial number of nursing homes found to have a pattern of harming residents. Most states failed to refer at least some cases and a few states did not refer a significant number of cases.[1] While seven states appropriately referred all cases, the number of cases that should have been but were not referred ranged from 1 to 169. Four states accounted for about 55 percent of cases that should have been referred. Table 13 shows the number of cases that states should have but did not refer for immediate sanction (711) as well as the number of cases that states appropriately referred (4,310) from January 2000 through March 2002.

Table 13: Number of Cases States Did Not Refer for Sanction, as Required, and the Number States Appropriately Referred, January 2000 through March 2002

State	Number of cases not referred as required	Number of cases referred*
Nation	**711**	**4,310**
Texas	169	423
New York	140	22
Massachusetts	46	81
Pennsylvania	38	164
Connecticut	26	244
Washington	26	227
Illinois	24	241
Florida	21	150
New Jersey	20	56
Tennessee	20	46
Minnesota	19	68
Missouri	18	108
South Carolina	18	3
North Carolina	10	242
Arizona	9	24
Maryland	9	34
Wyoming	9	11
California	7	96
Michigan	7	284
Arkansas	6	115
Montana	6	14
Ohio	6	323
Idaho	5	31

[1]We use the term "cases" because some homes had multiple referrals for immediate sanctions.

State	Number of cases not referred as required	Number of cases referred[a]
Indiana	5	270
Louisiana	5	82
Oklahoma	4	53
West Virginia	4	11
Delaware	3	14
Georgia	3	81
Hawaii	3	1
Iowa	3	44
New Hampshire	3	20
Colorado	2	116
District of Columbia	2	1
Oregon	2	51
Rhode Island	2	3
South Dakota	2	18
Virginia	2	41
Wisconsin	2	61
Alabama	1	50
Kansas	1	175
Maine	1	18
New Mexico	1	19
Nevada	1	12
Alaska	0	0
Kentucky	0	75
Mississippi	0	23
Nebraska	0	30
North Dakota	0	20
Utah	0	11
Vermont	0	3

Source: CMS regional office review of cases identified through GAO's analysis of OSCAR data and the CMS Enforcement Database.

[a]Reflects cases entered in CMS's enforcement database by March 28, 2002.

Appendix VIII: HCFA State Performance Standards for Fiscal Year 2001

Table 14 summarizes HCFA's state performance standards for fiscal year 2001, describes the source of the information CMS used to assess compliance with each standard, and identifies the criteria the agency used to determine whether states met or did not meet each standard.

Table 14: Overview of HCFA's Seven State Performance Standards for Nursing Home Survey Activities for Fiscal Year 2001

Description	Source of information	Criteria for determining compliance with standard
1. Surveys are planned, scheduled, and conducted in a timely manner		
At least 10 percent of standard surveys begin on weekends or "off-hours"	OSCAR and state survey schedules	At least 10 percent of standard surveys begin on weekends or off-hours
Standard surveys are conducted within prescribed time limits	OSCAR	100 percent of nursing homes are surveyed within statutory time limits
2. Survey findings (deficiencies) are supportable		
State surveyors explain and properly document all deficiencies in survey reports following HCFA guidance known as the "principles of documentation"	A random sample of 10 percent (maximum of 40, minimum of 5) of the state's survey results in which certain deficiencies were cited at "D" or higher levels of scope and severity	At least 85 percent of the deficiencies reviewed meet the principles of documentation
3. Surveys are fully documented and consistent with applicable laws, regulations, and general instructions		
Surveys are adequately conducted by state agencies using the standards, protocols, forms, methods, procedures, policies, and systems specified by HCFA instructions	Reports generated from HCFA's database on federal monitoring surveys	100 percent of standard surveys are adequately conducted by state agencies using the standards, protocols, forms, methods, procedures, policies, and systems specified by HCFA instructions
4. When states certify that nursing homes are not in compliance, they follow adverse action procedures set forth in regulations and general instructions		
"Immediate and Serious Threat" cases are processed in a timely manner	OSCAR, Enforcement Tracking System reports, and state agency provider certification files	In 95 percent of cases in which there is immediate jeopardy or a serious threat to resident health and safety, the state agency adheres to the 23-day termination process
Payments are not made to nursing homes that have not achieved substantial compliance within 6 months of their last surveys	OSCAR, Enforcement Tracking System reports, and state agency provider certification files	The state provides timely notice to HCFA (i.e., 20 days prior to the home's termination date) on 100 percent of the cases in which the nursing home has not achieved timely compliance
5. All expenditures and charges to the program are substantiated to the Secretary's satisfaction		
The state agency employs an acceptable process for charging federal programs	HCFA budget expenditure and workload reports	More than 20 different items on the two reports submitted by the states are reviewed for accuracy, completeness, and timeliness and are scored as either on time or late, or met or not met for a reporting period
The state agency has an acceptable method for monitoring its current rate of expenditures	OSCAR reports	Numerous items submitted by the states, such as quarterly expenditure reports and supplemental budget requests, are reviewed to determine if state requirements for monitoring expenditures are met, not met, or not applicable

Description	Source of information	Criteria for determining compliance with standard
6. Conduct and reporting of complaint investigations are timely and accurate, and comply with general instructions for handling complaints		
Investigate immediate jeopardy complaints within 2 workdays	Semiannual review of a 10 percent sample of a state's complaint files (maximum of 20 cases)	100 percent of immediate jeopardy complaints are investigated within 2 days
Investigate actual harm complaints within 10 workdays		100 percent of actual harm complaints are investigated within 10 days
Maintain and follow guidelines for the prioritization of all other complaints		The state agency has and follows its own written criteria governing the prioritization of complaints that do not allege immediate jeopardy or actual harm
State enters complaint data into OSCAR appropriately and in a timely manner	Semiannual on-site reviews of 20 state complaint survey reports	100 percent of deficiencies cited in the sampled complaints are cited under the correct federal citation
	OSCAR data are reviewed quarterly for timely entry	Average time to enter results of complaint investigations does not exceed 20 calendar days from completion of the case
7. Accurate data on survey results are entered into OSCAR in a timely manner		
Results of standard surveys are entered into OSCAR in a timely manner	Semiannual review of all standard surveys based on OSCAR data	The statewide average time between state agency sign-off of the certification and transmittal form and entry of the survey results into OSCAR does not exceed 20 calendar days
Results of surveys are entered into OSCAR accurately	Semiannual review of a random sample of nursing home survey results	No less than 85 percent of cases reviewed demonstrate that data were entered into OSCAR accurately

Source: HCFA's *State Performance Review Protocol Guidance* for fiscal year 2001.

Note: HCFA did not finalize and issue the fiscal 2001 performance standards and guidance until April 2001.

Appendix IX: Highlights of State Compliance with CMS Performance Standards

Table 15 summarizes the results of CMS's fiscal year 2001 state performance review for each of the five standards we analyzed. We focused on five of CMS's seven performance standards: statutory survey intervals, the supportability of survey findings, enforcement requirements, the adequacy of complaint activities, and OSCAR data entry. Because several standards included multiple requirements, the table shows the results of each of these specific requirements separately.

Table 15: State Compliance with Selected CMS Performance Standards, Fiscal Year 2001

CMS standard and requirements	Number of states not meeting standard
Survey timeliness	
The state begins no less than 10 percent of its standard surveys during weekends or "off-hours." (Standard 1, criterion 1)	2
The state conducts standard surveys in prescribed times. (Standard 1, criterion 2)	
• The average statewide interval between consecutive standard surveys is not greater than 12 months.	9
• Each home is surveyed within 15 months of its prior survey.	17
Supportability of survey findings	
The state explains and properly documents deficiencies. (Standard 2)	Due to complications with the review protocol, this standard was not reported.
Enforcement	
The state properly follows termination procedures. (Standard 4, criterion 1)	3
The state notifies CMS when a nursing home has not achieved substantial compliance in a timely manner. (Standard 4, criterion 2)	4
Complaints	
The state investigates all complaints alleging immediate jeopardy to a resident within 2 workdays. (Standard 6, criterion 1)	12
The state investigates all complaints alleging actual harm to a resident within 10 workdays. (Standard 6, criterion 2)	42
The state has and follows guidelines for prioritizing complaints not alleging immediate jeopardy or actual harm. (Standard 6, criterion 3)	15
The state enters citations resulting from complaint investigations into CMS's complaint database. (Standard 6, criterion 4)	13
OSCAR	
The state enters survey results into CMS's database in a timely manner. (Standard 7, criterion 1)	9
The state enters survey results into CMS's database accurately. (Standard 7, criterion 2)	24

Source: GAO analysis of results of CMS Fiscal Year 2001 State Performance Standard Reviews.

Note: We reviewed five of the seven CMS performance standards. See app. VIII, table 14, for a description of standards three and five, which we did not review.

Appendix X: Comments from the Centers for Medicare & Medcaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 20 2003

TO: Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

FROM: Thomas A. Scully
Administrator

SUBJECT: General Accounting Office (GAO) Draft Report, *NURSING HOME QUALITY: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, (GAO-03-561)

Thank you for the opportunity to review your draft report to Congress concerning enforcement and oversight of Federal nursing home standards. We agree with the report's findings that the Centers for Medicare & Medicaid Services should continue to strengthen its ability to make sure that nursing homes comply with Medicare and Medicaid quality-of-care standards.

Attached are our specific comments to the report. We look forward to working with GAO on this and other issues in the future.

Attachment

The Centers for Medicare & Medicaid Comments to GAO's
Draft Report, *NURSING HOME QUALITY: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*,
(GAO-03-561)

GAO Recommendation

Finalize the development, testing, and implementation of a more rigorous survey methodology including guidance for surveyors in documenting deficiencies at the appropriate level of scope and severity.

CMS Response

We agree and have already taken steps to assist states in improving the effectiveness of the survey process. For example, we led a contract to develop a series of surveyor guidance on a series of clinical issues. Some of the clinical areas that have been identified include pressure sores, hydration and nutrition, accidents, unnecessary medications, and psychosocial harm. Additionally, we're continuing to refine data used by surveyors to help focus resources more effectively during a survey. Lastly, we are communicating to states through the Budget Call Letter more specific priorities of survey workload to assure that statutorily mandated surveys be completed.

GAO Recommendation

Require States to have a quality assurance process that includes, at a minimum, a review of a sample of survey reports below the level of actual harm (less than G-level) to assess the appropriateness of the scope and severity cited and to help reduce instances of understated quality of care problems.

CMS Response

We believe this to be an important concept and have already incorporated this concept into Standard 2 of the State Performance Standards. This standard requires regions to take a sample of statement of deficiencies to evaluate a state's ability to document deficiencies. We will continue to refine this standard to better evaluate the sufficiency of documentation of varying harm levels. In addition to reviewing the appropriateness of the scope and severity of deficiencies, we have completed a number of data analyses to look nationally, and by state, at the number of deficiency free facilities and those with high and low numbers of deficiencies. We are working on a data system (Aspen Enforcement Module) so that we can more easily assess these trends in deficiencies.

GAO Recommendation

Finalize the development of guidance to States for their complaint investigation processes and ensure that it addresses key weaknesses, including the prioritization of complaints for investigation, particularly those alleging harm to resident; the handling of facility self-reported incidents; and, the use of appropriate complaint investigation practices.

CMS Response

We concur and are developing and implementing the Aspen Complaints/Incident Tracking System (ACTS). The ACTS will be a national complaint system that will standardize state complaints and incidents so that analysis across states can be accomplished. Over time, we expect to advance complaint improvement efforts that will not only address complaint investigation practices toward improvement, but also the prioritization of complaints.

GAO Recommendation

Further refine annual state performance reviews so that they (1) consistently distinguish between systemic problems and less serious issues regarding state performance, (2) analyze the trends in the proportion of homes that harm residents, (3) assess state compliance with the immediate sanctions policy for homes with a pattern of harming residents, and (4) analyze the predictability of state surveys.

CMS Response

We have already modified our FY'03 state performance standards to take into account assessing state compliance in a manner that differentiates between statutory and non-statutory performance standards. We have built in the ability to distinguish between systemic problems and less serious issues. We will continue to look at homes with varying levels of harm though the work we have done with our Nursing Home Data Compendium that is widely available to regions, states, Congress and other stakeholders. We are working on a data program to ascertain when individual nursing homes have deficiencies that would cause an immediate sanction for repeated instances of actual harm.

Regarding predictability of nursing home surveys, the report shows that two thirds of nursing home surveys are not predictable using the definition established by GAO. There is "predictability" that the law requires in that surveys be conducted other than on average of every twelve months, not to exceed 15 months. Within the bounds of those legal constraints, we have instituted a policy of "off-hour" surveys where survey teams conduct surveys either before or after the regular starting time, on weekends, evenings, and holidays. We have encouraged surveyors to start at a different time of the week, i.e., Wednesday instead of Monday. States have changed the way they are doing business. The findings in the report only capture the

number of days from the previous survey and don't take into account other predictors of when a survey occurs, for example the time of day or day of the week.

In addition to the CMS initiatives mentioned in the report, CMS is also working on other initiatives to help in the implementation, evaluation and monitoring of the nursing home program.

- Compiling a nursing home data compendium with information on nursing home characteristics, resident demographics and quality of care data,
- Evaluating the accuracy of the MDS through the Data Verification and Evaluation (DAVE) contract,
- Publishing a proposed rule on Feeding Assistants in nursing homes, and
- Enhancing centralized data monitoring capabilities for use by CMS staff, such as the ability to determine where states should refer cases for immediate sanctions to states.

Appendix XI: GAO Contact and Staff Acknowledgements

GAO Contact	Walter Ochinko, (202) 512-7157
Acknowledgements	The following staff made important contributions to this work: Jack Brennan, Patricia A. Jones, Dan Lee, Dean Mohs, and Peter Schmidt.

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.

Nursing Homes: Quality of Care More Related to Staffing than Spending. GAO-02-431R. Washington, D.C.: June 13, 2002.

Nursing Homes: More Can Be Done to Protect Residents from Abuse. GAO-02-312. Washington, D.C.: March 1, 2002.

Nursing Homes: Federal Efforts to Monitor Resident Assessment Data Should Complement State Activities. GAO-02-279. Washington, D.C.: February 15, 2002.

Nursing Homes: Success of Quality Initiatives Requires Sustained Federal and State Commitment. GAO/T-HEHS-00-209. Washington, D.C.: September 28, 2000.

Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives. GAO/HEHS-00-197. Washington, D.C.: September 28, 2000.

Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality. GAO/HEHS-00-6. Washington, D.C.: November 4, 1999.

Nursing Homes: HCFA Should Strengthen Its Oversight of State Agencies to Better Ensure Quality of Care. GAO/T-HEHS-00-27. Washington, D.C.: November 4, 1999.

Nursing Home Oversight: Industry Examples Do Not Demonstrate That Regulatory Actions Were Unreasonable. GAO/HEHS-99-154R. Washington, D.C.: August 13, 1999.

Nursing Homes: HCFA Initiatives to Improve Care Are Under Way but Will Require Continued Commitment. GAO/T-HEHS-99-155. Washington, D.C.: June 30, 1999.

Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit. GAO/HEHS-99-157. Washington, D.C.: June 30, 1999.

Nursing Homes: Complaint Investigation Processes in Maryland. GAO/T-HEHS-99-146. Washington, D.C.: June 15, 1999.

Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents. GAO/HEHS-99-80. Washington, D.C.: March 22, 1999.

Nursing Homes: Stronger Complaint and Enforcement Practices Needed to Better Ensure Adequate Care. GAO/T-HEHS-99-89. Washington, D.C.: March 22, 1999.

Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS-99-46. Washington, D.C.: March 18, 1999.

California Nursing Homes: Federal and State Oversight Inadequate to Protect Residents in Homes with Serious Care Problems. GAO/T-HEHS-98-219. Washington, D.C.: July 28, 1998.

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight. GAO/HEHS-98-202. Washington, D.C.: July 27, 1998.

Ordering Information

The first copy of each GAO report is free. Additional copies of reports are $2 each. A check or money order should be made out to the Superintendent of Documents. VISA and MasterCard credit cards are accepted, also.

Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:
U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

Orders by visiting:
Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders by phone:
(202) 512-6000
fax: (202) 512-6061
TDD (202) 512-2537

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

Orders by Internet:
For information on how to access GAO reports on the Internet, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web home page at:

http://www.gao.gov

To Report Fraud, Waste, or Abuse in Federal Programs

Contact one:

- **Web site: http://www.gao.gov/fraudnet/fraudnet.htm**
- **e-mail: fraudnet@gao.gov**
- **1-800-424-5454 (automated answering system)**

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Service Requested

Presorted Standard
Postage & Fees Paid
GAO
Permit No. G100

GAO
Accountability * Integrity * Reliability
United States General Accounting Office
Washington, DC 20548

CCAR-03-1246

August 29, 2003

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

In response to your August 14, 2003, letter to GAO, we are providing answers to questions you submitted to us that were not asked, due to time constraints, during the July 17, 2003, hearing entitled, "Nursing Home Quality Revisited: The Good, The Bad, and The Ugly."

1. Your report showed that about 3,500 homes were found to have harmed residents during the most recent period you reviewed and suggests that the number would be even higher if surveyors were more accurate in identifying deficiencies that harm residents. What further actions do you believe CMS, states, and others, including the nursing home industry, should take to address the continued prevalence of actual harm?

Our review found that the level of actual harm deficiencies in nursing homes was unacceptably high and, at the same time, understated. Because we believe that it is critical for CMS to determine the true level of harm to residents, we made recommendations to the CMS Administrator with regard to (1) implementing a more rigorous survey methodology; (2) requiring states to conduct management reviews of a sample of survey reports that contain deficiencies below the level of actual harm; (3) finalizing the development of guidance to states to improve complaint investigation processes; and (4) strengthening oversight of state survey agencies through improved annual state performance reviews, including analyzing both trends in the proportion of homes that harm residents and the predictability of surveys. We made an additional recommendation concerning CMS's and the states' need to ensure that they make effective use of sanctions for homes that harm residents. We found that CMS's 2000 policy for sanctioning homes that repeatedly harm residents got off to a rocky start because states, and even some CMS regions, were unclear about when and how to implement it. It is important that CMS monitor states to ensure that homes are appropriately referred for immediate sanctions in order to achieve the intended effect of this new policy. With respect to the nursing home industry, its introduction last year of a "Quality First" initiative—a commitment to find means to improve care in all homes, including those already free of serious deficiencies—is

laudable. We strongly believe that the nursing home industry needs to support actions related to its own initiative and to strengthened survey and enforcement processes that focus most intensely on the minority of nursing homes with deficient care resulting in harm to residents. Reducing the number of such homes has to be our number one priority.

2. The proportion of homes with actual harm deficiencies has decreased, but still 1 in 5 homes harmed residents. What do you think is needed for a major break-through to bring these numbers down and in a way that we can be assured that these are real improvements in quality?

Some may say the survey and enforcement process has proven inadequate to ensure nursing home quality, but our perspective is different. We do not believe the survey and enforcement process as envisioned in OBRA 87 and further defined by CMS (and its predecessor, HCFA) have been adequately tested. The execution of the nursing home survey process has been inadequate and the enforcement actions that should follow have been insufficient such that we really do not know how effective the process could be. The HHS OIG and we have identified a series of actions that could be taken that would provide the survey and enforcement processes a much better chance of being more effective in ensuring minimum quality. At face value, the survey and enforcement processes have promise. We simply need to implement them adequately to discover how much of that promise can be realized and how much poor quality nursing home care can be eliminated.

3. In 1998, you recommended that HCFA consider strengthening the survey methodology and HCFA agreed to study the change. It is now 5 years later and the new methodology is apparently still being studied. Are you still advocating that a new methodology is needed? Has CMS provided you with information on when they expect the new methodology to be available to surveyors?

We believe a strengthened survey process is critical to improving the measurement of quality in nursing homes. During our review of California nursing homes in 1998, we used a modified survey methodology—similar to the one CMS has been studying for the past 5 years—to identify deficiencies at two nursing homes. Generally, compared with CMS's survey methodology, we used a larger random sample of several types of residents, including the most vulnerable, and we took a sufficiently large sample to permit us to estimate how common the problems we found were in the homes we surveyed. Using this methodology, we were able to spot cases in which the homes had not intervened appropriately for residents experiencing weight loss, dehydration, pressure sores, and incontinence—cases state surveyors using CMS's survey protocol either missed or identified as affecting fewer residents. We continue to believe that an improved survey methodology is needed to better detect problems and assess their prevalence, an opinion, we would add, that is shared by experts in the field and many survey officials we have consulted in working on this topic over the past 5 years.

We have received somewhat conflicting information from CMS about the status of its effort to field the improved methodology—an effort that will have cost about $4.7 million through September 2003. In April 2003, CMS told us that it appeared that additional funding needed to complete the project was not available. In July 2003, however, CMS told us that additional funding in the amount of $508,000 was "slated" for the needed additional testing, but was not yet approved. Not funding additional testing could jeopardize the entire initiative, in which a substantial investment has already been made.

4. GAO has now been working on nursing home issues since 1997. In a nutshell, could you give us your view on where CMS has succeeded in making improvements and where it has fallen short of your expectations?

There have been some successes and some shortfalls in CMS's efforts, as detailed below.

Successes:

- Complaint Investigations. In 1999, as a result of our findings, CMS instructed states to investigate within 10 days any complaint that alleges actual harm to a nursing home resident. Prior to this new instruction, some states were not required to investigate such complaints for 30 or more days.

- Immediate Sanctions. CMS implemented a policy, as we recommended, requiring that nursing homes that repeatedly harm residents be sanctioned immediately. Previously, such homes were given a grace period, during which time they could return to compliance, and thus escape any sanctions. Although the immediate sanctions policy got off to a rough start in some states, we believe it is generally now working as intended.

- State Performance Reviews. CMS has strengthened federal oversight by initiating annual reviews to measure state performance against specific standards, such as the timeliness of standard and complaint surveys. As part of these reviews, federal surveyors use standardized reports produced from OSCAR data and examine survey reports and other records at state survey agency offices. Prior to these reviews, CMS had essentially relied on states to write their own report cards on compliance with several federal requirements.

- Comparative Surveys. Believing that comparative surveys are one of the best tools available for assessing the adequacy of state surveys, we recommended that CMS increase the number of these surveys conducted yearly. At the time we reviewed the program in 1999, the agency planned to conduct about 90 comparative surveys each year. Since our 1999 report, this number has increased to about 160. CMS plans to hire a contractor to perform about 170 additional surveys annually, bringing the total to about 330 per year. CMS expects to begin these additional surveys early in 2004.

Shortfalls:

- Complaints. Despite establishing a policy requiring states to investigate complaints alleging actual harm within 10 days, CMS has not yet developed additional guidance for the states, such as identifying model complaint investigation programs or practices, to increase the effectiveness of complaint investigations, even though it started this project in 1999. CMS has told us that it plans to issue revised complaint investigation guidance later this year.

- Revised Survey Methodology. Although CMS has been developing a revised survey methodology for nearly 5 years, it is still not clear if and when the new methodology will be made available to surveyors. The new methodology addresses weaknesses in the current survey process that we first identified in our 1998 report on California nursing homes, and found more recently to be ongoing problems, such as helping surveyors to better detect problems and assess their prevalence.

- Survey Predictability. CMS has done too little to address the problem of survey predictability. If nursing homes know when a survey will occur, they can conceal problems if they chose to do so. Although CMS has directed states to "stagger" surveys by starting them on off-hours, such as early morning or on weekends, this approach has not effectively addressed the issue of predictability. We found that about one-third of the most recent state surveys could have been predicted by the nursing homes.

5. GAO has repeatedly reported that nursing homes are too often able to determine approximately when they will be surveyed. In your 1998 and 2000 reports, you noted that one possible way to overcome this predictability would be to "segment" the standard survey into more than one review. Would you please explain again how this approach would work, and comment on whether you believe CMS should reconsider its use? Would a legislative change be needed to adopt this approach?

We do not believe that the method chosen by CMS to reduce survey predictability–by starting surveys during off-hours, such as early morning or on weekends—can effectively overcome survey predictability. We found that, even though states are generally following CMS's policy in this area, too many nursing homes are still able to predict when their surveys will occur. In 1998, we suggested that CMS could segment the standard survey into more than one review to reduce concerns about the predictability of surveyors' visits. If surveyors visit homes frequently, there is no option of improving operations to be ready for the surveyor—homes would need to be ready all the time for a surveyor visit. This would also provide more opportunities for surveyors to observe problematic homes and initiate broader reviews at these homes when warranted. Given that CMS's chosen method of starting surveys on off-hours has not been effective in reducing predictability, we believe the agency should

give further consideration to using some type of segmented review. We believe CMS could implement a program of segmenting surveys without a legislative change.

6. How important is it that CMS upgrade the information systems it uses to monitor information about nursing home reviews, and how successful has it been in modernizing its system?

It is very important that CMS have up-to-date information systems. The system it primarily relies on now—known as OSCAR—is old and has several limitations. For instance, its ability to track information about complaints is extremely limited. It is not possible, for example, for OSCAR to identify how many complaints each state has received during a given period, how many complaints were investigated during the state's visit to a nursing home, how long it took to investigate each complaint, or how each individual complaint was resolved. CMS is in the process of developing a new system and told us that the redesign should be completed in 2005. However, the redesign has not been without problems, such as inadvertent modifications of survey data results when data are transferred from the OSCAR database into the new system and delays in the development of the complaint-tracking portion of the new system, which was supposed to be available for use by all states in the fall of 2002. Implementation of the new complaint tracking system has been delayed by about a year because of lack of system compatibility with some state complaint tracking systems and the need to acquire OMB approval to implement the system.

We trust you will find this information helpful. Please call me at (202) 512-7114 if we can be of further assistance.

Sincerely yours,

William J. Scanlon

William J. Scanlon
Director, Health Care Issues

TESTIMONY OF
THOMAS A. SCULLY
ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
NURSING HOME QUALITY
BEFORE THE
SENATE FINANCE COMMITTEE
JULY 17, 2003

Chairman Grassley, Senator Baucus, distinguished Committee members, thank you for inviting me to discuss the quality of care provided by nursing homes across the nation. The care of nursing home residents is a high priority for the Bush Administration, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS). In 2003, about 3.5 million elderly and disabled Americans will receive care in our nation's nearly 17,000 Medicare- and Medicaid-certified nursing homes. Just more than half of these are long-term nursing home residents, but nearly as many will utilize nursing homes for rehabilitation care for shorter periods after an acute hospitalization.

The status of the nursing home industry is of no small concern to CMS. The nation is aging, and with an increasing percentage of the baby boom generation entering retirement, the need for high quality nursing home care will grow in the coming years. State and federal governments now pay roughly 60 percent of all long-term care costs, while those needing care and their families pay for 30 percent of costs. A variety of sources, including long-term care coverage, account for the remaining 10 percent. Among the larger nursing home companies, Medicare beneficiaries typically account for 10 percent to 15 percent of the home's population, while Medicaid beneficiaries typically account for 65 to 70 percent of nursing home residents. As the number of older Americans continues to increase, CMS is committed to working with Congress to ensure that America's elderly and disabled receive the high quality care they need.

Mr. Chairman, I would like to take this opportunity to commend you for your leadership on the important issue of nursing home quality. Through your work with CMS, you have highlighted the importance the Administration places on quality, something Secretary Thompson and I have championed since we started with HHS. You also have continually shined a spotlight on areas that need improvement. The GAO reports you have commissioned have served as a tool for evaluating our progress in improving nursing home quality, while at the same time highlighting issues that warrant our attention. Today, I would like to bring to your attention the efforts we are taking to publicly report information about the quality of care available and how that has informed quality improvement efforts in nursing homes nationwide.

GAO NURSING HOME ASSESSMENT

A General Accounting Office report, requested by Chairman Grassley and released today, indicates that the proportion of nursing homes nationwide with serious quality problems has declined "significantly" in recent months. For an 18-month period ending January 2002, actual harm at nursing homes was cited in one-third fewer homes, down to 20 percent from 29 percent in the prior period. In addition, the report found fewer discrepancies between federal and State surveys of the same nursing facilities, indicating that State surveyors are doing a more accurate job and that the drop in the number of serious problems at nursing homes is real. Additionally, the report found that CMS oversight of State survey activities has improved.

The report made several recommendations for how CMS should continue to ensure that nursing homes comply with Medicare and Medicaid quality standards. We are actively addressing the report's recommendations. For example, the report recommended that CMS finalize the development, testing, and implementation of a more rigorous survey methodology to include guidance for surveyors in documenting deficiencies. To this end, we have moved to assist States in improving the effectiveness of the survey process, including contracting to develop surveyor guidance on a series of clinical issues such as pressure sores, hydration and nutrition, accidents, unnecessary medications, and psychosocial harm. The report recommended that the Agency finalize the development of guidance to States for their complaint investigation processes and ensure that the guidance addresses key weaknesses, including the prioritization of complaints for investigation, the handling of facility self-reported incidents and the use of appropriate complaint

investigation practices. Regarding this concern, CMS is developing and implementing the Aspen Complaints Incident Tracking System (ACTS). The ACTS will be a national complaint system that will standardize reported complaints and incidents so that analysis across States can be accomplished. Eventually, we expect to advance complaint improvement efforts that will not only address complaint investigation practices toward improvement, but also the prioritization of complaints.

The GAO report also recommended that CMS further refine annual State performance reviews so they: consistently distinguish between systemic problems and less serious issues regarding State performance; analyze the trends in the proportion of homes that harm residents; assess State compliance with the immediate sanctions policy for homes with a pattern of harming residents; and analyze the predictability of State surveys. CMS has already modified our FY 2003 State performance standards to differentiate between statutory and non-statutory performance standards. We have incorporated the ability to distinguish between systemic problems and less serious issues and will continue to look at homes with varying levels of harm through the work we have done with our Nursing Home Data Compendium, which is widely available to regions, States, Congress, and other stakeholders. Currently, we are working on a data program to ascertain when individual nursing homes have deficiencies that would cause an immediate sanction for instances of actual harm.

Additionally, the GAO report indicated CMS should require States to review a sample of survey reports below the level of actual harm to assess the appropriateness of the scope and severity rating cited to help reduce instances of understated quality of care problems. Given the importance of this concept, CMS has already incorporated such reviews into Standard 2 of the State Performance Standards, which requires regions to take a sample of Statement deficiencies to evaluate a State's ability to document deficiencies. We will continue to refine this standard to better evaluate the sufficiency of documentation of varying harm levels. Additionally, we have completed a number of data analyses to look nationally, and by State, at the number of deficiency-free facilities and those with above- and below-average numbers of deficiencies. We are working on a data system (Aspen Enforcement Module) so that we can more easily assess these trends in deficiencies.

FOUR-PRONGED EFFORT TO IMPROVE CARE

Apart from actively implementing the GAO recommendations, the Administration has taken a number of steps to improve nursing home quality nationwide, including the Nursing Home Quality Initiative, which Secretary Thompson announced in November 2001. Working with measurement experts, the National Quality Forum, and a broad group of nursing home industry stakeholders – consumer groups, unions, patient groups and nursing homes – CMS adopted a set of improved nursing home quality measures and launched a six-state pilot.

What We Learned From the Pilot Program

CMS decided to launch the national Nursing Home Quality Initiative based on the success of the six-state pilot program. To evaluate the pilot, CMS surveyed nursing home administrators and related stakeholders and studied processes designed to stimulate quality improvement activities in nursing homes and to promote awareness and use of the new quality measures among consumers, including beneficiaries, caregivers, nursing home facilities, and other constituent groups. CMS measured exposure to state and national media and local live events/workshops, tracking CMS website hits and calls to the toll-free number, online satisfaction surveys, and consumer interviews. In addition to the formal evaluation, CMS met with constituent groups throughout the pilot program to solicit feedback, which was used to refine the pilot and to adjust the national implementation.

Our review of the pilot found that the vast majority of nursing homes (88 percent) knew about the quality initiative, and more than half of the nursing homes (52 percent) in the six pilot states requested quality improvement technical assistance from the QIOs. Additionally, more than three-quarters of nursing homes (78 percent) reported making quality improvement changes during the pilot and 77 percent indicated that the quality initiative was partially responsible for their decision to undertake these activities.

We also determined that the quality initiative increased people's search for nursing home quality information. For instance, phone calls to 1-800-MEDICARE concerning nursing home information more than doubled during the pilot rollout, and visits to www.medicare.gov's

nursing home quality information increased tenfold in the six pilot states. Web users indicated the information available was clear, easy to understand, easy to search and valuable. On a scale of "0" to "10," more than 40 percent of web users scored the information a "10" on these dimensions and approximately 70 percent gave the information an "8" or higher. From December 29, 2002, to June 29, 2003, the Nursing Home Compare site has been viewed more than six million times.

Encouraged by the success of the pilot, we expanded the Nursing Home Quality Initiative to all 50 States in November 2002. The quality initiative, which is an important component of CMS' comprehensive strategy to improve the quality of care provided by America's nursing homes, is a four-pronged effort, including: regulation and enforcement efforts conducted by CMS and State survey agencies; continual, community-based quality improvement programs; collaboration and partnership with stakeholders to leverage knowledge and resources; and improved consumer information on the quality of care in nursing homes.

Regulation of State Survey Agencies

The Nursing Home Quality Initiative's approach to regulate State survey agencies is designed to complement CMS' broader survey and certification activities, which are addressed later in this testimony, that ensure that Medicare- and Medicaid-certified nursing homes comply with regulatory requirements for patient health and safety and quality of care. To this end, CMS monitors data that nursing homes report (the Minimum Data Set). In addition, CMS reviews administrative data from the Online Survey, Certification, and Reporting System (OSCAR). These aggregated data sets provide a comprehensive view of the individual receiving care in the nursing home. State Survey and Certification Agencies focus on the quality of care furnished to residents as measured by indicators of medical, nursing and rehabilitative care, dietary and nutrition services, activities and social participation, sanitation, infection control, and the physical environment. Surveys include a review of compliance with residents' rights, written plans of care, and an audit of the residents' assessment.

The heart of the nursing home survey process is a four-to-five day onsite inspection to see that a nursing home is meeting federal health and safety requirements. Standard surveys take a

"snapshot" of the care beneficiaries receive at the time of the survey. These surveys are unannounced and, by law, must take place based on a statewide average of once every 12 months, but no longer than once every 15 months. The survey process requires States to conduct surveys within prescribed time frames any time a serious problem is alleged. Survey results and complaint data are available on the Nursing Home Compare Web site.

Community-based Quality Improvement Programs

Based on past experience, CMS has found that targeted quality improvement initiatives improve the quality of care. Medicare Quality Improvement Organizations (QIOs), formerly known as Peer Review Organizations (PROs), have been leaders in this type of improvement work. The QIOs have worked with providers, hospitals and others on improvement activities in the past, and have seen providers achieve a 10 to 20 percent relative improvement in performance simply by focusing on identified quality problem areas. As part of the Nursing Home Quality Initiative, QIOs are working with nursing homes to improve performance on the published measures and to develop and implement quality improvement projects. For example, QIOs are available to assist in interpreting and communicating data to nursing homes, which can motivate homes to improve quality. When mistakes or errors occur, QIOs help the nursing home determine what problems exist and implement systems to prevent recurrence, such as certain patient care protocols and standing orders. The QIOs work with community, health care, and business organizations, and with the local media. Together they provide quality information to the public and encourage nursing homes to use the information to improve care.

Facilitated Collaboration

During the pilot phase of the initiative, CMS learned the importance of collaboration and partnerships to improving quality of care in skilled nursing facilities. The quality initiative is designed to foster and improve communication among all parties – including Federal and State agencies, quality improvement organizations, independent health quality organizations, consumer advocates, and nursing home providers – to positively impact quality of care. By creating partnerships to expand our knowledge and resources, we can achieve greater and more immediate improvements in the quality of nursing home care.

While developing the Quality Initiative, CMS worked with the National Quality Forum (NQF) to identify areas of care for the public reporting pilot. NQF's nursing home steering committee included providers, State government representatives, consumer advocates, and others who reviewed the available measures. CMS adopted 10 new quality measures for the Initiative, and subsequently made minor revisions to the list of existing measures, such as dropping the resident weight loss measure. The new quality measures used in the initiative differ for long-stay and short-stay residents.

There are six measures for long-stay residents:

- Percentage of residents with loss of ability in basic daily tasks
- Percentage of residents with infections
- Percentage of residents with pain
- Percentage of residents with pressure sores
- Percentage of residents with pressure sores (with facility-level risk adjustment)
- Percentage of residents in physical restraints

The initiative includes four measures for short-stay residents:

- Percentage of short-stay residents with delirium
- Percentage of short-stay residents with delirium (with facility-level risk adjustment)
- Percentage of short-stay residents who walk as well or better (with facility-level risk adjustment)
- Percentage of short-stay residents with pain

These quality measures are reliable, valid and risk-adjusted so that consumers can use them to assess ways in which facilities differ from one another. The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay (the Minimum Data Set). These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop the 10 quality measures, giving consumers another source of information that shows how well nursing homes are caring for their

residents' physical and clinical needs. We are committed to enhancing these quality measures to better risk adjust and measure quality.

Improved Consumer Information and Outreach

As part of the Nursing Home Quality Initiative, CMS is promoting the use of the aforementioned quality measures through an integrated communications campaign, including paid advertising and publicity, as well as grassroots outreach through Medicare's Quality Improvement Organizations (QIOs) and other health care intermediaries. As part of the rollout of the Initiative, CMS worked closely with physicians and nurses, discharge planners, community organizations and the media. The campaign has cultivated an environment, in cooperation with nursing home industry leadership, to promote improvement in the quality of care. English- and Spanish-language advertisements ran in 71 major daily newspapers on November 13, 2002, to help raise awareness of the quality initiative throughout the country. The advertising highlighted the availability of the nursing home quality measures and illustrated to consumers how to obtain that information. In addition, consumers can call 1-800-MEDICARE or visit www.medicare.gov to review the quality measures, or to obtain a copy of Medicare's Guide to Selecting a Nursing Home as additional information sources.

IMPROVING SURVEY AND CERTIFICATION EFFORTS

As I mentioned earlier, CMS is using the Nursing Home Quality Initiative to support its efforts to improve the survey, certification, and monitoring of Medicare- and Medicaid-certified nursing facilities. CMS also uses Federal Monitoring Surveys (FMS) – or "comparative" surveys. Sections 1819(g)(3) and 1919(g)(3) of the Social Security Act requires the Secretary to conduct federal onsite surveys in each State each year within 2 months of the completion of the State's survey. In October 1998, CMS introduced its current program of overseeing State agency performance, referred to as the federal monitoring survey. As part of the program, called a comparative survey, a team of federal surveyors conducts a complete, independent survey of a long-term care facility after the State has completed its survey of that facility. The results of both surveys are then compared for discrepancies. In addition, the program includes an observational survey in which one or two federal surveyors accompany State surveyors to a long-term care facility, either as part of the facility's annual standard survey, or as part of a revisit or a

complaint investigation. The combination of the comparative survey and the observational survey is used to meet the federal oversight requirement.

OSCAR data from FY 2001 indicate that CMS regional offices conducted a total of 146 comparative surveys on skilled nursing homes and dually participating nursing homes. Consistent with the recommendations in the GAO report mentioned earlier, CMS is moving toward improving the consistency and number of comparative surveys. For example, CMS intends to award a contract to conduct additional comparative surveys. Such a contract would permit CMS to increase the number of Federal comparative surveys being conducted and assist CMS regional offices experiencing constrained human and financial resources to perform additional comparative surveys. As part of this effort, a request for proposals was published June 18, 2003, in Federal Business Opportunities. The deadline for proposals to be submitted is July 18, 2003.

Additionally, CMS is maintaining its nursing home oversight improvement program. This effort includes initiatives to strengthen survey and enforcement activities relating to Medicare- and Medicaid-participating nursing homes. As part of the program, the Agency continues to employ the off-hour survey cycle, which has been incorporated into the set of State performance measures. The Department and CMS are committed to home and community-based service programs, which ensure that people are afforded the opportunity to live independently in their own homes, while receiving quality care and support in a community setting.

It should be noted that the Medicare survey and certification budget is funded through the annual HHS appropriation bill that funds CMS Program Management. The amount earmarked in the FY 2004 budget for State survey agencies decreased one percent from the FY 2003 level. While Medicare State survey and certification nursing home expenses are funded at the federal level, States are responsible for 25 percent of the cost of Medicaid survey and certification programs. State budget crises remain a critical issue for the accomplishment of Medicaid survey and certification workload because State survey agencies must obtain hiring authority from State legislatures each year to maintain staffing levels, to hire new State surveyors, and to fill vacant State surveyor positions. In times of significant budget pressure, States will often initiate State

hiring freezes in certain State departments, severely limiting the staffing levels in certain State departments and agencies. This situation strains the ability of States to accomplish federal workload requirements. Therefore, it is vital for States to receive adequate funding to fulfill their survey and certification commitments and work to ensure high quality care.

FINANCIAL STATUS OF THE NURSING HOME INDUSTRY

Under the prospective payment structure, Medicare pays skilled nursing facilities a case-mix adjusted per diem amount intended to cover the routine, ancillary, and capital-related costs of providing care. Medicare covers such services for beneficiaries who have recently been discharged from an acute care hospital where they received care for at least three days. Given that coverage is limited to 100 days per spell of illness, Medicare does not cover care in a skilled nursing facility on a long-term basis. Most beneficiaries requiring such care must pay out-of-pocket or rely on Medicaid. A small number of beneficiaries have private long-term care insurance to cover these expenses.

In response to concerns about the payment system, a series of temporary rate increases were instituted through the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 to help the facilities transition from a cost-based to a prospective payment system. This year, CMS proposed a rule to increase Medicare payments to skilled nursing facilities due to inflation for FY 2004 by 2.9 percent. This proposed rule would result in about $400 million more in Medicare payments to the facilities. The comment period for the proposal ended July 7, and the Agency will publish the final rule by August 1 so it can be implemented October 1, 2003, the start of FY 2004.

Medicare's Cross-Subsidization of Medicaid

Medicare covers about 10 to 15 percent of the nursing home population. Medicaid covers about 65 to 70 percent, and generates about 45 percent of revenue for skilled nursing facilities. Medicare payment rates are higher and effectively cross-subsidize lower Medicaid reimbursements. In 2001, Medicare reimbursed $268 per covered day of care, which does not include beneficiaries' coinsurance payments. In FY 2002, the Medicaid State agencies for 48 States and Washington, D.C., reimbursed an average of $124.26 per day (See Attachment 1).

Medicaid projects spending approximately $90 billion (Federal and State) on LTC services in FY 2004, with $49.1 billion spent in nursing home care. The average stay in a nursing home is 2.6 years with the total cost reaching $137,500. Medicaid funds other types of long-term care coverage through the use of home- and community-based waivers.

Fiscal Pressures Compound to Challenge Nursing Homes

The economic outlook for the nursing facility industry has grown more negative over the past year (See Attachment 2). Wall Street nursing home analysts' main concerns are the sunset of certain Medicare add-on payment provisions, potential Medicaid cuts by States, and skyrocketing liability costs. Due to mounting budgetary pressure, analysts have concluded that States will freeze or cut payments to nursing facilities in an effort to balance their budgets. With the end of some of the Medicare payment provisions in the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, nursing facilities may be less able to absorb the impact of lower Medicaid payments due to slimmer operating profit margins and declines in investment incomes from endowments and charitable contributions. To control costs, facilities may cut staff, which could adversely impact the quality of care provided to nursing home residents.

In addition, nursing facility margins have declined due to increases in patient care liability cases, average claim sizes, and insurance premium costs. About 28 percent of nursing homes operate under a not-for-profit status. Among these homes, the GAO has found the median total margin for such facilities was 0.6 percent in 1999 and 0.3 percent in 2000, compared to 1.6 percent in 1999 and 2.2 percent in 2000 for for-profit facilities. According to the American Association of Homes and Services for the Aging (AAHSA), the average total margin of a non-for-profit skilled nursing facility was 1.9 percent in tax year 2001. Additionally, AAHSA found that not-for-profit facilities had a negative 4.3 percent operating margin and relied on the sale of assets, principal from endowments, and investment income to cover the operating losses.

FINANCING OF LONG-TERM CARE

The economic outlook of the nursing home industry becomes ever more critical with the aging of the baby boom generation, and the issue of how we pay for long-term care becomes increasingly

pressing. This is an issue of significant concern for beneficiaries, their families, caregivers, providers, and the people that administer the public programs that finance nursing home care; however, the burden on families is significant. Family caregivers provide the vast majority of long-term care, as few families can afford the $50,000 to $100,000 in annual costs of nursing home care or the expenses associated with assisted living and home care alternatives that average more than $20,000 per year. As a result, spending down assets to qualify for Medicaid has been the most viable alternative for many seniors.

Given that reliance on public funding is problematic, exploring the options for expanded financing in the private sector becomes a necessity. One approach to financing long-term care is to encourage consumers to buy long-term care insurance. For example, the President has proposed to expand the four State programs on Long-Term Care Partnerships, as well as two important tax relief measures for caregivers and those who purchase long-term care insurance. In addition, the President's budget includes additional funding to increase the flexibility of health savings accounts.

CONCLUSION

Mr. Chairman, I would like to thank you again for the opportunity to testify this morning on the quality of care in nursing homes and to reiterate my appreciation for your leadership in this area. With our combined efforts and continued vigilance, I am confident we will continue to see improvements in the quality of care delivered in America's nursing homes. I hope that I have been able to express the Administration's dedication to strengthening the quality of our nation's 17,000 Medicare- and Medicaid-certified skilled nursing facilities as well as our commitment to work with you to do so. I look forward to answering your questions.

Attachment 1

Medicaid Nursing Facility Average Per Diem Payment Rates 1994-2002

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Alabama	$75.37	$82.76	$85.57	$94.73	$98.69	$103.54	108.53	114.34	120.69
Alaska	211.21	214.77	225.38	237.47	253.48	263.78	231.62	258.06	323.03
Arizona	77.80	82.36	88.23	86.23	93.82	97.39	90.21	94.72	106.34
Arkansas	58.02	60.28	61.98	61.98	61.98	64.33	69.41	77.69	94.21
California	76.27	79.71	79.77	81.54	83.12	88.71	91.32	110.27	112.93
Colorado	73.59	75.93	90.31	90.31	101.55	105.88	111.16	114.68	*
Connecticut	120.27	125.06	126.26	126.62	133.83	137.06	155.30	158.94	164.64
Delaware	90.10	93.78	99.14	104.15	108.56	111.70	124.85	136.33	152.61
Florida	86.45	87.95	90.62	95.95	97.99	101.12	113.45	120.70	127.07
Georgia	68.85	72.99	77.15	72.60	76.30	83.64	88.50	91.32	95.10
Hawaii	119.39	124.05	129.65	132.59	130.42	133.29	137.16	142.44	146.84
Idaho	75.45	81.28	88.03	86.29	94.26	100.13	112.50	120.79	133.28
Illinois	70.08	70.08	70.22	70.28	74.23	80.04	87.05	90.06	*
Indiana	71.28	78.48	81.75	80.32	80.32	92.20	92.83	97.88	104.92
Iowa	57.72	58.87	64.62	68.11	71.70	76.56	84.24	89.11	101.12
Kansas	56.14	60.08	63.68	67.11	71.98	77.25	84.12	91.43	96.02
Kentucky	69.32	73.44	76.00	83.00	88.81	96.28	100.35	101.76	106.42
Louisiana	60.60	63.78	63.52	61.12	65.54	67.48	64.77	78.19	82.92
Maine	101.40	105.85	114.09	113.41	115.77	113.41	115.77	119.61	127.00
Maryland	81.35	89.16	94.19	98.88	106.62	*	122.89	134.42	150.54
Massachusetts	98.84	100.73	103.35	111.92	114.92	118.72	123.83	131.07	140.63
Michigan	71.01	74.25	79.46	84.17	91.79	*	103.79	115.12	124.57
Minnesota	88.21	92.24	95.61	101.79	106.47	108.78	116.66	123.18	123.18
Mississippi	58.08	68.00	72.89	76.77	80.60	84.55	88.65	97.42	103.77
Missouri	58.15	70.39	73.18	83.33	88.34	*	96.05	96.03	97.27
Montana	74.62	80.15	83.09	85.89	87.54	90.39	93.39	96.98	102.03
Nebraska	62.03	66.17	70.99	76.70	81.96	*	81.42	91.13	121.92
Nevada	76.35	79.33	82.51	85.71	86.17	*	98.00	102.09	121.66
New Hampshire	105.36	105.34	104.00	108.47	115.07	116.49	118.91	119.82	124.18
New Jersey	100.35	102.35	102.35	112.01	115.76	119.39	127.68	133.90	141.80
New Mexico	75.79	77.69	86.80	111.31	129.04	132.15	136.52	118.54	118.54
New York	138.11	143.00	157.60	151.76	158.93	165.43	160.66	166.57	174.94
North Carolina	79.20	83.53	86.87	92.82	93.12	98.43	102.31	107.62	111.29
North Dakota	75.92	80.86	85.77	90.86	94.31	104.94	104.94	115.03	127.05
Ohio	86.55	88.50	96.76	101.72	109.96	112.75	121.76	143.54	143.96
Oklahoma	49.70	52.50	54.94	56.77	64.20	66.38	66.56	84.61	93.58
Oregon	75.36	76.54	76.54	81.86	89.18	91.31	95.85	100.06	110.39
Pennsylvania	88.07	96.19	102.13	109.13	114.23	119.54	127.18	134.57	141.65
Rhode Island	103.78	98.00	101.50	101.50	103.97	108.12	116.03	124.53	129.97
South Carolina	67.57	71.22	74.69	78.08	82.75	87.13	94.10	97.56	102.72
South Dakota	64.37	68.89	77.91	74.26	76.96	78.92	80.39	83.80	86.62
Tennessee	56.18	62.75	77.91	87.74	83.16	90.06	95.69	95.78	103.19
Texas	60.55	63.34	66.52	71.12	75.15	79.83	83.55	85.50	96.25
Utah	70.38	74.24	76.76	78.55	83.11	85.67	89.01	89.55	105.55
Vermont	89.78	94.24	97.20	100.46	104.10	105.26	113.19	118.20	123.27
Virginia	71.01	72.97	75.07	77.27	79.47	79.77	95.60	102.50	100.32
Washington	92.74	98.91	104.96	109.93	116.60	117.75	113.75	123.28	128.99
Washington DC	152.05	155.44	157.47	148.86	179.94	136.00	162.35	166.94	194.50
West Virginia	80.86	77.27	89.93	101.94	106.27	105.89	118.39	127.40	129.88
Wisconsin	76.32	80.05	85.85	93.85	91.79	*	111.13	113.82	102.12
Wyoming	73.06	75.94	90.68	92.43	93.72	95.37	96.96	101.51	117.11
Mean	79.96	83.86	88.39	91.45	95.72	*	103.35	114.79	124.26

Source: State Medicaid Reimbursement Surveys, DCHS/WSU, 1994-2002

Attachment 2

HEALTH CARE INDUSTRY MARKET UPDATE

Nursing Facilities

May 20, 2003

Dear Friends of CMS:

As the regulators of over $500 billion per year of Medicare, Medicaid, and S-CHIP funds, we believe it is incumbent on us to better understand the finances of our contractors, health providers, and other related businesses that provide services to the more than 70 million beneficiaries these programs serve. Health plans, hospitals, nursing homes, home health agencies, medical device manufacturers, and pharmaceutical companies are just some of those whose finances depend heavily on these public programs.

I have always been surprised at how little Wall Street and Washington interact—and how companies often paint different financial pictures for each audience. I am a strong believer in adequate funding for our major partners in these programs, but I do not think they should be saying one thing to investors and another to regulators (as it is occasionally in their interest to do). If health plans or providers are struggling to serve our beneficiaries, we should have a thorough understanding of their real financial status to assess the true level of need. Many investment banking firms conduct detailed analyses of major health providers, both for the equity investors in for-profit companies, and for the debt holders of for-profit and nonprofit entities. Health systems typically provide these investors with clear financial data. These data can be used by regulators and legislators to assess funding adequacy or the need for regulatory reforms.

CMS' Office of Research, Development & Information (ORDI) has gathered research reports from the major investment firms, summarized their analyses, and condensed them into a short, and hopefully, understandable format. Our goal is to provide objective summary information that can be quickly used by CMS, HHS, Congress, and their staffs that oversee these programs. The primary person at CMS assigned to this task is Lambert van der Walde. Lambert previously worked for Salomon Smith Barney in New York and is experienced with corporate financial analysis and research review. Also on the team is Kristen Choi who previously worked for JPMorgan in New York in health care equity research.

This Market Update focuses on nursing facility companies, updating our first report about this sector published February 6, 2002. The industry currently faces issues including the effect of the sunset of certain Medicare add-on payment provisions, risk to Medicaid payments as states balance tight budgets, and rising liability costs. In coming months, we will continue to review the major provider and supplier sectors. Though I am proud of this effort, and believe it will add to understanding of the programs, we welcome comments on the content and format of this report. We want to make this as consumer friendly as possible for everyone who reads it. Please provide comments to Lambert van der Walde at lvanderwalde@cms.hhs.gov or Kristen Choi at kchoi@cms.hhs.gov.

Sincerely,

Tom Scully

CMS CENTERS for MEDICARE & MEDICAID SERVICES

HEALTH CARE INDUSTRY MARKET UPDATE

Nursing Facilities

May 20, 2003

Tom Scully
Administrator

Office of Research, Development & Information:

Lambert van der Walde
lvanderwalde@cms.hhs.gov

Kristen Choi
kchoi@cms.hhs.gov

Wall Street's View of Nursing Facilities

Investor sentiment is mostly negative due to uncertainties related to government payment and the rising cost of liability insurance.

- **Profit margins continue to decline after the October 2002 sunset of over $1 billion of federal Medicare add-on payment provisions, exacerbating Wall Street's concerns about Medicaid payment levels.**
- **Rising insurance costs and aggressive litigation have led to the exit of many nursing facility chains from states where liability costs are high.**
- **Analysts worry how some chains, especially those that have recently emerged from bankruptcy, will weather the uncertain government payment environment.**
- **Three chains have filed for bankruptcy in the last six months.**
- **For nursing facilities, access to equity financing is essentially nonexistent and debt financing is available to only a few.**

CONTENTS

EXECUTIVE SUMMARY

Wall Street is more pessimistic about sector prospects.

Wall Street's outlook for the nursing facility sector has grown more negative over the past year. Investment analysts' main concerns are the sunset of certain Medicare add-on payment provisions, potential Medicaid cuts by states, and skyrocketing liability costs.

About $1.4 billion of Medicare add-on payment provisions sunset on October 1, 2002.

The Medicare add-on payment provisions sunset on October 1, 2002. Congress originally created these add-on payments to help skilled nursing facilities transition from a cost-based to a prospective payment system. Average profit margins of the publicly traded, for-profit nursing facility companies were declining both before the sunset, (from 2.8% in the first quarter of 2002 to 2.0% in the third quarter) and after the sunset (down to 1.4% in the fourth quarter of 2002 and 1.1% in first quarter of 2003). Some investment analysts believe the not-for-profit and smaller facilities may be hit harder by the sunset. These facilities may be less able to absorb the sunset's impact due to slimmer operating profit margins and declines in investment income from endowments and charitable contributions in 2002.

Higher Medicare payments subsidize lower Medicaid payments for nursing facilities.

Wall Street analysts understand that many nursing facilities use higher Medicare and private pay rates to subsidize lower Medicaid payments. Medicare, however, covers only about 10%-15% of nursing facility residents while Medicaid covers 65%-70% at typically lower per diem rates. The Medicare add-on provision sunset has exacerbated Wall Street analyst concerns about Medicaid payment. Analysts worry that fiscal concerns may force states to reduce or freeze Medicaid rates. According to a January 2003 Kaiser Commission on Medicaid and the Uninsured study, 37 states plan to reduce or freeze funding for nursing care in fiscal 2004.

Many chains are exiting states where liability costs are prohibitively high.

Nursing facility margins have also declined due to increases in patient care liability cases, average claim sizes, and insurance premium costs. High and unpredictable liability costs have become a significant driver in many business decisions, including asset sales, relatively expensive financing structures, and bankruptcy filings. Many chains are divesting nursing facilities in those states where liability costs are disproportionately high. In 2002, the three largest nursing facility chains each had large, unexpected increases to the amount of resources reserved that estimate future settlement payments.

Although most investment analysts believe the industry is struggling, many do not believe that the industry is necessarily returning to the early days of PPS implementation, during which time five of the top eight nursing facility chains filed for bankruptcy. Two of these companies emerged from bankruptcy in 2001, and another two emerged in 2002. Some investors, however, are concerned that current market conditions could result in a second wave of bankruptcies. Since December 2002, Centennial Healthcare (the 12th largest chain) and two smaller regional chains have filed for bankruptcy.

Access to capital is extremely limited.

With these uncertainties looming, access to capital is limited. New equity capital is almost non-existent, while publicly-held debt is available to only the highest quality issuers. Other sources of capital, including real estate investment trusts (REITs) and commercial banks, have also diminished for those facilities that have not branched out into other more profitable types of senior care businesses, such as assisted living and continuing care retirement communities (CCRCs). The industry will require a significant amount of capital to refinance maturing debt and maintain facilities in the near-term.

WALL STREET'S VIEW

Skilled nursing facilities struggled after the BBA and profit margins continue to decline due to the sunset of certain BBRA and BIPA add-on provisions on October 1, 2002.[1] Congress created these temporary provisions to help nursing facilities transition from a cost-based to a prospective payment system. Waxing and waning prospects for legislation that would restore these add-on payments have clouded the outlook for the sector, whose profit margins have been declining. Jerry Doctrow of Legg Mason writes, "2002 began and ended with concerns over government reimbursement for nursing home operators taking a toll on share prices." The future is especially murky for the smaller and not-for-profit homes, as well as the larger chains that have recently re-emerged from Chapter 11 bankruptcy filings. A.J. Rice of Merrill Lynch describes CMS' recently proposed 2.9% full market basket increase to Medicare SNF payments in fiscal 2004 as "welcome," although "the nursing home industry continues to be in dire straights...."

Decreased Medicare payments have reduced profit margins.

With states under increasing fiscal pressure, analysts worry that Medicaid nursing facility rates may be frozen or reduced. Every Wall Street nursing facility analyst is concerned states will freeze or cut Medicaid payments to nursing facility providers due to mounting fiscal distress and rising Medicaid costs. Unlike the federal government, many states must balance their budgets. As state revenues fall, funding must be cut. Several states have announced Medicaid provider payment cuts, others have maintained existing levels, and a smaller number have announced modest increases. It is widely understood by Wall Street that for most nursing facilities higher Medicare payment helps subsidize lower Medicaid payment. With the sunset of Medicare add-on provisions, investors worry that nursing facilities will not have much room to absorb potential Medicaid cuts as well.

Investors worry that nursing facilities will not be able to absorb Medicaid cuts.

Skyrocketing liability insurance cost increases are a major contributor toward the exit or bankruptcy of nursing facility operators in certain states. Jason Kroll of Bear Stearns estimates that nursing facility liability insurance costs continue to rise between 25% and 35%. Both the number of lawsuits per 1,000 beds as well as the average claim size have tripled over the past ten years, according to AON Risk Consultants. Unexpected material increases in insurance accruals (*i.e.*, reserved resources which estimate future settlement payments) have also depressed stock prices: in 2002, Beverly's annual insurance accruals grew 50% to $66 million, Kindred's grew 50% to $82 million, and Manor Care's grew 20% to $72 million. Doctrow writes, "[V]ery high liability expense levels will continue to pressure nursing home operator cash flows and operating margins for the next year or two at least, in some cases forcing firms into bankruptcy reorganization when liability costs are added to Medicare and potential Medicaid cuts." In states where liability costs have become too burdensome, or where liability insurers have been unwilling to offer products to long-term care providers, nursing facilities are being closed or divested. Wall Street analysts believe state tort reform may help control rising costs.

Aggressive patient care litigation has driven up insurance premiums and uncertainty over the timing and magnitude of future settlement payments.

[1] BBA: Balanced Budget Act of 1997.
BBRA: Balanced Budget Refinement Act of 1999.
BIPA: Beneficiary Improvement and Protection Act of 2000.

INDUSTRY OVERVIEW

Nursing homes provide both short-term rehabilitative and long-term care for patients who require skilled nursing and therapy care on an inpatient basis. There are about 16,500 nursing homes certified to provide Medicare and/or Medicaid care in the United States, with approximately 1.8 million total beds. About 3.5 million people will live in a nursing home during the course of a year.

Medicare does not cover nursing care on a long-term basis, as Medicaid does.

Skilled nursing facility (SNF) is the Medicare designation for a facility that provides beneficiaries with short-term, residentially-based skilled nursing and therapy care. Medicare SNF coverage is limited to 100 days per spell of illness for those beneficiaries who require daily skilled care following a discharge from a stay in an acute care hospital lasting at least three days. Medicare does not cover SNF care on a long-term basis. If beneficiaries continue to require care in a skilled nursing facility once Medicare coverage expires, they can pay out-of-pocket (private pay) as long as they have assets or sufficient income. Once their assets are "spent-down," they become Medicaid eligible.[2] Most SNFs are also certified as nursing facilities under Medicaid and furnish Medicaid and private pay patients with a combination of skilled rehabilitative care and long-term treatment for functional deficits and chronic conditions.

Medicare classifies about 15,000 nursing homes as SNFs. About 85% of SNFs are freestanding nursing homes while the other 15% are hospital-based (a SNF unit of an acute care hospital or under administrative control of a hospital). Three-quarters of freestanding SNFs are operated as for-profit entities, while the majority of hospital-based SNFs are attached to not-for-profit hospitals.

In total, approximately 65% of nursing homes are owned by for-profit entities, while 28% are owned by not-for-profit organizations and the remainder are owned by government agencies usually at the city or county level. About half of all freestanding SNFs, or two-thirds of all for-profit SNFs, are owned or operated by chains. Many of the largest chains also have significant non-nursing facility lines of business including home health services, long-term acute care hospitals, and assisted living facilities. The financial results for these chains are presented on a consolidated basis in this report.

Figure 1: Nursing Home Facilities and Beds, by Type of Ownership

For-profit entities own 65% of nursing homes.

Type of Ownership	Number of Facilities	Percent	Number of Beds	Percent
For-profit	10,759	65.4%	1,188,643	66.2%
Not-for-profit	4,676	28.4%	485,706	27.1%
Government	1,011	6.1%	120,923	6.7%
Total	**16,446**	**100.0%**	**1,795,272**	**100.0%**

Source: CMS, OSCAR data as of April 2003.

The industry remains very fragmented, with no dominant providers. As of April 2003, the top ten nursing facility companies by bed count accounted for 15.5% of beds, declining from 18.5% in January 2002. The largest chains have divested beds faster than the overall sector. The combined bed count of the top ten chains showed a decline of 17.9% compared to an overall decline in nursing facility beds of 2.1%. This trend may be due to recent exits of the largest chains from states with high liability costs such as Florida.

[2] Income and asset tests to determine Medicaid eligibility vary from state to state.

Figure 2: Top Ten Nursing Home Facility Companies by Bed Count

	April-03		January-02		Change in
	Number of Beds	% of Total Beds	Number of Beds	% of Total Beds	Number of Beds
Beverly Enterprises Inc.	49,396	2.8%	61,716	3.4%	-20.0%
Manor Care, Inc.	38,666	2.2%	39,659	2.2%	-2.5%
Kindred Healthcare, Inc. (formerly Vencor)	36,417	2.0%	38,909	2.1%	-6.4%
Mariner Health Care, Inc.	34,702	1.9%	44,607	2.4%	-22.2%
Integrated Health Services, Inc.	25,169	1.4%	38,282	2.1%	-34.3%
Sun Healthcare Group, Inc.	24,267	1.4%	32,311	1.8%	-24.9%
Genesis Health Ventures, Inc.	24,264	1.4%	29,666	1.6%	-18.2%
Life Care Centers of America	16,587	0.9%	19,928	1.1%	-16.8%
The Evangelical Lutheran Good Samaritan Society	14,892	0.8%	16,077	0.9%	-7.4%
Extendicare Health Services, Inc.	13,600	0.8%	17,529	1.0%	-22.4%
Top 10 Total	**277,960**	**15.5%**	**338,684**	**18.5%**	**-17.9%**
Total Beds	1,795,272	100.0%	1,834,448	100.0%	-2.1%

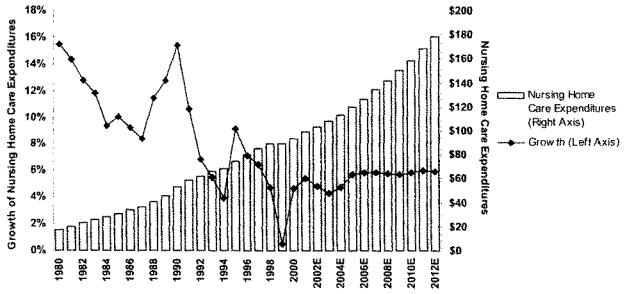
Source: CMS, OSCAR data.

The largest chains have divested beds faster than the overall sector.

From 1980 to 1997, Medicare nursing home spending grew eight times more than total nursing home spending.

According to CMS' Office of the Actuary, U.S. spending on freestanding nursing home care was $98.9 billion in 2001, up 5.5% from 2000. As seen in Figure 3, national freestanding nursing home expenditures grew from $17.7 billion in 1980 to $85.1 billion in 1997, growth of 381% or an average annual rate of 9.7%. During this same period, Medicare freestanding nursing home expenditures exploded from $307 million to $9.6 billion, growth of 3022% or an average annual rate of 30.0%. Nursing home care was one of the fastest growing components of the Medicare program during that time.

Figure 3: National Freestanding Nursing Home Care Expenditure Growth, 1980-2012E



Source: CMS, Office of the Actuary, National Health Statistics Group.

Before BBA 1997 mandated the implementation of SNF PPS, Medicare paid SNFs based on their reported costs of care, subject to certain limits for routine costs (*e.g.*, nursing, room, and board). Not being subject to the same limits, ancillary services skyrocketed during this time. Utilization also grew rapidly, while average acute-care hospital length of stay decreased.

To curb these growth rates, Congress mandated the implementation of a SNF prospective payment system, which pays a per diem rate adjusted for resource needs and geographic

location. The implementation of SNF PPS caused Medicare freestanding nursing home spending to decline 18% in 1999 and national freestanding nursing home spending grew only 0.5%. Growth picked up again after Congress created temporary add-on payment provisions to help the industry transition from the cost-based to the PPS in BBRA 1999 and BIPA 2000.

Credit Suisse First Boston (CSFB) believes that Medicare's prospective payment system for inpatient hospital stays, implemented in 1983, encourages hospitals to discharge patients "quicker and sicker" compared to a cost-based payment system. The average acute-care hospital length of stay decreased from 4.95 days in 1992 to 4.00 days in 1999, a drop of 19%. CSFB believes this trend resulted in relatively sicker hospital discharges, increasing the number and acuity of cases requiring skilled nursing facility care. Increased utilization and payment per stay contributed to the rapid rise of Medicare nursing home care expenditures in the 1990s.

INDUSTRY PERFORMANCE

Add-on Payment Sunset

About $1.4 billion of SNF add-on payment provisions sunset on October 1, 2002. For fiscal 2003, the effect of the sunset was partially offset by a market basket[3] increase of 3.1% minus 0.5% as set forth in BIPA 2000, for a net increase of 2.6% (about $400 million). In addition, SNFs retained about $1.0 billion of separate add-on payments in fiscal 2003, which will remain in effect until case-mix refinements are made to the resource utilization group (RUG) system.[4] CMS has indicated that it does not plan to implement the case-mix refinements for fiscal 2004. CMS is required to report to Congress alternatives to the existing RUG system by January 1, 2005. The add-on provision sunset is further described in the text box on page 9. In May 2003, CMS proposed a full market basket increase of 2.9% to Medicare SNF payments for fiscal 2004. The proposed rule will result in nearly $400 million in increased payments.

For-profit, Publicly Traded Nursing Facility Chains

The major, publicly traded, U.S.-based companies in the nursing facility sector are Manor Care, Beverly Enterprises, Extendicare Health Services (the U.S. subsidiary of the Canadian-based Extendicare, Inc.), Kindred Healthcare (formerly Vencor), Mariner Health Care (formerly Mariner Post-Acute Network), Sun Healthcare, and Genesis Health Ventures. Kindred and Genesis both emerged from bankruptcy proceedings in 2001. Mariner and Sun emerged from bankruptcy in 2002. Integrated Health Services, which is not publicly traded, continues to undergo Chapter 11 bankruptcy restructuring.

Figure 4: Market Cap Table, U.S. Nursing Facility Companies

($ in millions)

	Ticker	Market Cap
Manor Care	HCR	$ 2,113
Genesis Health Ventures	GHVI	$ 672
Beverly Enterprises	BEV	$ 322
Kindred Healthcare	KIND	$ 293
Extendicare Health Services	EXE/A	$ 200
Mariner Health Care	MHCA	$ 91
Sun Healthcare	SUHG	$ 15

Source: Bloomberg. As of May 15, 2003.
Note: Market capitalization is a measure of company's equity value or size, calculated by multiplying share price by the number of shares outstanding.

[3] CMS uses a skilled nursing facility "market basket" to measure inflation in the prices of an appropriate mix of goods and services included in covered skilled nursing facility stays. The price of items in the market basket is measured each year, and Medicare payments are adjusted accordingly.

[4] Medicare pays for SNF services under a prospective payment system (PPS). Under the PPS, each beneficiary is designated to one of 44 resource utilization groups (RUGs). Each RUG includes patients with similar service needs that are expected to require similar amounts of resources. The per diem payment rate for each RUG is calculated as the sum of three components for 1) routine services (*e.g.*, room and board, linens, and administrative services), 2) nursing services, and 3) therapy services.

Post-BBA Medicare Add-On Payments

After the skilled nursing facility industry asserted financial difficulty as a result of the prospective payments system (PPS) implementation, Congress passed several temporary Medicare reimbursement increases in BBRA 1999 and BIPA 2000 to help skilled nursing facilities transition from a cost-based payment system to the PPS. Congress mandated the SNF PPS in order to encourage efficiency and control skyrocketing costs of Medicare nursing facility care. Deutsche Bank's Henry Reukauf believes the nursing facility industry has already cut costs significantly and does not have many more remaining avenues to improve efficiency.

Figure 5: SNF Add-on Payment Descriptions

Add-on Description	Statute	Comment	Status	Average Per Diem Effect, FY2003	Annual Payments, FY2003
20% increase for 15 high-acuity RUGs[1]	BBRA 1999	20% increase will be eliminated once HHS refines the RUGs	Current	$19.88	$1.0 billion
6.7% increase for 14 rehabilitation therapy RUGs	BIPA 2000	Redirected the 20% increase granted in BBRA 1999 from 3 of those 15 RUGS to an additional 11 RUGs	Current	Neutral	Neutral to 20% increase in BBRA 1999
4% increase across all RUGs	BBRA 1999	Increased adjusted Federal per idem payment rate, exclusive of 20% increase	Sunset on 10/1/02	$9.94	$500 million
16.66% increase for nursing component	BIPA 2000	Increased nursing component of case-mix adjusted Federal rate	Sunset on 10/1/02	$17.89	$900 million
Elimination of market basket index reduction of 1.0% (enacted by BBA 1997)	BIPA 2000	1.0% increase in fiscal year 2001 retained in base rate when CMS applied update for fiscal 2002 rates	Current	$1.99	$100 million

Source: CMS.
Note: Average Medicare per diem payment, including beneficiary co-payment, is estimated to be $295 in fiscal year 2003. The fiscal year for SNF Medicare payment begins October 1.
(1) Resource Utilization Group (RUG). Under the SNF prospective payment system, each beneficiary is designated to one of 44 RUGs. Each RUG includes patients with similar service needs that are expected to require similar amounts of resources. Each RUG has a per diem payment rate.

Provisions for the 4% across-the-board increase and the 16.66% nursing component increase sunset as scheduled on October 1, 2002. Wall Street analysts generally do not expect legislation to restore these add-on payments given increased concerns about deficit spending and conflict in the Middle East. Even Ankur Gandhi, a Goldman Sachs debt analyst who is known for her atypically more positive outlook on the nursing facility sector, characterizes the negative impact on certain nursing facility operators:

> [T]he October 1, 2002 reduction in Medicare reimbursement has been detrimental for the nursing home sector. This, combined with Medicaid rate pressure and increases in professional liability costs, has resulted in a worsening of operating results for nursing homes and minimal future growth potential, a lack of access to capital markets for many operators, and bankruptcies of smaller chains such as Centennial Healthcare and now potentially Sun Healthcare.

In the mid-1990s, profit margins of the large, for-profit nursing facility chains were in the 5% to 7% range. In 2002, the average profit or net income margin was 2.2% for Beverly, Extendicare, Genesis, Kindred, and Manor Care, Mariner, and Sun. Calendar year 2002 results were impacted by one quarter of operations after the add-on provision sunset.

Figure 6: Publicly-Held Nursing Facility Company Income Statement Summaries, 2002

($ in millions)

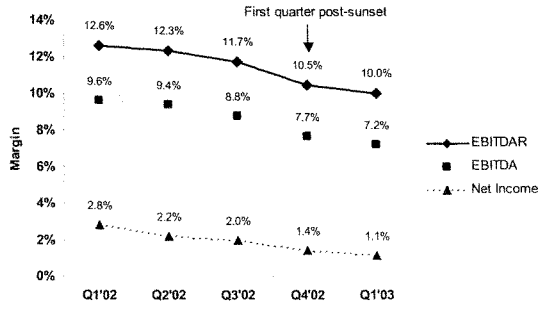
	Beverly (BEV)	Extendicare (EXE/a)[1]	Genesis (GHVI)[2]	Kindred (KIND)[2]	Manor Care (HCR)	Mariner (MHCA)[2,3]	Sun (SUHG)[2,4]	Average[5]
Revenue	$ 2,494.2	$ 815.1	$ 2,654.3	$ 3,357.8	$ 2,903.4	$ 1,183.7	$ 1,598.2	NM
EBITDAR Margin	11.9 %	11.2 %	9.6 %	12.3 %	13.9 %	8.6 %	9.1 %	10.9 %
EBITDA Margin	8.4 %	9.9 %	8.5 %	4.3 %	13.2 %	6.1 %	1.1 %	7.4 %
EBIT Margin	5.0 %	5.3 %	6.1 %	2.1 %	8.9 %	4.2 %	(0.6)%	5.2 %
Pretax Margin	2.5 %	1.1 %	4.3 %	2.0 %	7.7 %	2.3 %	(1.5)%	3.3 %
Net Inome Margin	1.6 %	0.6 %	2.6 %	1.2 %	4.8 %	2.2 %	(1.5)%	2.2 %

Sources: Company filings and analyst models.
Notes: Income statement data presented on a consolidated basis and included non-nursing facility lines of business, which may be significant. All non-recurring items are excluded from results.
(1) Canadian-based Extendicare generated 73% of 2002 revenue in the U.S. through its wholly owned subsidiary Extendicare Health Services and its subsidiaries; results shown are for U.S. operations only in U.S. dollars.
(2) Because these companies emerged from Chapter 11 bankruptcy using "fresh-start" accounting, results are shown for 2002 operations post-emergence only. Unless noted otherwise, results are shown for full calendar year 2002.
(3) Mariner results include operations for eight months ended December 31, 2002 only.
(4) Sun results include operations for ten months ended December 31, 2002 only.
(5) Averages exclude negative margin values.
Definitions: Margin: Value expressed as a percent of total revenues.
EBITDAR: Earnings before Interest, Taxes, Depreciation, Amortization, and Rent
EBITDA: Earnings before Interest, Taxes, Depreciation, and Amortization.
EBIT: Earnings before Interest and Taxes.
Pretax: Earnings before Taxes.

Since the add-on provision sunset, the nursing facility industry has reported financial results for the fourth quarter of 2002 and the first quarter of 2003. The sunset's impact varied from provider to provider. Fourth quarter revenue declines attributed to the sunset were $14.0 million for Beverly (2.3% of revenues), $8.8 million for Mariner (2.0%), and $15.0 million for Kindred (1.8%). Following the sunset, margins continued to decline.

Figure 7: Average Margins for Large Publicly Traded Nursing Facility Chains, Quarterly

The Medicare add-on provision sunset reduced margins further in the fourth quarter of 2002.



Source: Public filings, company information, and analyst models.
Note: Results exclude extraordinary and non-recurring items. Companies represented include Beverly, Extendicare Health Services, Kindred, Genesis, and Manor Care. Calendar year quarters. Meaningful quarterly data is unavailable for Sun and Mariner, which both emerged from bankruptcy mid-year. Kindred and Genesis financials reflect company reorganizations post-Chapter 11 filings.

Both Wall Street and the nursing facility industry recognize Medicare payment rates more than cover the cost of care for Medicare patients. Both the General Accounting Office (GAO)[5] and the Medicare Payment Advisory Commission (MedPAC)[6] concur that Medicare payment for nursing care exceeds costs. In its March 2003 report to Congress, MedPAC estimates that the Medicare margin for all SNFs will be about 5% in fiscal 2003. GAO estimates the median Medicare margin for all freestanding SNFs was 19% in 2000.

Medicare and private pay revenue subsidize Medicaid losses.

Investors and industry representatives also agree that many nursing facilities depend on higher payments from Medicare and private pay (about one-third of patient days combined) to subsidize lower payments from Medicaid (two-thirds of patient days).[7] The GAO acknowledges that the larger Medicaid's share of a SNF's patient days, the smaller the SNF's total margin. MedPAC also acknowledges the cross-subsidy, but believes that it is "an inefficient way of improving the financial situation of this industry." MedPAC cites Medicare's small revenue mix, a disincentive for states to increase Medicaid funding, and inappropriate fund allocation towards high-Medicare-mix instead of high-Medicaid-mix facilities as flaws in the cross-subsidy. Industry representatives counter that, although not ideal, this cross-subsidization is critical for the industry's short- to medium-term sustainability. In an industry-commissioned survey, accounting firm BDO Seidman estimated that the average Medicaid payment of about $115 per day fell short of costs by $9.78 per day in 2000. BDO also estimated that unreimbursed Medicaid nursing care costs exceeded $3.0 billion in a survey of 37 states, or $3.5 billion when extrapolated to all 50 states, in 2000.

Industry estimates suggest that average Medicaid payment falls short of costs.

Not-for-profit Nursing Facilities

About 28% of nursing homes are not-for-profit entities, meaning that revenues generated in excess of costs must be reinvested back into the entity. The GAO has used Medicare cost report data to look at nursing home profit margins by ownership. The GAO found that the median total margin for not-for-profit SNFs was 0.6% in 1999 and 0.3% in 2000, compared to for-profit margins of 1.6% in 1999 and 2.2% in 2000.

The American Association of Homes and Services for the Aging (AAHSA), an industry association for the not-for-profit long-term care industry, did a similar analysis of not-for-profit SNF margins. AAHSA bases its analysis on the 990 federal tax form, which not-for-profit organizations with annual revenues over $25,000 are required to file with the IRS. AAHSA estimated that average total margin of a not-for-profit, freestanding, Medicare-certified SNF was 1.9% for the tax year 2001. The AAHSA study found that facilities incurred a *negative* 4.3% operating margin, and relied on public contributions, investment income and principal from endowments, and the proceeds from sales of assets to cover operating losses.

Not-for-profit margins are slim.

Although neither of these analyses is directly comparable to the GAAP (generally accepted accounting principles) financial reporting required of the publicly traded nursing facilities, they do corroborate each other in showing that not-for-profit margins are slim. The GAO study shows that not-for-profit margins are lower than those of the for-profit facilities. Also, the AAHSA study illustrates how not-for-profit facilities rely on supplemental sources of income beyond program revenues.

---

[5] The General Accounting Office (GAO) is the audit, evaluation, and investigative arm of Congress.
[6] MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program.
[7] For further discussion on payor mix, see pages 23-24.

Expenses

Nursing facilities incur a variety of operating expenses for rent, labor, food, supplies, drugs, equipment, insurance, administration, and other overhead. Investment analysts recently have focused primarily on labor and liability insurance cost trends.

Labor

During the late 1990s, many nursing facilities cited rapidly escalating labor costs, which were exacerbated by a nursing shortage, as a contributor to deteriorating financial performance. Employee costs represent nursing facilities' largest expense at approximately 55% to 65% of net revenues, according to Bear Stearns' Jason Kroll.

A labor shortage continues to challenge the industry, although this pressure may be moderating.

While the nursing shortage continues, analysts have noticed a recent moderation in labor cost growth as nursing facilities are decreasing reliance on more expensive nursing staffing agencies and turnover is lower in a weak economy. Merrill's A.J. Rice comments that Manor Care's 2002 and first quarter 2003 results showed that "[l]abor rate pressures are showing signs of moderating." A 2002 industry survey found that nursing facilities experienced lower vacancy rates among nursing positions in June 2002 compared to June 2001. Nonetheless, a significant nursing shortage—about 96,000 vacancies in 2002, particularly for the most highly trained nurses—continues to challenge the industry. High turnover also demands that nursing facilities offer attractive wages and benefits to retain staff.

Liability Insurance

More concerning to analysts than labor costs is the rising cost of liability insurance and settlement payments. JPMorgan's Matthew Ripperger reports that in 2002, three major nursing facility companies announced unexpected material increases in their annual insurance accruals (*i.e.*, reserved resources which estimate future settlement payments): Beverly was up 50% to $66 million, Kindred was up 50% to $82 million, and Manor Care was up 20% to $72 million. Jason Kroll of Bear Stearns estimates that nursing facility liability insurance costs continue to grow between 25% and 35%.

Liability costs are skyrocketing.

Lehman's Adam Feinstein notes the rising number of lawsuits and cost of settlements has depressed earnings. Based on data provided by the long-term care industry, AON Risk Consultants found, "Countrywide increases are the result of an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country." The national average of liability costs per occupied skilled nursing bed has grown at an average rate of 24% per year since 1991. The analysis also found that the average size of claims, as well as the number of claims per 1,000 beds, has tripled over the past ten years. Figure 8 shows the growth of these costs in recent years.

The average liability claim size has tripled over the last ten years.

Figure 8: Long-Term Care Faces Increasing Liability Costs

	2000	Growth	2001	Growth	2002	Growth
Average liability loss costs / occupied long term care bed	$2,100	15%	$2,340	11%	$2,880	23%
Average size of a professional liability claim	$182,000	9%	$182,000	0%	$198,000	9%
Average claims per year per 1,000 beds	11.5	6%	12.8	11%	14.5	13%

Source: AON Risk Consultants

These increasing costs parallel the exit of many insurance carriers from the long-term care provider liability market altogether. Over the past five to six years, the number of carriers offering long-term care provider liability insurance has been declining according to a preliminary study conducted by HHS' Office of the Assistant Secretary for Planning and

Evaluation. For example, in Texas, the number of state-licensed insurance carriers who provide this type of insurance has dropped from 8 in 1996 to 2 in 2002. In Florida, there are no state-licensed carriers of long-term care provider liability insurance. Goldman's Ankur Gandhi writes:

Liability insurance premiums rise while coverage is reduced.

> As a result of the rise in severity and frequency of claims filed, and owing to the unpredictable nature of results, many insurance companies have exited the market and no longer provide coverage. Consequently, annual commercial insurance premium levels increased more than 130% on average between 2000 and 2001, often with reduced coverage. This increase is significantly higher than the annual countrywide professional liability loss cost increase of 24%, and is the result of the inadequacy of past premium levels and the uncertainty associated with projecting future claims.

Legg Mason's Jerry Doctrow writes, "[V]ery high liability expense levels will continue to pressure nursing home operator cash flows and operating margins for the next year or two at least, in some cases forcing firms into bankruptcy reorganization when liability costs are added to Medicare and potential Medicaid cuts."

Many nursing facility companies either have divested or plan to divest operations in certain states with high liability costs, including Florida, Texas, and other Gulf states. Extendicare exited the Texas market in the fourth quarter of 2001 and the Florida market in the second quarter of 2002. Beverly plans to divest facilities that represent 50% of projected 2002 patient care liability costs. Kindred plans to divest its Florida operations. Kroll believes that this strategy may stave off further increases in accruals in the near-term future, rather than reduce costs outright. Strategic exits may help limit future liability, but nursing facilities are still exposed to a liability "tail" for incidents previous to the closure or sale of the facility, depending on state statutes of limitation.

Some nursing facilities have elected to operate without liability insurance.

There have also been reports of smaller, independent nursing facilities that have elected to operate without insurance altogether. For example, a University of South Florida study found that before Florida required all nursing facilities to have liability coverage, one in five facilities were without coverage. The Texas not-for-profit nursing home association estimates that 50% of nursing facilities operate without liability coverage.

Nursing facilities may benefit from state tort reform measures, notably in Florida, Texas, California, and Mississippi. Recently enacted reform measures will, however, likely be subject to court challenges by the plaintiff bar, further delaying positive changes to nursing facility liability insurance costs. Many other state legislatures are considering reform proposals. Ohio, which has not historically been a highly litigious state from the perspective of nursing facility claims, passed pre-emptive tort reform measures as well in January 2003.

Some nursing facilities have begun using arbitration to limit medical liability. Patients are asked upon admission to agree to arbitration to settle future disputes. In the fourth quarter of 2002, Beverly reported it was able to sign up 75% of newly admitted patients for arbitration. While Kroll is hopeful that arbitration may be part of the solution, he points out, "[I]t is unclear whether it is only the less litigious patients who are agreeing to arbitration" and therefore whether this approach will materially affect liability costs.

ACCESS TO CAPITAL

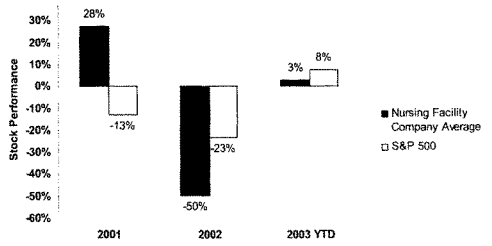
Sources & Uses of Capital

Nursing facilities invest capital for purposes including maintaining and updating current facilities, building or acquiring new facilities, reducing debt and debt payments, and repurchasing stock. If nursing facilities do not generate sufficient cash flow, capital may also be used to sustain operations.

Equity

Equity analysts have a generally negative outlook on the nursing facility sector. The publicly traded nursing facility chains have averaged a 3% year-to-date return, compared to the S&P 500 performance of 8%.

Figure 9: Average Nursing Facility Company Stock Performance versus S&P



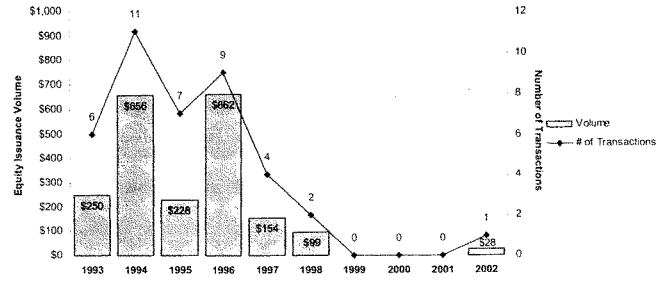
Source: Bloomberg. As of May 15, 2003. Average is equally weighted. Average includes Beverly (BEV), Extendicare (EXE/A), Genesis (GHV1), Kindred (KIND), Manor Care (HCR), Mariner (MHCA), and Sun Healthcare (SUHG) while trading under noted tickers for specified years.

Uncertainty reduces the industry's ability to forecast and manage finances, which in turn reduces access to capital. Most analysts do not believe the industry can raise capital in the equity markets due to continuing uncertainty about the possibility of legislation that may affect Medicare rates, threats to Medicaid rates, and skyrocketing liability insurance costs.

Figure 10: Public Equity Issuance for Nursing Facility Industry, 1993-2002

($ in millions)

No public equity was issued for the nursing facility sector in 1999, 2000, and 2001.



Source: SDC and Salomon Smith Barney. As of April 18, 2003.

Debt

The nursing home industry obtains most long-term financing from the debt markets. The interest rate payment typically rises as the quality of the bond declines. Being highly leveraged negatively impacts a company's profitability, as interest payments eat into profit margins.

Debt analysts focus on a company's ability to pay its debt service and other obligations. In other words, debt analysts look at what major payments are due and whether a company has the ability to meet these obligations without entering bankruptcy. The three main statistics used in this type of analysis are:

- EBITDAR - earnings before interest, taxes, non-cash charges (depreciation and amortization), and rent. EBITDAR shows cash flow available to pay interest, rent, and taxes after paying operational costs. EBITDAR is used to make apples-to-apples comparisons between companies because most companies finance their businesses differently and it represents earnings before financing costs.[8]
- Rent Adjusted Leverage - measures how much the company has borrowed or obligated through leases as a multiple of the cash flow available to pay such debt service and lease payments. The rule of thumb is that at a rent adjusted leverage multiple of 5x it is very difficult to raise new capital—at 6x it is nearly impossible.
- Fixed Charge Coverage - indicates the company's ability to pay rent and interest based on the amount of cash flow remaining after capital expenditures. Analysts consider a 2x fixed charge coverage to be the minimum required to raise capital.

The following CSFB analysis in Figure 11 shows these three ratios for the publicly traded, for-profit chains. The analysis includes a sensitivity analysis of how these ratios would have been impacted if the sunset had affected the full year of 2002 instead of just the fourth quarter. This may help investors understand ratio trends for 2003, which will be the first full year post-sunset.

Figure 11: Publicly Traded Nursing Facility Chain Debt Ratios, Sensitivity Analysis

	Actual 2002 Ratios			Estimated Ratios as if Sunset was in Effect for Full-Year 2002		
Company	Adjusted EBITDAR[1] Margin	Net Rent Adjusted Leverage[2]	Fixed Charge Coverage[3]	Adjusted EBITDAR[1] Margin	Net Rent Adjusted Leverage[2]	Fixed Charge Coverage[3]
Beverly Enterprises	12.0 %	4.8 x	1.3 x	10.9 %	5.3 x	1.1 x
Genesis Health Ventures	9.5 %	3.1 x	2.7 x	8.7 %	3.4 x	2.4 x
Extendicare Health Services	11.8 %	4.7 x	1.8 x	10.8 %	5.3 x	1.6 x
HCR Manor Care	14.1 %	2.0 x	5.1 x	12.8 %	2.2 x	4.4 x
Kindred Healthcare	12.7 %	4.9 x	1.2 x	11.9 %	5.3 x	1.1 x
Average	**12.0 %**	**3.9 x**	**2.4 x**	**11.0 %**	**4.3 x**	**2.1 x**

Source: Credit Suisse First Boston analysis based on company reports.
(1) EBITDAR is Earnings Before Interest, Tax, Depreciation, Amortization, Rent, and unusual or extraordinary items
(2) Net Rent Adjusted Leverage = (Total Debt + 8 x Rent Expense) / EBITDAR
(3) Fixed Charge Coverage = (EBITDAR - Capital Expenditures) / (Rent Expense + Net Interest)

Most debt analysts share the negative outlook of equity analysts on the nursing facility sector for the same reasons. Deutsche Bank's Reukauf believes that the add-on provision sunset could push some other highly levered nursing facilities into bankruptcy, given that facilities are already tightly constrained in how much they can cut back on expenses. This

[8] Note: The EBITDAR margin is *not* the same as a net income margin. A net income margin is earnings (profits) after all other obligations have been met, divided by net revenues.

is particularly true for those facilities that depend heavily on Medicare revenue to subsidize Medicaid patients.

Other analysts, although in the minority, believe that certain nursing facility bonds are trading below value. Ankur Gandhi of Goldman Sachs uses Extendicare as an example of her more positive outlook for debt holders. She writes:

> From a bondholder's prospective, however, we continue to be bullish on the Extendicare subordinated notes, even though we look for marginal revenue growth and for EBITDA to decline 14.1% in 2003, owing to the Medicare reduction. We are bullish because (1) the company does not face an imminent liquidity crisis, as it has no major debt due until 2007; (2) the company does not operate in states with high patient liability costs; (3) at a current yield of 13.1%, the bonds offer an attractive relative buying opportunity versus the rest of high-yield healthcare, which trades at an average yield of 8.7%; and (4) a strong management team has been able to drive improvements in operating results by improving its quality mix.

Gandhi also notes that the price of Extendicare's subordinated notes has not moved in tandem with the improvement in certain credit statistics. This reflects investors' ongoing concerns about an uncertain external environment for all nursing facility operators.

Figure 12 shows the major debt issues for the nursing facility sector and the relative rating by Moody's and Standard and Poor's. Deteriorating industry performance has resulted in rating agency downgrades.

Figure 12: Publicly-Held Nursing Facility Bonds

($ in millions)

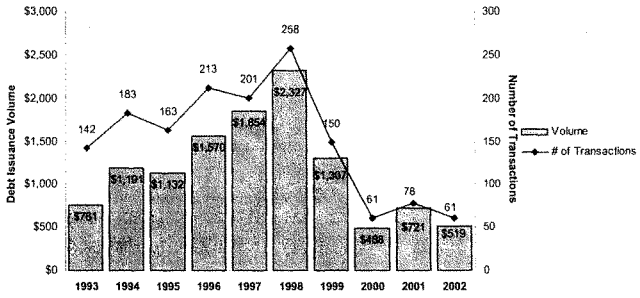
Issuer	Amount Issued	Amount Outstanding	Issue Date	Coupon	Maturity	Moody's Rating	S&P Rating
Beverly Enterprises Inc.	$ 30.0	$ 17.9	7/22/1993	8.625 %	10/1/2008	Ba2	B+
	20.0	11.0	4/29/1993	8.750 %	7/1/2008	Ba2	B+
	180.0	180.0	2/15/1996	9.000 %	2/15/2006	B1	B+
	200.0	200.0	4/25/2001	9.625 %	4/25/2009	B1	B+
Extendicare Health Services, Inc.	$ 200.0	$ 200.0	11/25/1997	9.350 %	12/15/2007	B3	CCC+
	150.0	150.0	6/20/2002	9.500 %	7/1/2010	B2	B-
Genesis Health Ventures	$ 25.0	$ 19.3	10/8/1992	9.250 %	9/1/2007	NR	NR
Kindred Healthcare Inc.	$ 300.0	$ 160.5	4/20/2001	LIBOR+4.5 %	4/20/2008	NR	NR
Manor Care Inc.	$ 200.0	$ 200.0	3/8/2001	8.000 %	3/1/2008	Ba1	BBB
	150.0	150.0	6/4/1996	7.500 %	6/15/2006	Ba1	BBB
	200.0	200.0	4/15/2003	6.250 %	5/1/2013	Ba1	BBB
	100.0 (1)	100.0	4/15/2003	2.125 %	4/15/2023	Ba1	BBB
Mariner Health Care, Inc.	$ 150.0	$ 150.0	5/13/2002	LIBOR+5.5%	5/13/2009	B3	B-

Source: Company management.
Note: Issuance of these kinds of debt involve costs such as underwriting commissions, legal & trustee expenses, debt rating fees, discounted issue price, etc. When such costs are factored in, the effective cost of financing is higher than the nominal coupon rate.
(1) Convertible bond that also has contingent interest component. Absent conversion and contingent interest components, estimated coupon is 7.34%.

As seen in Figure 13, debt issuance has been low in recent years. Debt issuance volume of $519 million in 2002 is less than one-quarter of its peak issuance of $2.3 billion in 1998.

Figure 13: Public Debt Issuance for Nursing Facility Industry, 1993-2002

($ in millions)



Source: SDC and Salomon Smith Barney. As of April 18, 2003.

Over the past twelve months, both Extendicare and Manor Care completed refinancing transactions. Extendicare completed a bond offering in the summer of 2002, although these bonds traded down as investors saw decreased likelihood of Congress extending the add-on payment provisions past October 1, 2002. Manor Care arranged for a refinancing package in April 2003. The company was advised that it would not be able to refinance the entire maturing facility as a bank loan due to the withdrawal of many banks from the nursing facility loan market. This reduced lending pool affected Manor Care even though it does not share the generally weak financial history of other nursing facility chains. In the refinancing, Manor Care arranged for $200 million in new 10-year bonds at 6.25%, another $100 million in 20-year convertible bonds at 2.125%, and a new $200 million, 3-year line of bank credit. Even though the terms of the refinancing were relatively favorable in the current nursing facility environment, the refinancing still resulted in $1 million per month in increased interest expense for Manor Care, according to the company.

Many nursing facility chains will need to refinance in the next several years as illustrated in Figure 14. Debt analysts' outlooks on access to debt markets vary based on the quality of the specific nursing facility's financial information. A high-yield analyst at CSFB believes that Manor Care's success is not a good proxy for the rest of the sector. CSFB believes that nursing facility companies with weaker balance sheets or who lease all of their properties from third party owners, such as Kindred and Sun that (which both recently emerged from bankruptcy), may have difficulty accessing the debt markets.

Figure 14: Nursing Facility Refinancing Outlook

($ in millions)

Issuer	Type of Debt to be Retired	Size of Debt	Maturity	Potential (*Actual*) Source of Refinancing	Refinancing Date	Refinancing Size	Interest Rate Increase (Decrease)
Beverly	Synthetic Lease	$ 50.0	4/26/2004	Asset sales, cash and public	-	-	-
	Revolving Credit Line	100.0	4/26/2004	bonds as available			
	Med Term Notes (BFC)	70.0	6/15/2004				
	Publicly-Held Bonds	180.0	2/15/2006				
Extendicare	Bank credit facility	$ 124.5	12/31/2003	*Publicly-Held Bonds*	6/20/2002	$ 150.0	-
Genesis	Secured Notes	$ 242.0	4/2/2007	Subordinated Debt	-	$ 150.0	2.000 %
				Cash		110.0	
	Secured Credit Facility	332.0	10/2/2006	Secured Credit Facility	-	200.0	1.000 %
	Mortgages	50.0	-	-	-	-	-
Kindred	Publicly-Held Bonds	$ 160.5	4/20/2008	Publicly-Held Bonds	-	-	-
	Revolving Credit Line	120.0	4/20/2006	Commercial Bank	-	-	-
	FloridaLeaseDivestiture	72.0	ASAP	Sublease or Purchase&Sale	-	-	-
Manor Care	5 Year Revolving Credit Line	$ 500.0	9/24/2003	*3 Yr. Revolving Credit Line*	4/21/2003	$ 200.0	0.925 %
				10-Yr. Notes	4/15/2003	200.0	4.740 %
				Convertible Notes	4/15/2003	100.0	0.575 %
Mariner	Term Loan	$ 210.0	3/31/2005	Public bonds as available,	-	-	-
	Revolving Credit	22.0	3/31/2005	bankloans	-	-	-
Sun	Revolving Credit Line	$ 150.0	2/28/2005	Revolving Line of Credit	-	$ 125.0	-
	Term Loan and Discount Note	40.0	2/28/2005	Private Placement, Asset Sales, and/or Cash	-	34.0	-
	Unpaid rent	10.5	N/A	Settlement/FacilityDisposal	-	-	-
	Bank Mortgage	20.0	5/1/2004	Private Placement	-	17.0	-

Source: Company management.
Note: Potential Source of Refinancing is speculative and based on management's expectations. Future refinancing will depend upon market conditions and company performance.

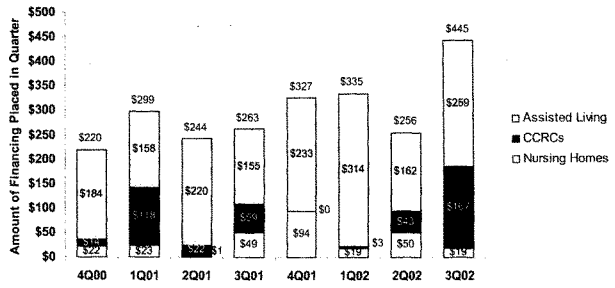
Many nursing facility chains will need to refinance in the next several years.

In addition to the public bond market, SNFs may also seek debt financing from commercial banks and other lenders. This type of financing, although usually more expensive, can be used when access to the public debt and equity markets is not viable. This type of financing is also often short-term in nature and can be attractive for companies looking to grow that are planning to recapitalize later. Figure 15 shows an industry survey of major national lenders and loan volume representing targeted, project-specific financing (not general corporate financing) for the assisted living, continuing care retirement communities (CCRCs), and nursing facility industries combined. Total loan volume peaked in the third quarter of 2002, also the most recently surveyed quarter, while nursing facility loan volume peaked in the fourth quarter of 2001.

The nursing facility long-term debt market is encouraged by government-chartered organizations such as Fannie Mae and Freddie Mac. The Department of Housing and Urban Development and the Federal Housing Administration (HUD/FHA) also supports debt by insuring loans originated by private lenders for new construction, substantial rehabilitation, refinancing, and acquisition for nursing facilities, intermediate care facilities, board care homes, and assisted living facilities. This guaranteed loan program traditionally serves as a credit enhancer in times of tightening mortgage capital availability. The agency insured $1.2 billion in nursing facility loans (which includes a very small loan amount to intermediate care facilities) in FY 2002 compared to $828 million in FY 2001. Most of the increase was to support refinancing activity in the current low-interest environment. Although access to these capital sources exists, competition for funding from these agencies is strong. Nursing facilities must meet certain underwriting requirements and are subject to ongoing certification and regulation.

Figure 15: Total Loan Volume to Long-Term Care Industry by a Sample of Major National Lenders

($ in millions)



Source: National Investment Center for the Seniors Housing & Care Industries.

REITs

Many nursing facility operators lease facilities from REITs.

Real estate investment trusts (REITs) are generally considered higher cost alternatives to more traditional debt financing. Instead of owning their facilities outright, many nursing facility operators lease facilities from REITs. These leases are a form of levered financing. Merrill Lynch's Rice explains how REITs can be the best option for both nursing facilities and other long-term care sectors such as assisted living:

> REIT financing in sale/leaseback deals generally represents 100% of the financing for a given asset, whereas a more traditional asset purchase by an operator is generally financed with a 60%/40% mix of debt and equity.... There are sectors of the healthcare services industry, such as assisted living and skilled nursing, which are utilizing substantial amounts of REIT financing. Generally speaking, the equity market does not currently represent an attractive funding option for these sectors, and the financial troubles of these sectors over the last few years have caused many traditional lenders to exit the market. Against this backdrop, the 100% financing provided by a REIT is, in many cases, the best option for many assisted living and skilled nursing operators.

REITs do not assume the same liability risks as those of the tenant operators.

Because nursing facility operators are struggling, one might ask why REITs invest in nursing home facilities. As property owners and landlords, REITs do not assume the same patient care liability risks as those of the tenant operators. Many operators who lease these facilities may be small and carry minimal insurance, or none at all. If faced with a large settlement, these operators may simply close their businesses. Although a bankrupted operator obviously can no longer pay rent, the REIT can still fall back on the hard assets of the facility and can choose to seek another operator to run the facility. There are a number of healthcare REITs, most of which have some investments in nursing facilities.

Figure 16: Examples of Health Care REITs and SNF Rental Income

($ in millions)

REIT	Nursing Facilities Owned	2002 Nursing Facility Rental Income	Percent of Total Rental Income	Total Rental Income
Health Care Property Investors	184	$85.8	24.7%	$347.8
Health Care REIT	76	$64.4	35.9%	$179.5
Healthcare Realty Trust	31	$174.0	11.7%	$1,484.9
National Health Investors	N/A	$10.6	68.9%	$15.4
Nationwide Health	158	$55.9	40.2%	$139.1
Senior Housing Properties Trust	60	$12.9	10.6%	$122.4
Ventas	220	$127.9	67.5%	$189.5

Source: Company filings.

One REIT analyst notes that financing for the health care REITs became more difficult after the add-on provision sunset. Nursing facility operators that function in a "hand-to-mouth" business environment may have less flexibility to meet lease obligations as Medicare payments are reduced and Medicaid payments are threatened. However, health care REIT financing is still available, albeit at a higher cost relative to both pre-PPS days as well as other REIT sectors. Despite the analyst's cautious outlook, he does not believe the sector is returning to the worst days of 1998 and 1999: "The current nursing home environment does not resemble 1998 when everybody tipped over at once, but it is more likely that we will see some fall-out throughout 2003 as a result of the add-on sunset."

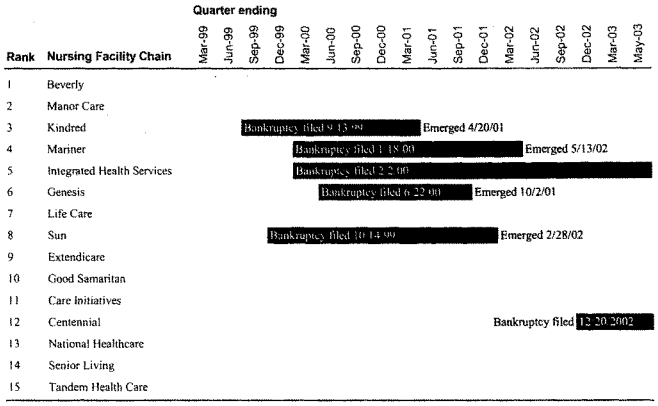
Solvency

Ultimately, access to capital is related to whether a nursing facility can generate positive operating cash flow and stay solvent to avoid bankruptcy. Ankur Gandhi, high-yield debt analyst at Goldman Sachs, notes, "We have seen a number of small operators file for bankruptcy since October 1, 2002. The largest so far has been the December 27, 2002 filing announced by Centennial Health, which operates 100 skilled nursing facilities." These continuing bankruptcies raise concerns among investors that the industry is returning to the 1999-2000 period when five of the top eight nursing facility operators filed for bankruptcy. While in bankruptcy proceedings, these nursing facilities were able to continue to operate and provide care.

Integrated Health Services continues to undergo Chapter 11 bankruptcy restructuring. Kindred and Genesis both emerged from bankruptcy in 2001. Mariner Post-Acute Network and Sun Healthcare emerged from bankruptcy in 2002. However, a CSFB high-yield bond analyst believes Mariner and Sun are "not yet fully out of the woods," with higher exposure to the California market (where Medicaid rate cuts loom) and fragile capital structures that rely on renegotiating leases to be successful. For example, Sun is withholding rent and mortgage payments for over half of its facilities to stave off re-filing for bankruptcy. Sun hopes to transition these facilities to new operators. If the landlords of these properties aggressively pursue and obtain leasehold or other property damages over the next year, Sun may be forced to re-file for bankruptcy protection, according to the company's filings with the SEC. For other large nursing facility chains, CSFB believes that despite thin margins, well-managed nursing facilities should be able to survive under current conditions. CSFB notes, "The key obstacles to these companies accessing the capital markets is the uncertainty over patient care liability, Medicaid eligibility and reimbursement levels and the possibility, however remote, that Medicare rates could be cut."

One chain is withholding rent and mortgage payments to stave off bankruptcy re-filing.

Figure 17: Bankruptcy Filings among Top 15 Nursing Facility Chains since 1999



Source: Public filings, company information, and analyst models.
Note: Chains ranked by bed count, as of April 3, 2003.

Three nursing facility chains filed for bankruptcy during the past six months.

Although most of these bankrupted chains have emerged, there have been several notable, albeit smaller, nursing facility bankruptcy filings in recent months. Centennial Healthcare (which operates 77 SNFs with 8,600 beds in 19 states and the District of Columbia) filed for bankruptcy in December 2002. Regional chains Lexington Healthcare Group (which operates 8 facilities in Connecticut) and Ballantrae Healthcare (which operates 35 facilities in six states and is based in New Mexico) filed for bankruptcy in the spring of 2003.

Not-for-Profit Access to Capital

The smaller for-profit and not-for-profit facilities are estimated to comprise 70% of the industry.

The outlook for the smaller and not-for-profit facilities may be bleaker compared to the larger, for-profit facilities. The smaller or not-for-profit facilities must rely on the debt markets to raise capital or in some cases attract philanthropic donations. Gandhi notes that the add-on had a greater impact on the smaller for-profit and not-for-profit facilities, which comprise 70% of the nursing facility industry. While not-for-profit organizations can file for bankruptcy similar to their for-profit peers, many smaller not-for-profits tend to choose to close down operations altogether when unable to overcome a liquidity crisis according to industry sources.

Nursing facilities issue a small portion of the total debt issued by not-for-profit health care providers. According to a Fitch credit rating agency analysis:

> Nonprofit nursing home bond issuance volume fell dramatically to $508.7 million in 2002 from $2.3 billion in 1998, a 78% decline. Nonprofit nursing facility bond volume composed only 1.9% of total health care bond issuance in 2002, with nearly all nursing facility issuance being speculative grade. This is a decrease from 7.1% of total health care bond issuance in 1997. Fitch expects the nonprofit nursing facility sector's volume in 2003 to approximate 2002 levels.

SNF bonds rarely achieve investment grade ratings.

Bonds that finance nursing facility operations are typically unrated because they are generally neither investment grade nor secure enough to warrant the fees associated with obtaining a credit rating. The riskiness of these bonds means that the high interest rates are often prohibitively expensive to nursing facility issuers. Skilled nursing facilities rarely have the credit strength on their own to achieve investment grade ratings, and have difficulty in securing credit enhancement in the form of private bond insurance or letters of credit from government mortgage insurance programs like HUD/FHA or Ginnie Mae. Jeanette Price, a public finance investment banker with Salomon Smith Barney, explains that access to the unrated market is helped by a strong balance sheet, adequate debt service coverage, a credible sponsor, high occupancy, decent Medicaid reimbursement, and strong Certificate-of-Need protection. If the bond issue is small, Price believes that it can find sufficient investors without needing to meet the higher credit standards of a large investor pool.

Emily Wong, an analyst at Fitch Ratings notes that her 2003 outlook for nonprofit nursing facilities is "much more negative than [her] outlook for hospitals or continuing care retirement communities," due to nursing facilities' high reliance on Medicaid, limited revenue streams, and rising costs. Wong believes, "Nonprofit nursing home credit profiles will continue to weaken in the near to long term due to industry pressures. Demand from aging baby boomers may save nursing facilities, but this demand is more than 20 years away."

Access to capital is better for SNFs that expand into assisted living and CCRC lines of business.

Rod Rolett of Herbert J. Sims Company, an underwriter that focuses on tax-exempt financing of not-for-profit long-term care companies, believes that access to capital is better for SNFs that are expanding into other types of long-term options, including assisted living and continuing care retirement communities (CCRCs). Rolett observes that seniors paying for their own care are opting for less institutional CCRC and assisted living facilities over SNFs. Charles Lynch of CIBC notes that many of the for-profit, publicly traded chains have begun to diversify in this way:

> Reimbursement environment is restrictive to organic growth for nursing homes, with Medicare rates reduced in 2002 and Medicaid rates moderating. As a result, most companies are in the midst of embarking on strategic initiatives to diversify into adjunct business, such as home care, hospice, therapy, and pharmacy services.

Not-for-profit facilities, many of which may have a religious or civic mission to provide care for seniors, typically are reluctant to respond to decreased demand by self-financed seniors by cutting beds, according to Rolett. Many aim to operate at high occupancy rates without regard to the Medicaid and charity care census.

Many of the nonprofit nursing facilities are dependent on investment income from endowments, funded by philanthropic donations. Because the nursing facility business does not have high margins and does not generate much cash flow, developing adequate endowments is one of the greatest credit challenges for long-term care facilities, according to Price. Fitch notes, "[T]he financial ratios of these [nursing homes that depend on endowment income] have suffered due to reduced investment returns in the past three years.... [P]rudent cash management is important, as the reliance on volatile investment earnings is unpredictable." Following the terrorist attacks of September 11th, philanthropic donations have also fallen off, further challenging not-for-profit SNFs.

REVENUE SOURCES

In 2001, national freestanding nursing home care expenditures totaled $98.9 billion, or 6.9% of total national health expenditures. Medicaid paid for the greatest component of nursing home expenditures at 48%, compared to private sector at 38% and Medicare at 12%.

Figure 18: Freestanding Nursing Home Care Expenditures

($ in millions)

	2001	% of Nursing Home Care Expenditures
Total National Health Expenditures	**$1,424,541**	**NA**
Nursing Home Care Expenditures	**$98,911**	100 %
Private	**$38,058**	38 %
Out of Pocket	26,866	27 %
Private Insurance	7,523	8 %
Other	3,670	4 %
Public	**$60,853**	**62 %**
Medicare	$11,588	12 %
Medicaid	$46,994	48 %
Federal	28,119	28 %
State and Local	18,875	19 %
Other	$2,271	2 %
Federal	2,100	2 %
State and Local	171	0 %

Source: CMS, Office of the Actuary, National Health Statistics Group.
Note: Under "Public" spending, "Medicaid" includes SCHIP expansion and "Other" includes SCHIP.

Medicaid is the largest payor for nursing home care.

The census mix of Medicare, Medicaid, and private pay patients affects nursing home profitability both due to differentials in payment rates as well as length of stays.

Private Sources

Private Pay

Residents who spend down their assets can become Medicaid eligible.

Among the large for-profit nursing facility companies, private pay and other sources typically comprise 20% of the resident census and typically generate 30% of revenue for nursing facilities. Nursing home residents who pay themselves may eventually spend down their assets to become Medicaid eligible. Some nursing facilities (such as some of those in the Manor Care chain) have historically catered to more affluent customers and still benefit from higher private-pay margins. They do, however, face increasing competition from assisted-living alternatives and expect slowing revenue growth from their private pay business.

Long-Term Care Insurance

Very few Americans buy private long-term care health insurance.

A revenue source in its infancy, long-term care insurance generates a very small portion of nursing facility revenue. Very few aging Americans buy private long-term care health insurance and when they do it is often initiated at an advanced age—defeating the purpose of the insurance design. Inevitably, unless this trend is reversed, likely through changes in tax policy, the growing financing burden will remain on the taxpayer base and present rapidly increasing fiscal pressures on the public programs—Medicare and Medicaid.

Public Sources

Medicare

Among the large for-profit nursing facility companies, Medicare typically comprises 10-15% of the resident census and approximately 25% of revenue. This revenue has dropped from prior years as a result of the Balanced Budged Act of 1997 and the implementation of SNF PPS in 1998. As noted earlier, Medicare payments exceed those of Medicaid. While many of the large for-profit nursing facilities were building up their ancillary services businesses prior to the implementation of the SNF PPS, Medicare revenues allowed the industry to expand despite losses on other lines of business. Now, under the constraints of PPS, providers are forced to operate more efficiently.

Medicare does not cover SNF care on a long-term basis.

Medicare covers SNF services for beneficiaries who have recently been discharged from a stay in an acute care hospital lasting at least 3 days and who need daily skilled care. SNF coverage is limited to 100 days per spell of illness. Medicare does not cover SNF care on a long-term basis. If beneficiaries continue to require care in a skilled nursing facility once Medicare coverage expires, they can pay out-of-pocket as long as they have assets or sufficient income (private pay). Once their assets are "spent-down," they become Medicaid eligible. The per diem rate to the provider typically decreases as patients move along each step from Medicare to private pay to Medicaid.

Medicaid

Medicare payments cross-subsidize lower Medicaid payments in nursing facilities.

Among the large for-profit nursing facility companies, Medicaid typically comprises 65-70% of the resident census and typically generates 45% of revenue for nursing facilities. A nursing home industry trade association estimates that the average Medicaid rate for nursing home care was $113.50 per day in 2001. Higher Medicare payments cross-subsidize lower Medicaid payments in nursing facilities. With Medicaid comprising a much greater percentage of nursing home residents and revenues than Medicare, CSFB believes that uncertainty over Medicaid reimbursement poses a greater threat than Medicare.

As most states must balance their budgets annually, spending for state programs must be cut as revenues fall. Several states have announced Medicaid payment cuts, others have maintained existing levels, and a smaller number have announced modest increases. According to a January 2003 Kaiser Commission on Medicaid and the Uninsured study, 37 states plan to reduce or freeze the amount of funding for nursing care in fiscal 2004.

For the state fiscal year beginning July 1, 2003, the major for-profit nursing facilities chains have projected Medicaid payment increases of 2% to 3%. However, many analysts are more pessimistic, as major hospital chains have projected neutral to negative changes in Medicaid payment to providers.

Recent CMS Issues Related to Medicare SNFs

Proposed 2.9% Increase to Medicare SNF Payments in Fiscal 2004

On May 8, 2003, CMS announced a proposed 2.9% increase in Medicare payment rates to SNFs for fiscal year 2004. The increase will result in nearly $400 million more in Medicare SNF payments. The proposed rule, published in the Federal Register on May 16, also reflects the decision by CMS to retain the current RUG classification system that establishes daily payment rates to skilled nursing facilities based on the needs of Medicare beneficiaries. CMS is continuing to research case mix refinement methods that could appropriately pay nursing facilities for complicated care. The 60-day public comment period ends July 7. CMS will publish the final rule by August 1 for implementation on October 1, 2003, the first day of fiscal year 2004.

Rehabilitation Therapy Caps

The Balanced Budget Act of 1997 created SNF therapy caps for Part B outpatient rehabilitation services. The caps apply to certain providers of outpatient rehabilitation, including SNFs. The payment caps are an annual $1,590 per beneficiary limit on certain Part B outpatient rehabilitation services. The cap applies twice: one $1,590 cap applies to occupational therapy, and a separate $1,590 cap applies to physical therapy and speech therapy combined. The therapy caps were enacted in 1999, but Congress declared a moratorium on these therapy caps in both 2000 and 2001. CMS currently plans to implement these therapy caps in July 2003.

The therapy caps are intended to be per beneficiary. However when initially implemented in 1999, CMS did not have the systems capability to apply this cap if a beneficiary moved to a different provider in another venue. When therapy caps are re-implemented later this year, CMS systems are expected to be able to implement the caps as required by law.

Jason Kroll of Bear Stearns has not included the impact of therapy cap implementation in his financial estimates yet. However, "While this eventuality is not reflected in our projections, there is substantial likelihood, in our view, that the therapy caps could be implemented in July, in which case there would be downside to our estimates...."

Bad Debt Reimbursement

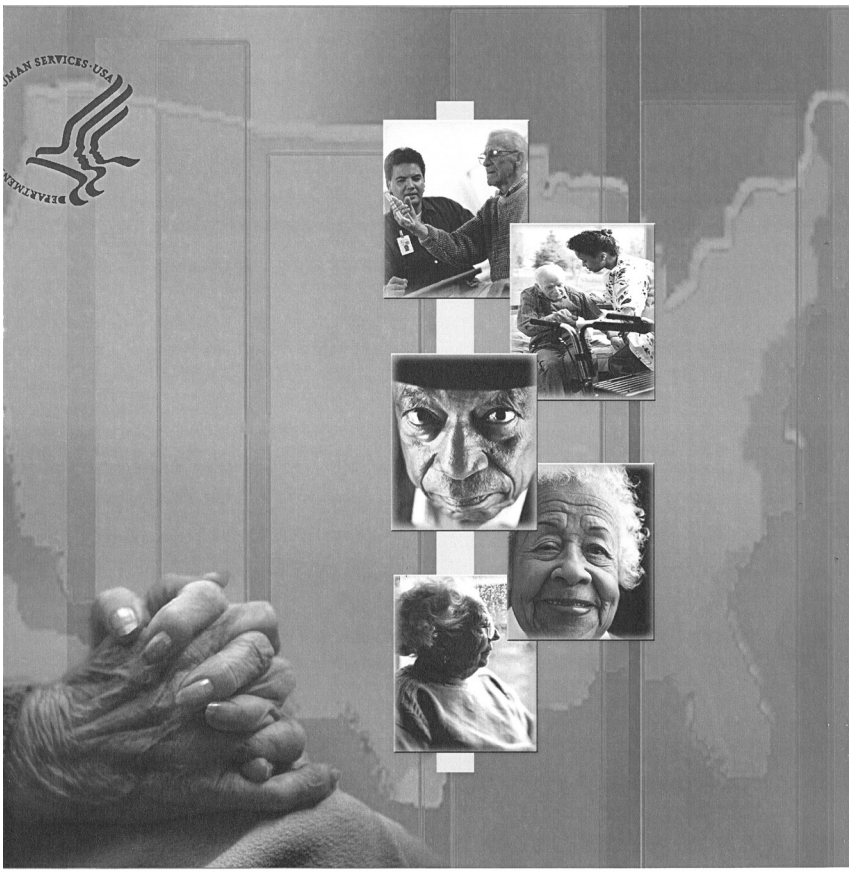
SNFs that provide care to Medicare beneficiaries sometimes incur bad debt because of beneficiaries' failure to pay deductibles. In February 2003, CMS issued a proposed rule to reduce SNF bad debt reimbursements from 100% to 70% over three-year period beginning October 1, 2003. By doing so, CMS would bring the bad debt reimbursement level in line with hospital rates, and hopes to further encourage collection of bad debt by SNFs and other affected providers. In total, this regulatory change will reduce bad debt payments by about $20 million in FY 2004 and $100M when fully implemented in 2006. Comments on the proposed rule were accepted through mid-April and will be considered in the final rule. Schwab/Washington Research Group believes the effect will be minimal on the major nursing facility chains. Schwab writes, "On average, the change will result in an approximately $1 a day reduction in reimbursements, though the effect may be greater for some companies." Schwab notes that the industry estimates the effect could rise to as much as $6 a day in 2006.

Nursing Home Quality Initiative

In November 2002 CMS released quality measures for all Medicare and Medicaid certified nursing homes. Measures are given for nearly 17,000 nursing homes in all 50 states, the District of Columbia, and some U.S. Territories. This quality initiative is a four-prong effort that consists of: 1) regulation and enforcement efforts conducted by state survey agencies and CMS; 2) improved consumer information on the quality of care in nursing homes; 3) continual, community-based quality improvement programs designed for nursing homes to improve their quality of care; and 4) collaboration and partnership to leverage knowledge and resources. Information on nursing home quality can be found on the Nursing Home Compare site at www.medicare.gov/NHCompare/Home.asp.

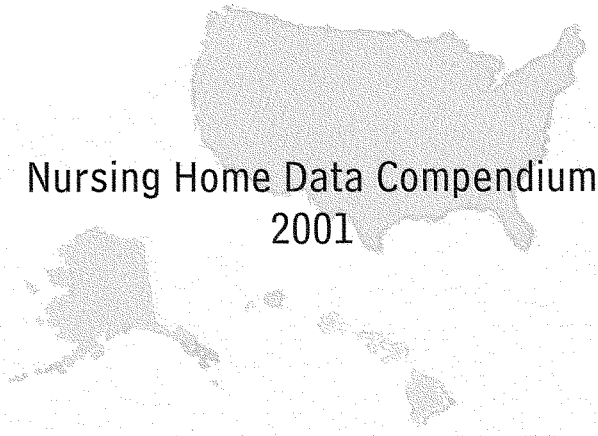
SUMMARY

- Profit margins for the large, publicly traded nursing facility chains continue to decline, although no dramatic drop-off has been observed after certain add-on provisions sunset on October 1, 2002.
- The effect of government spending reductions may not yet be fully realized as results for only six months have been reported since the Medicare add-on provisions expired and many new state budget cuts have not yet been implemented.
- Two additional nursing facility chains emerged from bankruptcy in 2002. However, some analysts worry how these chains will be able to weather the uncertain government payment environment. The facilities at greatest risk are those that heavily subsidize Medicaid revenue with Medicare payments.
- While Wall Street continues to watch Congress for signs of legislation that would restore Medicare add-on payments, investors are increasingly concerned by the risk of Medicaid payment cuts and rising liability costs.
- Rising insurance costs and aggressive litigation have led to the exit of many chains from states where liability costs are high.
- Most analysts believe that access to capital remains very limited for the sector in an uncertain payment environment. Access to capital for not-for-profit nursing facilities is particularly difficult.
- Investment analysts worry that some nursing facilities, recently emerged from bankruptcy, may need to re-enter bankruptcy protection. Three nursing facility chains have filed for bankruptcy since December 2002.



Centers for Medicare & Medicaid Services

Nursing Home Data Compendium 2001



Nursing Home Data Compendium 2001

Introduction to the CMS Nursing Home Data Compendium, 2001

This is the second edition of the Centers for Medicare & Medicaid Services (CMS) annual Nursing Home Data Compendium. CMS, which oversees quality of care in the nation's Medicare- and Medicaid-certified nursing homes, publishes this volume to provide a more detailed picture of the residents of these nursing homes. We hope that this data compendium will serve as a useful resource for policy makers, researchers, and consumers.

The compendium contains figures and tables presenting data on all residents in Medicare- and Medicaid-certified nursing homes in the United States. A series of graphs, charts, and maps highlights some of the most interesting data, while detailed data are available in accompanying tables. Appendix A lists the sources of the data used in this report and explains the methods used in calculating many of the data elements presented in the Data Compendium tables.

Overview of Contents

Nursing Home Certification and Ownership

In 2001, just over 16,600 nursing homes participated in the Medicare and/or Medicaid programs. The number of nursing homes participating in Medicare and Medicaid decreased steadily from 1997 to 2001. This decrease occurred in most, but not all, states. The bulk of the decrease occurred among for-profit nursing homes and among nursing homes with fewer than 50 beds. The number of government-owned nursing homes, which represent the smallest category of ownership at about 6.4% of nursing homes, experienced the greatest proportional decline.

More than 80% of these homes participated in both Medicare and Medicaid. Slightly more than 6% were certified to participate only in Medicare, while 12% participated only in Medicaid. By state, the percentage of nursing homes certified only for Medicaid varied from 0 to 39 percent.

More than three-fourths of nursing homes had between 50 and 200 beds. In 2001, only about 15% of nursing homes had fewer than 50 beds—down from 17% of nursing homes in 1997. By state, the percentage of nursing homes with fewer than 50 beds varied from 5 to 60 percent.

For-profit facilities accounted for about 65% of the certified homes and cared for almost two-thirds of nursing home residents. About 28% of nursing homes were non-profit. The others were government-operated. By state, the percentage of for-profit nursing homes varied from 6.7 to 83 percent.

Nursing Home Residents

Nursing homes completed MDS assessments for more than 3 million individuals in 2001. About 70% of these residents were female. By state, the female to male ratio varied from 1.4 to 1 in Alaska to 2.7 to 1 in Alabama. Seventy-five percent of all nursing home residents were 75 years of age or older. Alaska, Puerto Rico, and Louisiana had the highest proportions of young nursing home residents (under the age of 65 years) while South Dakota, Iowa, and North Dakota had the highest proportions of residents aged 95 years and older.

These data show that about 15% of the U.S. nursing population consists of Asian, African-American, or other ethnic and racial minorities. Minorities make up a larger proportion of the population of large nursing homes (with 200 or more beds).

According to these data, more than 68% of nursing home residents are over the age of 75, while a steadily increasing proportion of residents are under the age of 30. The proportion of residents under the age of 30 increased from 10.0% to 10.7% from 1999 to 2001.

Occupancy rates for nursing home increased slightly from 1999 to 2001, after a period of slight decrease. In 1996, nursing homes, on average had about 86% of their beds occupied. In 2001, occupancy was 84.3%.

Both cognitive and functional impairment were common in nursing homes. About 28.5% of residents had no cognitive impairment as measured by the Cognitive Performance Scale (CPS). This proportion remained constant from 1999 to 2001. The proportion of residents with severe or very severe cognitive impairment scores on the CPS decreased slightly, from 16.8 % to 16.2%, between 1999 and 2001. Residents of nursing homes with fewer than 50 beds were about half as likely as residents of larger nursing homes to have severe cognitive impairment. More than one third of nursing home residents required extensive assistance with at least four of the five Activities of Daily Living (ADL) that were examined (bed mobility, transferring, dressing, eating, or toileting). Facilities with fewer than 50 beds reported lower levels of ADL impairment in residents than did larger facilities.

Clinical problems were also common in nursing homes. As noted in the Nursing Home Data Compendium 2000, incontinence remained a severe problem. More than one-third of nursing home residents were incontinent of bowel or bladder all or most of the time. The median prevalence of pressure ulcers across all nursing homes increased slightly over the observation period: from 7.4% to 7.9%. The incidence remained relatively stable at about 2%.

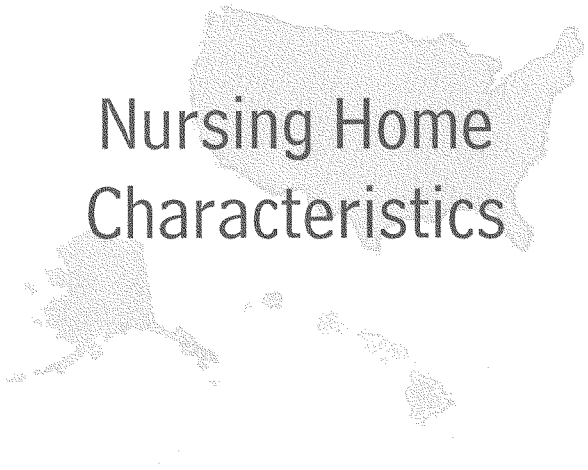
The median prevalence of physical restraint use decreased from 1999 to 2000, but remained approximately constant from 2000 to 2001. Data on reported involuntary weight loss also suggest a downward trend from 1999 to 2001, decreasing from 11.4% to 9.3% during that period. From 1991 to 2001 the prevalence of tube feeding was steady, at 4.2% to 4.4%. Fewer nursing homes reported high proportions of residents who were dehydrated, as represented by the 90th percentile of facility-reported prevalence measures.

Results from the on-site surveys of nursing homes also changed from 1996 to 2001. The average number of health deficiencies cited during the survey increased from 5.1 per facility in 1996 to 6.3 per facility in 2001. The percentage of nursing homes that did not receive any citations for health deficiencies during the survey decreased substantially: While 22% of nursing homes were not cited for health deficiencies in 1996, about 11% were not cited in 2000. The proportion of facilities cited for deficiencies at the level of actual harm or greater varied widely from 1996 to 2001. There was an overall decrease from 26.3 to 21.3 from 1996 to 2001 with an intervening increase to 31.4 in 1999. (The proportion of deficiencies cited at this level decreased by 45%).

The percentage of nursing homes cited for substandard quality of care fluctuated somewhat from year to year, but never rose above 5.8% during the five-year period. The lowest proportion, 4.3%, was in 1995.

Additional information about the material highlighted above is available at the state level in the figures, maps, and tables that follow.

Table of Contents



Nursing Home Characteristics

Characteristics of Nursing Homes

- In 2001, about 16,600 nursing homes participated in the Medicare or Medicaid programs. The number of participating nursing homes continued to decline through 2001, having decreased by about 4% from its high in 1997 (17,253).

  Figure 1.2; Tables 1.1(a)-1.1(f), 1.2(a)-1.2(f), and 1.3(a)-1.3(f)

- The greatest decrease in the number of nursing homes occurred among homes with fewer than 50 beds. The number of nursing homes in this group declined by about 14% from 1996 to 2001. By contrast, the number of nursing homes with more than 100 beds has increased by about 1% during the same period.

  Figure 1.4; Tables 1.1 (a)-(f)

- California has the largest number of nursing homes in the United States (1,338), followed by Texas (1,167) and Ohio (995). Alaska has the fewest number of nursing homes (15). Alaska, Delaware, the District of Columbia, Hawaii, Nevada, Vermont, and Wyoming each had fewer than 50 nursing homes.

  Figure 1.3; Tables –1.1(f), 1.2(f), and 1.3(f)

Distribution and Accessibility

- In 2001, most facilities had 50 to 199 beds. Slightly more than 1,200 nursing homes had 200 beds or more. About 2,500 facilities had fewer than 50 beds.

  Figure 1.4, Table 1.1(f)

- The number of beds in Medicare- and Medicaid-certified nursing homes per 1,000 people age 65 and older varies greatly from one state to another. In 2001, this proportion ranged from 21.2 in Alaska to 79.7 in Iowa.

  Table 1.5

- Hawaii had the fewest number of beds in Medicare- and Medicaid-certified nursing homes per person age 85 years and older (229.1) in 2001, while Louisiana had the greatest number of beds (670.5)

  Table 1.5

- The highest "density" of nursing home beds exists in the upper Mississippi River and upper Ohio River states, and in New England.

- Average nursing home occupancy rates have declined slightly since 1996, although they increased from 83.9% in 2000 to 84.3% in 2001.

  Table 1. 4

Ownership

- In 2001, approximately 65 percent (10,802) of nursing homes were for-profit, and about 29 percent (4,762) were non-profit. Federal, State, county, and local government agencies controlled the remainder (1,064)

  Figure 1.5, Table 1.2(f)

- For-profit nursing homes represent 75% or more of the market in 10 states: California, Texas, Oklahoma, Arkansas, Alabama, Georgia, Utah, Connecticut, Rhode Island, and Louisiana. The 10 jurisdictions with the lowest proportion of for-profit nursing homes are: Alaska, North Dakota, Minnesota, the District of Columbia, South Dakota, Montana, Wyoming, Pennsylvania, Hawaii, and Delaware.

  Figure 1.9, Table 1.2(f)

- The number of for-profit nursing homes has declined by about 5%, or 530 facilities, in the past six years. Among the 10 states with the highest proportion of for-profit facilities, the decline was 6.3%.

  Figure 1.5, Tables 1.2(a)-1.2(f)

- The number of non-profit nursing homes has increased by about 1%, or 47 facilities, since 1996.

  Figure 1.5, Tables 1.2(a)-1.2(f)

- The number of government-owned nursing homes has decreased by about 6%, or 72 facilities, since 1996.

  Figures 1.5 and 1.9, Tables 1.2(a)-1.2(f)

- In 2001, the ten largest chains owned about 2,800 nursing homes, or about 17% of all participating nursing homes.

Certification

- Most certified nursing homes participate in both Medicare and Medicaid. In 2001, 1,063 (6 percent) of nursing homes were certified only to participate in Medicare and 1,933 (12 percent) participated only in Medicaid.

  Figure 1.6, Table 1.3(f)

- The proportion of nursing homes that participate in both Medicare and Medicaid increased from 74 percent in 1996 to 82 percent in 2001.

  Figure 1.6, Tables 1.3(a)-1.3(f)

- In the past six years, the number of nursing homes participating in Medicare only has declined by about 24%, or 329 facilities.

  Figure 1.6, Tables 1.3(a)-1.3(f)

- The number of Medicaid-only nursing homes has declined 35%, or by 1,016 facilities, in the past six years.

  Figure 1.6, Tables 1.3(a)-1.3(f)

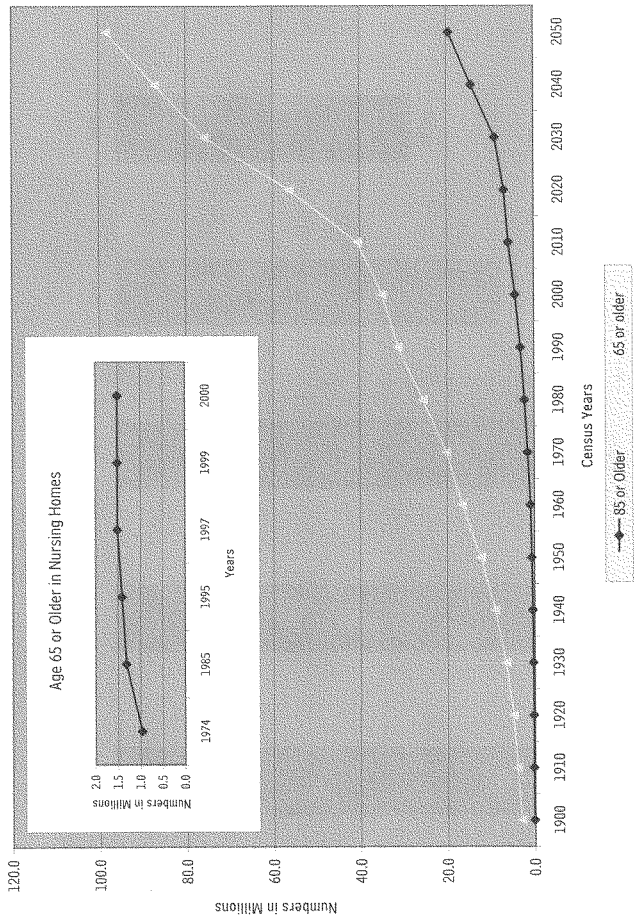
Technical Notes:

These data are from CMS's Online Survey Certification and Reporting (OSCAR) System, an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by survey teams.

The population data came from files developed by US Census Bureau staff, following specifications from WVMI. These files covered 1999 only. Thus, all ratios of beds-per-1000-people use 1999 population numbers.

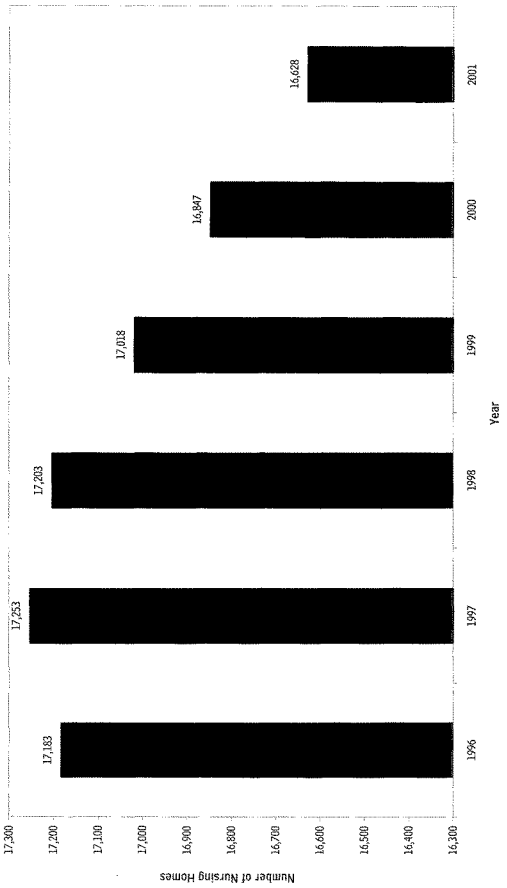
Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Figure 1.1. United States Aged Population with Out-year Projections: 1900 to 2050



Source: US Census

Figure 1.2. Number of Nursing Homes by Year: United States, 1996-2001



Source: OSCAR

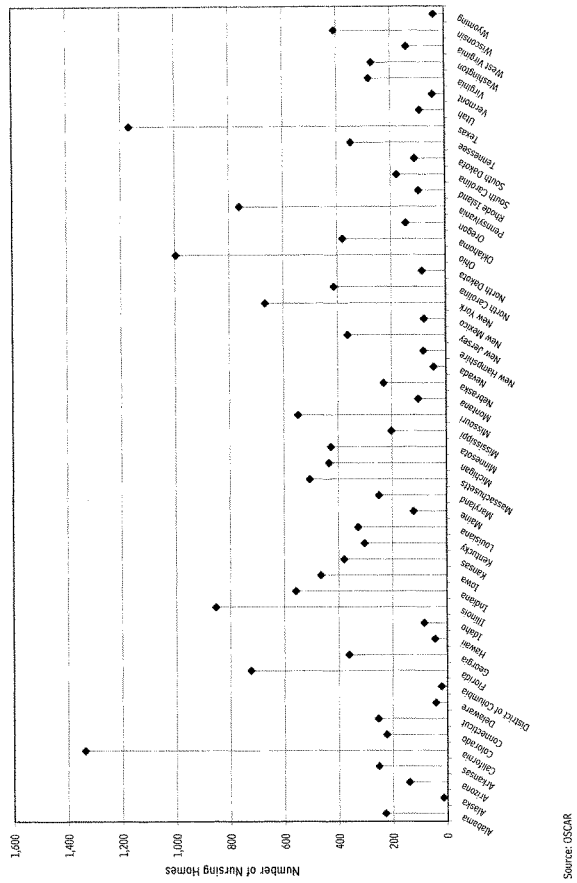
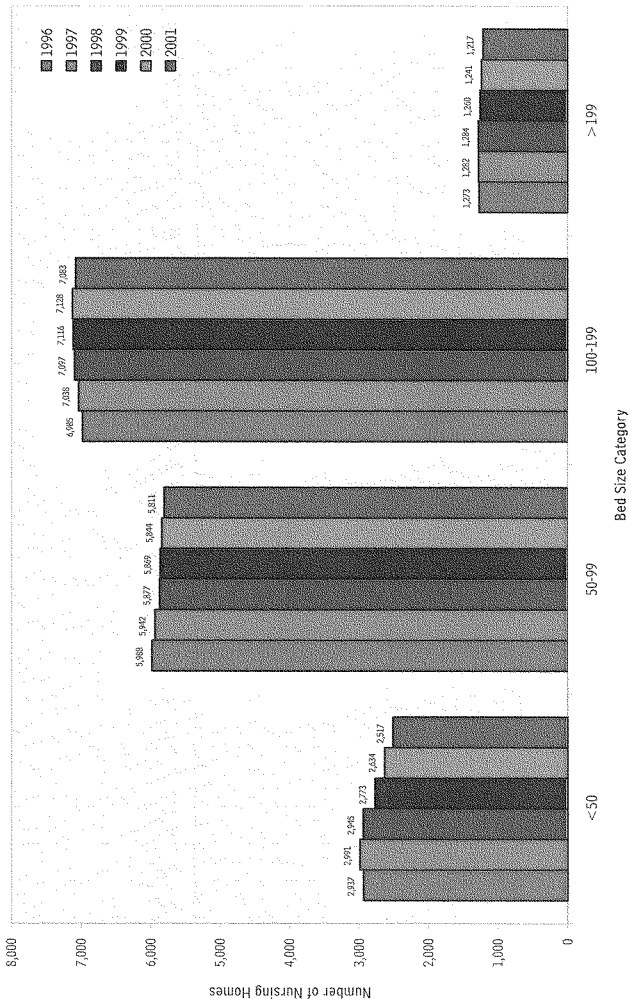


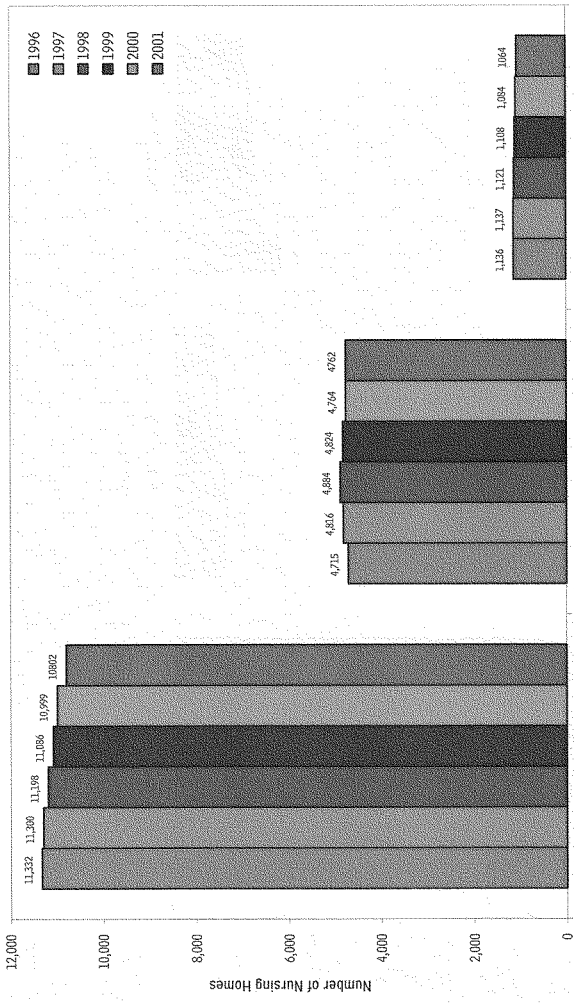
Figure 1.3. Number of Nursing Homes by State: United States, 2001

Figure 1.4. Number of Nursing Homes by Bed Size Category by Year: United States, 1996-2001



Source: OSCAR

Figure 1.5. Number of Nursing Homes by Ownership by Year: United States, 1996-2001



Source: OSCAR

Figure 1.6. Number of Nursing Homes by Certification by Year: United States, 1996-2001

Source: OSCAR

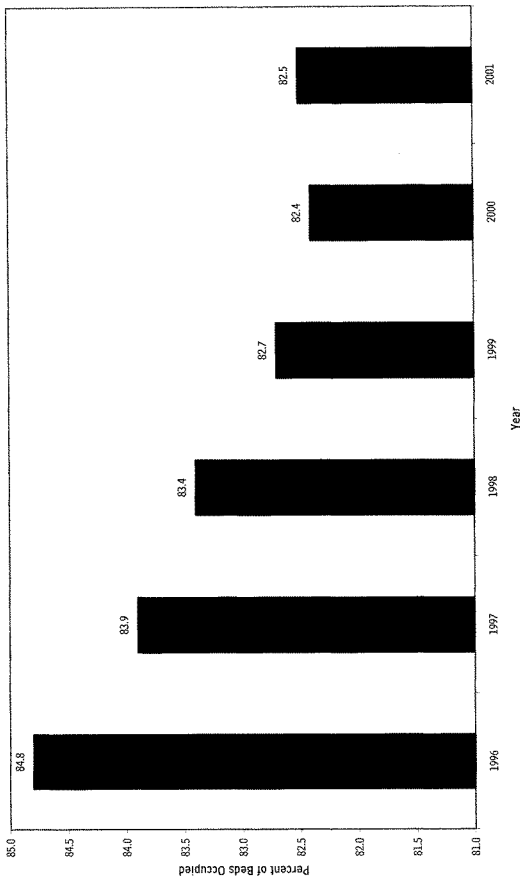
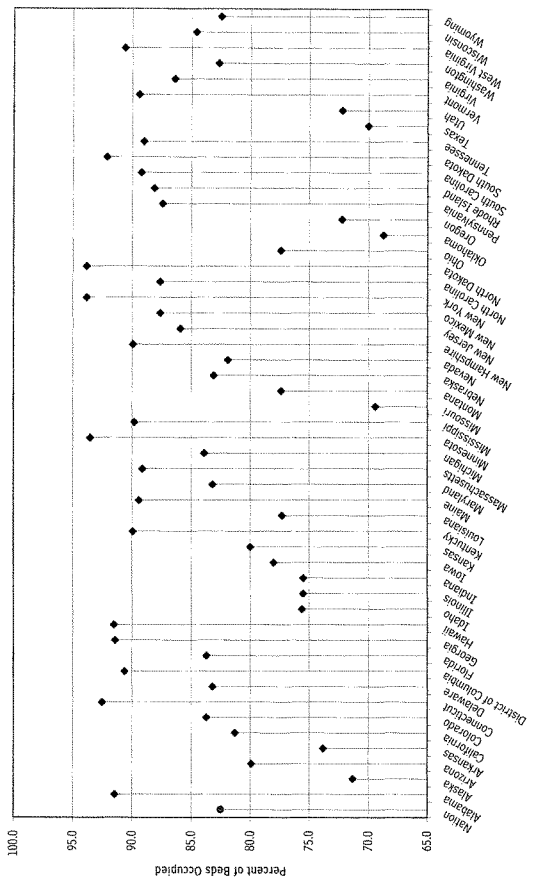


Figure 1.7. Nursing Home Occupancy Rates by Year: United States, 1996-2001

Source: OSCAR

Figure 1.8. Nursing Home Occupancy Rates by State: United States, 2001



Source: OSCAR

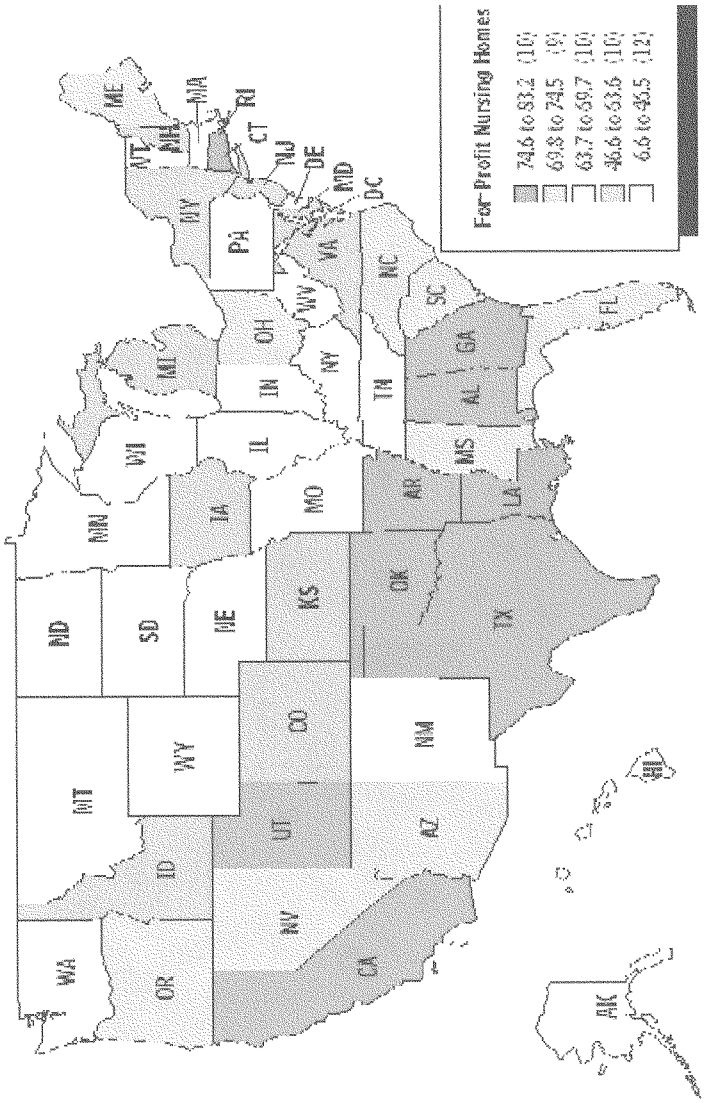
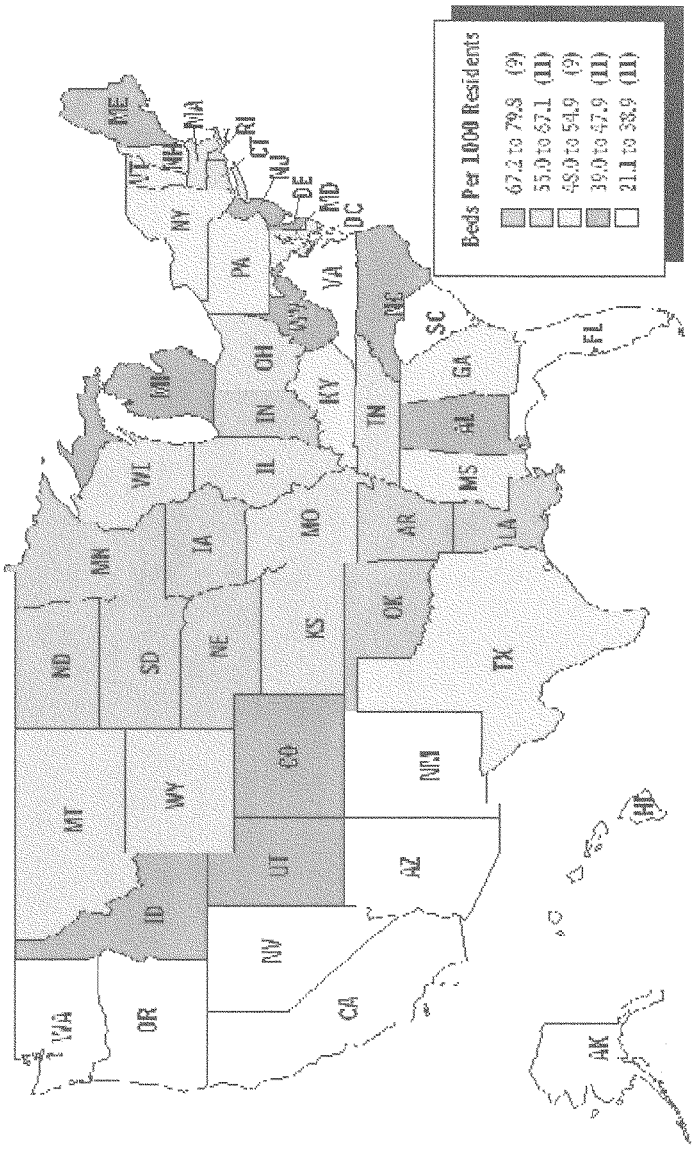
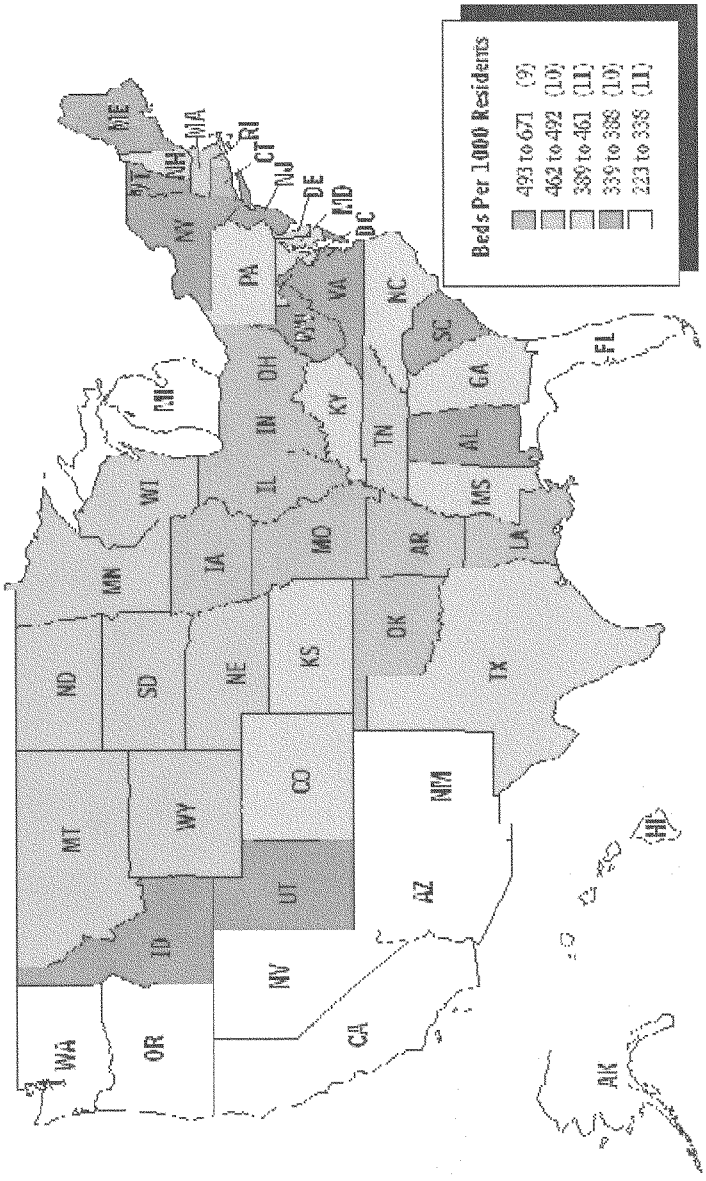

For-Profit Nursing Homes
74.6 to 93.2 (10)
69.8 to 74.5 (9)
63.7 to 69.7 (10)
46.6 to 63.6 (10)
6.6 to 45.5 (12)
ME
VT
NH
MA
RI
CT
NJ
DE
MD
DC
NY
PA
VA
NC
SC
GA
FL
AL
MS
LA
TX
AR
TN
KY
WV
OH
MI
IN
IL
WI
MN
IA
MO
KS
OK
NE
SD
ND
CO
NM
WY
MT
UT
AZ
ID
NV
CA
OR
WA
AK
HI
Source: OSCAR

Figure 1.10. Number of Certified Nursing Home Beds per Thousand Residents Aged 65 Years and Older by State: United States, 2001



Source: MDS and OSCAR

Figure 1.11. Number of Certified Nursing Home Beds per Thousand Residents Aged 85 Years and Older by State: United States, 2001



SOURCE: MDS/OSCAR

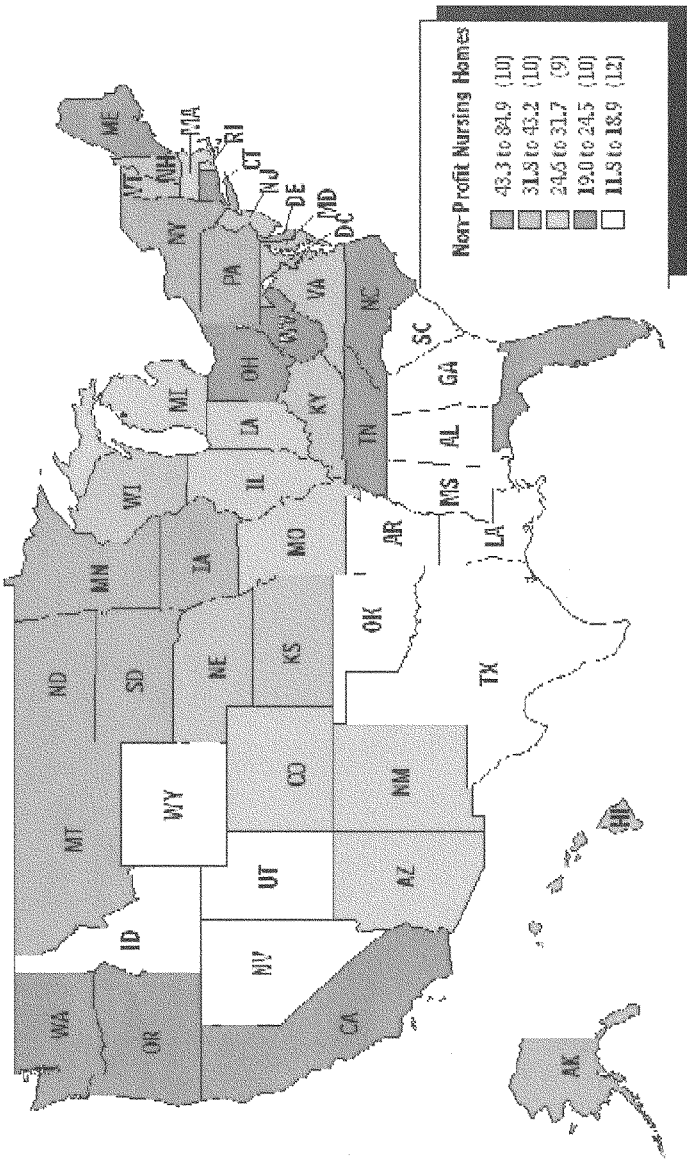


Figure 1.12. Percent of Nursing Homes that are Non-Profit by State: United States, 2001

SOURCE:MDS

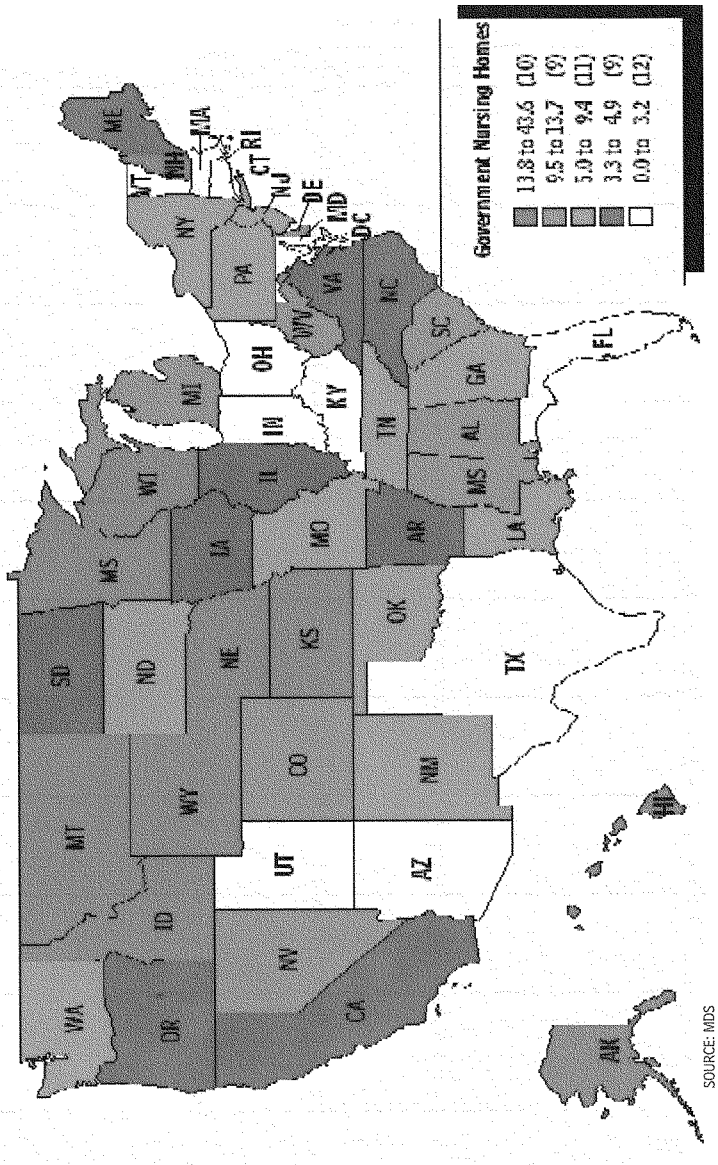


Figure 1.13. Percent of Nursing Homes that are Government Owned by State: United States, 2001

Table 1.1 (a). Number of Nursing Homes by Bed Size Category and State: United States, 1996

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2937**	**5988**	**6985**	**1273**	**17183**
Alabama	20	84	110	9	223
Alaska	12	3	0	1	16
Arizona	33	31	79	15	158
Arkansas	31	104	126	6	267
California	313	710	323	69	1415
Colorado	54	73	87	8	222
Connecticut	18	78	142	24	262
Delaware	5	12	25	1	43
District of Columbia	4	7	5	6	22
Florida	85	150	427	38	700
Georgia	26	116	192	23	357
Hawaii	15	12	12	4	43
Idaho	30	27	22	1	80
Illinois	110	279	328	144	861
Indiana	128	171	221	56	576
Iowa	78	275	109	11	473
Kansas	109	241	75	4	429
Kentucky	85	121	100	6	312
Louisiana	58	65	199	23	345
Maine	41	68	24	3	136
Maryland	42	50	122	34	248
Massachusetts	119	147	279	22	567
Michigan	45	135	223	40	443
Minnesota	55	215	158	28	456
Mississippi	47	78	73	5	203
Missouri	90	227	230	27	574
Montana	43	37	22	2	104
Nebraska	53	128	52	5	238
Nevada	15	8	16	4	43
New Hampshire	12	34	29	6	81
New Jersey	34	52	186	60	332
New Mexico	19	33	32	2	86
New York	51	119	267	222	659
North Carolina	48	149	192	11	400
North Dakota	21	41	24	2	88
Ohio	166	280	492	83	1021
Oklahoma	70	204	149	6	429
Oregon	34	71	57	2	164
Pennsylvania	148	164	373	92	777
Rhode Island	16	33	40	7	96
South Carolina	37	66	65	5	173
South Dakota	24	73	16	1	114
Tennessee	53	96	169	21	339
Texas	240	417	606	48	1311
Utah	28	34	32	1	95
Vermont	12	15	18	0	45
Virginia	42	87	125	22	276
Washington	45	113	119	10	287
West Virginia	28	58	49	2	137
Wisconsin	37	179	153	50	419
Wyoming	8	18	11	1	38

Source: OSCAR

Table 1.1 (b). Number of Nursing Homes by Bed Size Category and State: United States, 1997

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2991**	**5942**	**7038**	**1282**	**17253**
Alabama	15	86	111	11	223
Alaska	11	3	0	1	15
Arizona	30	36	82	16	164
Arkansas	34	99	125	6	264
California	320	708	327	68	1423
Colorado	55	73	90	7	225
Connecticut	15	76	144	25	260
Delaware	5	11	27	1	44
District of Columbia	5	6	5	6	22
Florida	99	147	442	38	726
Georgia	23	114	193	25	355
Hawaii	15	12	12	4	43
Idaho	33	24	28	0	85
Illinois	115	275	334	147	871
Indiana	128	168	222	57	575
Iowa	74	278	111	9	472
Kansas	111	231	70	4	416
Kentucky	84	122	104	6	316
Louisiana	57	67	195	23	342
Maine	45	67	20	3	135
Maryland	46	50	125	34	255
Massachusetts	109	148	287	22	566
Michigan	47	132	226	39	444
Minnesota	53	217	153	27	450
Mississippi	46	77	75	5	203
Missouri	90	222	235	27	574
Montana	41	34	26	2	103
Nebraska	57	126	49	5	237
Nevada	20	8	16	3	47
New Hampshire	12	35	29	6	82
New Jersey	35	56	189	60	340
New Mexico	18	32	33	2	85
New York	49	115	263	230	657
North Carolina	51	149	192	11	403
North Dakota	23	39	24	2	88
Ohio	162	274	499	83	1018
Oklahoma	71	195	141	6	413
Oregon	34	70	56	2	162
Pennsylvania	169	162	374	94	799
Rhode Island	19	33	42	6	100
South Carolina	39	63	68	6	176
South Dakota	26	72	15	1	114
Tennessee	56	96	176	21	349
Texas	238	422	601	46	1307
Utah	28	34	31	2	95
Vermont	12	15	18	0	45
Virginia	41	92	122	22	277
Washington	45	112	118	10	285
West Virginia	29	59	49	2	139
Wisconsin	41	183	153	48	425
Wyoming	10	17	11	1	39

Source: OSCAR

Table 1.1 (c). Number of Nursing Homes by Bed Size Category and State: United States, 1998

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2945**	**5877**	**7097**	**1284**	**17203**
Alabama	12	86	113	11	222
Alaska	11	3	0	1	15
Arizona	32	35	84	16	167
Arkansas	32	98	129	5	264
California	307	710	331	65	1413
Colorado	54	76	90	7	227
Connecticut	13	74	147	24	258
Delaware	4	11	28	1	44
District of Columbia	3	6	5	6	20
Florida	105	139	452	39	735
Georgia	27	113	194	25	359
Hawaii	16	12	12	4	44
Idaho	30	26	28	0	84
Illinois	118	276	332	152	878
Indiana	128	165	219	58	570
Iowa	74	280	108	9	471
Kansas	109	224	67	5	405
Kentucky	84	119	105	6	314
Louisiana	53	64	200	23	340
Maine	43	62	21	3	129
Maryland	50	48	125	33	256
Massachusetts	106	149	284	22	561
Michigan	49	131	228	39	447
Minnesota	52	212	153	29	446
Mississippi	42	75	76	5	198
Missouri	92	209	236	26	563
Montana	43	33	27	2	105
Nebraska	59	125	51	4	239
Nevada	19	8	18	3	48
New Hampshire	15	35	29	5	84
New Jersey	46	60	192	60	358
New Mexico	14	32	33	2	81
New York	49	114	264	234	661
North Carolina	50	143	200	12	405
North Dakota	25	38	23	2	88
Ohio	152	283	499	80	1014
Oklahoma	67	195	139	8	409
Oregon	34	67	57	2	160
Pennsylvania	167	165	375	92	799
Rhode Island	19	34	42	6	101
South Carolina	35	60	72	6	173
South Dakota	25	73	15	1	114
Tennessee	58	94	178	22	352
Texas	213	412	608	47	1280
Utah	27	33	31	2	93
Vermont	12	14	18	0	44
Virginia	39	89	129	19	276
Washington	49	112	114	9	284
West Virginia	31	60	50	2	143
Wisconsin	40	179	154	49	422
Wyoming	11	16	12	1	40

Source: OSCAR

Table 1.1 (d). Number of Nursing Homes by Bed Size Category and State: United States, 1999

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2773**	**5869**	**7116**	**1260**	**17018**
Alabama	14	85	115	11	225
Alaska	11	3	0	1	15
Arizona	24	31	85	16	156
Arkansas	31	93	130	5	259
California	281	706	330	67	1384
Colorado	52	81	87	7	227
Connecticut	13	75	146	23	257
Delaware	4	9	29	1	43
District of Columbia	2	7	5	6	20
Florida	96	135	472	36	739
Georgia	27	113	198	25	363
Hawaii	17	12	12	3	44
Idaho	29	26	27	0	82
Illinois	113	277	332	157	879
Indiana	128	184	218	39	569
Iowa	78	279	105	8	470
Kansas	109	214	69	6	398
Kentucky	77	118	107	6	308
Louisiana	47	68	200	24	339
Maine	44	63	16	3	126
Maryland	49	51	120	30	250
Massachusetts	95	137	285	22	539
Michigan	46	128	226	38	438
Minnesota	53	217	145	29	444
Mississippi	35	77	77	5	194
Missouri	82	216	233	26	557
Montana	42	34	26	2	104
Nebraska	58	125	51	3	237
Nevada	14	12	21	5	52
New Hampshire	14	35	29	5	83
New Jersey	47	60	197	59	363
New Mexico	15	32	33	2	82
New York	46	114	266	234	660
North Carolina	47	142	205	13	407
North Dakota	26	39	22	2	89
Ohio	144	279	506	77	1006
Oklahoma	65	194	139	8	406
Oregon	25	68	56	2	151
Pennsylvania	148	168	373	94	783
Rhode Island	19	34	42	6	101
South Carolina	38	59	74	6	177
South Dakota	30	68	15	1	114
Tennessee	52	96	179	22	349
Texas	177	408	609	45	1239
Utah	27	31	32	2	92
Vermont	14	13	18	0	45
Virginia	37	89	127	19	272
Washington	48	108	114	8	278
West Virginia	29	57	50	1	137
Wisconsin	42	183	151	49	425
Wyoming	12	16	12	1	41

Source: OSCAR

Table 1.1 (e). Number of Nursing Homes by Bed Size Category and State: United States, 2000

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2634**	**5844**	**7128**	**1241**	**16847**
Alabama	15	84	116	11	226
Alaska	10	4	n/a	1	15
Arizona	17	27	86	15	145
Arkansas	26	93	131	5	255
California	268	699	331	65	1363
Colorado	50	81	88	6	225
Connecticut	14	76	147	22	259
Delaware	4	10	28	1	43
District of Columbia	3	7	5	6	21
Florida	83	134	475	36	728
Georgia	26	113	198	25	362
Hawaii	17	11	14	3	45
Idaho	30	27	27	n/a	84
Illinois	104	277	330	154	865
Indiana	117	187	223	39	566
Iowa	86	271	103	7	467
Kansas	110	209	66	6	391
Kentucky	70	120	109	6	305
Louisiana	46	65	202	22	335
Maine	46	61	17	2	126
Maryland	45	50	125	33	253
Massachusetts	91	133	279	22	525
Michigan	46	131	225	35	437
Minnesota	61	215	130	26	432
Mississippi	30	79	78	5	192
Missouri	74	221	230	27	552
Montana	42	34	26	2	104
Nebraska	62	125	45	4	236
Nevada	13	12	21	5	51
New Hampshire	14	35	29	5	83
New Jersey	37	61	203	61	362
New Mexico	13	32	33	2	80
New York	48	110	269	237	664
North Carolina	49	142	211	13	415
North Dakota	25	39	22	2	88
Ohio	137	288	505	75	1005
Oklahoma	54	186	140	8	388
Oregon	22	70	54	2	148
Pennsylvania	135	170	373	89	767
Rhode Island	19	32	42	6	99
South Carolina	39	58	75	6	178
South Dakota	35	65	14	n/a	114
Tennessee	54	94	183	20	351
Texas	145	402	616	44	1207
Utah	25	32	34	2	93
Vermont	12	13	18	n/a	43
Virginia	37	91	130	20	278
Washington	50	109	110	8	277
West Virginia	28	59	50	1	138
Wisconsin	39	184	150	48	421
Wyoming	11	16	12	1	40

Source: OSCAR

n/a: Data unavailable

Table 1.1 (f). Number of Nursing Homes by Bed Size Category and State: United States, 2001

	Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2517**	**5811**	**7083**	**1217**	**16628**
Alabama	13	83	119	13	228
Alaska	9	5	0	1	15
Arizona	14	28	83	15	140
Arkansas	24	95	129	4	252
California	255	687	335	61	1338
Colorado	48	82	87	6	223
Connecticut	13	75	145	21	254
Delaware	4	11	26	1	42
District of Columbia	2	7	6	6	21
Florida	74	136	476	39	725
Georgia	25	116	196	25	362
Hawaii	16	12	14	3	45
Idaho	29	26	29	0	84
Illinois	102	272	332	148	854
Indiana	109	194	223	33	559
Iowa	86	271	100	9	466
Kansas	106	206	61	6	379
Kentucky	68	120	109	6	303
Louisiana	39	63	204	21	327
Maine	44	62	14	2	122
Maryland	46	50	122	31	249
Massachusetts	81	128	276	21	506
Michigan	45	133	220	36	434
Minnesota	62	210	132	23	427
Mississippi	29	89	81	3	202
Missouri	65	224	232	27	548
Montana	42	33	26	2	103
Nebraska	67	116	43	4	230
Nevada	13	9	19	5	46
New Hampshire	13	36	29	5	83
New Jersey	39	59	201	63	362
New Mexico	14	31	33	2	80
New York	48	111	270	239	668
North Carolina	45	141	211	16	413
North Dakota	26	37	21	2	86
Ohio	132	300	487	76	995
Oklahoma	54	179	140	6	379
Oregon	23	67	53	2	145
Pennsylvania	130	169	374	88	761
Rhode Island	18	32	41	6	97
South Carolina	38	58	74	7	177
South Dakota	36	62	14	0	112
Tennessee	50	94	184	19	347
Texas	123	392	611	41	1167
Utah	25	30	35	2	92
Vermont	14	13	17	0	44
Virginia	35	90	135	20	280
Washington	47	108	107	7	269
West Virginia	28	62	49	1	140
Wisconsin	38	182	145	43	408
Wyoming	11	15	13	0	39

Source: OSCAR

Table 1.2 (a). Number of Nursing Homes by Ownership and State: United States, 1996

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**11332**	**4715**	**1136**	**17183**
Alabama	172	28	23	223
Alaska	1	9	6	16
Arizona	100	54	4	158
Arkansas	215	39	13	267
California	1047	306	62	1415
Colorado	139	62	21	222
Connecticut	205	55	2	262
Delaware	21	18	4	43
District of Columbia	7	13	2	22
Florida	538	146	16	700
Georgia	269	64	24	357
Hawaii	18	14	11	43
Idaho	48	13	19	80
Illinois	554	258	49	861
Indiana	434	127	15	576
Iowa	256	192	25	473
Kansas	229	144	56	429
Kentucky	204	97	11	312
Louisiana	256	62	27	345
Maine	99	32	5	136
Maryland	149	92	7	248
Massachusetts	420	132	15	567
Michigan	277	123	43	443
Minnesota	152	238	66	456
Mississippi	139	29	35	203
Missouri	374	149	51	574
Montana	40	44	20	104
Nebraska	108	77	53	238
Nevada	32	6	5	43
New Hampshire	42	26	13	81
New Jersey	210	100	22	332
New Mexico	50	28	8	86
New York	316	286	57	659
North Carolina	296	87	17	400
North Dakota	10	76	2	88
Ohio	750	236	35	1021
Oklahoma	349	58	22	429
Oregon	124	34	6	164
Pennsylvania	332	398	47	777
Rhode Island	75	21	0	96
South Carolina	125	29	19	173
South Dakota	39	70	5	114
Tennessee	237	75	27	339
Texas	1080	199	32	1311
Utah	75	15	5	95
Vermont	34	10	1	45
Virginia	172	88	16	276
Washington	201	64	22	287
West Virginia	89	33	15	137
Wisconsin	205	153	61	419
Wyoming	18	6	14	38

Source: OSCAR

Table 1.2 (b). Number of Nursing Homes by Ownership and State: United States, 1997

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**11300**	**4816**	**1137**	**17253**
Alabama	171	30	22	223
Alaska	1	9	5	15
Arizona	102	58	4	164
Arkansas	209	42	13	264
California	1055	305	63	1423
Colorado	141	62	22	225
Connecticut	203	55	2	260
Delaware	20	20	4	44
District of Columbia	7	13	2	22
Florida	555	155	16	726
Georgia	271	61	23	355
Hawaii	18	14	11	43
Idaho	51	14	20	85
Illinois	556	267	48	871
Indiana	428	131	16	575
Iowa	256	192	24	472
Kansas	217	143	56	416
Kentucky	207	99	10	316
Louisiana	254	62	26	342
Maine	98	32	5	135
Maryland	147	100	8	255
Massachusetts	409	142	15	566
Michigan	280	121	43	444
Minnesota	146	240	64	450
Mississippi	137	35	31	203
Missouri	374	150	50	574
Montana	37	46	20	103
Nebraska	107	76	54	237
Nevada	35	4	8	47
New Hampshire	43	26	13	82
New Jersey	219	102	19	340
New Mexico	50	28	7	85
New York	316	284	57	657
North Carolina	296	89	18	403
North Dakota	10	76	2	88
Ohio	745	241	32	1018
Oklahoma	334	54	25	413
Oregon	123	33	6	162
Pennsylvania	324	429	46	799
Rhode Island	76	24	0	100
South Carolina	133	22	21	176
South Dakota	41	68	5	114
Tennessee	241	78	30	349
Texas	1061	206	40	1307
Utah	76	15	4	95
Vermont	34	10	1	45
Virginia	174	89	14	277
Washington	197	66	22	285
West Virginia	90	35	14	139
Wisconsin	207	157	61	425
Wyoming	18	6	15	39

Source: OSCAR

Table 1.2 (c). Number of Nursing Homes by Ownership and State: United States, 1998

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**11198**	**4884**	**1121**	**17203**
Alabama	170	30	22	222
Alaska	1	9	5	15
Arizona	105	57	5	167
Arkansas	209	42	13	264
California	1049	307	57	1413
Colorado	143	61	23	227
Connecticut	200	56	2	258
Delaware	20	20	4	44
District of Columbia	7	11	2	20
Florida	564	156	15	735
Georgia	272	63	24	359
Hawaii	19	14	11	44
Idaho	51	14	19	84
Illinois	560	271	47	878
Indiana	418	135	17	570
Iowa	250	197	24	471
Kansas	209	139	57	405
Kentucky	203	101	10	314
Louisiana	250	64	26	340
Maine	92	32	5	129
Maryland	149	99	8	256
Massachusetts	396	151	14	561
Michigan	282	122	43	447
Minnesota	142	247	57	446
Mississippi	138	31	29	198
Missouri	371	142	50	563
Montana	37	48	20	105
Nebraska	106	81	52	239
Nevada	36	4	8	48
New Hampshire	44	27	13	84
New Jersey	219	120	19	358
New Mexico	48	26	7	81
New York	317	287	57	661
North Carolina	298	91	16	405
North Dakota	10	76	2	88
Ohio	739	242	33	1014
Oklahoma	328	57	24	409
Oregon	118	36	6	160
Pennsylvania	327	429	43	799
Rhode Island	76	25	0	101
South Carolina	128	24	21	173
South Dakota	41	67	6	114
Tennessee	237	81	34	352
Texas	1029	210	41	1280
Utah	72	17	4	93
Vermont	31	12	1	44
Virginia	176	89	11	276
Washington	195	67	22	284
West Virginia	93	36	14	143
Wisconsin	205	155	62	422
Wyoming	18	6	16	40

Source: OSCAR

Table 1.2 (d). Number of Nursing Homes by Ownership and State: United States, 1999

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**11086**	**4824**	**1108**	**17018**
Alabama	171	32	22	225
Alaska	1	9	5	15
Arizona	102	50	4	156
Arkansas	202	43	14	259
California	1036	293	55	1384
Colorado	146	58	23	227
Connecticut	197	58	2	257
Delaware	19	20	4	43
District of Columbia	6	12	2	20
Florida	565	160	14	739
Georgia	276	63	24	363
Hawaii	19	14	11	44
Idaho	51	13	18	82
Illinois	570	264	45	879
Indiana	418	136	15	569
Iowa	245	201	24	470
Kansas	201	142	55	398
Kentucky	198	100	10	308
Louisiana	253	63	23	339
Maine	90	31	5	126
Maryland	141	100	9	250
Massachusetts	383	142	14	539
Michigan	273	122	43	438
Minnesota	130	254	60	444
Mississippi	139	28	27	194
Missouri	367	138	52	557
Montana	36	48	20	104
Nebraska	106	79	52	237
Nevada	37	8	7	52
New Hampshire	44	27	12	83
New Jersey	223	121	19	363
New Mexico	49	27	6	82
New York	315	290	55	660
North Carolina	298	92	17	407
North Dakota	11	74	4	89
Ohio	732	241	33	1006
Oklahoma	329	55	22	406
Oregon	113	32	6	151
Pennsylvania	327	412	44	783
Rhode Island	76	25	0	101
South Carolina	130	24	23	177
South Dakota	42	66	6	114
Tennessee	236	78	35	349
Texas	1003	197	39	1239
Utah	70	18	4	92
Vermont	31	13	1	45
Virginia	173	90	9	272
Washington	190	65	23	278
West Virginia	91	34	12	137
Wisconsin	207	156	62	425
Wyoming	18	6	17	41

Source: OSCAR

Table 1.2 (e). Number of Nursing Homes by Ownership and State: United States, 2000

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**10999**	**4764**	**1084**	**16847**
Alabama	174	30	22	226
Alaska	1	9	5	15
Arizona	102	40	3	145
Arkansas	203	40	12	255
California	1028	281	54	1363
Colorado	144	59	22	225
Connecticut	198	59	2	259
Delaware	19	20	4	43
District of Columbia	6	13	2	21
Florida	554	161	13	728
Georgia	273	62	27	362
Hawaii	20	15	10	45
Idaho	50	14	20	84
Illinois	566	256	43	865
Indiana	408	141	17	566
Iowa	246	201	20	467
Kansas	194	142	55	391
Kentucky	199	97	9	305
Louisiana	257	57	21	335
Maine	90	31	5	126
Maryland	143	101	9	253
Massachusetts	370	141	14	525
Michigan	274	120	43	437
Minnesota	123	251	58	432
Mississippi	140	29	23	192
Missouri	354	147	51	552
Montana	37	48	19	104
Nebraska	106	79	51	236
Nevada	37	8	6	51
New Hampshire	44	27	12	83
New Jersey	225	117	20	362
New Mexico	49	25	6	80
New York	319	290	55	664
North Carolina	304	93	18	415
North Dakota	11	74	3	88
Ohio	732	239	34	1005
Oklahoma	322	45	21	388
Oregon	110	32	6	148
Pennsylvania	329	396	42	767
Rhode Island	75	24	0	99
South Carolina	131	25	22	178
South Dakota	41	67	6	114
Tennessee	238	82	31	351
Texas	979	191	37	1207
Utah	72	17	4	93
Vermont	29	13	1	43
Virginia	176	92	10	278
Washington	190	64	23	277
West Virginia	90	34	14	138
Wisconsin	199	159	63	421
Wyoming	18	6	16	40

Source: OSCAR

Table 1.2 (f). Number of Nursing Homes by Ownership and State: United States, 2001

	Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**10802**	**4762**	**1064**	**16628**
Alabama	176	29	23	228
Alaska	1	9	5	15
Arizona	98	40	2	140
Arkansas	201	39	12	252
California	1010	276	52	1338
Colorado	142	59	22	223
Connecticut	194	58	2	254
Delaware	19	19	4	42
District of Columbia	6	13	2	21
Florida	540	170	15	725
Georgia	273	61	28	362
Hawaii	20	15	10	45
Idaho	50	14	20	84
Illinois	562	250	42	854
Indiana	382	161	16	559
Iowa	243	202	21	466
Kansas	187	138	54	379
Kentucky	197	99	7	303
Louisiana	244	62	21	327
Maine	87	30	5	122
Maryland	141	100	8	249
Massachusetts	353	142	11	506
Michigan	272	119	43	434
Minnesota	118	250	59	427
Mississippi	145	31	26	202
Missouri	351	157	40	548
Montana	37	47	19	103
Nebraska	106	74	50	230
Nevada	33	7	6	46
New Hampshire	44	27	12	83
New Jersey	225	117	20	362
New Mexico	51	23	6	80
New York	322	294	52	668
North Carolina	299	95	19	413
North Dakota	9	73	4	86
Ohio	725	241	29	995
Oklahoma	315	45	19	379
Oregon	106	33	6	145
Pennsylvania	334	386	41	761
Rhode Island	73	24	0	97
South Carolina	128	26	23	177
South Dakota	37	69	6	112
Tennessee	236	80	31	347
Texas	948	182	37	1167
Utah	73	16	3	92
Vermont	29	14	1	44
Virginia	177	92	11	280
Washington	185	60	24	269
West Virginia	91	34	15	140
Wisconsin	190	155	63	408
Wyoming	17	5	17	39

Source: OSCAR

Table 1.3 (a). Number of Nursing Homes by Type of Certification and State: United States, 1996

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**12797**	**1392**	**2994**	**17183**
Alabama	206	12	5	223
Alaska	16	0	0	16
Arizona	132	24	2	158
Arkansas	164	29	74	267
California	1,163	130	122	1,415
Colorado	164	35	23	222
Connecticut	242	7	13	262
Delaware	33	4	6	43
District of Columbia	20	0	2	22
Florida	608	82	10	700
Georgia	290	12	55	357
Hawaii	36	1	6	43
Idaho	72	8	0	80
Illinois	511	89	261	861
Indiana	433	47	96	576
Iowa	195	8	270	473
Kansas	235	34	160	429
Kentucky	281	31	0	312
Louisiana	121	59	165	345
Maine	129	7	0	136
Maryland	210	12	26	248
Massachusetts	497	12	58	567
Michigan	365	11	67	443
Minnesota	424	10	22	456
Mississippi	107	33	63	203
Missouri	401	55	118	574
Montana	97	4	3	104
Nebraska	141	4	93	238
Nevada	34	7	2	43
New Hampshire	54	0	27	81
New Jersey	243	19	70	332
New Mexico	66	8	12	86
New York	655	1	3	659
North Carolina	386	10	4	400
North Dakota	84	4	0	88
Ohio	730	82	209	1,021
Oklahoma	149	39	241	429
Oregon	125	3	36	164
Pennsylvania	628	119	30	777
Rhode Island	96	0	0	96
South Carolina	149	23	1	173
South Dakota	72	1	41	114
Tennessee	218	40	81	339
Texas	804	223	284	1,311
Utah	67	12	16	95
Vermont	40	0	5	45
Virginia	201	9	66	276
Washington	265	9	13	287
West Virginia	81	14	42	137
Wisconsin	326	7	86	419
Wyoming	31	2	5	38

Source: OSCAR

Table 1.3 (b). Number of Nursing Homes by Type of Certification and State: United States, 1997

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**13339**	**1478**	**2436**	**17253**
Alabama	207	11	5	223
Alaska	14	1	0	15
Arizona	135	27	2	164
Arkansas	166	32	66	264
California	1,174	136	113	1,423
Colorado	170	33	22	225
Connecticut	244	6	10	260
Delaware	34	6	4	44
District of Columbia	22	0	0	22
Florida	634	84	8	726
Georgia	304	12	39	355
Hawaii	37	1	5	43
Idaho	77	8	0	85
Illinois	548	92	231	871
Indiana	452	53	70	575
Iowa	256	12	204	472
Kansas	246	32	138	416
Kentucky	284	32	0	316
Louisiana	173	59	110	342
Maine	130	5	0	135
Maryland	221	13	21	255
Massachusetts	507	13	46	566
Michigan	373	11	60	444
Minnesota	420	8	22	450
Mississippi	116	36	51	203
Missouri	421	58	95	574
Montana	95	6	2	103
Nebraska	151	4	82	237
Nevada	35	10	2	47
New Hampshire	62	2	18	82
New Jersey	259	20	61	340
New Mexico	66	8	11	85
New York	655	0	2	657
North Carolina	390	9	4	403
North Dakota	84	4	0	88
Ohio	777	81	160	1,018
Oklahoma	181	38	194	413
Oregon	127	2	33	162
Pennsylvania	635	138	26	799
Rhode Island	100	0	0	100
South Carolina	148	28	0	176
South Dakota	84	1	29	114
Tennessee	222	49	78	349
Texas	855	237	215	1,307
Utah	69	12	14	95
Vermont	40	0	5	45
Virginia	205	10	62	277
Washington	267	7	11	285
West Virginia	87	16	36	139
Wisconsin	349	13	63	425
Wyoming	31	2	6	39

Source: OSCAR

Table 1.3 (c). Number of Nursing Homes by Type of Certification and State: United States, 1998

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**13536**	**1428**	**2239**	**17203**
Alabama	206	11	5	222
Alaska	15	0	0	15
Arizona	140	26	1	167
Arkansas	165	30	69	264
California	1,181	125	107	1,413
Colorado	173	31	23	227
Connecticut	243	6	9	258
Delaware	34	6	4	44
District of Columbia	20	0	0	20
Florida	644	84	7	735
Georgia	309	13	37	359
Hawaii	39	1	4	44
Idaho	74	10	0	84
Illinois	562	90	226	878
Indiana	451	54	65	570
Iowa	271	9	191	471
Kansas	241	29	135	405
Kentucky	279	35	0	314
Louisiana	159	54	127	340
Maine	125	4	0	129
Maryland	226	11	19	256
Massachusetts	511	15	35	561
Michigan	377	13	57	447
Minnesota	417	7	22	446
Mississippi	110	33	55	198
Missouri	423	53	87	563
Montana	96	6	3	105
Nebraska	169	4	66	239
Nevada	36	10	2	48
New Hampshire	63	3	18	84
New Jersey	318	38	2	358
New Mexico	66	5	10	81
New York	658	0	3	661
North Carolina	391	10	4	405
North Dakota	84	4	0	88
Ohio	796	74	144	1,014
Oklahoma	215	34	160	409
Oregon	128	2	30	160
Pennsylvania	640	138	21	799
Rhode Island	100	1	0	101
South Carolina	150	23	0	173
South Dakota	88	1	25	114
Tennessee	227	51	74	352
Texas	862	205	213	1,280
Utah	68	11	14	93
Vermont	38	3	3	44
Virginia	210	11	55	276
Washington	264	9	11	284
West Virginia	93	19	31	143
Wisconsin	350	13	59	422
Wyoming	31	3	6	40

Source: OSCAR

Table 1.3 (d). Number of Nursing Homes by Type of Certification and State: United States, 1999

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**13533**	**1305**	**2180**	**17018**
Alabama	212	8	5	225
Alaska	15	0	0	15
Arizona	133	22	1	156
Arkansas	163	29	67	259
California	1,164	115	105	1,384
Colorado	173	31	23	227
Connecticut	242	6	9	257
Delaware	33	5	5	43
District of Columbia	19	0	1	20
Florida	652	78	9	739
Georgia	313	12	38	363
Hawaii	40	1	3	44
Idaho	73	9	0	82
Illinois	572	89	218	879
Indiana	455	50	64	569
Iowa	283	10	177	470
Kansas	239	28	131	398
Kentucky	277	31	0	308
Louisiana	158	49	132	339
Maine	124	2	0	126
Maryland	222	11	17	250
Massachusetts	500	15	24	539
Michigan	372	14	52	438
Minnesota	414	8	22	444
Mississippi	110	25	59	194
Missouri	412	47	98	557
Montana	96	5	3	104
Nebraska	167	3	67	237
Nevada	43	7	2	52
New Hampshire	64	2	17	83
New Jersey	324	38	1	363
New Mexico	65	6	11	82
New York	657	0	3	660
North Carolina	393	10	4	407
North Dakota	85	4	0	89
Ohio	814	67	125	1,006
Oklahoma	213	34	159	406
Oregon	121	4	26	151
Pennsylvania	640	122	21	783
Rhode Island	100	1	0	101
South Carolina	152	25	0	177
South Dakota	88	1	25	114
Tennessee	227	47	75	349
Texas	857	170	212	1,239
Utah	68	10	14	92
Vermont	38	4	3	45
Virginia	212	9	51	272
Washington	261	6	11	278
West Virginia	93	17	27	137
Wisconsin	354	15	56	425
Wyoming	31	3	7	41

Source: OSCAR

Table 1.3 (e). Number of Nursing Homes by Type of Certification and State: United States, 2000

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**13634**	**1159**	**2054**	**16847**
Alabama	213	8	5	226
Alaska	15	0	0	15
Arizona	129	15	1	145
Arkansas	165	23	67	255
California	1,161	104	98	1,363
Colorado	176	26	23	225
Connecticut	243	7	9	259
Delaware	33	5	5	43
District of Columbia	20	0	1	21
Florida	651	70	7	728
Georgia	314	10	38	362
Hawaii	40	1	4	45
Idaho	72	9	3	84
Illinois	574	82	209	865
Indiana	446	51	69	566
Iowa	290	13	164	467
Kansas	242	19	130	391
Kentucky	279	26	0	305
Louisiana	188	47	100	335
Maine	124	2	0	126
Maryland	233	7	13	253
Massachusetts	491	13	21	525
Michigan	373	15	49	437
Minnesota	403	7	22	432
Mississippi	116	20	56	192
Missouri	415	42	95	552
Montana	96	5	3	104
Nebraska	170	2	64	236
Nevada	44	5	2	51
New Hampshire	64	3	16	83
New Jersey	329	32	1	362
New Mexico	63	6	11	80
New York	661	0	3	664
North Carolina	399	12	4	415
North Dakota	84	4	0	88
Ohio	824	64	117	1,005
Oklahoma	213	25	150	388
Oregon	117	5	26	148
Pennsylvania	637	111	19	767
Rhode Island	98	1	0	99
South Carolina	152	26	0	178
South Dakota	88	1	25	114
Tennessee	239	39	73	351
Texas	872	139	196	1,207
Utah	70	11	12	93
Vermont	41	1	1	43
Virginia	218	12	48	278
Washington	264	2	11	277
West Virginia	96	16	26	138
Wisconsin	358	12	51	421
Wyoming	31	3	6	40

Source: OSCAR

Table 1.3 (f). Number of Nursing Homes by Type of Certification and State: United States, 2001

	Type of Certification			
	Dually-Certified	Medicare Only	Medicaid Only	All Facilities
Nation	**13631**	**1063**	**1933**	**16627***
Alabama	214	9	5	228
Alaska	15	0	0	15
Arizona	122	17	1	140
Arkansas	172	21	59	252
California	1,147	94	97	1,338
Colorado	174	27	22	223
Connecticut	238	7	9	254
Delaware	32	5	5	42
District of Columbia	20	0	1	21
Florida	648	58	19	725
Georgia	317	12	33	362
Hawaii	40	1	4	45
Idaho	72	9	3	84
Illinois	583	72	198	853
Indiana	449	49	61	559
Iowa	301	10	155	466
Kansas	234	16	129	379
Kentucky	277	26	0	303
Louisiana	209	39	79	327
Maine	122	0	0	122
Maryland	227	8	14	249
Massachusetts	473	14	19	506
Michigan	374	15	45	434
Minnesota	399	7	21	427
Mississippi	128	19	55	202
Missouri	423	33	92	548
Montana	96	5	2	103
Nebraska	170	0	60	230
Nevada	39	5	2	46
New Hampshire	64	3	16	83
New Jersey	328	32	2	362
New Mexico	64	6	10	80
New York	665	0	3	668
North Carolina	396	13	4	413
North Dakota	82	4	0	86
Ohio	841	59	95	995
Oklahoma	206	25	148	379
Oregon	117	4	24	145
Pennsylvania	632	109	20	761
Rhode Island	95	1	1	97
South Carolina	154	23	0	177
South Dakota	86	1	25	112
Tennessee	250	28	69	347
Texas	865	119	183	1,167
Utah	70	11	11	92
Vermont	42	1	1	44
Virginia	224	13	43	280
Washington	254	3	12	269
West Virginia	99	16	25	140
Wisconsin	351	12	45	408
Wyoming	31	2	6	39

Source: OSCAR

*OSCAR certification data missing for one facility

Table 1.4. Nursing Home Occupancy Rates by State: United States, 1996-2001

	1996	1997	1998	1999	2000	2001
Nation	**85.9**	**85.2**	**84.6**	**83.8**	**83.9**	**84.3**
Alabama	93.2	93.3	92.6	91.1	92.2	90.9
Alaska	82.4	81.7	88.7	80.9	85.3	83.2
Arizona	81.5	80.2	77.6	76.7	74.5	73.9
Arkansas	80.2	78.2	77.8	77.4	78.0	80.8
California	84.4	83.6	83.3	83.2	83.4	84.4
Colorado	84.7	81.5	82.6	81.4	83.6	83.6
Connecticut	95.1	94.7	93.7	92.9	93.0	93.9
Delaware	91.4	86.5	92.1	89.7	93.4	92.3
District of Columbia	90.2	82.5	86.2	84.0	88.4	88.3
Florida	84.9	83.5	83.7	83.1	83.5	84.4
Georgia	93.6	91.9	91.5	90.7	92.0	90.7
Hawaii	91.0	91.0	89.8	87.9	87.7	90.0
Idaho	88.0	86.7	86.3	84.9	84.5	84.1
Illinois	80.3	72.1	79.3	76.3	74.6	76.0
Indiana	83.3	83.0	82.2	80.5	80.1	80.1
Iowa	80.1	78.4	77.1	75.7	75.1	76.3
Kansas	84.3	85.1	85.6	85.8	85.2	84.9
Kentucky	87.6	89.0	90.1	89.2	89.2	91.2
Louisiana	79.4	79.7	78.4	75.5	76.4	77.0
Maine	89.4	89.1	89.0	88.9	90.1	89.7
Maryland	84.3	84.2	83.2	82.4	83.6	86.1
Massachusetts	87.1	87.2	86.7	88.9	88.8	89.2
Michigan	90.0	90.0	89.1	87.7	87.3	88.1
Minnesota	92.6	93.6	91.7	90.8	92.0	93.2
Mississippi	81.1	80.1	78.2	76.9	76.7	75.9
Missouri	88.7	89.5	89.3	90.7	88.7	88.2
Montana	86.3	83.3	81.7	80.3	77.5	77.3
Nebraska	92.5	91.8	90.2	87.7	88.3	87.6
Nevada	93.3	93.2	91.8	90.0	89.0	90.7
New Hampshire	89.7	88.7	88.2	86.6	87.2	85.7
New Jersey	93.0	92.5	90.7	89.3	92.0	91.0
New Mexico	91.9	91.0	88.1	87.9	88.2	87.1
New York	82.7	83.7	85.8	88.5	85.6	85.1
North Carolina	84.6	83.4	81.5	71.1	75.8	84.4
North Dakota	95.6	95.3	94.6	94.0	93.9	93.8
Ohio	87.1	86.7	86.1	84.7	84.3	84.1
Oklahoma	75.7	73.6	72.2	72.7	70.1	70.0
Oregon	80.9	79.4	78.9	76.3	74.8	73.2
Pennsylvania	86.0	87.1	87.0	86.4	87.4	86.7
Rhode Island	91.7	89.6	90.2	90.1	90.5	90.9
South Carolina	88.7	88.1	87.4	86.7	86.9	89.8
South Dakota	94.1	93.5	92.0	90.6	89.9	91.2
Tennessee	88.3	87.7	87.8	88.4	87.7	87.7
Texas	75.0	74.1	73.8	73.9	74.7	76.2
Utah	82.4	79.3	77.0	76.1	74.3	73.2
Vermont	92.8	92.0	90.1	89.9	89.8	89.2
Virginia	94.6	93.4	91.2	91.6	91.7	91.6
Washington	85.2	82.7	82.7	80.6	82.0	83.1
West Virginia	90.1	87.9	87.0	85.3	83.9	85.0
Wisconsin	92.1	87.8	87.3	89.6	88.5	89.0
Wyoming	80.2	79.7	82.5	78.6	82.4	82.3

Source: OSCAR

Table 1.5. Medicare- and Medicaid-Certified Nursing Home Beds per Thousand Residents by Age group and State: 2001

	Beds Per 1000 State Residents: All Ages	Beds Per 1000 State Residents: Age 65+	Beds Per 1000 State Residents: Age 85+
Alabama	5.8	44.3	387.1
Alaska	1.2	21.2	304.0
Arizona	3.5	26.5	252.7
Arkansas	9.6	67.8	550.9
California	3.6	32.8	281.8
Colorado	4.8	48.0	410.9
Connecticut	9.6	67.1	497.1
Delaware	5.4	41.1	397.9
District of Columbia	5.7	40.7	318.1
Florida	5.3	29.2	250.0
Georgia	5.1	51.8	461.9
Hawaii	3.3	24.5	229.1
Idaho	4.9	43.3	343.0
Illinois	8.0	65.1	506.2
Indiana	9.2	73.8	607.3
Iowa	11.9	79.7	529.8
Kansas	9.0	67.2	460.6
Kentucky	6.2	49.7	426.8
Louisiana	8.6	74.8	670.5
Maine	6.2	44.3	350.1
Maryland	5.6	48.2	432.5
Massachusetts	8.7	62.7	467.4
Michigan	4.8	39.1	331.3
Minnesota	8.5	69.7	482.9
Mississippi	6.2	50.7	413.8
Missouri	8.9	65.1	494.7
Montana	8.6	64.4	492.9
Nebraska	10.1	73.5	488.8
Nevada	3.0	26.5	335.6
New Hampshire	6.5	53.9	436.1
New Jersey	6.2	45.9	381.3
New Mexico	3.8	32.8	303.3
New York	6.5	48.5	380.0
North Carolina	5.3	42.7	389.2
North Dakota	10.9	74.9	468.8
Ohio	8.2	61.6	524.2
Oklahoma	9.6	71.8	562.8
Oregon	3.8	29.0	224.0
Pennsylvania	7.6	48.1	393.1
Rhode Island	10.1	65.0	475.1
South Carolina	4.3	35.5	359.2
South Dakota	10.4	72.3	479.2
Tennessee	6.8	55.0	475.0
Texas	5.4	53.4	461.2
Utah	3.5	40.4	348.6
Vermont	6.2	50.8	382.1
Virginia	4.3	37.7	348.1
Washington	4.3	37.6	299.6
West Virginia	6.0	39.7	339.2
Wisconsin	8.5	64.5	470.8
Wyoming	6.4	55.5	477.6

Source: Oscar & U.S. Census

No similar data available for 2000/Denominator is residents in state, not nursing homes.

Certified Beds per Thousand Residents

Table 1.6. Nursing Home Residents by Sex and Type of Nursing Home: United States, 1999-2001.

	1999			2000			2001		
		Percent of Residents			Percent of Residents			Percent of Residents	
	Residents	Male	Female	Residents	Male	Female	Residents	Male	Female
Nation	**2,927,152**	**30.9**	**67.5**	**2,975,209**	**31.7**	**68.3**	**3,026,529**	**32.0**	**68.0**
Ownership									
For-Profit (Proprietary)	1,816,646	31.8	68.2	1,861,268	32.2	67.8	1,902,027	32.7	67.3
Voluntary Non-Profit	931,264	29.8	70.2	934,523	29.9	70.1	947,120	30.0	70.0
Government	179,242	35.0	65.0	179,418	35.2	64.8	177,382	35.5	64.5
Certification									
Medicare and Medicaid	2,465,048	31.1	68.9	2,510,797	31.4	68.6	2,580,419	31.7	68.3
Medicare only	298,297	34.7	65.3	302,577	34.9	65.5	283,425	34.6	65.4
Medicaid only	163,807	30.5	69.5	161,835	30.7	69.3	162,685	32.2	67.8
Bed Size									
Less than 50	348,988	34.2	65.8	353,267	34.1	65.9	369,218	34.3	65.7
50 - 99	642,362	30.4	69.6	648,855	30.5	69.5	665,625	30.8	69.2
100 - 199	1,439,444	30.7	69.3	1,473,851	31.1	68.9	1,514,324	31.5	68.5
200 or more	496,358	32.7	67.3	499,236	33.2	66.8	477,362	33.5	66.5

Source: MDS and OSCAR

Table 1.7. Nursing Home Residents by Age Group and Type of Nursing Home: United States, 1999-2001

1999		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**2,927,152**	**0.7**	**9.3**	**14.9**	**34.5**	**34.1**	**6.5**
Ownership							
For-Profit	1,816,646	0.7	9.5	14.5	34.4	34.5	6.4
Voluntary non-profit	931,264	0.7	7.4	14.9	34.9	35.2	7.0
Government	179,242	1.0	11.8	15.1	33.4	32.3	6.2
Certification							
Medicare and Medicaid	2,465,048	0.6	8.8	14.1	34.3	35.4	6.9
Medicare only	298,297	0.7	8.5	21.4	39.7	26.4	3.3
Medicaid only	163,807	1.9	12.1	11.2	28.7	37.5	8.7
Bed Size							
Less than 50	348,988	1.0	9.7	20.9	38.1	26.6	3.7
50 - 99	642,362	0.7	8.0	12.9	33.2	37.4	7.8
100 - 199	1,439,444	0.7	8.4	13.8	34.6	35.8	6.8
200 or more	496,358	0.8	11.3	15.0	33.5	33.0	6.4

2000		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**2,975,209**	**0.7**	**9.7**	**14.7**	**34.6**	**33.9**	**6.5**
Ownership							
For-Profit	1,861,268	0.6	10.1	14.6	34.5	33.8	6.3
Voluntary non-profit	934,523	0.6	7.6	14.6	35.0	35.2	7.0
Government	179,418	1.0	12.2	14.8	33.5	32.3	6.3
Certification							
Medicare and Medicaid	2,510,797	0.6	9.3	14.1	34.4	34.9	6.8
Medicare only	302,577	0.6	8.7	20.9	39.8	26.8	3.2
Medicaid only	161,835	1.8	12.6	11.2	28.7	37.0	8.8
Bed Size							
Less than 50	353,267	0.8	10.0	20.6	38.1	26.7	3.8
50 - 99	648,855	0.6	8.3	12.8	33.3	37.2	7.7
100 - 199	1,473,851	0.6	8.9	13.8	34.7	35.2	6.7
200 or more	499,236	0.7	12.0	15.0	33.6	32.4	6.3

2001		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**3,026,529**	**0.6**	**10.1**	**14.6**	**34.6**	**33.7**	**6.4**
Ownership							
For-Profit	1,902,027	0.6	10.9	14.7	34.5	33.2	6.1
Voluntary non-profit	947,120	0.6	7.8	14.4	34.9	35.2	7.1
Government	177,382	0.9	12.3	14.8	33.8	32.1	6.2
Certification							
Medicare and Medicaid	2,580,419	0.5	9.9	14.2	34.4	34.4	6.6
Medicare only	283,425	0.5	8.7	20.5	40.2	26.8	3.3
Medicaid only	162,685	2.0	14.3	11.2	28.2	35.8	8.6
Bed Size							
Less than 50	369,218	0.8	10.2	20.7	38.3	26.4	3.7
50 - 99	665,625	0.6	8.9	12.8	33.3	36.8	7.6
100 - 199	1,514,324	0.5	9.6	14.0	34.8	34.6	6.6
200 or more	477,362	0.7	12.9	14.4	33.0	32.6	6.4

Source: MDS and OSCAR

Table 1.8. Nursing Home Residents by Race and Nursing Home Ownership Type: United States, 1999-2001.

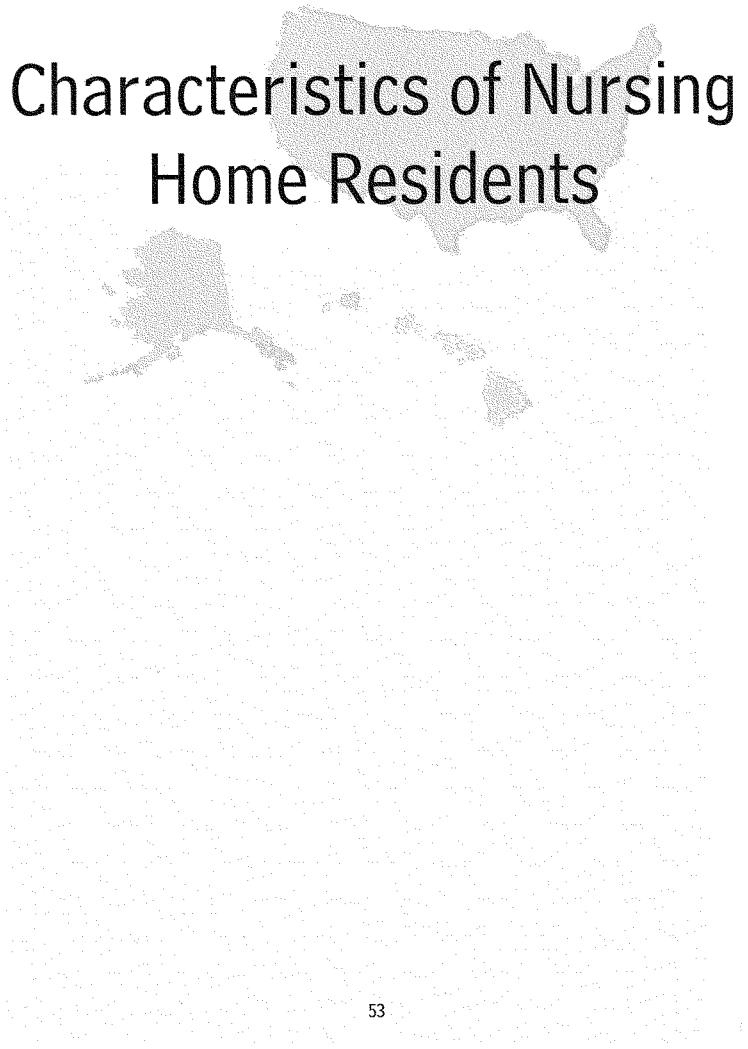
1999		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**2,927,152**	**0.5**	**1.0**	**10.0**	**2.9**	**85.6**
Ownership						
For-Profit (Proprietary)	1,816,646	0.5	1.0	11.0	3.3	84.2
Voluntary Non-Profit	931,264	0.5	0.9	7.6	2.1	89.0
Government	179,242	0.5	1.1	9.4	2.1	86.9
Certification						
Medicare and Medicaid	2,465,048	0.5	1.1	10.0	2.9	85.5
Medicare only	298,297	0.3	0.4	7.5	2.9	88.8
Medicaid only	163,807	0.7	0.5	10.8	2.0	85.9
Bed Size						
Less than 50	348,988	0.5	0.9	7.6	3.0	87.9
50 - 99	642,362	0.7	1.1	7.0	3.0	88.2
100 - 199	1,439,444	0.4	0.8	9.9	2.5	86.4
200 or more	496,358	0.4	1.3	14.8	3.5	79.9

2000		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**2,975,209**	**0.4**	**1.1**	**10.2**	**3.1**	**85.2**
Ownership						
For-Profit (Proprietary)	1,861,268	0.4	1.1	11.3	3.5	83.7
Voluntary Non-Profit	934,523	0.4	0.9	7.8	2.2	88.6
Government	179,418	0.5	1.1	9.6	2.2	86.5
Certification						
Medicare and Medicaid	2,510,797	0.4	1.1	10.3	3.1	85.0
Medicare only	302,577	0.2	0.5	7.5	3.2	88.6
Medicaid only	161,835	0.7	0.6	11.1	2.0	85.5
Bed Size						
Less than 50	353,267	0.5	1.0	7.6	3.1	87.8
50 - 99	648,855	0.6	1.2	7.2	3.2	87.8
100 - 199	1,473,851	0.4	0.9	10.2	2.7	85.9
200 or more	499,236	0.4	1.4	15.3	3.8	79.2

2001		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**3,026,529**	**0.4**	**1.1**	**10.4**	**3.2**	**84.8**
Ownership						
For-Profit (Proprietary)	1,902,027	0.4	1.2	11.7	3.7	83.1
Voluntary Non-Profit	947,120	0.4	0.9	8.1	2.2	88.4
Government	177,382	0.5	1.2	9.5	2.2	86.7
Certification						
Medicare and Medicaid	2,580,419	0.4	1.2	10.7	3.2	84.4
Medicare only	283,425	0.2	0.5	7.5	2.4	89.4
Medicaid only	162,685	0.8	0.9	10.4	2.9	85.0
Bed Size						
Less than 50	369,218	0.5	1.0	7.4	2.9	88.3
50 - 99	665,625	0.6	1.3	7.5	3.1	87.5
100 - 199	1,514,324	0.4	0.9	10.5	2.9	85.3
200 or more	477,362	0.3	1.5	16.4	4.2	77.6

Source: MDS and OSCAR

Characteristics of Nursing Home Residents



Characteristics of Nursing Home Residents

- More than 3 million individuals resided in our nation's nursing homes during some or all of 2001.

  Table 2.1(a)

Sex

- In 2001, 68% of nursing home residents were female. There has been a steady decrease in the ratio of female to male residents over the period, 1998 to 2001.

  Figure 2.1; Tables 2.1(a), 2.3, and 2.4

- The female-to-male ratio is lowest in government-owned facilities (1.8:1), Medicare-only facilities, and in facilities with fewer than 50 beds.

  Table 2.3 (2001)

- The female-to-male ratio of nursing home residents is quite variable among States. Alabama has the highest ratio (2.6:1 in 2001), while Alaska has the lowest (1.4:1).

  Table 2.4

Age

- In 2001, 75 percent all nursing home residents were 75 years of age or older. However, more than 10% of nursing home residents were under the age of 65.

  Figure 2.2; Tables 2.1(a), 2.5 and 2.6(a)-2.6(c)

- Residents under the age of 65 are more likely to be in facilities with more than 200 beds than in smaller facilities.

  Tables 2.1(a) and 2.5

- Nursing homes on the west coast and in the southwest have lower percentages of residents age 65 years and older, on average, than did nursing homes in other regions. Nursing homes in north-central states have higher percentages of residents age 65 years and older.

  Figure 2.3, Table 2.6(a) – 2.6(c)

- Hawaii, Iowa, Kansas, Minnesota, Nebraska, North Dakota, South Dakota, Vermont and Wisconsin have the highest proportions of residents age 95 years and older. Alaska, California, Illinois, and Louisiana have the highest proportion of nursing home residents under the age of 65.

  Table 2.6(c)

Race

- Over 20 percent of the population of nursing homes with 200 or more beds consist of non-white residents, while minority groups account for less than 15 percent of the population of smaller nursing homes.

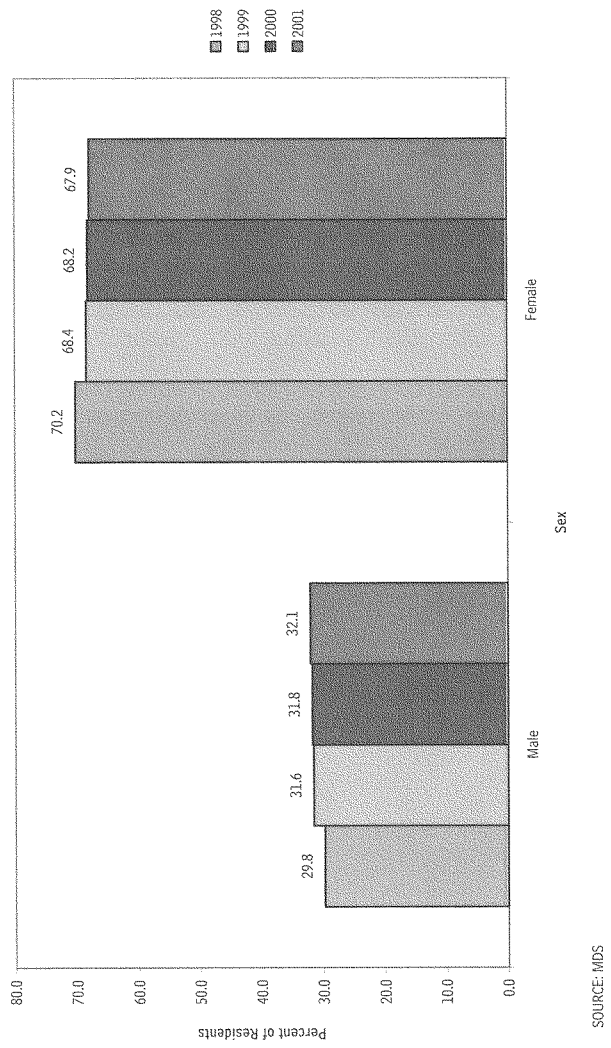
  Figure 2.5, Tables 2.1(a) and 2.7 (2001)

Technical Notes:

The sources of these data are the Minimum Data Set (MDS) and CMS's Online Survey Certification and Reporting (OSCAR) System. MDS data are primarily clinical in nature and are collected and reported by nursing homes. OSCAR is an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by survey teams.

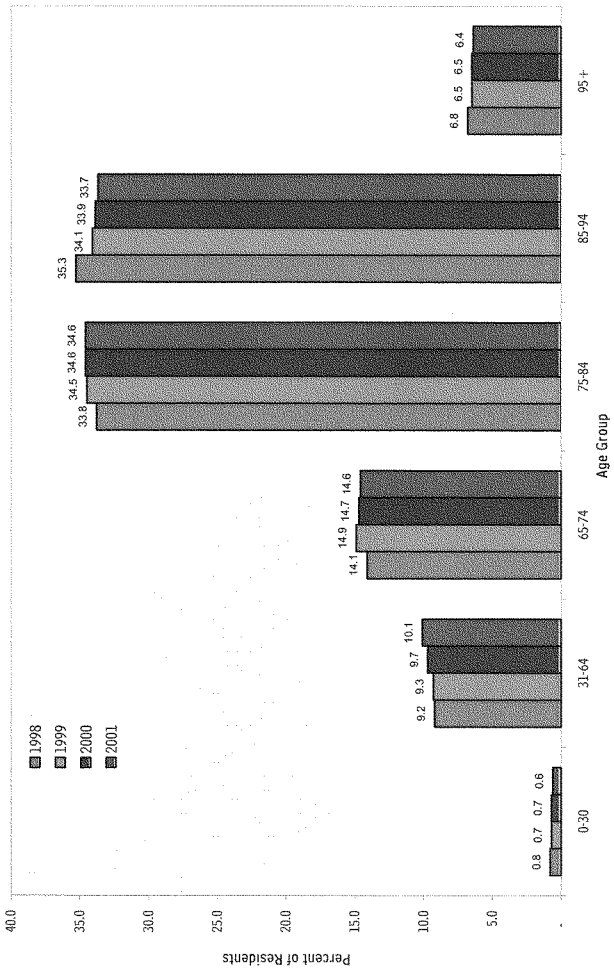
For analyses dependent on resident-specific (MDS) data only, we include every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we exclude every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Figure 2.1. Nursing Home Residents by Sex by Year: United States, 1998-2001



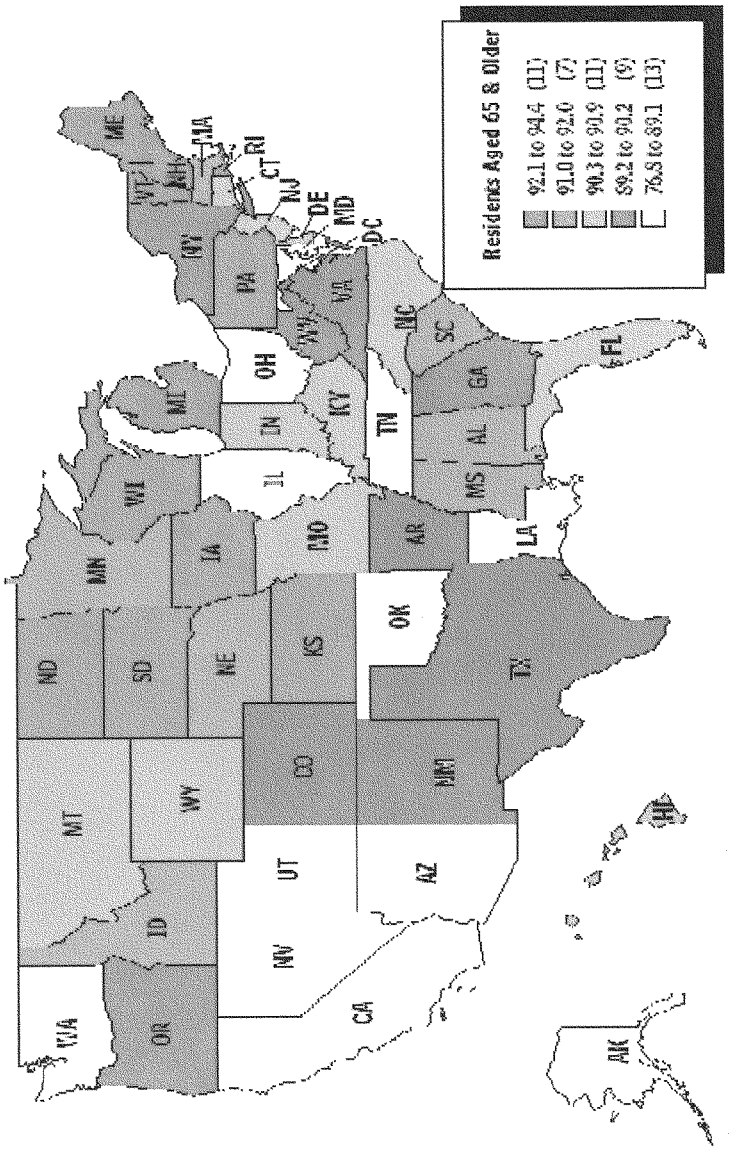
SOURCE: MDS

Figure 2.2. Nursing Home Residents by Age Group by Year: United States, 1998-2001



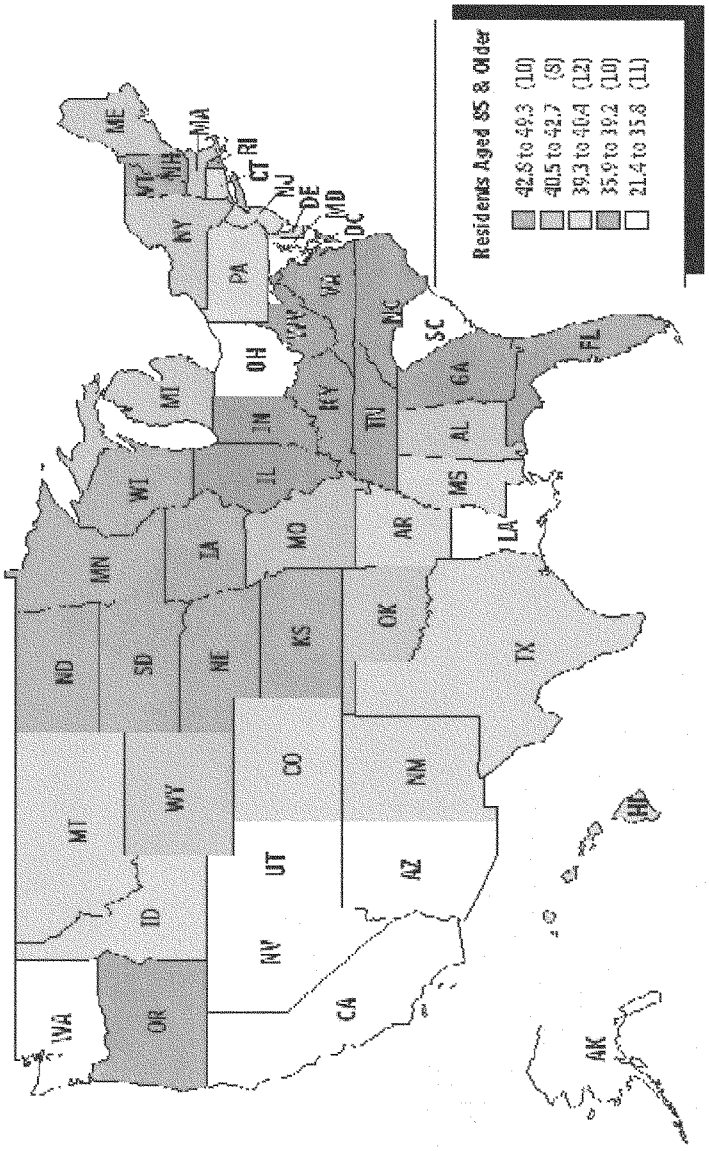
SOURCE: MDS

Figure 2.3. Percent of Nursing Home Residents Aged 65 Years and Older by State: United States, 2001



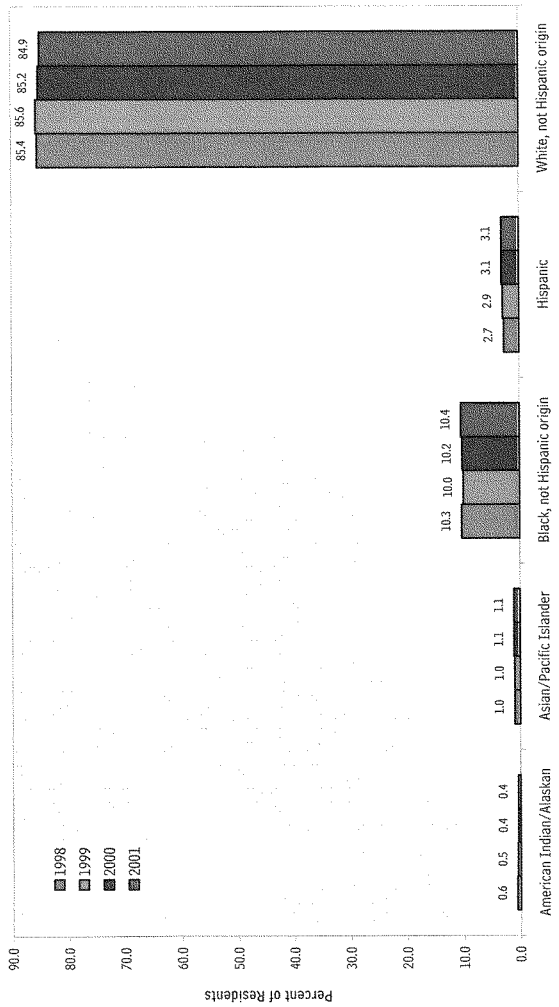
SOURCE: MDS

Figure 2.4. Percent of Nursing Home Residents Aged 85 Years and Older by State: United States, 2001



SOURCE: MDS

Figure 2.5. Nursing Home Residents by Race by Year: United States, 1998-2001



SOURCE: MDS

Table 2.1. Characteristics of Nursing Home Residents in the United States, 2001

Resident Characteristic	All Residents		Facility Ownership			Bed Size			
	Number	Percent	For- profit	Nonprofit	Government	< 50	50-99	100-199	200 & up
Number	3,026,529		1,902,027	947,120	177,382	369,218	665,625	1,514,324	477,362
Percent	100.0		62.8	31.3	5.9	12.2	22.0	50.0	15.8
Sex			Number and Percent of Nursing Home Residents by Sex						
Male	983,792	32.1	32.7	30	35.2	34.3	30.8	31.5	33.5
Female	2,082,702	67.9	67.3	70	64.5	65.7	69.2	68.5	66.5
Age in Years			Number and Percent of Nursing Home Residents by Age						
30 and Under	18,500	0.6	0.6	0.6	0.9	0.8	0.6	0.6	0.7
31-64	303,000	10.0	10.2	7.9	12.3	10.2	8.9	9.6	12.9
65-74	441,600	14.6	14.7	14.4	14.8	20.7	12.8	14.0	14.4
75-84	1,046,900	34.6	34.5	34.9	33.8	38.3	33.3	34.8	33.0
85-94	1,021,800	33.8	33.2	35.2	35.2	26.4	36.8	34.6	32.6
95 and Older	194,600	6.4	6.2	7.0	6.2	3.7	7.6	6.6	6.4
Race			Number and Percent of Nursing Home Residents by Race						
American Indian/Alaskan Native	12,800	0.4	0.4	0.4	0.5	0.5	0.6	0.4	0.3
Asian/Pacific Islander	34,000	1.1	1.2	0.9	1.2	1.0	1.3	0.9	1.5
Black, not of Hispanic origin	320,300	10.4	11.7	8.1	9.5	7.4	7.5	10.5	16.4
Hispanic	98,600	3.2	3.7	2.2	2.2	2.9	3.1	2.9	4.2
White, not of Hispanic origin	2,603,000	84.8	83.1	88.4	86.7	88.3	87.5	85.3	77.6
Number of ADL Impairments			Number and Percent of Nursing Home Residents by ADL Impairments						
0	1,134,100	34.8	34.4	35.9	33.0	42.4	34.7	33.6	32.3
1	304,200	9.4	8.6	10.9	9.9	13.5	8.9	8.8	8.6
2	281,700	8.7	8.5	9.1	8.8	8.7	8.4	8.7	9.1
3	321,000	9.9	10.0	9.7	9.9	8.3	9.7	10.0	11.1
4	554,400	18.2	18.7	17.8	17.0	15.2	18.7	19.0	17.9
5	611,500	18.9	19.9	16.7	21.3	12.0	19.6	19.9	21.0
Cognitive Performance Scale			Number and Percent of Nursing Home Residents by CPS Score						
0	925,300	28.5	25.0	35.9	25.8	52.2	24.7	25.3	23.9
1	405,400	12.5	12.9	11.7	12.5	11.7	12.8	12.5	12.6
2	433,000	13.3	13.7	12.9	12.2	10.6	13.8	13.7	13.5
3	750,700	23.0	24.3	20.5	23.4	13.3	24.8	24.5	24.3
4	227,500	7.0	7.7	5.6	6.8	3.0	7.1	7.5	8.6
5	211,900	6.5	6.8	5.8	7.5	3.7	7.3	6.9	6.4
6	295,900	9.1	9.6	7.5	11.8	4.6	9.4	9.6	10.8

Source: OSCAR and MDS

Population data may vary due to slight differences in selection criteria/rounding.

Table 2.2(a). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Alabama	All	0.8%	7.4%	15.4%	35.7%	40.7%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.1%	1.1%	2.3%	4.6%	5.5%	13.6%
	Black Male	0.1%	1.4%	1.7%	2.0%	1.5%	6.7%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	White Female	0.3%	2.6%	7.3%	21.6%	27.7%	59.5%
	White Male	0.3%	2.3%	4.1%	7.4%	5.8%	19.9%
Alaska	All	1.4%	21.7%	23.2%	32.2%	21.5%	100.0%
	Asian Female	0.0%	0.2%	0.1%	1.1%	0.2%	1.6%
	Asian Male	0.0%	0.2%	0.6%	0.5%	0.5%	1.7%
	Black Female	0.0%	0.4%	0.7%	0.5%	0.4%	2.0%
	Black Male	0.2%	0.8%	0.3%	0.6%	0.0%	1.8%
	Hispanic Female	0.0%	0.2%	0.0%	0.2%	0.2%	0.6%
	Hispanic Male	0.0%	0.2%	0.0%	0.0%	0.1%	0.2%
	Native American Female	0.3%	2.7%	2.8%	4.3%	3.0%	13.1%
	Native American Male	0.4%	2.2%	2.8%	2.0%	1.4%	8.8%
	White Female	0.0%	7.0%	8.9%	13.8%	11.2%	40.8%
	White Male	0.6%	8.1%	7.0%	9.4%	4.5%	29.5%
Arizona	All	0.8%	11.9%	16.8%	35.9%	34.6%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Asian Male	0.0%	0.0%	0.1%	0.0%	0.1%	0.2%
	Black Female	0.0%	0.3%	0.3%	0.4%	0.4%	1.4%
	Black Male	0.0%	0.4%	0.2%	0.2%	0.2%	1.0%
	Hispanic Female	0.0%	0.7%	0.9%	1.3%	1.4%	4.2%
	Hispanic Male	0.1%	1.1%	0.9%	1.0%	0.6%	3.6%
	Native American Female	0.0%	0.4%	0.4%	0.5%	0.4%	1.8%
	Native American Male	0.1%	0.7%	0.3%	0.3%	0.2%	1.6%
	White Female	0.3%	4.0%	8.1%	20.4%	23.7%	56.3%
	White Male	0.3%	4.3%	5.7%	11.7%	7.6%	29.6%
Arkansas	All	0.5%	10.0%	15.3%	34.9%	39.4%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.1%	1.0%	1.4%	2.6%	3.5%	8.5%
	Black Male	0.0%	1.2%	1.2%	1.5%	1.3%	5.2%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	White Female	0.2%	3.9%	7.6%	21.2%	27.3%	60.2%
	White Male	0.2%	3.8%	4.9%	9.4%	7.0%	25.3%

Table 2.2(b). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
California	All	1.3%	12.1%	16.2%	34.8%	35.8%	100.0%
	Asian Female	0.0%	0.3%	0.6%	1.2%	1.1%	3.3%
	Asian Male	0.1%	0.4%	0.5%	0.8%	0.6%	2.3%
	Black Female	0.1%	0.8%	0.9%	1.5%	1.5%	4.8%
	Black Male	0.1%	1.0%	0.7%	0.8%	0.4%	3.1%
	Hispanic Female	0.1%	0.7%	1.0%	1.6%	1.6%	5.0%
	Hispanic Male	0.2%	1.2%	1.0%	1.1%	0.6%	4.1%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.1%	0.0%	0.1%	0.0%	0.2%
	White Female	0.3%	3.7%	6.8%	18.2%	23.3%	52.3%
	White Male	0.3%	3.9%	4.7%	9.4%	6.7%	24.9%
Colorado	All	0.5%	10.3%	14.4%	34.4%	40.5%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.2%	0.1%	0.4%
	Asian Male	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%
	Black Female	0.0%	0.3%	0.4%	0.6%	0.6%	1.9%
	Black Male	0.0%	0.4%	0.2%	0.3%	0.1%	1.0%
	Hispanic Female	0.0%	0.4%	0.6%	1.2%	1.5%	3.7%
	Hispanic Male	0.1%	0.8%	0.7%	0.9%	0.6%	3.1%
	Native American Female	0.0%	0.1%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.1%	0.0%	0.1%	0.0%	0.2%
	White Female	0.2%	3.9%	7.3%	20.8%	29.2%	61.4%
	White Male	0.2%	4.2%	5.0%	10.2%	8.3%	27.9%
Connecticut	All	0.5%	8.7%	15.2%	35.8%	39.8%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.6%	0.6%	1.0%	0.9%	3.1%
	Black Male	0.0%	0.7%	0.5%	0.6%	0.3%	2.1%
	Hispanic Female	0.0%	0.3%	0.2%	0.3%	0.3%	1.1%
	Hispanic Male	0.0%	0.4%	0.3%	0.2%	0.1%	1.0%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.5%	7.9%	22.6%	30.0%	64.2%
	White Male	0.2%	3.2%	5.5%	11.1%	8.1%	28.1%
Delaware	All	0.7%	8.9%	15.2%	34.9%	40.3%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Asian Male	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.6%	1.8%	2.7%	2.9%	9.1%
	Black Male	0.1%	1.6%	1.5%	1.6%	0.9%	5.7%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.2%	0.5%
	Hispanic Male	0.0%	0.1%	0.1%	0.0%	0.0%	0.3%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	White Female	0.2%	2.8%	7.0%	20.7%	29.2%	60.0%
	White Male	0.2%	2.7%	4.5%	9.5%	7.0%	23.9%

Certified Beds per
Thousand Residents

Table 2.2(c). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
District of Columbia	All	0.6%	10.8%	19.6%	35.9%	33.0%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.2%	0.3%
	Asian Male	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Black Female	0.3%	4.6%	9.5%	19.4%	19.1%	52.8%
	Black Male	0.2%	5.0%	5.8%	7.0%	4.2%	22.2%
	Hispanic Female	0.0%	0.1%	0.2%	0.2%	0.2%	0.6%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.1%	0.7%	2.7%	6.3%	7.6%	17.4%
	White Male	0.0%	0.4%	1.3%	2.7%	1.5%	5.9%
Florida	All	0.6%	8.5%	16.3%	36.7%	38.0%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.0%	1.2%	1.9%	1.8%	5.9%
	Black Male	0.1%	1.2%	1.0%	1.0%	0.6%	3.9%
	Hispanic Female	0.0%	0.2%	0.6%	1.4%	1.7%	4.0%
	Hispanic Male	0.0%	0.4%	0.5%	0.7%	0.5%	2.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	2.7%	7.6%	20.2%	25.1%	55.7%
	White Male	0.2%	2.9%	5.3%	11.3%	8.2%	27.9%
Georgia	All	0.7%	10.0%	16.4%	35.7%	37.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.9%	2.8%	5.3%	6.1%	16.2%
	Black Male	0.1%	2.3%	2.3%	2.5%	1.5%	8.7%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	2.9%	6.9%	20.4%	24.2%	54.6%
	White Male	0.2%	2.8%	4.3%	7.3%	5.2%	19.7%
Hawaii	All	0.8%	8.6%	15.1%	35.7%	39.9%	100.0%
	Asian Female	0.2%	2.3%	5.6%	14.7%	19.1%	42.0%
	Asian Male	0.4%	3.5%	4.9%	10.8%	10.4%	29.9%
	Black Female	0.0%	0.1%	0.0%	0.1%	0.1%	0.2%
	Black Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.1%	0.1%	0.3%	0.5%	1.1%
	Hispanic Male	0.0%	0.1%	0.2%	0.2%	0.2%	0.8%
	Native American Female	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	White Female	0.0%	1.2%	2.2%	6.3%	7.2%	16.9%
	White Male	0.1%	1.3%	2.0%	3.2%	2.4%	8.9%

Table 2.2(d). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Idaho	All	0.5%	8.1%	15.4%	35.8%	40.1%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Male	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.6%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Female	0.0%	0.1%	0.1%	0.2%	0.1%	0.5%
	Native American Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.4%
	White Female	0.3%	4.2%	9.2%	23.3%	29.4%	66.4%
	White Male	0.2%	3.4%	5.6%	11.7%	10.2%	31.2%
Illinois	All	0.7%	12.4%	15.6%	34.0%	37.3%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.5%
	Asian Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Black Female	0.1%	1.5%	1.3%	1.9%	1.9%	6.7%
	Black Male	0.2%	2.3%	1.1%	1.1%	0.6%	5.2%
	Hispanic Female	0.0%	0.2%	0.2%	0.2%	0.2%	0.8%
	Hispanic Male	0.0%	0.3%	0.2%	0.2%	0.1%	0.8%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.8%	7.6%	20.8%	27.2%	59.5%
	White Male	0.2%	4.2%	5.0%	9.5%	7.2%	26.1%
Indiana	All	0.7%	8.8%	16.1%	36.7%	37.8%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	0.5%	0.8%	1.5%	1.4%	4.3%
	Black Male	0.1%	0.7%	0.7%	0.8%	0.4%	2.6%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	3.9%	9.0%	23.6%	28.2%	65.0%
	White Male	0.3%	3.5%	5.4%	10.6%	7.5%	27.3%
Iowa	All	0.4%	5.7%	12.8%	34.1%	47.0%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.6%
	Black Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	2.9%	7.4%	22.4%	36.4%	69.3%
	White Male	0.2%	2.6%	5.0%	11.3%	10.2%	29.3%

Certified Beds per
Thousand Residents

Table 2.2(e). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Kansas	All	0.3%	6.6%	12.5%	33.5%	47.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.3%	0.4%	0.9%	0.9%	2.5%
	Black Male	0.0%	0.3%	0.4%	0.4%	0.3%	1.4%
	Hispanic Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.5%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	White Female	0.1%	2.9%	6.8%	21.5%	35.5%	66.9%
	White Male	0.1%	2.8%	4.6%	10.3%	10.0%	27.8%
Kentucky	All	0.6%	8.5%	16.5%	36.1%	38.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.5%	0.7%	1.3%	1.7%	4.2%
	Black Male	0.0%	0.4%	0.5%	0.7%	0.4%	2.0%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	4.0%	9.3%	24.2%	28.7%	66.5%
	White Male	0.3%	3.7%	5.9%	9.8%	7.2%	26.8%
Louisiana	All	0.7%	13.9%	18.3%	33.6%	33.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	2.4%	3.0%	4.9%	5.4%	15.9%
	Black Male	0.2%	3.5%	2.6%	2.7%	1.8%	10.9%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.8%	7.4%	18.0%	20.8%	50.2%
	White Male	0.2%	4.0%	5.0%	7.6%	5.1%	22.0%
Maine	All	0.3%	7.3%	15.5%	36.4%	40.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.9%	9.1%	23.7%	31.7%	68.5%
	White Male	0.2%	3.3%	6.3%	12.4%	8.7%	30.8%

Table 2.2(f). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Maryland	All	0.8%	11.8%	17.8%	36.0%	33.7%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.6%
	Asian Male	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Black Female	0.1%	2.4%	2.7%	4.5%	4.1%	13.8%
	Black Male	0.2%	3.1%	2.3%	2.3%	1.1%	8.9%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Hispanic Male	0.0%	0.1%	0.0%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	3.2%	7.6%	19.6%	22.1%	52.7%
	White Male	0.2%	2.9%	5.0%	9.0%	5.9%	22.9%
Massachusetts	All	0.8%	8.2%	14.6%	35.6%	40.9%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Asian Male	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%
	Black Female	0.1%	0.4%	0.4%	0.6%	0.5%	1.9%
	Black Male	0.0%	0.4%	0.3%	0.3%	0.1%	1.2%
	Hispanic Female	0.0%	0.1%	0.1%	0.2%	0.1%	0.6%
	Hispanic Male	0.0%	0.2%	0.1%	0.1%	0.1%	0.5%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	3.5%	8.1%	23.3%	31.9%	67.1%
	White Male	0.3%	3.5%	5.5%	10.8%	7.9%	27.9%
Michigan	All	0.3%	7.5%	14.0%	36.6%	41.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.8%	1.1%	2.4%	2.4%	6.8%
	Black Male	0.1%	1.1%	1.0%	1.2%	0.7%	4.1%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.4%
	Hispanic Male	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	White Female	0.1%	2.9%	7.2%	22.4%	29.9%	62.5%
	White Male	0.1%	2.5%	4.5%	10.2%	8.1%	25.4%
Minnesota	All	0.5%	7.6%	12.1%	33.7%	46.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Black Female	0.0%	0.2%	0.1%	0.2%	0.2%	0.7%
	Black Male	0.0%	0.3%	0.1%	0.1%	0.1%	0.6%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.3%
	White Female	0.2%	3.3%	6.9%	22.1%	35.2%	67.6%
	White Male	0.2%	3.5%	4.8%	10.9%	10.5%	29.9%

Certified Beds per
Thousand Residents

Table 2.2(g). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Mississippi	All	0.3%	8.6%	16.6%	34.1%	40.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.1%	1.6%	3.0%	5.6%	7.7%	17.9%
	Black Male	0.1%	2.0%	2.4%	2.7%	2.6%	9.6%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
	White Female	0.1%	2.7%	7.3%	19.6%	25.1%	54.8%
	White Male	0.1%	2.2%	3.8%	6.1%	5.0%	17.2%
Missouri	All	0.6%	8.5%	15.0%	35.0%	41.0%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.1%	0.6%	0.8%	1.7%	1.7%	4.9%
	Black Male	0.1%	0.8%	0.6%	0.7%	0.5%	2.7%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.6%	8.1%	22.1%	30.4%	64.4%
	White Male	0.2%	3.4%	5.3%	10.3%	8.2%	27.4%
Montana	All	0.4%	8.6%	14.6%	36.6%	39.8%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Black Male	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%
	Native American Female	0.0%	0.4%	0.3%	0.5%	0.4%	1.6%
	Native American Male	0.0%	0.6%	0.3%	0.3%	0.2%	1.5%
	White Female	0.2%	3.7%	8.2%	23.2%	29.0%	64.2%
	White Male	0.2%	3.8%	5.6%	12.5%	10.0%	32.1%
Nebraska	All	0.8%	7.9%	13.4%	32.5%	45.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.2%	0.2%	0.4%	0.4%	1.3%
	Black Male	0.0%	0.2%	0.2%	0.2%	0.2%	0.8%
	Hispanic Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Native American Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Male	0.0%	0.1%	0.1%	0.0%	0.0%	0.2%
	White Female	0.3%	3.7%	7.5%	21.1%	34.6%	67.3%
	White Male	0.3%	3.3%	5.1%	10.5%	10.0%	29.3%

Certified Beds per Thousand Residents

Table 2.2(h). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Nevada	All	0.8%	11.5%	19.4%	36.8%	31.5%	100.0%
	Asian Female	0.0%	0.1%	0.2%	0.3%	0.2%	0.8%
	Asian Male	0.0%	0.1%	0.1%	0.2%	0.1%	0.4%
	Black Female	0.0%	0.5%	0.5%	0.8%	0.8%	2.5%
	Black Male	0.0%	0.6%	0.5%	0.4%	0.3%	1.8%
	Hispanic Female	0.0%	0.1%	0.3%	0.4%	0.5%	1.3%
	Hispanic Male	0.0%	0.4%	0.3%	0.3%	0.2%	1.3%
	Native American Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.1%	0.1%	0.0%	0.1%	0.3%
	White Female	0.3%	4.8%	10.2%	22.2%	22.7%	60.3%
	White Male	0.3%	4.8%	7.2%	12.1%	6.6%	31.0%
New Hampshire	All	0.5%	5.9%	14.0%	35.7%	44.0%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Male	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.3%	8.2%	25.3%	35.7%	72.8%
	White Male	0.2%	2.6%	5.6%	10.2%	8.1%	26.7%
New Jersey	All	0.9%	8.6%	15.3%	36.0%	39.3%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Asian Male	0.0%	0.1%	0.0%	0.1%	0.1%	0.2%
	Black Female	0.1%	1.0%	1.4%	2.1%	2.0%	6.6%
	Black Male	0.1%	1.1%	1.1%	1.1%	0.5%	3.9%
	Hispanic Female	0.0%	0.2%	0.3%	0.5%	0.6%	1.6%
	Hispanic Male	0.1%	0.3%	0.3%	0.3%	0.2%	1.2%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.3%	3.0%	7.2%	21.5%	28.6%	60.6%
	White Male	0.2%	2.8%	4.9%	10.2%	7.1%	25.2%
New Mexico	All	0.6%	9.1%	15.5%	34.7%	40.1%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.2%	0.4%
	Asian Male	0.0%	0.1%	0.0%	0.0%	0.1%	0.2%
	Black Female	0.0%	0.1%	0.2%	0.4%	0.5%	1.2%
	Black Male	0.0%	0.1%	0.2%	0.2%	0.2%	0.6%
	Hispanic Female	0.1%	1.2%	2.2%	4.6%	6.0%	14.0%
	Hispanic Male	0.1%	2.0%	2.3%	3.2%	2.6%	10.3%
	Native American Female	0.0%	0.4%	0.7%	1.1%	1.4%	3.7%
	Native American Male	0.1%	0.6%	0.6%	0.8%	0.6%	2.7%
	White Female	0.2%	2.4%	5.6%	15.7%	22.4%	46.3%
	White Male	0.1%	2.2%	3.6%	8.6%	6.1%	20.6%

Certified Beds per
Thousand Residents

Table 2.2(i). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
New York	All	0.8%	9.5%	14.7%	33.9%	41.1%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.3%	0.3%	0.8%
	Asian Male	0.0%	0.1%	0.1%	0.2%	0.1%	0.5%
	Black Female	0.1%	1.1%	1.5%	2.5%	2.5%	7.7%
	Black Male	0.1%	1.5%	1.3%	1.3%	0.6%	4.8%
	Hispanic Female	0.1%	0.4%	0.5%	0.7%	0.7%	2.4%
	Hispanic Male	0.1%	0.8%	0.5%	0.4%	0.2%	2.0%
	Native American Female	0.0%	0.0%	0.1%	0.1%	0.3%	0.5%
	Native American Male	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	White Female	0.2%	2.8%	6.3%	19.4%	29.2%	57.9%
	White Male	0.2%	2.7%	4.4%	8.9%	7.2%	23.3%
North Carolina	All	0.5%	8.9%	17.3%	37.3%	36.1%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.5%	2.4%	4.6%	4.6%	13.2%
	Black Male	0.1%	1.9%	2.0%	2.4%	1.3%	7.6%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.1%	0.2%	0.2%	0.4%
	Native American Male	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
	White Female	0.2%	2.8%	7.8%	21.4%	24.4%	56.6%
	White Male	0.2%	2.5%	4.8%	8.6%	5.5%	21.6%
North Dakota	All	0.2%	5.4%	12.1%	33.0%	49.3%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.2%	0.1%	0.4%	0.2%	0.9%
	Native American Male	0.1%	0.3%	0.2%	0.2%	0.1%	0.8%
	White Female	0.1%	2.3%	6.3%	20.3%	36.7%	65.7%
	White Male	0.1%	2.6%	5.4%	12.2%	12.2%	32.5%
Ohio	All	0.6%	10.3%	17.1%	36.6%	35.5%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.0%	1.3%	2.1%	1.9%	6.4%
	Black Male	0.1%	1.1%	1.0%	1.1%	0.6%	3.8%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	4.1%	8.9%	22.6%	26.0%	61.8%
	White Male	0.2%	3.9%	5.8%	10.7%	6.8%	27.4%

Table 2.2(j). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Oklahoma	All	0.5%	10.4%	14.9%	33.3%	40.9%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.6%	0.7%	1.1%	1.4%	3.8%
	Black Male	0.0%	0.6%	0.5%	0.6%	0.4%	2.1%
	Hispanic Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.2%
	Native American Female	0.0%	0.4%	0.4%	0.6%	0.8%	2.2%
	Native American Male	0.0%	0.4%	0.4%	0.4%	0.2%	1.4%
	White Female	0.2%	4.3%	7.9%	21.4%	30.3%	64.2%
	White Male	0.2%	3.9%	5.0%	8.9%	7.6%	25.6%
Oregon	All	0.9%	9.0%	15.0%	37.5%	37.7%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.4%
	Asian Male	0.0%	0.1%	0.0%	0.1%	0.1%	0.2%
	Black Female	0.0%	0.1%	0.1%	0.2%	0.2%	0.7%
	Black Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.5%
	Hispanic Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Female	0.0%	0.1%	0.0%	0.1%	0.0%	0.2%
	Native American Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	White Female	0.4%	4.0%	8.3%	23.1%	27.6%	63.3%
	White Male	0.4%	4.3%	6.1%	13.5%	9.4%	33.7%
Pennsylvania	All	0.4%	7.4%	14.9%	37.3%	40.0%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.6%	0.8%	1.5%	1.6%	4.5%
	Black Male	0.0%	0.7%	0.7%	0.7%	0.4%	2.4%
	Hispanic Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	White Female	0.2%	3.2%	8.0%	23.9%	29.8%	65.1%
	White Male	0.2%	2.9%	5.2%	10.9%	8.0%	27.2%
Rhode Island	All	0.2%	5.8%	12.6%	36.5%	44.9%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
	Asian Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Black Female	0.0%	0.3%	0.3%	0.5%	0.4%	1.5%
	Black Male	0.0%	0.2%	0.2%	0.2%	0.1%	0.8%
	Hispanic Female	0.0%	0.1%	0.1%	0.2%	0.1%	0.5%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.1%	2.8%	7.1%	25.1%	35.5%	70.5%
	White Male	0.1%	2.3%	4.7%	10.2%	8.4%	25.7%

Certified Beds per Thousand Residents

Table 2.2(k). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
South Carolina	All	0.4%	8.4%	17.5%	38.1%	35.6%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.1%	1.7%	3.0%	5.7%	5.9%	16.3%
	Black Male	0.0%	2.1%	2.4%	3.0%	1.7%	9.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.1%	2.4%	7.6%	21.0%	23.1%	54.2%
	White Male	0.1%	2.2%	4.5%	8.3%	4.7%	19.8%
South Dakota	All	0.3%	6.7%	11.5%	32.2%	49.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.5%	0.6%	0.6%	0.4%	2.1%
	Native American Male	0.0%	0.8%	0.6%	0.4%	0.2%	1.9%
	White Female	0.1%	2.8%	6.0%	20.7%	37.0%	66.5%
	White Male	0.2%	2.7%	4.4%	10.5%	11.6%	29.2%
Tennessee	All	0.5%	10.4%	17.3%	35.7%	36.2%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.1%	1.1%	1.5%	2.8%	3.2%	8.5%
	Black Male	0.1%	1.3%	1.2%	1.4%	0.9%	4.8%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.9%	9.0%	22.1%	25.6%	60.6%
	White Male	0.2%	4.1%	5.6%	9.3%	6.4%	25.6%
Texas	All	0.7%	9.4%	15.9%	34.2%	39.8%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.3%
	Asian Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
	Black Female	0.1%	0.9%	1.2%	2.1%	2.4%	6.6%
	Black Male	0.1%	0.9%	1.0%	1.0%	0.8%	3.7%
	Hispanic Female	0.1%	0.7%	1.3%	2.3%	2.5%	6.9%
	Hispanic Male	0.1%	1.0%	1.2%	1.5%	1.1%	4.9%
	Native American Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
	White Female	0.2%	3.0%	6.7%	18.9%	26.5%	55.3%
	White Male	0.2%	2.8%	4.3%	8.1%	6.4%	21.9%

Table 2.2(l).. Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
Utah	All	1.0%	11.1%	18.0%	36.0%	33.9%	100.0%
	Asian Female	0.0%	0.1%	0.1%	0.2%	0.1%	0.5%
	Asian Male	0.0%	0.1%	0.0%	0.1%	0.1%	0.3%
	Black Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Black Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.3%
	Hispanic Female	0.0%	0.2%	0.3%	0.4%	0.2%	1.2%
	Hispanic Male	0.1%	0.3%	0.3%	0.3%	0.2%	1.2%
	Native American Female	0.0%	0.1%	0.1%	0.2%	0.3%	0.7%
	Native American Male	0.0%	0.3%	0.1%	0.2%	0.2%	0.8%
	White Female	0.4%	5.1%	10.2%	22.9%	24.4%	63.0%
	White Male	0.4%	4.8%	6.7%	11.5%	8.3%	31.8%
Vermont	All	0.3%	6.2%	14.2%	36.4%	42.8%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Black Male	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Hispanic Male	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	White Female	0.2%	3.2%	8.0%	24.5%	33.3%	69.1%
	White Male	0.1%	3.0%	6.1%	11.8%	9.3%	30.2%
Virginia	All	0.6%	9.2%	16.3%	37.2%	36.7%	100.0%
	Asian Female	0.0%	0.0%	0.1%	0.1%	0.1%	0.4%
	Asian Male	0.0%	0.1%	0.0%	0.1%	0.0%	0.2%
	Black Female	0.1%	1.4%	2.2%	4.4%	4.1%	12.2%
	Black Male	0.1%	1.6%	2.0%	2.3%	1.2%	7.2%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.3%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	White Female	0.2%	3.1%	7.3%	21.1%	25.4%	57.1%
	White Male	0.2%	2.9%	4.6%	9.0%	5.7%	22.3%
Washington	All	0.8%	11.7%	15.7%	36.2%	35.5%	100.0%
	Asian Female	0.0%	0.1%	0.2%	0.4%	0.4%	1.1%
	Asian Male	0.0%	0.1%	0.2%	0.3%	0.2%	0.7%
	Black Female	0.0%	0.2%	0.2%	0.4%	0.3%	1.2%
	Black Male	0.0%	0.5%	0.2%	0.3%	0.1%	1.0%
	Hispanic Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.4%
	Hispanic Male	0.1%	0.2%	0.1%	0.1%	0.1%	0.5%
	Native American Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.5%
	Native American Male	0.0%	0.2%	0.1%	0.1%	0.0%	0.4%
	White Female	0.3%	5.1%	8.5%	22.0%	25.6%	61.4%
	White Male	0.3%	5.1%	6.1%	12.5%	8.8%	32.7%

Certified Beds per Thousand Residents

Table 2.2(m). Nursing Home Residents by Race, Sex and Age by State, 2001

State	Race/Sex	Age < 30	Age 30 - 64	Age 65 - 74	Age 75 - 84	Age > 84	Total
West Virginia	All	0.3%	9.7%	18.0%	36.1%	35.9%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.1%	0.1%	0.2%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.2%	0.4%	0.8%	1.0%	2.5%
	Black Male	0.0%	0.3%	0.3%	0.4%	0.3%	1.2%
	Hispanic Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Hispanic Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Native American Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Native American Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	White Female	0.1%	4.9%	10.8%	24.3%	27.2%	67.2%
	White Male	0.2%	4.3%	6.5%	10.5%	7.3%	28.7%
Wisconsin	All	0.2%	6.8%	12.7%	35.5%	44.8%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Black Female	0.0%	0.3%	0.2%	0.3%	0.3%	1.2%
	Black Male	0.0%	0.3%	0.2%	0.2%	0.1%	0.8%
	Hispanic Female	0.0%	0.0%	0.0%	0.1%	0.0%	0.2%
	Hispanic Male	0.0%	0.1%	0.1%	0.1%	0.0%	0.2%
	Native American Female	0.0%	0.1%	0.1%	0.1%	0.1%	0.3%
	Native American Male	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%
	White Female	0.1%	3.1%	7.0%	22.9%	34.1%	67.2%
	White Male	0.1%	2.9%	5.0%	11.7%	10.1%	29.8%
Wyoming	All	0.5%	8.8%	14.5%	33.9%	42.4%	100.0%
	Asian Female	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
	Asian Male	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Black Female	0.0%	0.2%	0.1%	0.2%	0.1%	0.6%
	Black Male	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
	Hispanic Female	0.0%	0.2%	0.4%	0.5%	0.6%	1.7%
	Hispanic Male	0.0%	0.1%	0.2%	0.4%	0.3%	1.1%
	Native American Female	0.0%	0.2%	0.2%	0.3%	0.2%	0.9%
	Native American Male	0.0%	0.5%	0.2%	0.2%	0.1%	1.0%
	White Female	0.2%	4.0%	8.2%	21.9%	31.5%	65.9%
	White Male	0.2%	3.6%	5.2%	10.3%	9.5%	28.7%

Table 2.3. Nursing Home Residents by Sex and Type of Nursing Home: United States, 1999-2001.

	1999			2000			2001		
		Percent of Residents			Percent of Residents			Percent of Residents	
	Residents	Male	Female	Residents	Male	Female	Residents	Male	Female
Nation	**2,927,152**	**30.9**	**67.5**	**2,975,209**	**31.7**	**68.3**	**3,026,529**	**32.0**	**68.0**
Ownership									
For-Profit (Proprietary)	1,816,646	31.8	68.2	1,861,268	32.2	67.8	1,902,027	32.7	67.3
Voluntary Non-Profit	931,264	29.8	70.2	934,523	29.9	70.1	947,120	30.0	70.0
Government	179,242	35.0	65.0	179,418	35.2	64.8	177,382	35.5	64.5
Certification									
Medicare and Medicaid	2,465,048	31.1	68.9	2,510,797	31.4	68.6	2,580,419	31.7	68.3
Medicare only	298,297	34.7	65.3	302,577	34.9	65.5	283,425	34.6	65.4
Medicaid only	163,807	30.5	69.5	161,835	30.7	69.3	162,685	32.2	67.8
Bed Size									
Less than 50	348,988	34.2	65.8	353,267	34.1	65.9	369,218	34.3	65.7
50 - 99	642,362	30.4	69.6	648,855	30.5	69.5	665,625	30.8	69.2
100 - 199	1,439,444	30.7	69.3	1,473,851	31.1	68.9	1,514,324	31.5	68.5
200 or more	496,358	32.7	67.3	499,236	33.2	66.8	477,362	33.5	66.5

Source: MDS and OSCAR

Table 2.4. Nursing Home Residents by Sex and State: United States, 1999-2001.

	1999			2000			2001		
		Percent of Residents			Percent of Residents			Percent of Residents	
	Residents	Male	Female	Residents	Male	Female	Residents	Male	Female
Nation	**3,065,168**	**31.6**	**68.4**	**3,050,255**	**31.8**	**68.2**	**3,066,494**	**32.1**	**67.9**
Alabama	42,195	26.7	73.3	43,730	27.1	72.9	45,421	27.5	72.5
Alaska	1,295	42.1	57.9	1,372	41.5	58.5	1,368	40.9	59.1
Arizona	38,699	36.5	63.5	37,634	37.0	63.0	37,336	37.3	62.7
Arkansas	35,259	30.8	69.2	33,798	30.7	69.3	33,431	30.9	69.1
California	258,946	35.0	65.0	254,493	35.3	64.7	251,007	35.4	64.6
Colorado	35,174	32.3	67.7	35,548	32.5	67.5	35,963	32.8	67.2
Connecticut	58,405	31.4	68.6	59,183	31.2	68.8	59,857	31.6	68.4
Delaware	7,766	30.0	70.0	7,849	29.8	70.2	8,335	30.8	69.2
District of Columbia	5,212	28.6	71.4	5,281	28.6	71.4	5,453	30.2	69.8
Florida	185,411	34.2	65.8	189,373	34.5	65.5	192,101	34.9	65.1
Georgia	62,712	28.7	71.3	62,217	28.9	71.1	62,925	29.3	70.7
Hawaii	6,911	40.3	59.7	7,194	39.8	60.2	7,408	39.7	60.3
Idaho	11,817	32.3	67.7	12,135	32.8	67.2	12,553	34.9	65.1
Illinois	169,000	32.9	67.1	165,633	33.3	66.7	164,910	33.6	66.4
Indiana	87,033	30.6	69.4	86,188	30.7	69.3	85,194	31.1	68.9
Iowa	52,009	29.8	70.2	51,198	29.9	70.1	51,014	29.8	70.2
Kansas	40,972	30.4	69.6	39,894	30.4	69.6	38,273	29.9	70.1
Kentucky	48,304	29.5	70.5	47,572	29.5	70.5	47,446	29.6	70.4
Louisiana	53,792	33.4	66.6	52,043	33.5	66.5	50,719	33.6	66.4
Maine	18,030	31.2	68.8	17,927	31.9	68.1	18,037	32.0	68.0
Maryland	58,941	32.5	67.5	60,116	32.9	67.1	61,631	33.1	66.9
Massachusetts	103,900	30.4	69.6	103,144	30.4	69.6	102,299	30.5	69.5
Michigan	84,945	30.0	70.0	84,381	30.4	69.6	86,046	30.6	69.4
Minnesota	70,656	31.2	68.8	69,301	31.0	69.0	69,982	31.5	68.5
Mississippi	28,458	27.4	72.6	27,734	27.7	72.3	27,319	27.8	72.2
Missouri	82,664	30.8	69.2	78,102	30.4	69.6	76,773	30.8	69.2
Montana	12,853	33.9	66.1	12,756	34.7	65.3	12,770	34.4	65.6
Nebraska	28,362	30.9	69.1	27,881	30.8	69.2	27,740	31.5	68.5
Nevada	9,383	35.0	65.0	10,580	35.9	64.1	10,477	35.1	64.9
New Hampshire	13,415	26.9	73.1	13,862	27.7	72.3	13,838	27.9	72.1
New Jersey	94,807	30.9	69.1	98,750	31.6	68.4	102,213	32.0	68.0
New Mexico	12,538	34.1	65.9	12,494	34.6	65.4	12,826	35.7	64.3
New York	195,409	31.1	68.9	202,198	31.5	68.5	208,361	31.8	68.2
North Carolina	72,047	29.6	70.4	73,611	29.7	70.3	76,288	30.0	70.0
North Dakota	10,961	33.9	66.1	10,429	34.2	65.8	10,712	34.4	65.6
Ohio	169,765	31.5	68.5	169,473	31.7	68.3	171,154	31.9	68.1
Oklahoma	44,447	29.8	70.2	42,837	29.9	70.1	41,791	30.3	69.7
Oregon	26,220	35.0	65.0	25,333	35.0	65.0	25,781	35.1	64.9
Pennsylvania	181,978	30.3	69.7	178,452	30.3	69.7	177,026	30.4	69.6
Rhode Island	16,720	27.0	73.0	16,918	27.4	72.6	17,003	28.1	71.9
South Carolina	32,614	29.3	70.7	33,749	30.1	69.9	34,112	30.3	69.7
South Dakota	11,989	31.2	68.8	11,687	32.1	67.9	11,724	31.9	68.1
Tennessee	71,446	30.5	69.5	70,713	30.5	69.5	71,661	30.6	69.4
Texas	174,522	31.3	68.7	169,605	31.5	68.5	169,690	31.7	68.3
Utah	15,247	34.2	65.8	15,627	35.0	65.0	15,778	35.9	64.1
Vermont	6,486	30.3	69.7	6,459	30.2	69.8	6,491	29.6	70.4
Virginia	55,949	30.0	70.0	56,642	29.9	70.1	58,765	30.7	69.3
Washington	58,320	35.5	64.5	57,600	35.3	64.7	57,641	35.5	64.5
West Virginia	22,843	30.1	69.9	22,532	30.3	69.7	22,793	30.9	69.1
Wisconsin	73,379	32.0	68.0	72,111	32.0	68.0	72,225	32.0	68.0
Wyoming	4,962	31.0	69.0	4,916	31.1	68.9	4,833	31.3	68.7

Source: MDS

Table 2.5. Nursing Home Residents by Age Group and Type of Nursing Home: United States, 1999-2001

1999		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**2,927,152**	**0.7**	**9.3**	**14.9**	**34.5**	**34.1**	**6.5**
Ownership							
For-Profit	1,816,646	0.7	9.5	14.5	34.4	34.5	6.4
Voluntary non-profit	931,264	0.7	7.4	14.9	34.9	35.2	7.0
Government	179,242	1.0	11.8	15.1	33.4	32.3	6.2
Certification							
Medicare and Medicaid	2,465,048	0.6	8.8	14.1	34.3	35.4	6.9
Medicare only	298,297	0.7	8.5	21.4	39.7	26.4	3.3
Medicaid only	163,807	1.9	12.1	11.2	28.7	37.5	8.7
Bed Size							
Less than 50	348,988	1.0	9.7	20.9	38.1	26.6	3.7
50 - 99	642,362	0.7	8.0	12.9	33.2	37.4	7.8
100 - 199	1,439,444	0.7	8.4	13.8	34.6	35.8	6.8
200 or more	496,358	0.8	11.3	15.0	33.5	33.0	6.4

2000		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**2,975,209**	**0.7**	**9.7**	**14.7**	**34.6**	**33.9**	**6.5**
Ownership							
For-Profit	1,861,268	0.6	10.1	14.6	34.5	33.8	6.3
Voluntary non-profit	934,523	0.6	7.6	14.6	35.0	35.2	7.0
Government	179,418	1.0	12.2	14.8	33.5	32.3	6.3
Certification							
Medicare and Medicaid	2,510,797	0.6	9.3	14.1	34.4	34.9	6.8
Medicare only	302,577	0.6	8.7	20.9	39.8	26.8	3.2
Medicaid only	161,835	1.8	12.6	11.2	28.7	37.0	8.8
Bed Size							
Less than 50	353,267	0.8	10.0	20.6	38.1	26.7	3.8
50 - 99	648,855	0.6	8.3	12.8	33.3	37.2	7.7
100 - 199	1,473,851	0.6	8.9	13.8	34.7	35.2	6.7
200 or more	499,236	0.7	12.0	15.0	33.6	32.4	6.3

2001		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	74-84	85-94	95+
Nation	**3,026,529**	**0.6**	**10.1**	**14.6**	**34.6**	**33.7**	**6.4**
Ownership							
For-Profit	1,902,027	0.6	10.9	14.7	34.5	33.2	6.1
Voluntary non-profit	947,120	0.6	7.8	14.4	34.9	35.2	7.1
Government	177,382	0.9	12.3	14.8	33.8	32.1	6.2
Certification							
Medicare and Medicaid	2,580,419	0.5	9.9	14.2	34.4	34.4	6.6
Medicare only	283,425	0.5	8.7	20.5	40.2	26.8	3.3
Medicaid only	162,685	2.0	14.3	11.2	28.2	35.8	8.6
Bed Size							
Less than 50	369,218	0.8	10.2	20.7	38.3	26.4	3.7
50 - 99	665,625	0.6	8.9	12.8	33.3	36.8	7.6
100 - 199	1,514,324	0.5	9.6	14.0	34.8	34.6	6.6
200 or more	477,362	0.7	12.9	14.4	33.0	32.6	6.4

Source: MDS and OSCAR

Table 2.6(a). Nursing Home Residents by Age Group and State: United States, 1999

		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	75-84	85-94	95+
Nation	**3,065,168**	**0.7**	**9.3**	**14.9**	**34.5**	**34.1**	**6.5**
Alabama	42,195	0.8	7.0	14.5	34.5	36.7	6.5
Alaska	1,295	1.5	20.7	21.3	33.3	19.8	3.3
Arizona	38,699	0.9	12.0	16.6	35.3	30.2	5.0
Arkansas	35,259	0.5	9.4	14.8	34.0	35.0	6.2
California	258,946	1.3	12.6	15.5	33.7	30.9	6.0
Colorado	35,174	0.6	10.0	13.8	33.5	35.2	6.8
Connecticut	58,405	0.6	8.3	14.3	34.8	35.1	6.8
Delaware	7,766	0.8	8.8	14.3	34.0	35.3	6.8
District of Columbia	5,212	0.7	10.0	18.6	35.0	29.3	6.3
Florida	185,411	0.7	8.1	15.5	35.9	33.7	6.1
Georgia	62,712	0.8	9.6	15.7	34.6	33.6	5.7
Hawaii	6,911	1.1	9.4	14.3	34.6	32.5	8.0
Idaho	11,817	0.5	7.6	14.4	35.2	35.9	6.2
Illinois	169,000	0.9	12.7	14.8	32.8	32.5	6.3
Indiana	87,033	0.8	8.6	15.5	35.8	33.1	6.2
Iowa	52,009	0.5	5.4	12.0	32.7	39.7	9.7
Kansas	40,972	0.4	7.2	12.2	31.9	39.4	8.9
Kentucky	48,304	0.7	8.5	16.0	35.5	33.3	6.0
Louisiana	53,792	0.8	13.3	17.6	32.8	30.2	5.2
Maine	18,030	0.5	7.4	14.6	35.4	35.2	7.0
Maryland	58,941	0.9	11.6	16.9	35.3	30.0	5.3
Massachusetts	103,900	0.8	8.1	14.0	34.8	35.2	7.0
Michigan	84,945	0.4	7.3	13.2	35.6	36.3	7.1
Minnesota	70,656	0.5	7.4	11.4	32.5	39.6	8.7
Mississippi	28,458	0.4	8.4	16.5	33.3	34.8	6.6
Missouri	82,664	0.6	8.5	14.6	34.1	35.6	6.7
Montana	12,853	0.5	8.3	13.8	35.9	34.9	6.7
Nebraska	28,362	0.8	7.7	13.2	31.5	38.3	8.5
Nevada	9,383	0.8	11.1	18.3	36.7	28.5	4.6
New Hampshire	13,415	0.5	5.6	13.0	34.7	38.6	7.5
New Jersey	94,807	0.9	8.2	14.4	35.0	35.1	6.4
New Mexico	12,538	0.8	9.5	15.4	33.8	34.4	6.1
New York	195,409	0.9	9.4	13.9	32.8	35.5	7.5
North Carolina	72,047	0.6	8.5	16.3	36.3	32.8	5.5
North Dakota	10,961	0.3	5.1	11.9	32.0	41.7	8.9
Ohio	169,765	0.7	9.8	16.3	35.8	31.7	5.7
Oklahoma	44,447	0.6	9.9	14.5	32.3	35.9	6.7
Oregon	26,220	0.9	8.7	14.4	36.4	33.5	6.0
Pennsylvania	181,978	0.5	7.5	14.5	36.4	34.9	6.1
Rhode Island	16,720	0.2	5.6	11.8	35.3	39.3	7.8
South Carolina	32,614	0.5	7.8	17.0	37.3	32.1	5.3
South Dakota	11,989	0.4	6.3	10.8	31.0	40.9	10.6
Tennessee	71,446	0.5	9.8	16.5	35.0	32.8	5.4
Texas	174,522	0.8	9.3	15.6	33.4	34.5	6.3
Utah	15,247	1.1	10.8	17.2	35.2	31.1	4.6
Vermont	6,486	0.4	6.0	13.2	35.3	37.9	7.3
Virginia	55,949	0.6	8.9	15.5	36.1	33.0	5.8
Washington	58,320	0.9	11.3	14.9	35.3	31.8	5.8
West Virginia	22,843	0.3	9.0	17.1	35.7	32.3	5.6
Wisconsin	73,379	0.3	6.8	12.2	34.2	38.4	8.0
Wyoming	4,962	0.6	8.5	13.4	33.0	37.1	7.5

Source: MDS

Table 2.6(b). Nursing Home Residents by Age Group and State: United States, 2000

		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	75-84	85-94	95+
Nation	**3,060,578**	**0.7**	**9.7**	**14.7**	**34.6**	**33.9**	**6.5**
Alabama	43,755	0.7	7.5	15.1	34.8	35.6	6.3
Alaska	1,374	1.3	19.8	23.4	34.0	18.2	3.3
Arizona	37,774	0.9	12.5	16.3	35.3	30.0	5.0
Arkansas	33,895	0.4	9.4	14.4	33.6	35.5	6.7
California	255,139	1.2	13.1	15.0	33.7	30.9	6.0
Colorado	35,612	0.5	10.1	13.5	33.5	35.4	7.0
Connecticut	59,234	0.5	9.0	14.3	34.5	34.7	6.9
Delaware	7,860	0.7	8.8	14.4	34.4	34.7	7.0
District of Columbia	5,292	0.7	10.8	18.7	34.3	29.5	6.1
Florida	189,639	0.6	8.7	15.8	35.9	33.1	6.0
Georgia	62,304	0.7	10.0	15.4	35.0	33.1	5.9
Hawaii	7,201	0.8	9.7	13.6	34.4	33.6	8.0
Idaho	12,129	0.5	8.1	15.1	36.1	34.5	5.6
Illinois	166,475	0.8	13.5	14.7	32.7	32.2	6.0
Indiana	86,222	0.7	9.0	15.4	35.7	33.0	6.2
Iowa	51,261	0.4	5.6	12.2	32.5	39.9	9.4
Kansas	39,977	0.3	7.4	11.6	32.4	39.3	8.9
Kentucky	47,623	0.6	8.4	15.9	35.7	33.4	6.1
Louisiana	52,096	0.8	13.6	17.2	32.8	30.2	5.3
Maine	17,963	0.5	7.8	14.6	35.4	34.8	6.9
Maryland	60,262	0.7	12.2	16.7	35.7	29.6	5.2
Massachusetts	103,298	0.7	8.4	13.9	34.7	35.2	7.1
Michigan	84,474	0.3	7.6	13.0	35.6	36.4	7.1
Minnesota	69,335	0.4	7.6	11.4	32.4	39.4	8.8
Mississippi	27,745	0.3	8.8	16.3	33.0	34.7	6.9
Missouri	78,351	0.5	8.9	14.0	34.1	35.6	6.9
Montana	12,775	0.5	8.5	14.2	35.0	35.3	6.6
Nebraska	27,881	0.8	7.8	12.8	32.0	38.2	8.5
Nevada	10,597	0.8	11.6	18.2	37.0	27.8	4.5
New Hampshire	13,872	0.5	5.4	13.2	35.2	38.3	7.3
New Jersey	99,101	0.9	8.6	14.5	35.1	34.6	6.2
New Mexico	12,542	0.8	9.7	14.4	34.3	34.5	6.3
New York	203,366	0.8	9.9	13.9	32.9	35.1	7.4
North Carolina	73,730	0.5	8.9	16.2	36.5	32.4	5.5
North Dakota	10,432	0.3	5.4	11.2	31.1	42.9	9.1
Ohio	169,665	0.6	10.3	15.9	36.0	31.6	5.6
Oklahoma	42,951	0.4	10.5	14.1	32.4	35.6	7.0
Oregon	25,393	1.0	9.4	14.1	36.4	33.4	5.8
Pennsylvania	178,835	0.4	7.7	13.7	36.7	35.2	6.3
Rhode Island	16,923	0.2	6.1	11.5	35.0	39.3	7.9
South Carolina	33,750	0.4	8.3	16.8	37.4	32.0	5.2
South Dakota	11,693	0.3	6.4	11.2	30.8	41.0	10.4
Tennessee	70,760	0.5	10.0	16.4	35.3	32.3	5.5
Texas	171,813	0.7	9.7	15.3	33.6	34.2	6.4
Utah	15,660	1.1	11.9	16.8	35.7	30.2	4.3
Vermont	6,459	0.3	5.9	12.8	35.2	38.1	7.8
Virginia	56,624	0.6	9.1	15.5	36.2	32.8	5.9
Washington	57,618	0.8	11.8	14.5	35.4	32.0	5.5
West Virginia	22,644	0.3	10.0	16.4	36.1	31.6	5.6
Wisconsin	72,258	0.3	7.0	12.1	34.2	38.4	7.9
Wyoming	4,927	0.5	9.1	13.7	33.6	35.7	7.4

Source: MDS

Table 2.6(c). Nursing Home Residents by Age Group and State: United States, 2001

		Percent of Residents					
		Age Groups					
	Residents	0-30	31-64	65-74	75-84	85-94	95+
Nation	**3,068,519**	**0.6**	**10.1**	**14.6**	**34.6**	**33.7**	**6.4**
Alabama	45,421	0.6	8.1	15.2	34.9	34.9	6.2
Alaska	1,368	1.4	22.1	21.2	34.3	17.8	3.3
Arizona	37,336	0.8	12.5	16.2	35.6	29.8	5.0
Arkansas	33,431	0.3	9.7	14.0	33.6	35.7	6.7
California	251,007	1.2	13.3	14.8	33.9	30.8	5.9
Colorado	35,963	0.5	10.5	13.2	33.9	34.7	7.1
Connecticut	59,857	0.4	9.3	14.0	34.5	35.1	6.7
Delaware	8,335	0.5	9.6	14.6	35.4	33.0	6.9
District of Columbia	5,453	0.4	11.5	19.4	34.5	28.2	6.0
Florida	192,101	0.5	9.4	15.7	36.1	32.4	5.9
Georgia	62,925	0.6	10.7	15.5	34.8	32.7	5.8
Hawaii	7,408	1.0	9.8	12.8	34.6	34.2	7.7
Idaho	12,553	0.4	8.7	15.0	36.0	33.9	5.9
Illinois	164,910	0.8	14.0	14.6	32.6	31.9	6.1
Indiana	85,194	0.7	9.5	15.3	35.4	32.8	6.2
Iowa	51,014	0.4	5.7	12.1	32.8	39.7	9.4
Kansas	38,273	0.3	7.4	11.5	32.4	39.3	9.1
Kentucky	47,446	0.6	8.7	15.8	35.8	33.3	5.8
Louisiana	50,719	0.7	13.6	17.0	33.3	29.9	5.5
Maine	18,037	0.4	8.1	14.8	35.3	34.3	7.0
Maryland	61,631	0.6	12.2	17.0	35.8	29.3	5.1
Massachusetts	102,299	0.7	8.8	13.6	34.4	35.6	7.0
Michigan	86,046	0.3	8.1	12.9	35.8	36.1	6.8
Minnesota	69,982	0.4	7.7	11.7	32.4	38.9	8.8
Mississippi	27,319	0.3	9.8	16.0	33.3	33.9	6.6
Missouri	76,773	0.5	9.3	14.1	33.6	35.5	7.0
Montana	12,770	0.5	8.6	14.2	35.2	35.1	6.3
Nebraska	27,740	0.7	8.3	12.9	32.0	37.4	8.6
Nevada	10,477	0.8	11.7	17.0	36.8	29.0	4.6
New Hampshire	13,838	0.6	5.7	12.9	34.8	38.3	7.6
New Jersey	102,213	0.8	9.5	14.4	35.2	34.0	6.1
New Mexico	12,826	0.7	10.3	14.3	33.8	34.3	6.5
New York	208,361	0.7	10.4	14.1	33.0	34.5	7.3
North Carolina	76,288	0.5	9.4	16.1	36.5	32.3	5.3
North Dakota	10,712	0.2	5.8	11.3	30.7	42.6	9.3
Ohio	171,154	0.5	11.0	15.9	35.7	31.4	5.4
Oklahoma	41,791	0.4	10.9	14.0	32.8	35.0	6.9
Oregon	25,781	1.0	10.0	14.4	36.3	33.0	5.3
Pennsylvania	177,026	0.3	8.1	13.4	36.3	35.5	6.4
Rhode Island	17,003	0.3	6.2	11.5	35.2	39.1	7.6
South Carolina	34,112	0.3	8.5	17.2	37.2	31.6	5.2
South Dakota	11,724	0.3	6.7	10.7	31.1	40.8	10.5
Tennessee	71,661	0.6	10.5	16.5	35.3	31.7	5.3
Texas	169,690	0.7	10.0	15.2	34.0	33.7	6.5
Utah	15,778	1.0	12.5	17.5	35.5	29.0	4.6
Vermont	6,491	0.1	5.8	13.3	35.4	37.8	7.7
Virginia	58,765	0.5	9.4	15.8	36.4	32.2	5.7
Washington	57,641	0.7	12.1	14.4	35.4	31.8	5.6
West Virginia	22,793	0.3	10.5	17.3	35.6	30.7	5.6
Wisconsin	72,225	0.3	7.1	12.1	33.7	38.8	8.0
Wyoming	4,833	0.3	8.6	13.7	32.9	37.4	7.0

Source: MDS

Table 2.7. Nursing Home Residents by Race and Nursing Home Ownership Type: United States, 1999-2001.

1999		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**2,927,152**	**0.5**	**1.0**	**10.0**	**2.9**	**85.6**
Ownership						
For-Profit (Proprietary)	1,816,646	0.5	1.0	11.0	3.3	84.2
Voluntary Non-Profit	931,264	0.5	0.9	7.6	2.1	89.0
Government	179,242	0.5	1.1	9.4	2.1	86.9
Certification						
Medicare and Medicaid	2,465,048	0.5	1.1	10.0	2.9	85.5
Medicare only	298,297	0.3	0.4	7.5	2.9	88.8
Medicaid only	163,807	0.7	0.5	10.8	2.0	85.9
Bed Size						
Less than 50	348,988	0.5	0.9	7.6	3.0	87.9
50 - 99	642,362	0.7	1.1	7.0	3.0	88.2
100 - 199	1,439,444	0.4	0.8	9.9	2.5	86.4
200 or more	496,358	0.4	1.3	14.8	3.5	79.9

2000		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**2,975,209**	**0.4**	**1.1**	**10.2**	**3.1**	**85.2**
Ownership						
For-Profit (Proprietary)	1,861,268	0.4	1.1	11.3	3.5	83.7
Voluntary Non-Profit	934,523	0.4	0.9	7.8	2.2	88.6
Government	179,418	0.5	1.1	9.6	2.2	86.5
Certification						
Medicare and Medicaid	2,510,797	0.4	1.1	10.3	3.1	85.0
Medicare only	302,577	0.2	0.5	7.5	3.2	88.6
Medicaid only	161,835	0.7	0.6	11.1	2.0	85.5
Bed Size						
Less than 50	353,267	0.5	1.0	7.6	3.1	87.8
50 - 99	648,855	0.6	1.2	7.2	3.2	87.8
100 - 199	1,473,851	0.4	0.9	10.2	2.7	85.9
200 or more	499,236	0.4	1.4	15.3	3.8	79.2

2001		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**3,026,529**	**0.4**	**1.1**	**10.4**	**3.2**	**84.8**
Ownership						
For-Profit (Proprietary)	1,902,027	0.4	1.2	11.7	3.7	83.1
Voluntary Non-Profit	947,120	0.4	0.9	8.1	2.2	88.4
Government	177,382	0.5	1.2	9.5	2.2	86.7
Certification						
Medicare and Medicaid	2,580,419	0.4	1.2	10.7	3.2	84.4
Medicare only	283,425	0.2	0.5	7.5	2.4	89.4
Medicaid only	162,685	0.8	0.9	10.4	2.9	85.0
Bed Size						
Less than 50	369,218	0.5	1.0	7.4	2.9	88.3
50 - 99	665,625	0.6	1.3	7.5	3.1	87.5
100 - 199	1,514,324	0.4	0.9	10.5	2.9	85.3
200 or more	477,362	0.3	1.5	16.4	4.2	77.6

Source: MDS and OSCAR

Table 2.8 (a). Nursing Home Residents by Race and State: United States, 1999

		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**3,066,539**	**0.5**	**1.0**	**10.0**	**2.9**	**85.6**
Alabama	42,195	0.1	0.1	20.3	0.1	79.4
Alaska	1,295	21.9	3.3	3.7	0.8	70.3
Arizona	38,699	3.3	0.5	2.5	7.9	85.7
Arkansas	35,259	0.4	0.1	13.7	0.2	85.6
California	258,946	0.4	5.5	7.9	9.2	76.9
Colorado	35,174	0.4	0.6	2.9	6.8	89.2
Connecticut	58,405	0.2	0.3	5.3	2.1	92.1
Delaware	7,766	0.3	0.4	15.5	0.9	83.0
District of Columbia	5,212	0.2	0.6	75.2	0.9	23.0
Florida	185,411	0.2	0.3	9.9	6.1	83.7
Georgia	62,712	0.2	0.3	25.2	0.3	74.1
Hawaii	6,911	0.2	72.7	0.3	1.8	25.0
Idaho	11,817	0.9	0.4	0.2	1.0	97.5
Illinois	169,000	0.2	0.7	12.5	1.6	85.0
Indiana	87,033	0.2	0.2	7.1	0.5	92.0
Iowa	52,009	0.2	0.1	0.9	0.3	98.5
Kansas	40,972	0.3	0.2	4.0	0.9	94.6
Kentucky	48,304	0.2	0.1	6.4	0.2	93.2
Louisiana	53,792	0.2	0.3	26.9	0.5	72.1
Maine	18,030	0.3	0.1	0.2	0.1	99.3
Maryland	58,941	0.3	0.9	23.9	0.5	74.4
Massachusetts	103,900	0.2	0.6	3.1	1.2	95.0
Michigan	84,945	0.4	0.3	11.4	0.6	87.4
Minnesota	70,656	0.7	0.3	1.4	0.3	97.4
Mississippi	28,458	0.4	0.1	28.0	0.2	71.3
Missouri	82,664	0.2	0.2	8.7	0.3	90.7
Montana	12,853	3.1	0.1	0.2	0.4	96.1
Nebraska	28,362	0.6	0.2	2.3	0.6	96.3
Nevada	9,383	0.6	1.2	4.5	2.7	90.9
New Hampshire	13,415	0.2	0.1	0.2	0.1	99.5
New Jersey	94,807	0.3	0.6	10.5	2.8	85.8
New Mexico	12,538	6.4	0.6	1.7	24.6	66.6
New York	195,409	0.7	1.3	12.8	4.5	80.7
North Carolina	72,047	0.6	0.2	20.9	0.2	78.2
North Dakota	10,961	1.7	0.0	0.0	0.1	98.2
Ohio	169,765	0.1	0.2	10.5	0.4	88.8
Oklahoma	44,447	3.5	0.2	6.2	0.6	89.5
Oregon	26,220	0.5	0.6	1.2	0.8	96.9
Pennsylvania	181,978	0.1	0.2	7.4	0.5	91.8
Rhode Island	16,720	0.2	0.4	2.3	0.8	96.2
South Carolina	32,614	0.4	0.1	25.2	0.1	74.3
South Dakota	11,989	3.9	0.1	0.1	0.1	95.8
Tennessee	71,446	0.1	0.1	13.2	0.2	86.3
Texas	174,522	0.4	0.4	10.6	11.8	76.8
Utah	15,247	1.6	0.7	0.6	2.4	94.7
Vermont	6,486	0.1	0.1	0.2	0.3	99.3
Virginia	55,949	0.1	0.6	19.7	0.4	79.2
Washington	58,320	0.9	1.9	2.2	1.0	94.1
West Virginia	22,843	0.1	0.2	3.6	0.0	96.0
Wisconsin	73,379	0.5	0.2	2.3	0.5	96.6
Wyoming	4,962	1.9	0.1	0.7	2.7	94.6

Source: MDS

Table 2.8 (b). Nursing Home Residents by Race and State: United States, 2000

		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**3,060,578**	**0.4**	**1.1**	**10.2**	**3.1**	**85.2**
Alabama	43,755	0.1	0.1	20.7	0.1	78.9
Alaska	1,374	21.6	2.7	3.4	1.0	71.3
Arizona	37,774	3.6	0.5	2.6	8.5	84.8
Arkansas	33,895	0.3	0.1	13.3	0.2	86.2
California	255,139	0.4	5.8	8.1	9.5	76.3
Colorado	35,612	0.5	0.6	3.0	7.0	88.9
Connecticut	59,234	0.2	0.3	5.5	2.2	91.8
Delaware	7,860	0.2	0.3	15.8	0.7	83.0
District of Columbia	5,292	0.2	0.7	74.3	1.1	23.8
Florida	189,639	0.1	0.3	10.0	6.2	83.4
Georgia	62,304	0.1	0.3	25.6	0.3	73.7
Hawaii	7,201	0.2	72.5	0.4	1.9	25.1
Idaho	12,129	0.8	0.4	0.2	1.2	97.4
Illinois	166,475	0.2	0.8	13.0	1.7	84.3
Indiana	86,222	0.2	0.2	7.0	0.5	92.1
Iowa	51,261	0.2	0.1	1.0	0.3	98.4
Kansas	39,977	0.4	0.2	4.1	1.0	94.3
Kentucky	47,623	0.2	0.1	6.3	0.2	93.2
Louisiana	52,096	0.2	0.2	27.4	0.7	71.5
Maine	17,963	0.2	0.1	0.2	0.1	99.5
Maryland	60,262	0.2	0.8	24.4	0.6	73.9
Massachusetts	103,298	0.2	0.6	3.2	1.3	94.7
Michigan	84,474	0.3	0.3	11.6	0.6	87.3
Minnesota	69,335	0.7	0.3	1.4	0.3	97.3
Mississippi	27,745	0.3	0.1	28.4	0.2	71.1
Missouri	78,351	0.2	0.2	8.9	0.3	90.5
Montana	12,775	3.1	0.1	0.2	0.4	96.2
Nebraska	27,881	0.5	0.2	2.4	0.6	96.3
Nevada	10,597	0.8	1.4	5.0	2.7	90.1
New Hampshire	13,872	0.1	0.1	0.2	0.1	99.4
New Jersey	99,101	0.3	0.6	11.0	2.9	85.2
New Mexico	12,542	6.3	0.4	1.8	24.6	66.9
New York	203,366	0.5	1.3	13.1	4.9	80.2
North Carolina	73,730	0.7	0.2	21.0	0.2	78.0
North Dakota	10,432	1.7	0.0	0.0	0.1	98.1
Ohio	169,665	0.1	0.2	10.9	0.5	88.4
Oklahoma	42,951	3.6	0.2	6.3	0.6	89.3
Oregon	25,393	0.5	0.6	1.3	0.8	96.8
Pennsylvania	178,835	0.1	0.3	7.7	0.5	91.5
Rhode Island	16,923	0.2	0.5	2.2	0.9	96.2
South Carolina	33,750	0.2	0.1	25.7	0.1	73.8
South Dakota	11,693	3.8	0.1	0.1	0.1	95.8
Tennessee	70,760	0.1	0.1	13.0	0.2	86.5
Texas	171,813	0.3	0.4	10.9	12.3	76.2
Utah	15,660	1.3	0.8	0.7	2.4	94.7
Vermont	6,459	0.2	0.1	0.1	0.2	99.4
Virginia	56,624	0.3	0.6	19.8	0.5	78.8
Washington	57,618	0.8	2.0	2.3	1.0	93.9
West Virginia	22,644	0.1	0.3	3.5	0.1	96.1
Wisconsin	72,258	0.4	0.2	2.5	0.4	96.5
Wyoming	4,927	1.9	0.3	0.5	2.2	95.0

Source: MDS

Table 2.8 (c). Nursing Home Residents by Race and State: United States, 2001

		Percent of Residents				
	Residents	American Indian/Alaskan Native	Asian/Pacific Islander	Black,not Hispanic origin	Hispanic	White,not Hispanic origin
Nation	**3,068,519**	**0.4**	**1.1**	**10.4**	**3.2**	**84.8**
Alabama	45,421	0.1	0.1	21.2	0.1	78.5
Alaska	1,368	20.9	3.1	3.1	1.2	71.7
Arizona	37,336	3.4	0.5	2.6	8.8	84.6
Arkansas	33,431	0.2	0.1	13.1	0.2	86.5
California	251,007	0.4	6.1	8.2	10.0	75.3
Colorado	35,963	0.5	0.7	2.8	7.0	89.0
Connecticut	59,857	0.2	0.3	5.6	2.3	91.7
Delaware	8,335	0.2	0.3	16.6	0.8	82.1
District of Columbia	5,453	0.2	0.9	72.3	1.0	25.5
Florida	192,101	0.1	0.3	10.3	6.6	82.7
Georgia	62,925	0.1	0.3	26.1	0.4	73.1
Hawaii	7,408	0.3	72.7	0.3	1.8	24.9
Idaho	12,553	0.7	0.3	0.2	1.3	97.5
Illinois	164,910	0.2	1.0	13.1	1.8	83.9
Indiana	85,194	0.2	0.2	7.2	0.5	92.0
Iowa	51,014	0.2	0.2	1.0	0.3	98.3
Kansas	38,273	0.4	0.2	4.0	1.0	94.4
Kentucky	47,446	0.1	0.1	6.6	0.2	93.0
Louisiana	50,719	0.2	0.2	27.8	0.6	71.3
Maine	18,037	0.1	0.1	0.1	0.1	99.5
Maryland	61,631	0.3	0.8	25.0	0.6	73.3
Massachusetts	102,299	0.2	0.6	3.4	1.4	94.4
Michigan	86,046	0.3	0.2	11.9	0.7	86.9
Minnesota	69,982	0.7	0.3	1.4	0.3	97.3
Mississippi	27,319	0.2	0.1	28.7	0.1	70.9
Missouri	76,773	0.2	0.2	8.8	0.4	90.4
Montana	12,770	3.0	0.1	0.1	0.4	96.3
Nebraska	27,740	0.6	0.2	2.5	0.7	96.0
Nevada	10,477	0.8	1.8	5.5	3.2	88.7
New Hampshire	13,838	0.2	0.1	0.2	0.1	99.3
New Jersey	102,213	0.2	0.7	11.5	3.1	84.5
New Mexico	12,826	6.2	0.5	1.8	24.9	66.6
New York	208,361	0.3	1.3	13.4	5.1	79.9
North Carolina	76,288	0.6	0.2	21.4	0.2	77.5
North Dakota	10,712	1.8	0.0	0.1	0.1	97.9
Ohio	171,154	0.1	0.2	11.0	0.5	88.2
Oklahoma	41,791	3.7	0.2	6.2	0.7	89.2
Oregon	25,781	0.5	0.7	1.2	0.8	96.8
Pennsylvania	177,026	0.1	0.3	8.0	0.5	91.1
Rhode Island	17,003	0.2	0.4	2.5	1.1	95.8
South Carolina	34,112	0.2	0.1	26.4	0.2	73.1
South Dakota	11,724	3.8	0.1	0.1	0.2	95.8
Tennessee	71,661	0.1	0.1	12.8	0.2	86.8
Texas	169,690	0.2	0.4	11.0	12.8	75.5
Utah	15,778	1.4	0.9	0.8	2.5	94.4
Vermont	6,491	0.5	0.1	0.2	0.2	99.0
Virginia	58,765	0.1	0.7	20.6	0.6	78.1
Washington	57,641	0.8	2.1	2.2	1.0	93.8
West Virginia	22,793	0.1	0.4	3.5	0.1	96.1
Wisconsin	72,225	0.4	0.2	2.6	0.3	96.5
Wyoming	4,833	1.6	0.2	0.5	2.4	95.2

Source: MDS

Nursing Home Resident Clinical Characteristics

Nursing Home Resident Clinical Characteristics

Activities of Daily Living (ADL)

- More than one third of nursing home residents require extensive assistance with 4 or more Activities of Daily Living (bed mobility, transferring, dressing, eating, or toileting).

  Figure 3.1; Tables 3.2 and 3.3(c)

- From 1998 to 2001 there was a slight decline in the proportion of residents with no ADL impairment. At the same time, there was a steady increase in residents with four or more ADL impairments.

  Figure 3.1; Tables 3.2 and 3.3 (a)-3.3(c)

- Facilities with fewer than 50 beds report smaller populations of residents with four or more ADL impairments than do larger facilities.

  Table 3.2

- Government-owned nursing homes report the lowest percentage of residents with no impairment and the highest percentage of residents with five ADL impairments.

  Table 3.2

- Non-profit nursing homes report the highest percentage of residents with no impairment and the lowest percentage with five.

- Within the for-profit organizations, large chains report a higher level of ADL impairment than do other nursing homes.

  Table 3.2

- The largest facilities—those with 200 beds or more—report the highest percentages of severe ADL impairment (four or five impairments).

  Table 3.2

- In one state, Illinois, the percentage of residents with no ADL impairment is greater than 45%; in three states—Mississippi, Hawaii, and Kentucky—the percentage of residents with 5 ADL impairments 25% is or greater.

  Table 3.3(c)

Technical Notes:

The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

The activities of daily living (ADLs) evaluated were: bed mobility, dressing, eating, transferring, and toileting. There are many ways to estimate the level of impairment involved with each of the "ADLs". For these charts and tables, dependency was considered to exist only when a resident required extensive assistance with one or more of these activities. The data presented are summary counts of the number of "ADLs" with which a resident requires extensive assistance.

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Cognitive Impairment

- As measured by the Cognitive Performance Scale, more than one-quarter of nursing home residents have no cognitive impairment, while more than 15 percent have severe or very severe cognitive impairment.

  Figure 3.2; Tables 3.4 and 3.5(c)

- From 1998 to 2001, reported cognitive impairment declined slightly, with the percentage of residents reported to have no impairment increasing and the percentage reported to have "Severe" and "Very Severe" impairment increasing.

  Figure 3.7; Tables 3.4 and 3.5(c)

- Government-owned nursing homes report that they care for a higher proportion of residents with severe or very severe cognitive impairment than do non-profit or for-profit facilities.

  Table 3.4

- Residents served by Medicaid-only certified nursing homes are more likely to be cognitively impaired than those served in Medicare-only or dually certified nursing homes.

  Figure 3.7; Table 3.4

- More than 50 percent of residents in nursing homes with fewer than 50 beds have no cognitive impairment.

  Table 3.4

- In four states—Arizona, Florida, Nevada, and New Jersey—the percentage of residents with no cognitive impairment is 35% or greater; only in Hawaii is the percentage of residents with very severe cognitive impairment greater than 15%.

  Table 3.5(c)

Technical Notes:

The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

The Cognitive Performance Scale (Morris, 1994) is one method for estimating the cognitive ability of nursing home residents based on items reported in the MDS assessment. Based on the scoring algorithm a resident is classified as having very severe, severe, moderately severe, moderate, mild, very mild, or no impairment.

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

References:

Morris JN, Fries BE, Mehr DR, Hawes C, Phillips C, Mor V, Lipsitz LA. MDS Cognitive Performance Scale : J Gerontol. 1994 Jul 49 (4): M174-82.

Pressure Ulcers

- The median pressure ulcer prevalence across all nursing homes increased steadily from 7.1 to 7.9 percent from 1998 to 2001. 7.4, and 7.7 in the third quarters of 1998, 1998, and 2000, respectively. Although the third quarter median prevalence (prevalence at the 50th percentile) of pressure ulcers increased from 7.1 in 1998 (third quarter) to 7.9 in 2001.
  Figure 3.8; Tables 3.1, 3.6, and 3.7

- Near the beginning of the period (1999, third quarter), the median prevalence of pressure ulcers was greater than 10% in the District of Columbia only. In the same quarter of 2001, the median prevalence exceeded 10% in seven states: California, District of Columbia, Maryland, Nevada, New Jersey, Pennsylvania, and Virginia.

  Figure 3.9, Table 3.5(a) – 3.5(c)

- Only one governmental unit, the District of Columbia, had 90th percentile pressure ulcer prevalence greater than 20% in 2001.

  Figures 3.9 and 3.10, Table 3.7

- The quarterly median incidence of pressure ulcers has increased slightly since 1998, but is still quite low—below 2.3% in 2001.

  Figure 3.11; Tables 3.1, 3.8, 3.9

- Government-owned facilities have the lowest median pressure ulcer incidence and prevalence rates; for-profit facilities have the highest.
  Tables 3.6 and 3.8

- Median pressure ulcer prevalence rates are higher in Medicare-only certified nursing homes than in Medicaid-only and dually certified nursing homes

  Table 3.6

- Medicaid-only certified facilities have the lowest median pressure ulcer prevalence rates

  Table 3.6

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Technical Notes:

The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

We defined pressure ulcer as any pressure ulcer of stage 2 or greater.

Prevalence was assessed using the midpoint of each calendar quarter as a starting point. Cases of interest occurred 60 days before or after the midpoint and were unique. That is, if a resident had two assessments collected during the observation period, only the one closest in time to the starting point was retained. Prevalence was calculated as the number of identified cases divided by the number of eligible residents at baseline (the midpoint estimate of the nursing home population).

Incidence of pressure ulcers was calculated by identifying all pressure ulcer cases that are not noted on admission or readmission assessments during a quarter of interest (e.g., January 1 to March 31). Each assessment indicating presence of a pressure ulcer is then compared with the resident's immediately preceding assessment. If the preceding comparison assessment indicates that no pressure ulcer is present, then the index assessment is considered an incident pressure ulcer. Incident pressure ulcers constitute the numerator of the quarter. The denominator consists of all eligible assessments closest to the midpoint of the quarter (but not more than 60 days from the midpoint) that indicate presence of no pressure ulcers.

Restraint Use

- In 5 States (Arkansas, California, Louisiana, Mississippi, and Texas), the median prevalence (prevalence at the 50th percentile) of the use of restraints was 15 percent or greater in the third quarter of 2001

  Figures 3.13 and 3.14, Table 3.11

- The median prevalence of restraints has decreased from 7.5 percent to 6.3 percent over the years examined, while the median incidence of new restraint use has remained steady at about 1 percent.

  Tables 3.1, 3.10, 3.11, 3.12, and 3.13

- Non-profit facilities had the lowest median prevalence of restraint use during the period (1999-2001), and this prevalence steadily declined during that period.

  Table 3.10

- For-profit facilities had the highest prevalence of the use of physical restraints, although this prevalence declined over this three-year period.

  Table 3.10

- The prevalence of restraint use at the 10th percentile is greater than zero in six states: Arkansas, California, Georgia, Louisiana, Tennessee, and Texas

  Figure 3.13, Table 3.11 (2001, third quarter)

Technical Notes:

The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

To estimate the incidence and prevalence of physical restraint use, we adopted a conservative approach, considering only individuals whom the nursing home reported were in a trunk restraint, limb restraint, or some sort of restraining chair at least once during the 7 days prior to the assessment. It is important to note that we did not report the use of bed rails for this measure, because of our concern about biases in the measurement of this item.

Prevalence was assessed using the midpoint of each calendar quarter as a starting point. Cases of interest occurred 60 days before or after the midpoint and were unique. That is, if a resident had two assessments collected during the observation period, only the one closest in time to the starting point was retained. Prevalence was calculated as the number of identified cases divided by the number of eligible residents at baseline (the midpoint estimate of the nursing home population).

Incidence of restraint use was calculated by identifying all restraint cases that are not noted on admission or readmission assessments during a quarter of interest (e.g., January 1 to March 31). Each assessment indicating presence of a restraint is then compared with the resident's immediately preceding assessment. If the preceding comparison assessment indicates that no restraints are present, then the index assessment is considered an incident restraint. Incident restraints constitute the numerator of the quarter. The denominator consists of all eligible assessments closest to the midpoint of the quarter (but not more than 60 days from the midpoint) that indicate presence of no restraints.

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Tube Feeding, Weight Loss, and Dehydration

- The prevalence of tube feeding has been fairly steady, at 4.2 – 4.4 percent, since the beginning of 1999.

  Tables 3.14 and 3.15

- Non-profit facilities had the lowest 90th percentile prevalence of tube feeding for the three years (1999-2001) and this rate declined from 11.3% (in the fourth quarter of 1999) to 10.5%.

  Table 3.14

- The tube feeding prevalence at the 90th percentile for Medicare-only certified facilities was lower than 9 percent in 2001, while the prevalence at the 90th percentile was over 13 percent for dually certified nursing homes.

  Table 3.14

- Facilities with fewer than 50 beds had the lowest tube feeding prevalence at the 90th percentile, slightly above 10%, which was 20% to 40% lower than all other size categories.

  Table 3.14

- The median prevalence of tube feeding ranged from 0.7 percent in Iowa to 10.7 percent in the District of Columbia.

  Figures 3.15 and 3.16, Table 3.14

- In the third quarter of 2001, the median prevalence (prevalence at the 50th percentile) of weight loss in nursing home residents was 9.5 percent. This represents no change from the median prevalence during the third quarter of 2000, but is lower than the median prevalence of any quarter of 1999.

  Table 3.16

- Washington, Idaho, and Vermont had the highest median prevalence of weight loss, 12 percent or greater, in the third quarter of 2001.

  Figure 3.17, Table 3.17

- The prevalence of dehydration at the 90th percentile has decreased from 2.4 percent in the third quarter of 1999 to 1.5 percent in the third quarter of 2001.

  Figure 3.18, Tables 3.18 and 3.19

- The prevalence of dehydration in for-profit nursing homes is lower than in government and non-profit facilities, and it has decreased since 1999.

  Table 3.18

- The 90th percentile prevalence of dehydration in Medicare-only certified nursing homes is often three to five times greater than in homes in other certification categories.

  Table 3.18

- No state had a 10th percentile prevalence of dehydration greater than zero in the third quarter of 2001; only four states—Alaska, Montana, Vermont, and Washington—had 90th percentile rates 3% percent or greater. The prevalence at the 90th percentile was equal to or greater than 3 percent in six states in the third quarter of 2000, and in fourteen states in the third quarter of 1999.

  Figure 3.19, Table 3.19

To estimate the prevalence of feeding tube use in nursing homes we identified all individuals whom the nursing home reported had a feeding tube, defined as "any tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system." We excluded individuals admitted to the nursing home with feeding tubes because we wanted to separate the use of feeding tubes by nursing homes from the use of feeding tubes by hospitals.

To estimate the prevalence of weight loss, we identified all individuals whom the nursing home indicated had experienced weight loss of more than 5 percent in the 30 days prior the assessment or more than 10 percent in the last 180 days. It is important to note that we excluded individuals who were reported by the nursing home to be in end-stage disease or who were receiving hospice care.

To estimate the prevalence of dehydration, we identified all individuals for whom the nursing home indicated that fluid output exceeds fluid input. It is important to note that we excluded individuals who were reported by the nursing home to be in end-stage disease or who were receiving hospice care.

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Technical Notes:

The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

Incontinence

- Nursing homes report that more than one third of their residents experience severe bowel or bladder incontinence.

  Figures 3.15, Tables 3.20 and 3.21

- The median prevalence of severe bowel or bladder incontinence has varied little since 1998; the range was 35.1 to 35.9 percent of residents during this period.

  Figure 3.15, Tables 3.1 and 3.20

- The reported prevalence of incontinence varies among states. In 2 states, the median (50th percentile) prevalence of severe incontinence is more than 50 percent, while 2 states report levels below 20 percent

  Figures 3.16 and 3.17, Table 3.21 (2001, third quarter)

- Non-profit facilities had the lowest median prevalence of severe incontinence, approximately 30%, over the three-year period (1999-2001), with low 10th percentile prevalence rates, generally below 10%.

  Table 3.20

- Medicare-only certified facilities had the lowest median prevalence of severe incontinence, compared to facilities in other certification categories, over the three-year period. The prevalence at the 10th percentile was also the lower than for Medicaid-only and dually certified facilities.

  Table 3.20

- Over the three-year period, nursing homes with fewer than 50 beds had lower median prevalence of severe incontinence rates than facilities with more beds — fewer than 23.5 percent in every quarter since the first quarter 1999.

  Table 3.20

- During the third quarter of 2001, Georgia, the District of Columbia, Alabama, Hawaii, and North Carolina had the highest prevalence of severe incontinence at the 10th percentile.

  Figure 3.16, Table 3.21

Technical Notes:

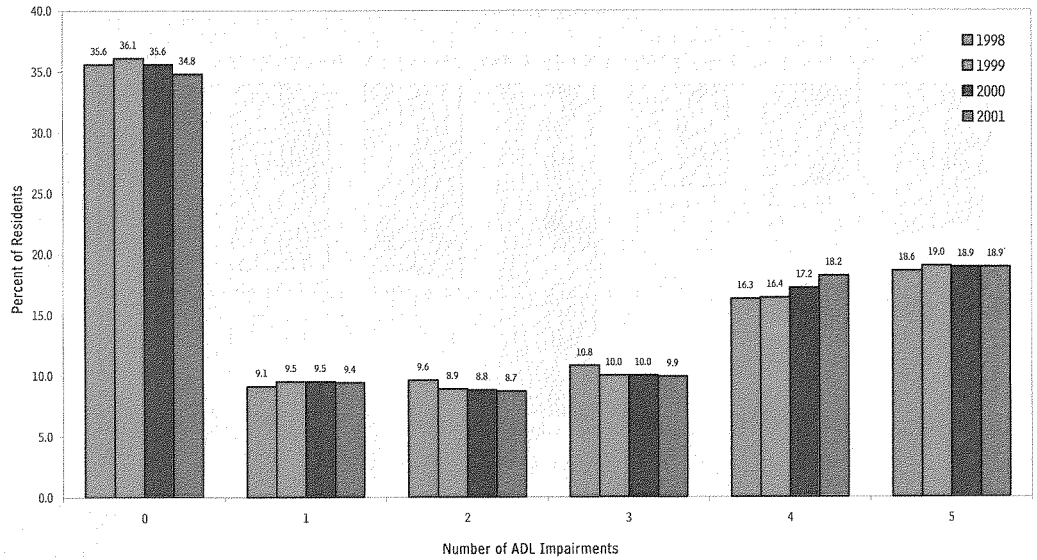
The source of these data is the Minimum Data Set (MDS). These data are collected and reported by nursing homes.

For this measure, incontinence, we identified persons who were incontinent of bladder or of bowel on almost all occasions. This is a measure of severe incontinence. It is important to note that this differs from the Quality Indicator on incontinence that is used in the survey process.

For analyses dependent on resident-specific (MDS) data only, we included every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we excluded every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

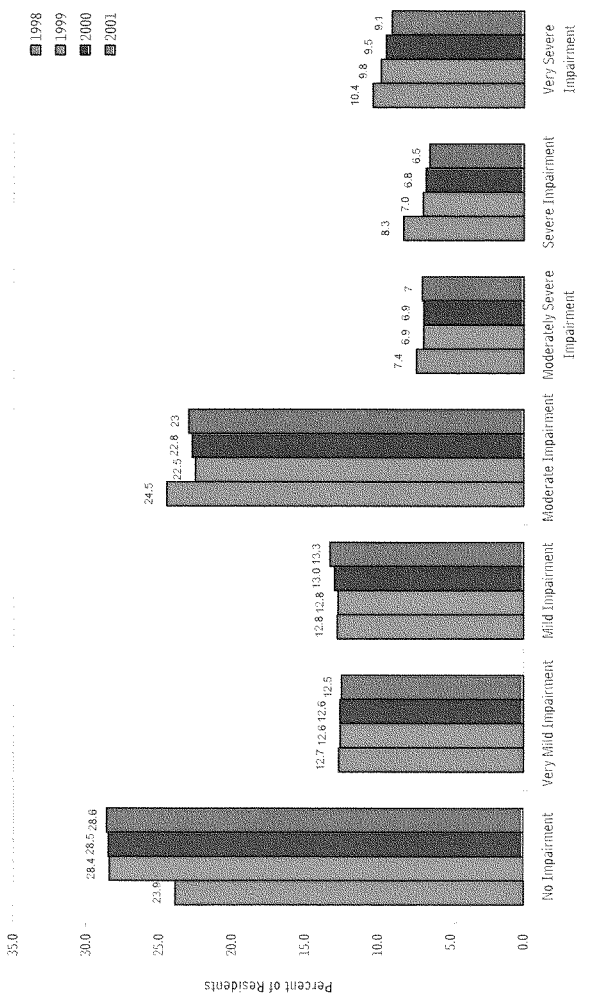
Nursing Homes in Puerto Rico and the Virgin Islands were excluded from the analysis. Fewer than 10 certified nursing homes operate in each of these entities.

Figure 3.1 Distribution of Number of ADL Impairments in Nursing Home Residents by Year: United States 1998-2001



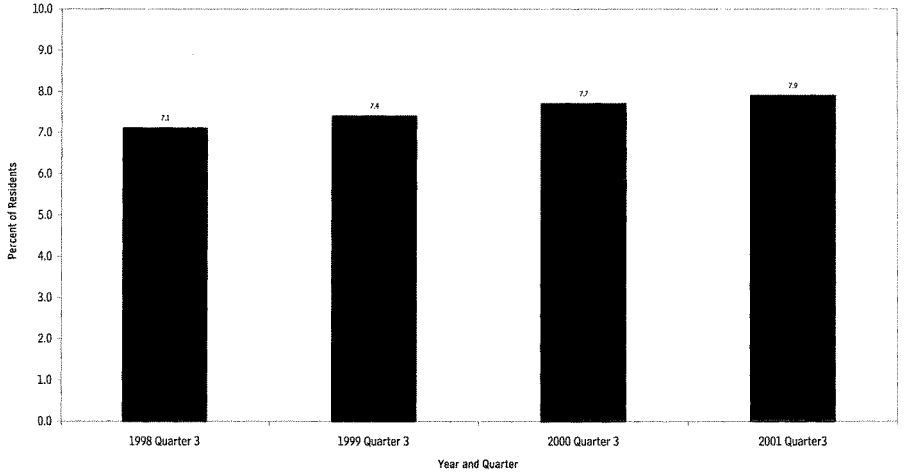
SOURCE: MDS

Figure 3.2. Distribution of Cognitive Impairments in Nursing Home Residents by Year: United States, 1998-2001



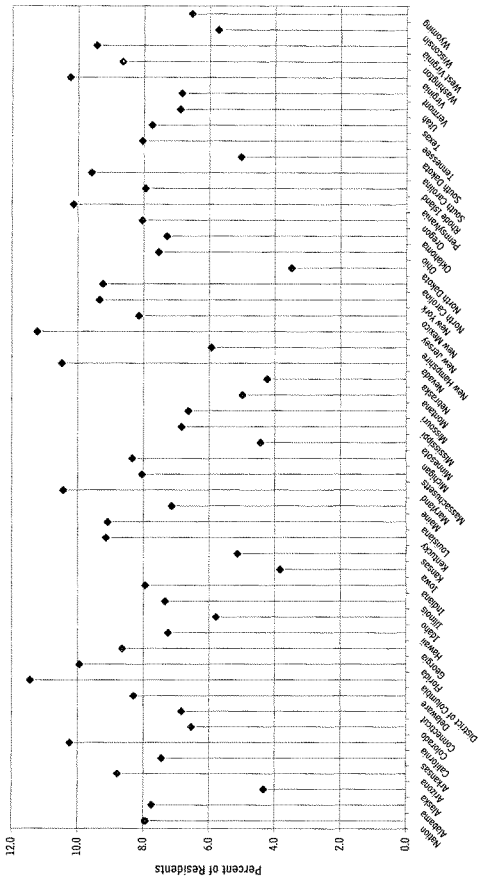
SOURCE: MDS

Figure 3.3. Median Pressure Ulcer Prevalence in Nursing Home Residents by Year: United States, Third Quarter 1998-2001



SOURCE: MDS

Figure 3.4. Median Pressure Ulcer Prevalence in Nursing Home Residents by State: United States, Third Quarter 2001



SOURCE: MDS

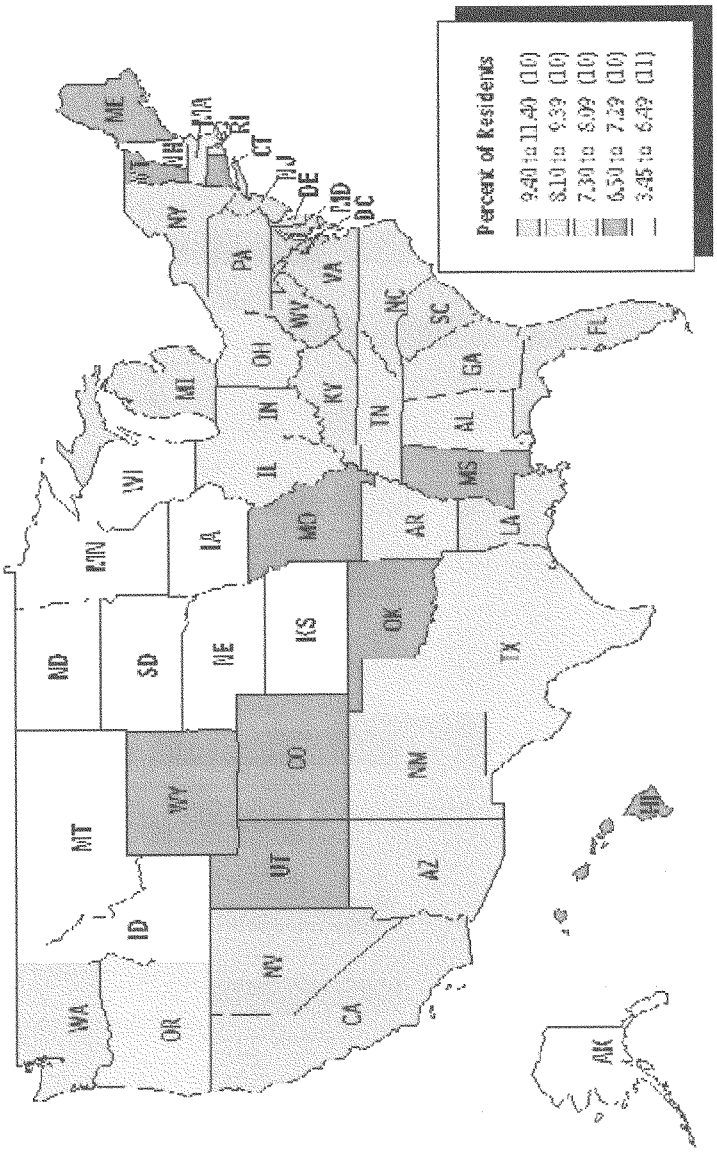
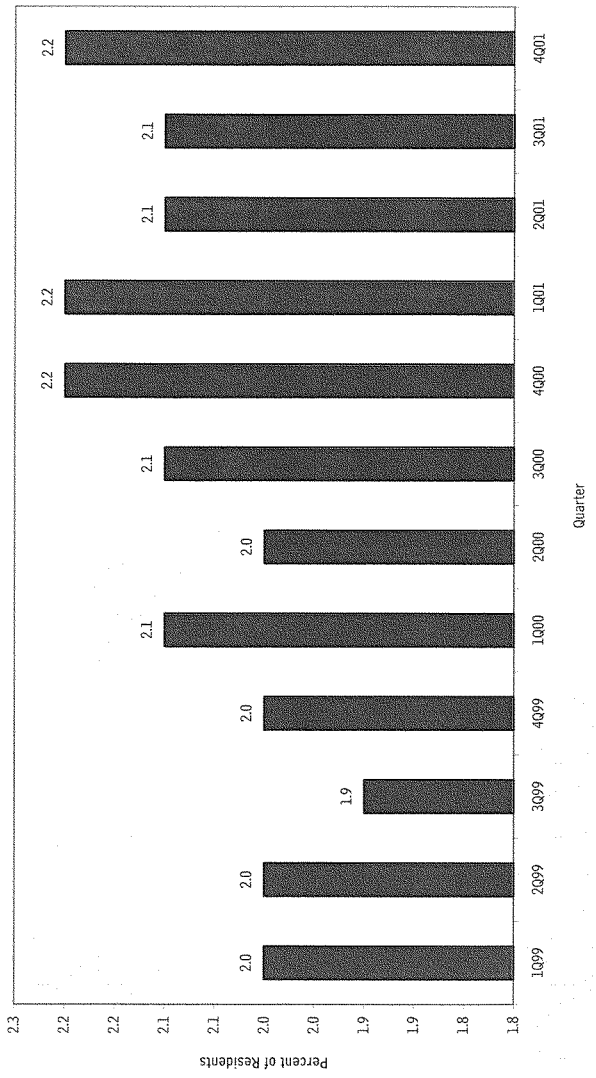


Figure 3.5. Prevalence of Pressure Ulcers in Nursing Home Residents by State: United States, 2001

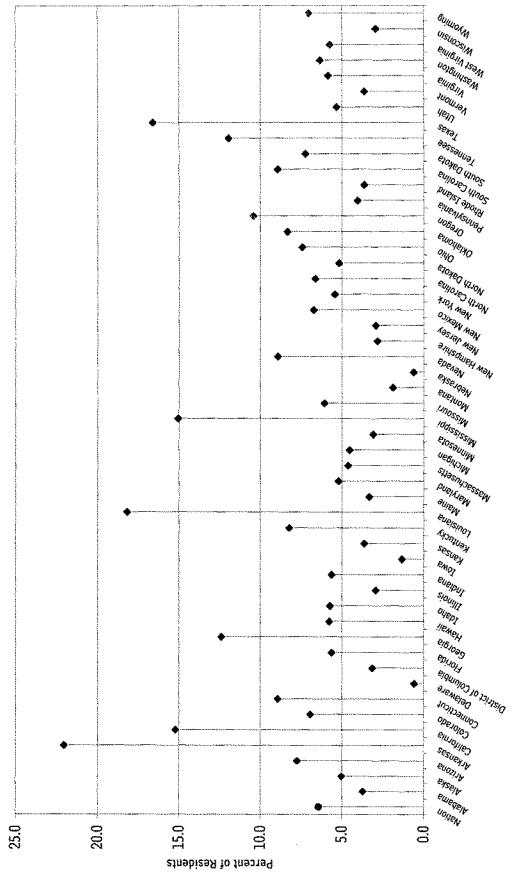
SOURCE: MDS

Figure 3.6. Incidence of Pressure Ulcers in Nursing Home Residents by Quarter: United States, 1999-2001



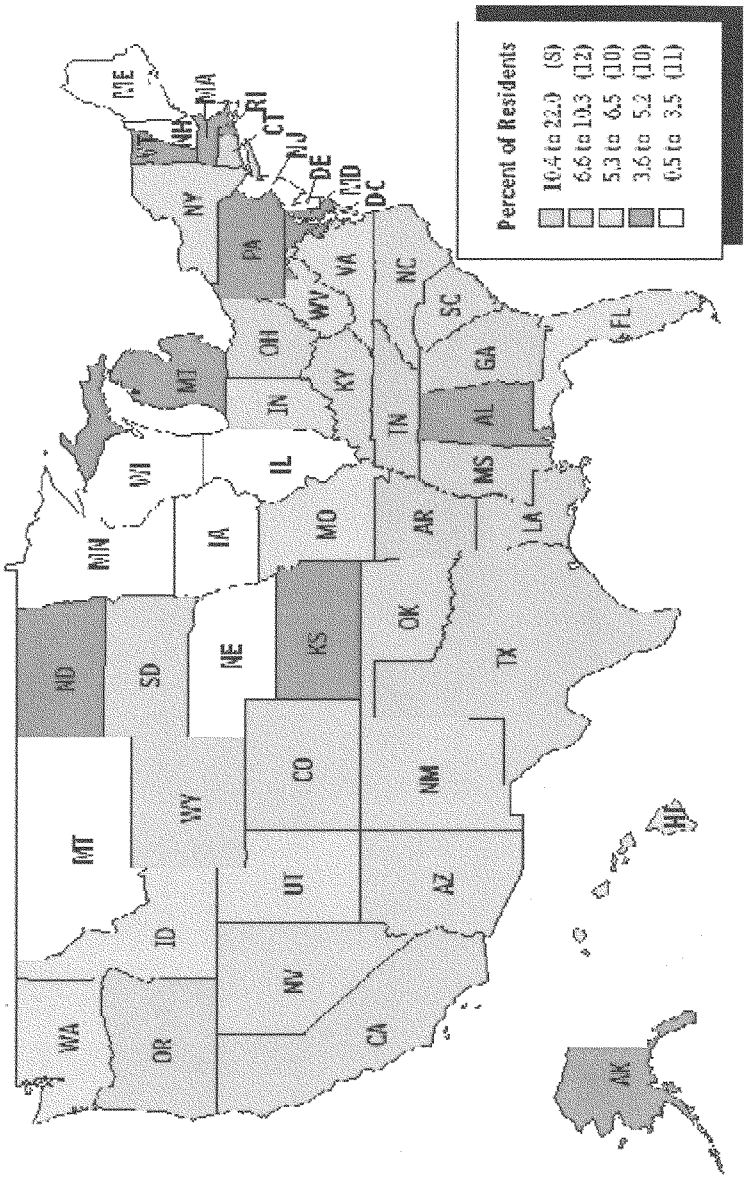
SOURCE: MDS

Figure 3.7. Median Prevalence of Use of Restraints in Nursing Home Residents by State: United States, Third Quarter 2001



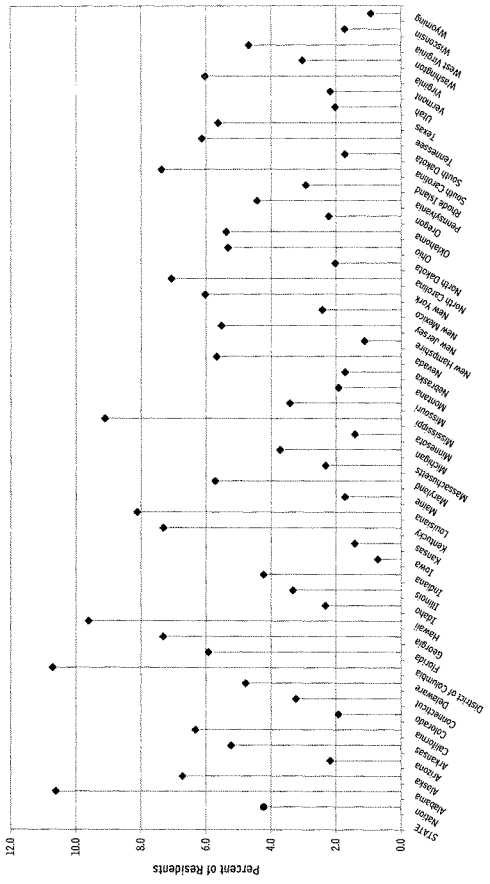
SOURCE: MDS

Figure 3.8. Median Prevalence of Use of Restraints in Nursing Home Residents by State: United States Third Quarter 2001

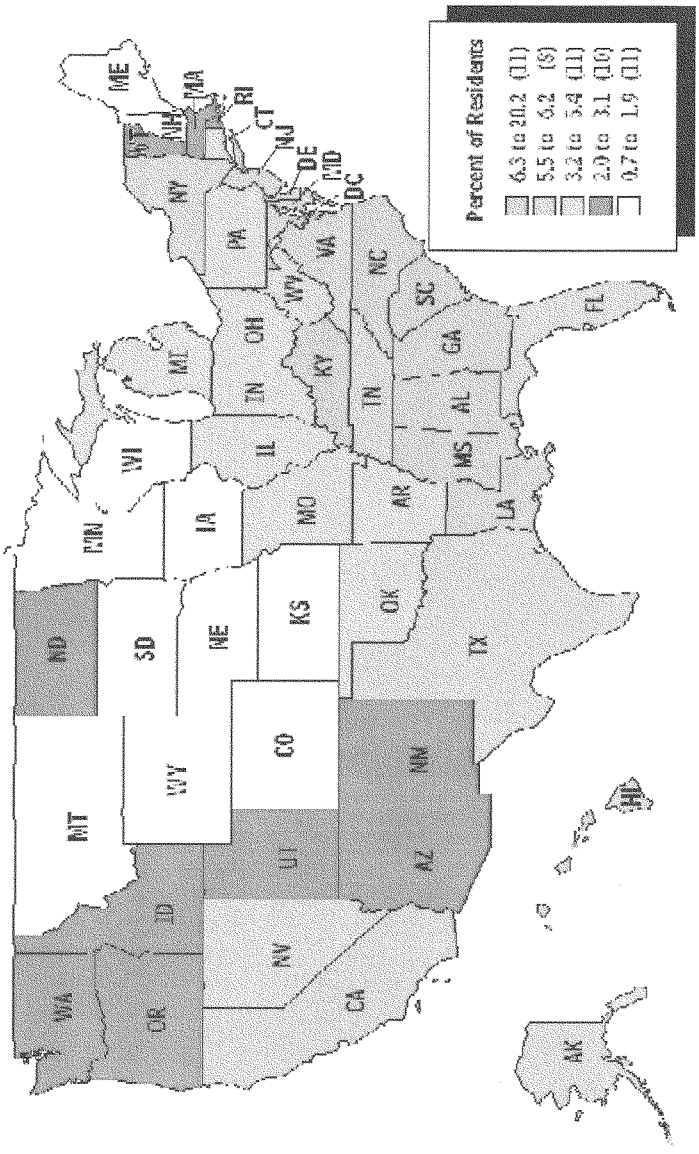


SOURCE: MDS

Figure 3.9. Median Prevalence of Tube Feeding in Nursing Home Residents by State: United States, Third Quarter 2001



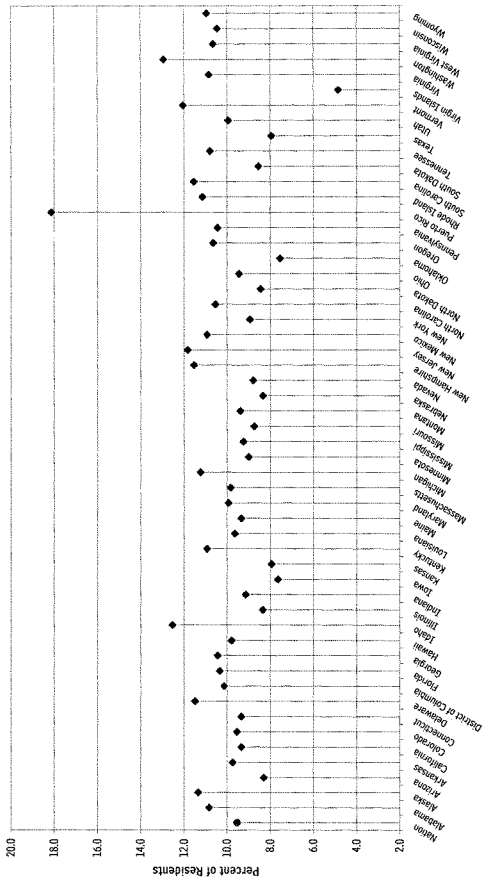
SOURCE: MDS



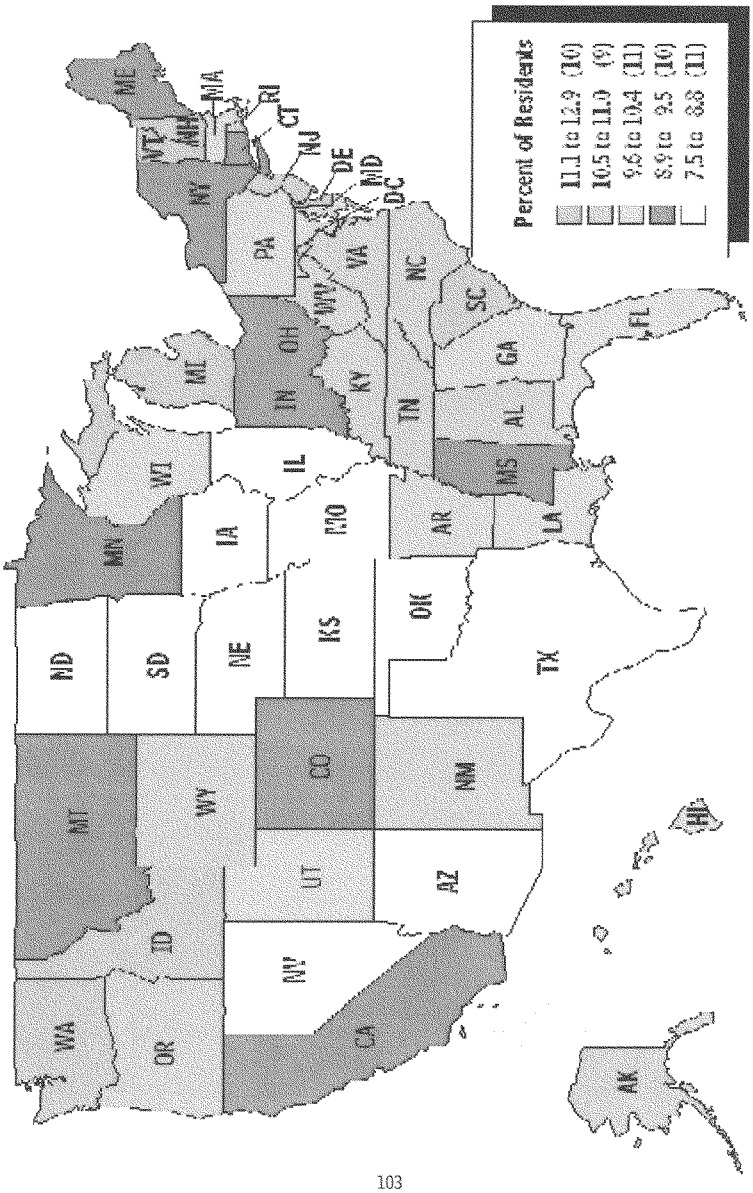
SOURCE: MDS

Figure 3.10. Median Prevalence of Tube Feeding in Nursing Home Residents by State: United States, Third Quarter 2001

Figure 3.11. Median Prevalence of Weight Loss in Nursing Home Residents by State: United States, Third Quarter 2001



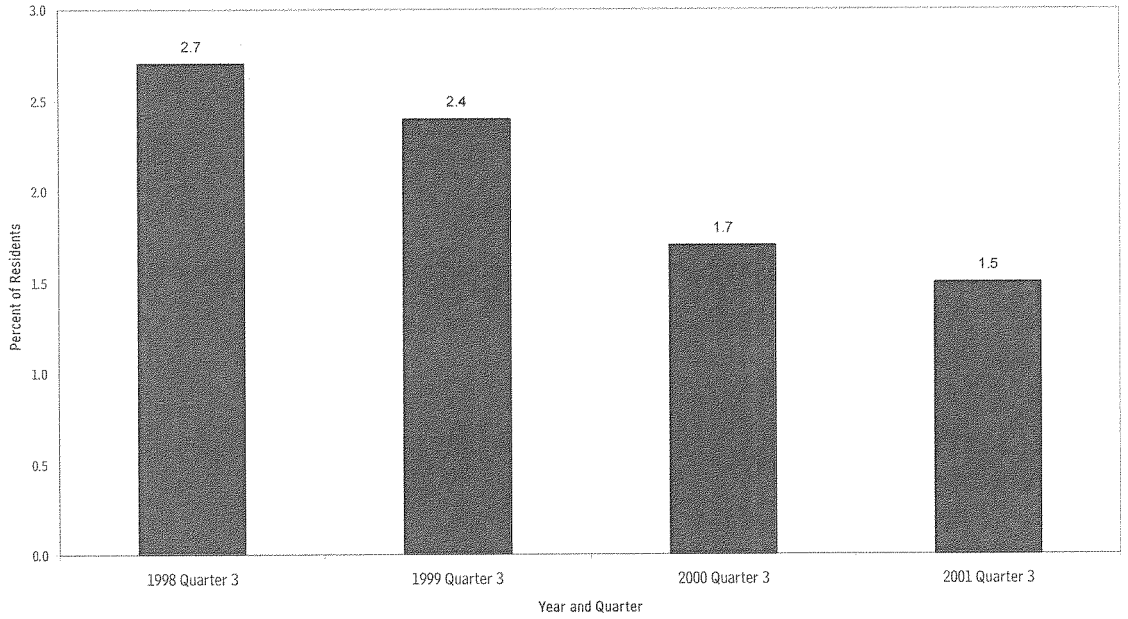
SOURCE: MDS



SOURCE: MDS

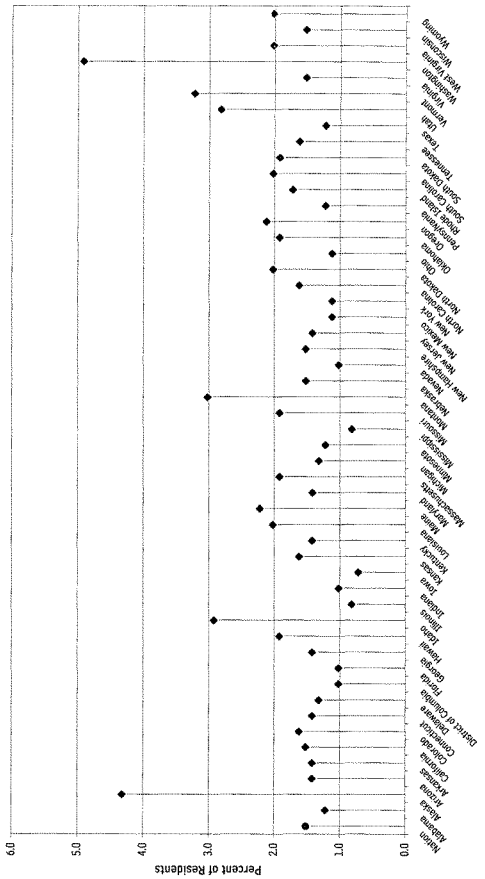
Figure 3.12. Median Prevalence of Weight Loss in Nursing Home Residents by State: United States, Third Quarter 2001

Figure 3.13. Prevalence of Dehydration in Nursing Home Residents at the 90th percentile by year: United States, Third Quarter 1998-2001



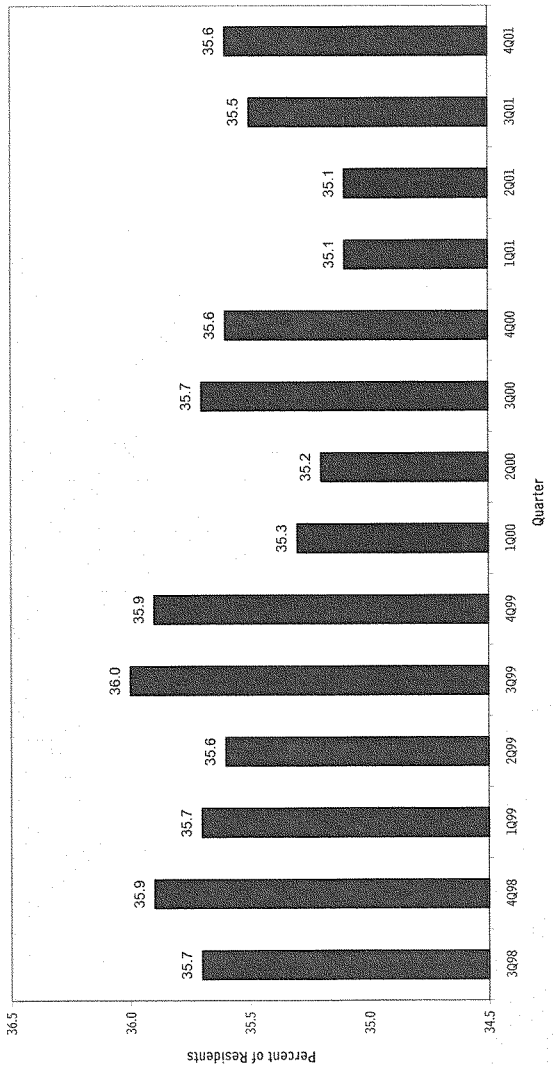
SOURCE:MDS

Figure 3.14. Prevalence of Dehydration in Nursing Home Residents at the 90th percentile
by State: United States, Third Quarter 2001



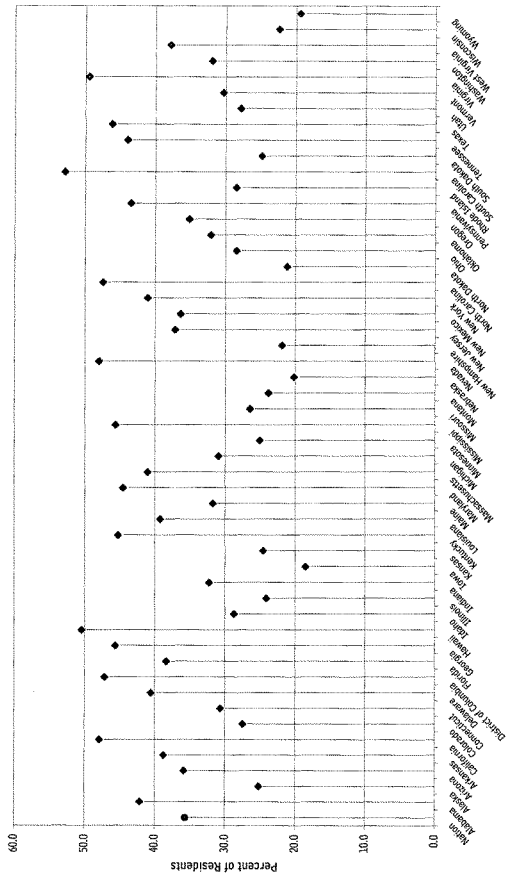
SOURCE: MDS

Figure 3.15. Prevalence of Severe Bowel and Bladder Incontinence in Nursing Home Residents: United States, Quarterly 1998-2001



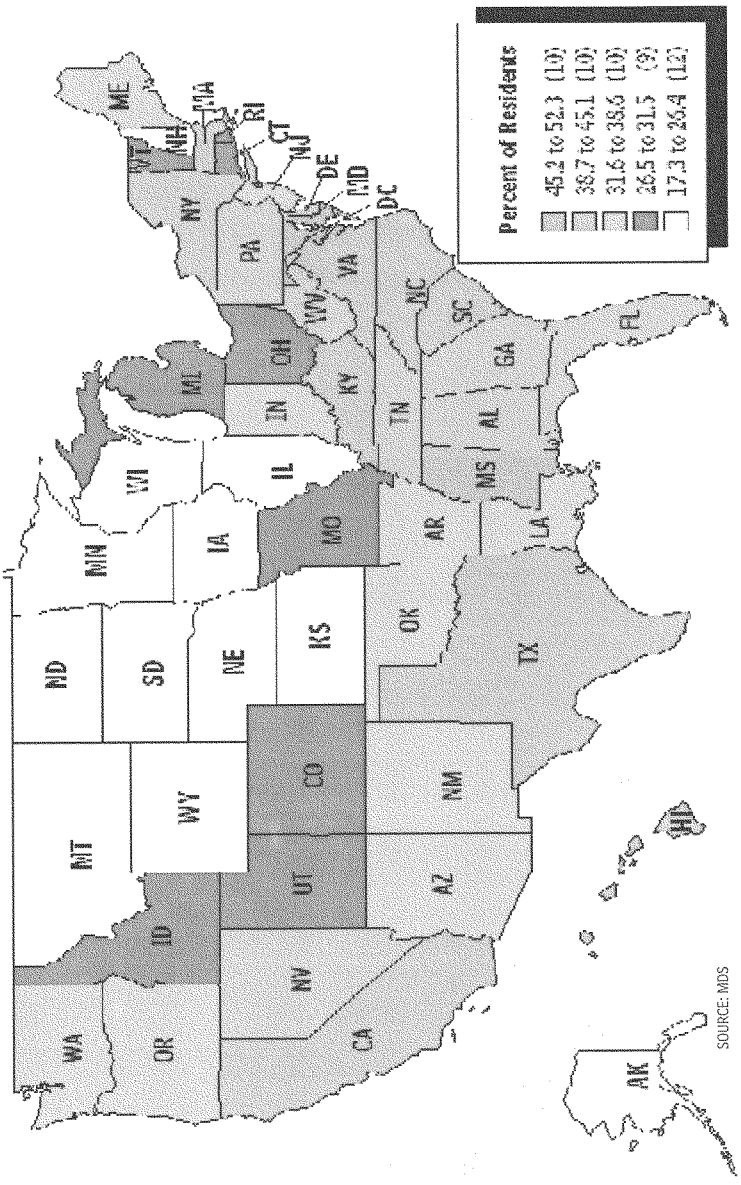
SOURCE: MDS

Figure 3.16. Median Prevalence of Severe Bowel or Bladder Incontinence in Nursing Home Residents by State: United States, Third Quarter 2001



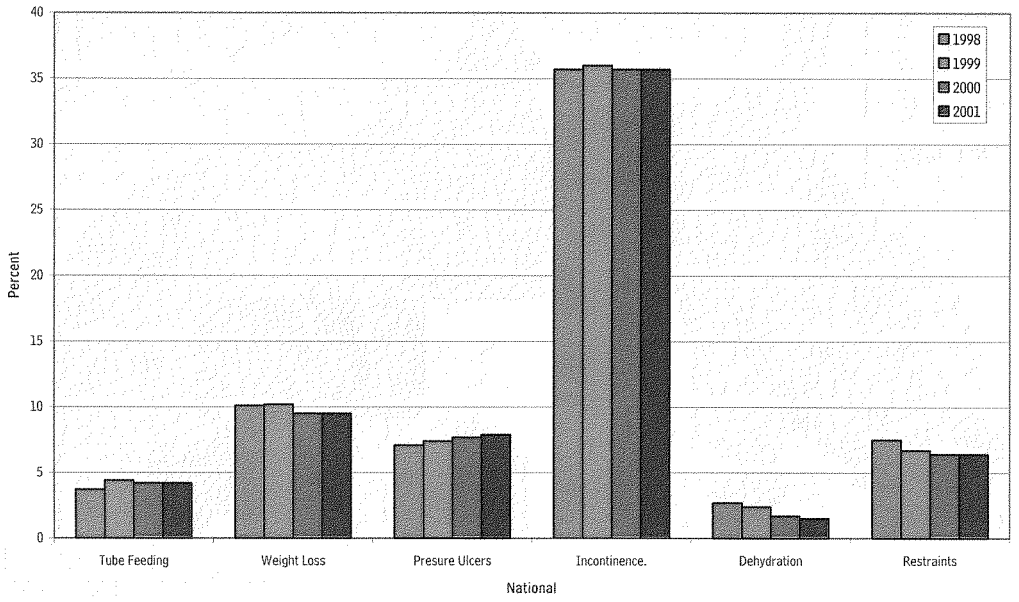
SOURCE: MDS

Figure 3.17. Median Prevalence of Severe Bowel or Bladder Incontinence in Nursing Home Residents by State: United States. Third Quarter 2001



SOURCE: MDS

Figure 3.18. Trend of Prevalence of Tube Feeding, Weight Loss, Pressure Ulcers, Incontinence, Dehydration and Restraints Usage in Nursing Homes: United States, 1998-2001



SOURCE: MDS

Table 3.1. Summary of Incidence and Prevalence of Clinical Measures in Nursing Home Residents: United States, Quarterly 1998-2001

	Percent of Residents, 50th Percentile														
	Calender Quarters														
Clinical Measure	1998 Qtr3	1998 Qtr4	1999 Qtr1	1999 Qtr2	1999 Qtr3	1999 Qtr4	2000 Qtr1	2000 Qtr2	2000 Qtr3	2000 Qtr4	2001 Qtr1	2001 Qtr2	2001 Qtr3	2001 Qtr4
Pressure Ulcer Prevalence	7.1	7.2	7.8	7.7	7.4	7.3	7.9	7.6	7.7	7.9	8.3	8.1	7.9	8.1
Pressure Ulcer Incidence	n/a	1.7	2.0	2.0	1.9	2.0	2.1	2.0	2.1	2.2	2.2	2.1	2.1	2.2
Restraints Prevalence	7.5	7.2	6.9	6.8	6.7	6.5	6.3	6.3	6.4	6.3	6.3	6.3	6.4	6.2
Restraints Incidence	n/a	1.0	1.0	1.1	1.2	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.2	1.1
Incontinence Prevalence	35.7	35.9	35.7	35.6	36.0	35.9	35.3	35.2	35.7	35.6	35.1	35.1	35.5	35.6
Tube Feeding Prevalence	3.7	3.8	4.4	4.2	4.2	4.4	4.4	4.3	4.3	4.3	4.2	4.2	4.2	4.2
Weight Loss Prevalence	10.1	10.1	11.4	10.8	10.2	9.9	10.7	9.7	9.5	9.6	10.1	9.7	9.5	9.3

Source: MDS

Table 3.2. Distribution of Activity of Daily Living (ADL) Impairments in Nursing Home Residents by Type of Nursing Home: United States, 1999-2001

1999	Percent of Residents by Number of ADL Impairments					
	0	1	2	3	4	5
Nation	**36.1**	**9.5**	**8.9**	**10.0**	**16.4**	**19.0**
Ownership						
For-Profit	35.2	8.7	8.9	10.2	16.8	20.2
Voluntary nonprofit	37.3	10.7	9.1	9.8	16.2	16.9
Government	32.8	9.7	9.1	10.4	16.0	21.9
Certification						
Medicare and Medicaid	34.3	9.0	9.0	10.3	17.1	20.2
Medicare only	43.7	13.1	8.8	8.7	13.6	12.0
Medicaid only	41.2	8.0	8.2	9.7	13.8	19.1
Bed Size						
Less than 50	43.4	12.6	8.5	8.6	13.7	13.2
50 - 99	35.5	8.9	8.7	9.9	17.2	19.7
100 - 199	34.6	8.9	9.0	10.2	17.2	20.2
200 or more	33.6	9.2	9.4	11.2	16.1	20.5
2000	Percent of Residents by Number of ADL Impairments					
	0	1	2	3	4	5
Nation	**35.6**	**9.5**	**8.8**	**10.0**	**17.2**	**18.9**
Ownership						
For-Profit	35.0	8.7	8.7	10.1	17.6	20.0
Voluntary nonprofit	36.6	11.0	9.0	9.8	16.8	16.8
Government	32.9	9.8	8.9	10.1	16.6	21.8
Certification						
Medicare and Medicaid	34.1	9.0	8.8	10.2	17.9	20.0
Medicare only	42.7	13.8	8.8	8.7	14.5	11.6
Medicaid only	40.9	8.1	8.2	9.7	14.0	19.1
Bed Size						
Less than 50	43.0	12.9	8.5	8.5	14.2	12.8
50 - 99	35.1	9.1	8.6	9.7	17.9	19.6
100 - 199	34.2	8.9	8.8	10.2	17.9	20.0
200 or more	33.3	9.3	9.2	11.0	16.8	20.3
2001	Percent of Residents by Number of ADL Impairments					
	0	1	2	3	4	5
Nation	**34.8**	**9.4**	**8.7**	**9.9**	**18.2**	**18.9**
Ownership						
For-Profit	34.4	8.6	8.5	10.0	18.7	19.9
Voluntary nonprofit	35.9	10.9	9.1	9.7	17.8	16.7
Government	33.0	9.9	8.8	9.9	17.0	21.3
Certification						
Medicare and Medicaid	33.4	8.9	8.7	10.1	18.9	20.0
Medicare only	42.2	14.0	8.9	8.6	15.4	10.8
Medicaid only	42.3	7.8	7.8	9.5	14.0	18.6
Bed Size						
Less than 50	42.4	13.5	8.7	8.3	15.2	12.0
50 - 99	34.7	8.9	8.4	9.7	18.7	19.6
100 - 199	33.6	8.8	8.7	10.0	19.0	19.9
200 or more	32.3	8.6	9.1	11.1	17.9	21.0

Source: MDS and OSCAR

Table 3.3 (a). Distribution of Activity of Daily Living (ADL) Impairments in Nursing Home Residents: United States, 1999

		Percent by Number of ADL Impairments					
	Residents	0	1	2	3	4	5
Nation	**3,309,646**	**36.1**	**9.5**	**8.9**	**10.0**	**16.4**	**19.0**
Alabama	44,289	32.2	8.2	8.5	10.3	15.1	25.7
Alaska	1,328	37.3	8.1	7.1	10.0	14.8	22.6
Arizona	42,450	41.1	12.1	9.2	10.0	14.5	13.2
Arkansas	38,201	39.8	9.4	7.4	9.0	13.5	20.9
California	287,330	31.1	9.3	9.6	10.1	18.0	22.0
Colorado	38,650	47.0	9.6	9.4	9.1	13.7	11.2
Connecticut	62,264	42.4	10.3	8.9	9.7	14.0	14.7
Delaware	8,197	38.4	8.7	8.9	10.2	14.8	19.0
District of Columbia	5,246	33.3	8.2	9.9	11.3	16.0	21.3
Florida	202,793	37.7	9.4	9.6	9.8	16.3	17.3
Georgia	65,471	33.1	8.8	9.2	11.0	15.3	22.7
Hawaii	7,149	28.5	8.1	8.5	9.7	15.4	29.8
Idaho	12,906	42.7	8.9	8.8	10.1	15.6	13.9
Illinois	185,371	46.9	9.0	8.2	8.8	12.9	14.1
Indiana	94,911	40.5	10.9	7.6	8.8	14.9	17.3
Iowa	55,707	43.2	11.1	8.7	9.8	14.5	12.6
Kansas	44,881	43.9	8.5	7.6	9.1	15.8	15.2
Kentucky	52,015	27.8	10.8	8.7	9.0	16.9	26.8
Louisiana	59,188	37.7	9.2	7.6	10.0	12.3	23.2
Maine	19,234	23.7	7.5	7.5	8.6	31.3	21.3
Maryland	63,691	32.0	8.8	9.3	10.1	18.1	21.7
Massachusetts	113,260	38.0	11.4	8.9	8.2	17.6	15.9
Michigan	90,064	36.0	9.2	10.3	11.1	15.9	17.5
Minnesota	75,782	33.6	9.9	8.8	8.3	21.8	17.5
Mississippi	30,250	34.1	8.2	7.3	9.0	17.2	24.3
Missouri	92,527	42.4	8.8	8.4	8.9	14.8	16.7
Montana	13,444	44.0	11.3	8.9	8.8	13.4	13.5
Nebraska	30,462	40.3	9.1	8.2	9.0	18.1	15.3
Nevada	10,503	37.4	9.4	9.3	12.4	15.4	16.2
New Hampshire	13,973	41.2	11.0	8.6	9.0	15.6	14.5
New Jersey	100,500	39.2	9.1	9.7	11.0	14.6	16.3
New Mexico	13,481	42.6	9.5	9.7	9.9	14.4	14.0
New York	202,589	29.6	9.4	10.3	14.0	15.7	21.1
North Carolina	76,084	32.0	9.0	9.4	10.9	15.6	23.2
North Dakota	11,518	33.9	12.1	9.1	9.1	17.5	18.3
Ohio	184,351	34.9	9.8	8.7	9.3	18.1	19.0
Oklahoma	49,553	40.6	9.9	7.8	9.1	13.2	19.3
Oregon	27,633	37.0	9.3	9.0	10.7	17.5	16.5
Pennsylvania	194,611	31.7	9.0	7.9	8.9	21.0	21.5
Rhode Island	18,071	40.6	10.9	10.2	10.4	13.3	14.6
South Carolina	34,258	29.3	9.4	10.1	12.4	15.9	22.9
South Dakota	12,507	40.5	8.2	6.9	8.1	19.2	17.0
Tennessee	77,250	30.4	10.0	9.5	10.8	16.2	23.1
Texas	193,761	35.1	8.7	8.1	10.6	15.7	21.8
Utah	16,656	40.4	10.8	10.2	9.5	16.1	12.9
Vermont	6,614	30.8	11.1	9.2	9.5	20.7	18.7
Virginia	58,931	27.1	9.1	10.5	11.7	17.4	24.2
Washington	63,240	35.1	9.9	9.2	9.3	19.2	17.3
West Virginia	24,309	31.3	10.8	8.0	10.0	17.6	22.3
Wisconsin	76,947	42.7	9.4	9.0	10.5	14.5	13.9
Wyoming	5,245	45.3	9.0	10.2	10.1	12.9	12.6

Source: MDS

Table 3.3 (b). Distribution of Activity of Daily Living (ADL) Impairments in Nursing Home Residents: United States, 2000

		Percent of Residents by Number of ADL Impairments					
	Residents	0	1	2	3	4	5
Nation	**3,303,369**	**35.6**	**9.5**	**8.8**	**10.0**	**17.2**	**18.9**
Alabama	45,896	32.9	8.0	8.1	10.2	15.6	25.2
Alaska	1,417	36.4	8.4	6.6	9.2	16.0	23.4
Arizona	41,260	41.6	10.1	9.3	10.1	16.0	12.9
Arkansas	36,623	39.1	9.1	7.3	9.3	14.2	21.0
California	282,158	30.6	9.1	9.5	10.0	18.5	22.3
Colorado	39,222	45.2	9.8	9.2	9.4	14.7	11.7
Connecticut	63,079	40.9	10.6	9.0	9.9	15.0	14.6
Delaware	8,256	36.6	9.1	9.6	10.1	15.6	19.1
District of Columbia	5,354	33.9	9.0	9.7	10.4	16.7	20.4
Florida	207,849	37.0	9.6	9.4	9.6	17.2	17.2
Georgia	65,073	32.6	8.7	9.3	11.3	15.6	22.5
Hawaii	7,441	26.7	9.4	8.6	9.6	15.9	29.8
Idaho	13,191	41.4	8.9	8.3	9.6	16.8	14.9
Illinois	182,569	47.1	9.2	7.9	8.7	13.3	13.8
Indiana	94,347	39.0	10.9	7.4	8.8	16.2	17.7
Iowa	55,039	41.3	11.7	8.7	9.5	15.8	13.0
Kansas	43,839	43.4	8.3	7.7	9.3	16.1	15.2
Kentucky	51,234	28.0	11.6	8.0	8.5	17.9	25.9
Louisiana	56,903	37.6	9.4	7.6	10.1	12.6	22.7
Maine	19,387	22.9	7.3	6.9	8.6	33.3	21.0
Maryland	65,095	31.1	8.9	8.8	10.4	19.0	21.8
Massachusetts	112,695	37.5	11.4	8.7	8.5	18.5	15.3
Michigan	89,828	35.5	9.6	9.9	10.9	16.8	17.3
Minnesota	75,047	33.1	9.8	8.9	8.1	22.5	17.6
Mississippi	29,244	34.1	7.5	6.7	8.4	18.2	25.0
Missouri	87,206	43.1	8.8	8.3	9.0	14.8	16.0
Montana	13,634	44.6	10.4	8.6	8.7	14.2	13.5
Nebraska	30,027	41.5	9.0	7.9	8.7	18.1	14.9
Nevada	11,649	37.1	9.6	9.4	11.6	16.6	15.8
New Hampshire	14,433	42.4	11.0	8.4	8.5	16.1	13.6
New Jersey	105,521	39.4	8.8	9.4	11.0	15.1	16.3
New Mexico	13,476	42.1	9.0	10.0	9.8	14.8	14.2
New York	210,847	29.9	9.5	10.0	13.8	16.2	20.7
North Carolina	78,104	31.4	8.7	9.4	10.8	16.4	23.3
North Dakota	10,910	32.8	10.6	8.6	8.7	19.7	19.6
Ohio	185,351	33.7	9.9	8.5	9.2	19.9	18.9
Oklahoma	47,815	41.8	9.4	7.6	9.2	13.2	18.9
Oregon	26,602	37.5	9.2	9.1	10.4	18.2	15.7
Pennsylvania	191,351	30.5	9.0	7.7	8.7	22.3	21.8
Rhode Island	18,390	40.1	11.2	10.2	9.9	14.4	14.2
South Carolina	35,480	28.5	9.5	9.9	12.8	16.5	22.8
South Dakota	12,235	38.7	8.6	7.3	8.0	19.6	17.8
Tennessee	76,411	28.9	10.5	9.5	10.7	16.9	23.4
Texas	189,978	35.4	8.8	7.9	10.7	15.7	21.5
Utah	17,236	39.1	10.2	10.3	9.6	17.4	13.4
Vermont	6,635	30.7	11.7	8.6	9.2	20.1	19.6
Virginia	59,637	26.3	8.9	10.5	11.5	18.9	23.8
Washington	62,591	34.2	10.4	8.8	9.0	20.2	17.5
West Virginia	24,135	32.9	10.1	7.5	9.8	17.9	21.8
Wisconsin	76,518	42.2	9.3	9.1	10.4	15.2	13.8
Wyoming	5,151	45.2	9.0	9.3	9.6	13.8	13.1

Source: MDS

Table 3.3 (c). Distribution of Activity of Daily Living (ADL) Impairments in Nursing Home Residents: United States, 2001

		Percent of Residents by Number of ADL Impairments					
	Residents	0	1	2	3	4	5
Nation	**3,317,005**	**34.8**	**9.4**	**8.7**	**9.9**	**18.2**	**18.9**
Alabama	47,698	32.8	8.2	8.3	9.9	16.4	24.4
Alaska	1,398	36.5	8.5	6.6	8.7	16.1	23.7
Arizona	40,556	41.7	9.7	8.8	10.1	17.0	12.6
Arkansas	36,140	39.6	9.0	7.4	9.2	14.0	21.0
California	276,840	30.0	8.7	9.1	9.9	19.6	22.7
Colorado	39,581	44.7	9.6	9.0	9.3	15.6	11.8
Connecticut	64,293	39.9	10.2	8.9	9.6	16.3	15.0
Delaware	8,834	36.5	8.1	9.1	10.5	17.2	18.7
District of Columbia	5,540	31.2	8.6	9.9	11.9	19.1	19.3
Florida	210,535	36.4	9.4	9.3	9.7	18.3	16.9
Georgia	65,781	31.7	8.1	8.8	11.0	17.0	23.4
Hawaii	7,796	25.5	8.9	7.9	9.0	17.9	30.8
Idaho	13,739	39.7	8.8	7.8	8.8	19.1	15.8
Illinois	181,293	46.4	8.9	8.2	8.9	13.9	13.7
Indiana	93,695	37.3	11.6	7.2	8.8	17.1	17.9
Iowa	55,239	39.9	11.5	8.9	9.2	16.9	13.4
Kansas	41,497	42.8	7.8	7.3	9.2	17.4	15.4
Kentucky	51,283	28.6	10.6	7.7	8.5	18.9	25.8
Louisiana	55,175	36.7	9.3	7.9	10.1	13.3	22.8
Maine	19,436	22.5	7.7	7.3	8.2	33.9	20.4
Maryland	67,546	30.1	9.0	9.0	10.1	20.6	21.3
Massachusetts	111,797	36.8	11.5	8.7	8.7	19.1	15.1
Michigan	91,555	34.3	9.8	9.6	10.7	18.5	17.2
Minnesota	75,939	32.8	10.1	8.8	8.2	22.8	17.4
Mississippi	29,235	33.6	7.1	6.5	8.6	18.7	25.5
Missouri	84,713	43.0	8.7	8.0	9.2	15.6	15.6
Montana	13,634	44.9	10.2	8.7	8.1	15.1	12.9
Nebraska	29,850	39.8	9.2	7.9	8.8	19.1	15.1
Nevada	11,884	36.7	9.4	9.1	11.1	16.6	17.1
New Hampshire	14,445	40.6	11.3	8.7	8.3	17.5	13.6
New Jersey	109,959	38.0	8.8	9.3	10.8	16.7	16.4
New Mexico	13,731	43.5	8.9	9.3	9.2	14.9	14.2
New York	217,294	29.5	9.5	10.0	13.7	16.9	20.5
North Carolina	80,724	31.4	8.3	9.2	10.7	17.2	23.1
North Dakota	11,219	32.3	11.3	8.6	8.3	20.8	18.8
Ohio	187,379	32.3	9.9	8.5	8.9	21.8	18.6
Oklahoma	46,447	42.1	9.2	7.6	9.4	13.7	18.0
Oregon	27,177	36.7	9.3	9.3	10.4	19.5	14.8
Pennsylvania	189,557	28.7	9.0	7.7	8.4	23.6	22.5
Rhode Island	18,506	39.0	11.6	10.1	9.7	15.3	14.3
South Carolina	35,879	28.7	9.4	9.7	12.6	17.2	22.4
South Dakota	12,251	37.7	8.7	6.5	7.5	22.2	17.4
Tennessee	77,562	28.8	11.0	9.1	10.4	17.6	23.1
Texas	187,831	34.7	8.5	7.9	11.0	16.3	21.6
Utah	17,427	37.7	10.6	10.7	9.2	18.6	13.3
Vermont	6,745	29.1	11.1	8.4	8.2	23.8	19.3
Virginia	62,070	26.0	8.8	10.1	11.4	19.9	23.9
Washington	62,351	32.1	10.0	9.1	9.0	22.2	17.6
West Virginia	24,321	34.1	10.5	7.8	8.7	17.9	21.0
Wisconsin	76,529	41.1	9.1	8.9	10.4	16.8	13.7
Wyoming	5,099	44.8	9.0	8.5	7.8	15.9	14.0

Source: MDS

Table 3.4. Distribution of Cognitive Impairments in Nursing Home Residents by Type of Nursing Home: United States, 1999-2001

1999	Percent of Residents						
	No Impairment (CPS=0)	Very Mild Impairment (CPS=1)	Mild Impairment (CPS=2)	Moderately Impairment (CPS=3)	Moderately Severe Impairment (CPS=4)	Severe Impairment (CPS=5)	Very Severe Impairment (CPS=6)
Nation	**28.4**	**12.6**	**12.8**	**22.5**	**6.9**	**7.0**	**9.8**
Ownership							
For-Profit	23.8	12.9	13.2	24.3	7.7	7.4	10.6
Voluntary Non-Profit	36.0	11.8	12.4	20.0	5.6	6.0	8.2
Government	25.2	12.6	11.6	22.6	6.9	8.1	12.9
Certification							
Medicare and Medicaid	25.3	12.4	13.2	23.8	7.5	7.2	10.5
Medicare only	54.2	11.7	10.3	12.3	2.9	3.9	4.7
Medicaid only	14.3	15.5	12.7	27.9	7.1	10.2	12.4
Bed Size							
Less than 50	51.7	11.9	9.9	13.5	3.0	4.4	5.6
50 - 99	24.7	12.7	13.4	24.1	7.0	7.9	10.2
100 - 199	24.1	12.6	13.3	24.5	7.5	7.4	10.5
200 or more	25.0	12.6	13.0	23.0	8.4	6.6	11.3

2000	Percent of Residents						
	No Impairment	Very Mild Impairment	Mild Impairment	Moderately Impairment	Moderately Severe Impairment	Severe Impairment	Very Severe Impairment
Nation	**28.5**	**12.6**	**13.0**	**22.8**	**6.9**	**6.8**	**9.5**
Ownership							
For-Profit	24.7	12.9	13.4	24.2	7.6	7.1	10.1
Voluntary Non-Profit	36.2	11.8	12.5	20.1	5.5	5.9	7.9
Government	25.6	12.7	11.8	22.8	6.9	7.8	12.4
Certification							
Medicare and Medicaid	25.9	12.4	13.4	23.8	7.4	7.0	10.1
Medicare only	55.0	11.6	10.3	12.4	2.9	3.5	4.3
Medicaid only	14.2	15.6	12.9	28.4	7.1	9.8	12.0
Bed Size							
Less than 50	52.2	11.9	10.1	13.5	3.1	4.0	5.2
50 - 99	25.0	12.8	13.5	24.4	7.0	7.5	9.8
100 - 199	24.8	12.5	13.5	24.4	7.5	7.2	10.1
200 or more	25.6	12.6	13.1	23.2	8.2	6.5	10.9

2001	Percent of Residents						
	No Impairment	Very Mild Impairment	Mild Impairment	Moderately Impairment	Moderately Severe Impairment	Severe Impairment	Very Severe Impairment
Nation	**28.5**	**12.6**	**13.0**	**22.8**	**6.9**	**6.7**	**9.5**
Ownership							
For-Profit	25.0	12.9	13.7	24.3	7.7	6.8	9.6
Voluntary Non-Profit	35.9	11.7	12.9	20.5	5.6	5.8	7.5
Government	25.8	12.5	12.2	23.4	6.8	7.5	11.8
Certification							
Medicare and Medicaid	26.3	12.3	13.6	24.0	7.5	6.7	9.6
Medicare only	55.4	11.6	10.8	12.3	2.8	3.3	3.8
Medicaid only	14.1	16.3	13.2	28.6	7.1	9.1	11.5
Bed Size							
Less than 50	52.9	11.7	10.6	13.3	3.0	3.7	4.6
50 - 99	24.7	12.8	13.8	24.8	7.1	7.3	9.4
100 - 199	25.3	12.5	13.7	24.5	7.5	6.9	9.6
200 or more	23.9	12.6	13.5	24.3	8.6	6.4	10.8

Source: MDS and OSCAR

Table 3.5 (a). Distribution of Cognitive Impairments in Nursing Home Residents by State: United States, 1999

		Percent of Residents						
	Residents	No Impairment (CPS=0)	Very Mild Impairment (CPS=1)	Mild Impairment (CPS=2)	Moderate Impairment (CPS=3)	Moderately Severe Impairment (CPS=4)	Severe Impairment (CPS=5)	Very Severe Impairment (CPS=6)
Nation	**3,289,107**	**28.4**	**12.6**	**12.8**	**22.5**	**6.9**	**7.0**	**9.8**
Alabama	44,051	21.9	12.1	12.7	24.2	7.9	5.8	15.5
Alaska	1,303	28.3	13.3	12.5	22.5	7.4	7.1	8.9
Arizona	42,167	37.7	11.9	10.3	20.2	4.7	8.9	6.3
Arkansas	37,906	25.3	12.6	11.9	23.8	5.7	9.0	11.6
California	284,158	30.0	11.2	13.1	19.5	9.4	5.9	10.9
Colorado	38,474	25.6	13.9	15.4	25.5	6.4	8.4	4.8
Connecticut	62,080	31.4	13.1	13.1	22.1	5.2	6.7	8.4
Delaware	8,153	29.1	13.4	13.7	20.7	4.9	6.9	11.2
District of Columbia	5,218	30.2	11.2	12.2	20.2	6.9	5.9	13.5
Florida	201,493	35.4	11.2	11.1	20.6	6.6	6.3	8.7
Georgia	65,122	18.9	11.8	13.6	26.7	8.7	7.1	13.2
Hawaii	7,016	21.2	10.0	11.8	23.2	14.1	4.3	15.4
Idaho	12,809	29.0	12.1	14.0	24.7	7.7	7.1	5.3
Illinois	184,449	29.9	16.1	12.7	23.5	7.0	4.5	6.4
Indiana	94,402	31.4	13.7	10.4	21.9	5.3	8.4	9.0
Iowa	55,432	28.2	13.1	14.7	25.5	5.3	7.5	5.7
Kansas	44,665	23.1	13.7	14.3	26.9	6.0	9.0	6.9
Kentucky	51,542	26.7	11.9	11.6	23.6	5.8	6.5	13.9
Louisiana	58,627	27.4	14.1	12.4	20.4	5.4	6.7	13.6
Maine	19,171	27.5	12.8	11.5	23.9	5.5	11.3	7.6
Maryland	63,430	32.9	11.7	11.1	20.7	5.1	6.9	11.5
Massachusetts	112,790	33.5	12.2	11.2	22.0	5.4	6.8	8.7
Michigan	89,509	24.0	10.7	14.8	27.0	9.2	6.2	8.1
Minnesota	75,486	25.4	14.0	14.9	24.9	6.0	7.6	7.1
Mississippi	30,096	27.2	13.6	9.8	23.5	6.5	6.5	13.0
Missouri	92,015	28.4	13.5	12.4	22.6	5.3	9.3	8.4
Montana	13,367	28.4	13.9	13.9	24.4	5.5	7.8	6.0
Nebraska	30,328	26.6	13.6	14.7	25.0	6.2	7.5	6.4
Nevada	10,424	34.9	11.6	11.5	20.6	5.5	8.1	7.9
New Hampshire	13,943	26.0	12.1	13.5	26.2	6.0	8.8	7.6
New Jersey	99,958	34.9	12.1	12.8	19.7	5.3	5.6	9.7
New Mexico	13,404	28.8	13.4	12.1	23.1	5.5	10.1	7.0
New York	201,433	26.0	12.6	13.7	21.0	9.1	5.5	12.1
North Carolina	75,661	27.1	11.5	11.4	22.8	7.1	6.9	13.3
North Dakota	11,462	24.7	12.5	14.2	27.6	7.3	5.8	8.0
Ohio	183,432	26.9	12.8	12.7	24.5	7.7	6.4	9.0
Oklahoma	49,158	25.7	15.1	12.1	21.9	4.6	9.6	11.0
Oregon	27,403	27.6	12.4	13.9	25.2	7.3	6.5	7.1
Pennsylvania	193,594	31.3	12.4	11.8	20.7	6.4	6.9	10.5
Rhode Island	18,006	30.1	11.9	13.8	23.7	6.4	5.6	8.5
South Carolina	34,040	25.9	10.9	9.6	23.9	7.2	8.6	13.9
South Dakota	12,469	22.0	14.4	14.2	27.6	6.9	7.7	7.2
Tennessee	76,714	23.3	11.4	11.8	23.9	7.4	9.0	13.3
Texas	192,195	23.8	13.0	14.6	21.2	6.2	8.8	12.4
Utah	16,516	32.2	12.7	13.8	21.8	6.1	8.5	4.9
Vermont	6,597	22.2	13.5	12.2	26.8	8.2	8.4	8.7
Virginia	58,544	23.3	12.2	12.4	23.2	7.2	7.8	14.0
Washington	62,826	26.0	12.3	14.1	25.2	9.6	6.2	6.8
West Virginia	24,156	32.4	10.5	11.2	21.6	5.7	7.3	11.1
Wisconsin	76,685	27.7	12.4	15.2	24.3	6.5	7.3	6.6
Wyoming	5,228	26.5	13.6	13.0	26.9	5.9	9.3	4.8

Source: MDS

Table 3.5 (b). Distribution of Cognitive Impairments in Nursing Home Residents by State: United States, 2000

		Percent of Residents						
	Residents	No Impairment (CPS=0)	Very Mild Impairment (CPS=1)	Mild Impairment (CPS=2)	Moderate Impairment (CPS=3)	Moderately Severe Impairment (CPS=4)	Severe Impairment (CPS=5)	Very Severe Impairment (CPS=6)
Nation	**3,276,257**	**28.5**	**12.6**	**13.0**	**22.8**	**6.9**	**6.8**	**9.5**
Alabama	45,657	22.4	11.8	12.8	24.7	8.2	5.5	14.6
Alaska	1,386	30.3	14.1	12.0	21.2	6.6	6.9	9.0
Arizona	40,802	37.2	11.8	10.8	20.6	5.0	8.6	6.0
Arkansas	36,280	24.0	13.1	12.3	24.4	5.9	8.7	11.5
California	278,414	29.5	11.3	13.4	19.8	9.5	5.6	10.9
Colorado	38,973	25.0	14.0	15.6	26.1	6.3	8.4	4.7
Connecticut	62,858	31.6	13.2	13.5	22.4	5.0	6.2	8.2
Delaware	8,190	28.7	13.0	15.2	20.7	4.9	6.8	10.7
District of Columbia	5,310	31.3	10.8	13.3	19.7	6.6	5.5	12.8
Florida	206,132	36.2	10.9	11.3	20.3	6.5	6.3	8.5
Georgia	64,683	18.4	11.2	14.4	27.9	8.8	6.6	12.8
Hawaii	7,317	21.7	10.2	12.3	22.6	14.4	3.3	15.4
Idaho	13,067	29.7	12.2	14.0	23.8	7.2	7.6	5.6
Illinois	180,313	30.0	16.6	13.1	23.4	6.8	4.2	5.9
Indiana	93,938	31.0	14.3	10.0	22.6	5.3	8.4	8.3
Iowa	54,745	27.7	13.4	14.7	25.8	5.4	7.5	5.6
Kansas	43,538	22.7	13.6	14.9	27.3	5.8	9.0	6.8
Kentucky	50,735	27.0	12.1	11.7	23.6	5.8	6.3	13.4
Louisiana	56,403	27.1	14.4	12.7	20.5	5.8	6.3	13.1
Maine	19,255	28.0	13.4	12.3	23.8	5.2	10.0	7.2
Maryland	64,567	33.6	11.6	11.5	20.3	5.0	7.1	10.9
Massachusetts	112,060	33.5	11.9	11.9	22.1	5.4	6.8	8.3
Michigan	89,176	24.1	10.7	15.0	27.3	9.0	6.2	7.6
Minnesota	74,747	24.9	13.8	15.2	25.2	5.8	8.0	7.0
Mississippi	29,110	25.7	14.2	9.6	23.8	6.8	6.4	13.4
Missouri	86,436	28.6	13.7	12.7	23.0	5.1	8.9	8.1
Montana	13,536	30.2	13.8	12.9	23.9	5.3	8.0	5.8
Nebraska	29,907	26.8	13.4	14.4	25.1	6.1	7.9	6.3
Nevada	11,554	35.4	10.9	11.6	21.2	6.3	7.1	7.6
New Hampshire	14,394	26.8	12.1	13.9	25.7	5.3	8.9	7.1
New Jersey	104,614	36.3	12.0	12.6	19.6	5.2	5.2	9.1
New Mexico	13,336	27.6	13.7	12.7	23.3	5.4	10.2	7.0
New York	208,366	27.2	12.3	13.9	21.0	8.9	5.1	11.6
North Carolina	77,539	26.5	11.9	12.0	22.7	7.2	6.5	13.1
North Dakota	10,851	22.8	12.6	14.4	28.7	7.3	6.1	7.9
Ohio	184,236	26.7	12.9	12.9	25.2	7.6	6.3	8.4
Oklahoma	47,270	25.8	15.8	12.8	22.4	4.3	8.8	10.0
Oregon	26,344	29.1	11.6	13.7	25.1	7.6	6.0	6.8
Pennsylvania	189,948	31.0	12.4	11.7	21.5	6.5	7.1	9.9
Rhode Island	18,335	29.9	11.9	14.5	23.8	6.5	5.5	8.0
South Carolina	35,263	25.9	11.3	9.9	24.1	6.9	8.0	13.9
South Dakota	12,191	21.7	13.8	14.6	27.4	7.7	7.4	7.5
Tennessee	75,856	23.0	11.3	12.1	24.6	7.9	8.2	12.9
Texas	188,312	23.0	13.3	14.9	21.7	6.3	8.5	12.3
Utah	17,097	31.9	12.8	14.0	22.4	6.3	7.8	4.7
Vermont	6,617	21.1	12.6	13.5	27.3	8.1	8.5	8.9
Virginia	59,323	23.8	12.6	12.4	23.6	7.3	7.3	13.1
Washington	62,178	26.6	12.1	14.5	24.8	9.5	6.0	6.6
West Virginia	23,854	32.7	10.1	11.3	22.2	5.8	7.2	10.7
Wisconsin	76,115	28.6	12.3	15.1	24.2	6.2	7.4	6.2
Wyoming	5,129	26.3	13.6	13.9	26.1	6.3	8.9	4.8

Source: MDS

Table 3.5 (c). Distribution of Cognitive Impairments in Nursing Home Residents by State: United States, 2001

		Percent of Residents						
	Residents	No Impairment (CPS=0)	Very Mild Impairment (CPS=1)	Mild Impairment (CPS=2)	Moderate Impairment (CPS=3)	Moderately Severe Impairment (CPS=4)	Severe Impairment (CPS=5)	Very Severe Impairment (CPS=6)
Nation	**3,284,003**	**28.5**	**12.6**	**13.0**	**22.8**	**6.9**	**6.7**	**9.5**
Alabama	45,684	22.4	11.8	12.8	24.7	8.2	5.5	14.6
Alaska	1,390	30.3	14.0	11.9	21.3	6.6	6.8	9.0
Arizona	40,983	37.3	11.8	10.8	20.6	5.0	8.5	6.0
Arkansas	36,405	24.0	13.2	12.3	24.4	5.9	8.7	11.5
California	279,249	29.5	11.3	13.4	19.8	9.5	5.6	10.9
Colorado	39,056	25.0	14.0	15.6	26.0	6.3	8.4	4.7
Connecticut	62,920	31.6	13.2	13.5	22.4	5.0	6.2	8.2
Delaware	8,204	28.7	13.0	15.2	20.8	4.9	6.8	10.7
District of Columbia	5,321	31.3	10.7	13.3	19.7	6.6	5.5	12.8
Florida	206,499	36.2	10.9	11.3	20.3	6.5	6.3	8.5
Georgia	64,779	18.4	11.2	14.4	27.9	8.7	6.6	12.7
Hawaii	7,325	21.7	10.2	12.3	22.5	14.4	3.3	15.4
Idaho	13,082	29.6	12.2	14.0	23.8	7.2	7.6	5.6
Illinois	181,477	30.1	16.6	13.1	23.4	6.8	4.2	5.9
Indiana	93,906	31.1	14.3	10.1	22.6	5.3	8.4	8.3
Iowa	54,770	27.7	13.4	14.7	25.8	5.4	7.5	5.5
Kansas	43,638	22.6	13.7	15.0	27.2	5.8	9.0	6.8
Kentucky	50,848	27.0	12.1	11.8	23.6	5.8	6.3	13.3
Louisiana	56,475	27.2	14.4	12.7	20.5	5.8	6.3	13.1
Maine	19,300	28.0	13.4	12.3	23.8	5.2	10.0	7.2
Maryland	64,744	33.6	11.6	11.5	20.3	5.0	7.1	10.9
Massachusetts	112,242	33.5	12.0	11.9	22.1	5.4	6.8	8.3
Michigan	89,279	24.1	10.7	15.0	27.3	9.0	6.2	7.6
Minnesota	74,787	24.9	13.8	15.2	25.2	5.8	8.0	7.0
Mississippi	29,131	25.7	14.2	9.7	23.8	6.8	6.4	13.4
Missouri	86,756	28.6	13.7	12.7	23.0	5.1	8.9	8.0
Montana	13,559	30.2	13.8	12.9	24.0	5.3	8.0	5.7
Nebraska	29,901	26.8	13.4	14.4	25.1	6.1	7.9	6.3
Nevada	11,571	35.4	10.9	11.6	21.2	6.3	7.1	7.5
New Hampshire	14,401	26.8	12.1	13.9	25.7	5.3	8.9	7.1
New Jersey	104,978	36.4	12.0	12.6	19.6	5.2	5.2	9.1
New Mexico	13,395	27.7	13.7	12.7	23.2	5.4	10.2	7.0
New York	209,664	27.3	12.3	13.9	21.0	8.9	5.1	11.5
North Carolina	77,669	26.5	11.9	12.0	22.7	7.2	6.5	13.1
North Dakota	10,854	22.9	12.6	14.4	28.7	7.3	6.1	7.9
Ohio	184,447	26.7	12.9	12.9	25.2	7.5	6.3	8.4
Oklahoma	47,450	25.8	15.8	12.9	22.4	4.3	8.8	10.0
Oregon	26,410	29.2	11.6	13.7	25.1	7.6	6.0	6.8
Pennsylvania	190,378	31.0	12.4	11.7	21.4	6.5	7.1	9.9
Rhode Island	18,345	29.9	11.9	14.5	23.8	6.5	5.5	8.0
South Carolina	35,274	25.9	11.3	9.9	24.1	6.9	7.9	13.9
South Dakota	12,197	21.7	13.7	14.6	27.4	7.7	7.4	7.5
Tennessee	75,944	23.0	11.3	12.1	24.6	7.9	8.2	12.9
Texas	188,621	23.0	13.3	14.9	21.7	6.3	8.5	12.2
Utah	17,136	31.9	12.8	14.0	22.4	6.3	7.8	4.7
Vermont	6,619	21.1	12.6	13.5	27.3	8.1	8.5	8.9
Virginia	59,334	23.8	12.6	12.4	23.5	7.3	7.3	13.1
Washington	62,197	26.6	12.0	14.5	24.8	9.5	6.0	6.6
West Virginia	23,981	32.8	10.1	11.3	22.2	5.7	7.2	10.7
Wisconsin	76,287	28.6	12.3	15.1	24.3	6.2	7.4	6.2
Wyoming	5,141	26.2	13.7	14.0	26.1	6.3	8.9	4.8

Source: MDS

Table 3.6. Prevalence of Pressure Ulcers in Residents by State at the 90th, Median, and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**15.5**	**7.8**	**2.0**	**15.2**	**7.7**	**2.0**	**14.8**	**7.4**	**1.8**	**14.9**	**7.3**	**1.9**
Ownership												
For-Profit	15.5	8.2	2.6	15.2	8.1	2.5	14.9	7.8	2.3	14.8	7.8	2.4
Voluntary Non-Profit	15.0	7.1	1.8	15.0	7.1	1.8	14.2	6.7	1.6	14.8	6.7	1.6
Government	14.0	6.2	1.2	13.5	6.2	1.4	13.4	5.7	0.9	13.5	5.8	0.6
Certification												
Medicare and Medicaid	15.4	8.2	2.7	15.1	8.0	2.7	14.6	7.7	2.5	14.7	7.7	2.6
Medicare only	20.4	9.5	2.6	20.3	10.0	3.0	20.3	9.4	2.5	20.9	9.5	2.9
Medicaid only	10.7	4.3	0.0	10.6	4.3	0.0	10.0	4.0	0.0	10.3	4.0	0.0
Bed Size												
Less than 50	18.2	6.8	0.0	17.7	7.0	0.0	17.5	6.7	0.0	18.4	6.7	0.0
50 - 99	14.7	6.8	1.6	14.3	6.7	1.6	13.9	6.3	1.5	13.9	6.3	1.5
100 - 199	14.9	8.5	3.4	14.9	8.3	3.3	14.4	7.9	3.1	14.3	8.0	3.1
200 or more	15.7	9.1	4.4	15.5	9.2	4.3	15.0	8.8	4.2	15.3	8.7	4.3

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**15.6**	**7.9**	**2.1**	**15.2**	**7.6**	**2.0**	**15.2**	**7.7**	**2.1**	**15.5**	**7.9**	**2.2**
Ownership												
For-Profit	15.6	8.3	2.6	15.2	8.1	2.6	15.2	8.2	2.7	15.4	8.3	2.7
Voluntary Non-Profit	15.3	7.1	1.9	15.1	7.0	1.7	15.2	7.1	1.8	15.5	7.3	1.9
Government	13.6	6.2	0.0	13.5	5.9	0.0	13.6	5.9	1.0	14.6	6.3	1.2
Certification												
Medicare and Medicaid	15.4	8.3	2.8	15.0	8.0	2.7	15.1	8.0	2.9	15.3	8.2	2.9
Medicare only	21.4	10.1	2.7	21.2	10.0	3.1	21.5	10.2	3.1	21.1	10.9	2.8
Medicaid only	10.4	4.3	0.0	10.3	4.1	0.0	10.1	4.3	0.0	10.2	4.3	0.0
Bed Size												
Less than 50	18.6	7.3	0.0	18.8	6.9	0.0	18.8	7.1	0.0	19.0	7.4	0.0
50 - 99	14.6	6.7	1.6	14.0	6.7	1.6	14.3	6.8	1.6	14.4	6.8	1.7
100 - 199	15.1	8.6	3.6	14.8	8.3	3.3	14.8	8.3	3.4	14.9	8.4	3.4
200 or more	15.9	9.2	4.5	15.4	9.0	4.2	15.6	9.0	4.3	15.9	9.3	4.5

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**16.1**	**8.3**	**2.4**	**15.7**	**8.1**	**2.4**	**15.4**	**7.9**	**2.2**	**15.5**	**8.1**	**2.3**
Ownership												
For-Profit	16.1	8.8	2.9	15.8	8.5	2.9	15.5	8.3	2.7	15.6	8.6	2.7
Voluntary Non-Profit	16.0	7.7	2.1	15.6	7.5	2.2	15.3	7.3	2.0	15.4	7.4	2.1
Government	14.7	6.3	1.0	14.7	6.2	0.9	13.4	6.0	0.0	14.4	6.2	0.0
Certification												
Medicare and Medicaid	15.9	8.7	3.1	15.6	8.4	3.1	15.3	8.2	2.9	15.4	8.4	3.0
Medicare only	21.7	11.2	3.9	21.6	10.7	3.6	21.0	10.5	3.6	22.1	10.7	3.6
Medicaid only	10.4	4.3	0.0	10.6	4.2	0.0	10.4	4.1	0.0	10.6	4.0	0.0
Bed Size												
Less than 50	19.3	8.0	0.0	19.1	7.6	0.0	18.2	7.4	0.0	18.8	7.7	0.0
50 - 99	15.0	7.3	1.8	14.6	7.0	1.8	14.5	6.8	1.7	14.7	6.9	1.7
100 - 199	15.7	9.0	3.9	15.4	8.7	3.6	15.1	8.6	3.6	15.1	8.7	3.7
200 or more	16.6	9.6	4.5	16.0	9.5	4.5	15.9	9.3	4.3	16.5	9.5	4.3

Source: MDS and OSCAR

Table 3.7. Prevalence of Pressure Ulcers in Nursing Home Residents by State at the 90th, Median, and 10th Percentile: United States, Third Quarter 1999-2001

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**14.8**	**7.4**	**1.8**	**15.2**	**7.7**	**2.1**	**15.4**	**7.9**	**2.2**
Alabama	14.2	7.2	2.3	13.2	7.8	2.6	14.1	7.7	3.3
Alaska	12.1	5.3	0.0	10.9	6.4	0.0	15.1	4.3	0.0
Arizona	15.3	8.8	4.0	13.7	7.7	3.5	13.6	8.8	4.5
Arkansas	13.8	7.5	2.4	13.6	7.1	2.7	14.3	7.4	2.8
California	19.0	9.8	2.0	19.1	10.0	2.2	19.8	10.2	2.1
Colorado	11.5	5.6	1.0	11.5	6.1	1.6	11.4	6.5	1.8
Connecticut	11.2	5.5	1.8	11.8	5.9	2.0	12.1	6.8	2.1
Delaware	13.0	7.1	2.3	14.7	8.4	1.4	16.4	8.3	2.3
District of Columbia	19.8	10.9	2.3	20.7	10.3	1.3	20.2	11.4	5.6
Florida	16.4	9.3	3.7	16.8	9.8	4.3	17.1	9.9	4.5
Georgia	14.3	8.2	3.6	15.5	9.0	3.7	16.9	8.6	3.3
Hawaii	18.0	6.3	2.1	14.7	7.2	0.0	18.9	7.2	2.4
Idaho	10.5	4.7	0.0	11.6	5.6	1.5	10.5	5.8	2.2
Illinois	14.0	7.4	1.5	15.7	7.2	1.3	15.0	7.3	1.1
Indiana	14.1	7.4	2.4	14.8	7.5	2.9	14.6	7.9	2.9
Iowa	8.3	3.1	0.0	8.9	3.6	0.0	9.1	3.8	0.0
Kansas	10.4	4.8	0.0	12.5	5.6	0.0	12.5	5.1	0.0
Kentucky	15.3	7.8	2.1	14.3	8.2	3.2	16.5	9.1	3.7
Louisiana	19.1	7.5	2.7	18.6	8.2	3.1	17.7	9.1	3.6
Maine	12.0	7.0	2.2	12.6	6.8	1.3	12.8	7.1	2.3
Maryland	16.7	9.9	2.4	17.2	9.0	3.2	17.3	10.4	4.4
Massachusetts	12.1	7.1	2.7	12.6	7.7	2.3	13.4	8.0	2.9
Michigan	14.8	7.5	2.4	15.4	7.9	3.0	16.4	8.3	3.1
Minnesota	8.3	4.1	0.0	8.0	3.9	0.0	8.5	4.4	0.3
Mississippi	15.9	8.1	2.2	16.3	7.6	2.4	15.4	6.8	1.6
Missouri	14.0	6.3	1.5	13.6	6.7	1.8	14.1	6.6	1.9
Montana	8.5	4.0	0.0	8.6	4.0	0.0	9.1	5.0	0.0
Nebraska	8.7	3.7	0.0	10.3	4.2	0.0	9.3	4.2	0.0
Nevada	19.8	8.8	0.0	19.4	11.1	4.2	17.7	10.5	3.9
New Hampshire	9.7	5.4	1.0	10.6	4.9	0.0	12.4	5.9	1.0
New Jersey	15.7	9.9	3.8	16.8	10.9	4.9	16.4	11.2	4.9
New Mexico	12.5	7.4	1.5	12.4	7.4	3.3	14.9	8.1	3.0
New York	15.0	8.5	3.4	15.4	8.9	4.0	16.0	9.3	4.0
North Carolina	15.5	8.6	3.5	16.9	8.9	4.1	16.0	9.2	4.5
North Dakota	7.5	3.0	0.0	7.7	3.7	0.0	7.7	3.5	0.0
Ohio	13.8	7.3	2.3	13.5	7.5	2.1	14.0	7.5	2.6
Oklahoma	14.3	6.8	1.8	15.2	7.5	2.4	15.3	7.3	2.4
Oregon	12.9	6.7	2.3	14.2	7.1	2.8	13.3	8.0	2.0
Pennsylvania	16.8	9.5	3.7	17.1	9.8	3.8	17.1	10.1	4.2
Rhode Island	13.1	7.7	2.7	14.8	7.4	2.8	13.4	7.9	2.8
South Carolina	15.3	7.7	2.6	15.9	9.1	3.7	16.0	9.6	4.2
South Dakota	9.1	4.2	0.0	10.0	5.3	1.6	9.4	5.0	1.5
Tennessee	14.9	8.5	2.8	14.5	8.5	3.0	14.9	8.0	3.3
Texas	16.5	7.9	2.0	16.2	8.1	2.3	16.0	7.7	2.4
Utah	10.1	5.0	0.0	11.0	5.7	1.3	12.7	6.9	1.6
Vermont	11.1	4.8	1.3	11.8	7.1	1.3	11.5	6.8	2.9
Virginia	15.6	8.9	2.3	15.9	9.3	3.3	17.2	10.2	3.8
Washington	13.1	7.6	3.0	14.6	8.3	3.8	13.3	8.6	3.2
West Virginia	15.2	9.5	2.7	16.5	8.7	3.3	15.8	9.4	4.3
Wisconsin	10.8	5.9	1.8	10.8	5.7	2.0	11.1	5.7	1.9
Wyoming	10.5	4.2	0.0	12.9	5.6	2.0	12.0	6.5	0.0

Source: MDS

Table 3.8. Incidence of Pressure Ulcers in Nursing Home Residents at the 90th, 50th and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	50th	10th	90th	50th	10th	90th	50th	10th	90th	50th	10th
Nation	**5.6**	**2.0**	**0.0**	**5.5**	**2.0**	**0.0**	**5.4**	**1.9**	**0.0**	**5.4**	**2.0**	**0.0**
Ownership												
For-Profit	5.8	2.2	0.0	5.7	2.2	0.0	5.6	2.1	0.0	5.6	2.2	0.0
Voluntary Non-Profit	5.3	1.7	0.0	5.2	1.7	0.0	4.9	1.7	0.0	5.1	1.7	0.0
Government	5.1	1.7	0.0	5.3	1.7	0.0	4.8	1.6	0.0	5.0	1.7	0.0
Certification												
Medicare and Medicaid	5.7	2.2	0.0	5.7	2.2	0.0	5.5	2.1	0.0	5.6	2.2	0.0
Medicare only	2.8	0.0	0.0	3.0	0.0	0.0	3.4	0.0	0.0	3.2	0.0	0.0
Medicaid only	5.4	1.7	0.0	5.4	1.6	0.0	5.2	1.4	0.0	5.6	1.5	0.0
Bed Size												
Less than 50	4.8	0.0	0.0	4.8	0.0	0.0	4.8	0.0	0.0	4.9	0.0	0.0
50 - 99	6.0	1.9	0.0	5.8	1.9	0.0	5.8	1.8	0.0	5.7	1.9	0.0
100 - 199	5.6	2.4	0.0	5.5	2.4	0.0	5.3	2.3	0.0	5.4	2.3	0.0
200 or more	5.1	2.6	0.5	5.1	2.6	0.8	4.8	2.4	0.6	4.8	2.5	0.7

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	50th	10th	90th	50th	10th	90th	50th	10th	90th	50th	10th
Nation	**5.6**	**2.1**	**0.0**	**5.3**	**2.0**	**0.0**	**5.7**	**2.1**	**0.0**	**5.7**	**2.2**	**0.0**
Ownership												
For-Profit	5.9	2.4	0.0	5.6	2.2	0.0	5.9	2.3	0.0	5.9	2.3	0.0
Voluntary Non-Profit	5.2	1.9	0.0	5.0	1.8	0.0	5.3	1.9	0.0	5.5	2.0	0.0
Government	5.5	1.8	0.0	4.9	1.7	0.0	5.2	1.9	0.0	5.4	2.0	0.0
Certification												
Medicare and Medicaid	5.7	2.4	0.0	5.5	2.2	0.0	5.8	2.3	0.0	5.9	2.4	0.0
Medicare only	3.6	0.7	0.0	3.4	0.7	0.0	3.8	0.8	0.0	3.8	0.8	0.0
Medicaid only	5.6	1.6	0.0	5.5	1.4	0.0	5.5	1.6	0.0	5.6	1.7	0.0
Bed Size												
Less than 50	5.1	0.0	0.0	5.0	0.0	0.0	5.3	0.0	0.0	5.3	0.0	0.0
50 - 99	5.8	2.0	0.0	5.7	1.9	0.0	5.9	2.0	0.0	6.0	2.0	0.0
100 - 199	5.7	2.5	0.6	5.4	2.2	0.0	5.6	2.4	0.0	5.7	2.5	0.5
200 or more	5.2	2.7	0.8	4.9	2.5	0.6	5.3	2.6	0.8	5.3	2.7	0.8

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	50th	10th	90th	50th	10th	90th	50th	10th	90th	50th	10th
Nation	5.9	2.2	0.0	5.6	2.1	0.0	5.6	2.1	0.0	5.7	2.2	0.0
Ownership												
For-Profit	6.0	2.4	0.0	5.7	2.3	0.0	5.8	2.3	0.0	5.8	2.3	0.0
Voluntary Non-Profit	5.6	1.9	0.0	5.2	1.8	0.0	5.2	1.9	0.0	5.5	1.9	0.0
Government	5.3	1.9	0.0	4.8	1.7	0.0	4.8	1.7	0.0	5.4	1.9	0.0
Certification												
Medicare and Medicaid	6.0	2.4	0.0	5.7	2.3	0.0	5.7	2.3	0.0	5.8	2.4	0.0
Medicare only	3.3	0.0	0.0	3.2	0.5	0.0	3.7	0.6	0.0	3.8	0.7	0.0
Medicaid only	5.6	1.7	0.0	5.4	1.5	0.0	5.5	1.5	0.0	5.5	1.5	0.0
Bed Size												
Less than 50	5.1	0.0	0.0	5.0	0.0	0.0	5.0	0.0	0.0	5.6	0.0	0.0
50 - 99	6.1	2.1	0.0	5.7	2.0	0.0	5.9	2.0	0.0	6.0	2.0	0.0
100 - 199	5.8	2.6	0.7	5.6	2.4	0.5	5.6	2.5	0.5	5.6	2.5	0.4
200 or more	5.4	2.9	1.0	5.2	2.8	1.0	5.1	2.7	1.0	5.4	2.9	1.0
Chain Status												
No	5.9	2.2	0.0	5.6	2.1	0.0	5.6	2.1	0.0	5.7	2.1	0.0
Yes	5.6	2.5	0.0	5.5	2.3	0.0	5.6	2.3	0.0	5.6	2.4	0.0

Source: MDS

Table 3.9. Incidence of Pressure Ulcers in Residents at the 90th, Median, and 10th Percentile: United States, 3rd Quarter 1999-2001

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**5.4**	**1.9**	**0.0**	**5.7**	**2.1**	**0.0**	**5.5**	**2.1**	**0.0**
Alabama	4.8	2.1	0.0	5.3	2.3	0.0	4.9	2.1	0.0
Alaska	5.7	0.0	0.0	4.7	2.2	0.0	4.6	0.0	0.0
Arizona	4.0	1.3	0.0	3.9	1.5	0.0	4.7	2.0	0.0
Arkansas	6.1	2.1	0.0	6.4	2.3	0.0	6.3	2.4	0.0
California	5.4	1.9	0.0	5.7	2.0	0.0	5.6	2.0	0.0
Colorado	4.0	1.2	0.0	4.8	1.4	0.0	4.8	1.9	0.0
Connecticut	4.2	1.6	0.0	4.2	1.8	0.0	4.5	1.9	0.0
Delaware	4.7	2.3	0.0	6.0	2.4	0.0	5.1	2.1	0.0
District of Columbia	5.4	2.3	0.0	6.3	3.2	0.0	5.9	2.9	0.0
Florida	4.7	2.0	0.0	5.1	2.2	0.0	4.6	2.0	0.0
Georgia	5.9	2.4	0.0	6.5	2.7	0.0	6.3	2.7	0.0
Hawaii	5.9	1.3	0.0	5.0	1.4	0.0	5.3	1.1	0.0
Idaho	3.8	1.1	0.0	5.4	1.1	0.0	4.2	1.5	0.0
Illinois	5.5	2.0	0.0	5.8	2.1	0.0	5.3	2.0	0.0
Indiana	6.0	2.4	0.0	6.6	2.4	0.0	6.4	2.7	0.0
Iowa	4.5	1.0	0.0	4.5	1.3	0.0	4.3	1.3	0.0
Kansas	4.4	1.7	0.0	5.9	1.8	0.0	5.5	1.8	0.0
Kentucky	6.1	2.2	0.0	5.6	2.5	0.0	6.3	2.9	0.0
Louisiana	5.6	2.3	0.0	6.3	2.3	0.0	6.3	2.6	0.0
Maine	5.5	2.2	0.0	6.7	1.9	0.0	6.3	2.1	0.0
Maryland	5.3	2.1	0.0	5.9	2.5	0.0	5.1	2.3	0.0
Massachusetts	5.0	2.0	0.0	5.3	2.3	0.0	5.5	2.3	0.0
Michigan	4.8	2.0	0.0	5.5	2.2	0.0	5.3	2.2	0.0
Minnesota	3.6	1.4	0.0	4.0	1.4	0.0	4.2	1.4	0.0
Mississippi	6.0	2.3	0.0	6.4	2.5	0.0	5.4	1.8	0.0
Missouri	5.1	1.6	0.0	5.3	2.0	0.0	5.3	1.9	0.0
Montana	3.8	0.6	0.0	4.1	0.0	0.0	4.2	1.1	0.0
Nebraska	4.7	1.4	0.0	5.4	1.7	0.0	4.5	1.3	0.0
Nevada	4.3	1.1	0.0	4.7	2.2	0.0	6.2	1.9	0.0
New Hampshire	4.3	1.8	0.0	4.2	1.2	0.0	4.8	1.4	0.0
New Jersey	5.1	2.4	0.0	6.3	2.9	0.0	5.6	2.6	0.0
New Mexico	4.8	1.8	0.0	4.7	2.1	0.0	5.0	1.7	0.0
New York	5.2	2.4	0.0	5.6	2.6	0.0	5.7	2.7	0.6
North Carolina	5.7	1.9	0.0	5.9	2.5	0.0	5.9	2.3	0.0
North Dakota	3.3	1.1	0.0	4.8	0.9	0.0	4.7	1.3	0.0
Ohio	5.3	2.0	0.0	5.3	2.0	0.0	5.5	2.1	0.0
Oklahoma	6.2	1.9	0.0	6.1	2.4	0.0	6.9	2.3	0.0
Oregon	4.6	1.5	0.0	5.0	2.1	0.0	5.3	1.6	0.0
Pennsylvania	6.1	2.6	0.0	6.3	2.6	0.0	6.1	3.0	0.0
Rhode Island	5.5	1.9	0.0	5.6	2.4	0.0	4.9	2.2	0.0
South Carolina	5.5	1.8	0.0	5.3	2.3	0.0	5.1	2.2	0.0
South Dakota	5.1	1.5	0.0	5.1	1.7	0.0	5.4	1.9	0.0
Tennessee	5.1	2.0	0.0	5.3	2.4	0.0	4.9	2.1	0.0
Texas	6.2	2.1	0.0	6.3	2.3	0.0	6.1	2.4	0.0
Utah	3.6	1.0	0.0	4.2	1.4	0.0	3.8	1.4	0.0
Vermont	5.2	2.0	0.0	5.8	3.3	0.0	5.2	2.2	0.0
Virginia	5.7	2.3	0.0	5.6	2.5	0.0	6.7	2.4	0.0
Washington	4.8	1.9	0.0	5.6	2.0	0.0	5.1	1.9	0.0
West Virginia	6.4	2.6	0.0	6.3	2.0	0.0	6.9	2.9	0.0
Wisconsin	4.7	1.8	0.0	4.6	1.9	0.0	4.3	1.8	0.0
Wyoming	4.8	0.4	0.0	5.9	2.2	0.0	5.9	1.8	0.0

Source: MDS

Table 3.10. Prevalence of Physical Restraint Use in Nursing Homes at the 90th, Median and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**24.2**	**6.9**	**0.0**	**24.4**	**6.8**	**0.0**	**24.1**	**6.7**	**0.0**	**23.5**	**6.5**	**0.0**
Ownership												
Proprietary	25.5	8.0	0.0	25.5	8.0	0.0	25.3	7.8	0.0	24.7	7.8	0.0
Voluntary Non-Profit	20.9	5.1	0.0	21.0	4.8	0.0	20.4	4.7	0.0	19.8	4.5	0.0
Government	24.6	7.6	0.0	25.4	7.2	0.0	25.0	6.7	0.0	25.0	6.5	0.0
Certification												
Medicare and Medicaid	24.1	7.5	0.0	24.3	7.3	0.0	23.9	7.2	0.0	23.4	7.0	0.0
Medicare only	12.5	2.3	0.0	13.0	2.3	0.0	11.9	2.2	0.0	12.7	1.9	0.0
Medicaid only	29.8	8.6	0.0	29.5	8.2	0.0	29.0	8.0	0.0	28.8	8.0	0.0
Bed Size												
Less than 50	18.2	3.2	0.0	17.9	3.2	0.0	17.6	3.1	0.0	17.1	2.6	0.0
50 - 99	25.8	7.8	0.0	25.8	7.5	0.0	25.4	7.4	0.0	24.6	7.0	0.0
100 - 199	25.2	8.1	0.8	25.2	8.1	0.7	25.0	7.9	0.7	24.5	7.9	0.7
200 or more	21.7	6.7	0.7	21.8	6.5	0.6	22.1	6.3	0.5	21.7	6.2	0.5

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**23.2**	**6.3**	**0.0**	**23.2**	**6.3**	**0.0**	**23.4**	**6.4**	**0.0**	**23.3**	**6.3**	**0.0**
Ownership												
Proprietary	24.3	7.5	0.0	24.5	7.5	0.0	24.6	7.7	0.0	24.5	7.6	0.0
Voluntary Non-Profit	19.1	4.3	0.0	18.8	4.3	0.0	19.2	4.3	0.0	19.1	4.1	0.0
Government	23.8	6.1	0.0	23.6	6.2	0.0	24.8	5.9	0.0	24.1	5.8	0.0
Certification												
Medicare and Medicaid	22.9	6.8	0.0	23.0	6.8	0.0	23.2	6.9	0.0	23.1	6.8	0.0
Medicare only	11.9	1.8	0.0	11.1	1.6	0.0	11.3	1.5	0.0	11.2	1.5	0.0
Medicaid only	28.1	7.4	0.0	27.8	7.4	0.0	28.1	7.4	0.0	27.8	7.2	0.0
Bed Size												
Less than 50	16.5	2.4	0.0	16.7	2.4	0.0	17.1	2.4	0.0	17.1	2.3	0.0
50 - 99	24.1	6.9	0.0	24.4	6.9	0.0	24.5	7.0	0.0	24.4	7.0	0.0
100 - 199	23.9	7.6	0.6	24.0	7.6	0.7	24.2	7.7	0.7	24.0	7.5	0.7
200 or more	20.9	6.2	0.5	20.9	5.9	0.5	20.6	5.9	0.4	21.4	5.9	0.4

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**22.9**	**6.3**	**0.0**	**22.9**	**6.3**	**0.0**	**22.8**	**6.4**	**0.0**	**22.2**	**6.2**	**0.0**
Ownership												
Proprietary	24.1	7.5	0.0	24.1	7.5	0.0	24.0	7.6	0.0	23.6	7.3	0.0
Voluntary Non-Profit	18.9	4.2	0.0	18.8	4.0	0.0	19.2	4.1	0.0	18.3	4.0	0.0
Government	23.5	5.7	0.0	23.3	5.7	0.0	23.3	5.8	0.0	21.8	5.4	0.0
Certification												
Medicare and Medicaid	22.7	6.8	0.0	22.7	6.8	0.0	22.6	6.9	0.0	22.0	6.6	0.0
Medicare only	10.7	1.4	0.0	11.0	1.1	0.0	10.6	0.9	0.0	10.6	1.0	0.0
Medicaid only	27.7	6.8	0.0	28.3	6.8	0.0	28.6	6.9	0.0	27.5	6.7	0.0
Bed Size												
Less than 50	17.4	2.3	0.0	17.4	2.1	0.0	17.6	2.0	0.0	17.1	1.9	0.0
50 - 99	24.0	6.9	0.0	24.1	6.9	0.0	24.0	7.0	0.0	23.6	6.7	0.0
100 - 199	23.4	7.5	0.6	23.5	7.5	0.7	23.4	7.7	0.7	22.7	7.3	0.7
200 or more	20.8	5.8	0.5	20.7	5.9	0.5	20.5	5.8	0.4	19.1	5.5	0.5

Source: MDS and OSCAR

Table 3.11. Prevalence of Physical Restraint Use in Nursing Homes at the 90th, Median and 10th Percentile: United States, Third Quarter 1999-2001

	Percent of Residents with Physical Restraint								
	1999			2000			2001		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**24.1**	**6.7**	**0.0**	**23.4**	**6.4**	**0.0**	**22.8**	**6.4**	**0.0**
Alabama	17.6	3.0	0.0	16.8	3.4	0.0	20.0	3.7	0.0
Alaska	19.0	6.8	0.0	24.5	5.3	0.0	14.9	5.0	0.0
Arizona	20.3	9.2	0.0	19.5	7.6	0.0	16.8	7.7	0.0
Arkansas	37.3	22.1	5.8	35.8	21.3	5.8	36.4	22.0	6.5
California	33.8	16.3	2.3	32.9	15.7	2.0	32.1	15.2	1.7
Colorado	18.9	7.7	0.8	18.4	6.3	0.0	16.3	6.9	0.0
Connecticut	24.5	9.7	0.8	23.8	9.1	0.9	25.8	8.9	0.0
Delaware	11.2	1.7	0.0	9.7	1.2	0.0	7.7	0.6	0.0
District of Columbia	13.8	3.5	0.0	15.4	3.4	0.0	12.8	3.1	0.0
Florida	16.1	4.9	0.0	14.7	4.9	0.0	14.5	5.6	0.0
Georgia	23.5	10.2	2.1	25.0	10.8	1.9	26.8	12.4	1.8
Hawaii	26.6	7.0	0.0	28.6	4.8	0.0	25.1	5.8	0.0
Idaho	13.7	5.2	0.0	13.7	5.5	0.0	15.1	5.7	0.0
Illinois	15.1	4.0	0.0	13.3	3.3	0.0	13.3	2.9	0.0
Indiana	17.8	5.9	0.0	16.1	5.4	0.0	15.5	5.6	0.0
Iowa	7.8	0.9	0.0	7.4	1.0	0.0	9.2	1.3	0.0
Kansas	12.5	3.6	0.0	14.1	3.6	0.0	15.6	3.6	0.0
Kentucky	22.3	6.8	0.0	18.8	7.1	0.0	21.6	8.2	0.0
Louisiana	35.5	20.3	4.7	35.6	20.4	4.7	31.8	18.2	3.4
Maine	16.7	4.1	0.0	15.3	3.7	0.0	15.8	3.3	0.0
Maryland	21.3	7.5	0.0	19.8	5.6	0.0	16.0	5.2	0.0
Massachusetts	14.9	4.4	0.0	14.2	4.1	0.0	13.9	4.6	0.0
Michigan	17.8	6.2	0.0	16.1	5.0	0.0	16.9	4.5	0.0
Minnesota	11.5	3.2	0.0	11.1	3.2	0.0	11.4	3.1	0.0
Mississippi	27.5	13.1	1.4	26.7	15.0	1.5	28.4	15.0	0.0
Missouri	19.0	5.6	0.0	18.3	5.9	0.0	18.5	6.1	0.0
Montana	13.6	3.8	0.0	11.0	2.6	0.0	12.0	1.9	0.0
Nebraska	6.0	0.0	0.0	5.0	0.0	0.0	8.0	0.6	0.0
Nevada	21.2	7.4	0.0	20.0	7.9	0.0	28.0	8.9	0.0
New Hampshire	9.6	2.2	0.0	7.8	2.3	0.0	8.8	2.8	0.0
New Jersey	10.2	2.4	0.0	9.8	2.8	0.0	10.7	2.9	0.0
New Mexico	15.3	7.8	0.0	19.5	6.8	0.0	16.4	6.7	0.0
New York	22.6	5.9	0.2	21.3	5.9	0.0	19.2	5.4	0.0
North Carolina	27.0	6.5	0.0	23.0	6.7	0.0	23.1	6.6	0.0
North Dakota	15.1	4.5	0.0	16.1	4.4	0.0	15.3	5.2	0.0
Ohio	20.2	6.8	0.0	20.0	7.2	0.0	20.7	7.4	0.0
Oklahoma	22.2	8.7	1.2	20.0	9.5	1.0	20.6	8.3	0.0
Oregon	23.6	10.3	0.8	24.4	9.2	1.1	23.4	10.4	0.0
Pennsylvania	22.0	5.1	0.0	17.2	4.2	0.0	15.3	4.0	0.0
Rhode Island	15.4	4.9	0.0	13.1	4.2	0.0	20.0	3.6	0.0
South Carolina	25.0	6.9	0.0	28.2	6.4	0.0	26.6	8.9	0.0
South Dakota	21.4	8.3	1.5	18.8	7.4	0.0	18.8	7.2	0.0
Tennessee	29.8	12.1	0.7	29.3	12.0	0.0	27.5	11.9	0.6
Texas	32.3	16.3	1.9	32.3	16.7	1.4	32.4	16.6	1.5
Utah	18.4	5.7	0.0	15.2	5.8	0.0	19.9	5.3	0.0
Vermont	14.0	3.9	0.0	10.6	3.5	0.0	14.7	3.6	0.0
Virginia	17.9	5.2	0.0	19.4	4.9	0.0	21.9	5.8	0.0
Washington	17.9	5.9	0.0	20.6	6.4	0.0	21.7	6.3	0.0
West Virginia	18.1	5.1	0.0	17.4	4.9	0.0	17.7	5.7	0.0
Wisconsin	16.7	4.8	0.0	12.1	3.9	0.0	12.0	2.9	0.0
Wyoming	14.3	5.8	0.0	15.9	6.3	0.0	18.6	7.0	0.0

Source: MDS

Table 3.12. Incidence of Physical Restraint Use in Nursing Homes at the 90th, Median, and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10t
Nation	**6.0**	**1.0**	**0.0**	**6.1**	**1.1**	**0.0**	**6.1**	**1.2**	**0.0**	**5.9**	**1.1**	**0.**
Ownership												
For-Profit	6.5	1.5	0.0	6.4	1.5	0.0	6.5	1.5	0.0	6.3	1.4	0.
Voluntary Non-Profit	5.1	0.6	0.0	5.2	0.6	0.0	5.2	0.6	0.0	5.0	0.5	0.
Government	6.0	1.0	0.0	6.3	1.1	0.0	6.3	1.0	0.0	5.6	0.9	0.
Certification												
Medicare and Medicaid	6.2	1.4	0.0	6.3	1.4	0.0	6.2	1.4	0.0	6.1	1.3	0.
Medicare only	1.8	0.0	0.0	2.0	0.0	0.0	2.1	0.0	0.0	2.0	0.0	0.
Medicaid only	7.1	1.2	0.0	6.8	1.0	0.0	7.1	1.1	0.0	6.7	0.0	0.
Bed Size												
Less than 50	4.3	0.0	0.0	4.5	0.0	0.0	4.3	0.0	0.0	4.2	0.0	0.
50 - 99	6.5	1.4	0.0	6.5	1.3	0.0	6.5	1.4	0.0	6.3	1.2	0.
100 - 199	6.3	1.6	0.0	6.3	1.6	0.0	6.3	1.6	0.0	6.3	1.6	0.
200 or more	5.5	1.4	0.0	5.9	1.5	0.0	5.6	1.4	0.0	5.5	1.3	0.

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10t
Nation	**5.9**	**1.1**	**0.0**	**5.9**	**1.1**	**0.0**	**5.9**	**1.1**	**0.0**	**5.9**	**1.1**	**0.**
Ownership												
For-Profit	6.2	1.4	0.0	6.5	1.5	0.0	6.7	1.5	0.0	6.4	1.5	0.
Voluntary Non-Profit	4.8	0.5	0.0	5.0	0.5	0.0	4.8	0.5	0.0	5.1	0.4	0.
Government	6.3	1.0	0.0	5.9	1.0	0.0	5.9	0.9	0.0	5.9	0.8	0.
Certification												
Medicare and Medicaid	5.9	1.4	0.0	6.1	1.4	0.0	6.3	1.4	0.0	6.1	1.4	0.
Medicare only	1.8	0.0	0.0	2.3	0.0	0.0	2.1	0.0	0.0	2.3	0.0	0.
Medicaid only	7.1	0.1	0.0	7.1	1.0	0.0	7.1	0.8	0.0	7.3	0.8	0.
Bed Size												
Less than 50	4.3	0.0	0.0	4.4	0.0	0.0	4.5	0.0	0.0	4.3	0.0	0.
50 - 99	6.3	1.3	0.0	6.5	1.3	0.0	6.5	1.3	0.0	6.4	1.3	0.
100 - 199	6.0	1.6	0.0	6.3	1.6	0.0	6.3	1.6	0.0	6.3	1.6	0.
200 or more	5.1	1.5	0.0	5.3	1.4	0.0	5.3	1.5	0.0	5.5	1.4	0.0

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**5.9**	**1.1**	**0.0**	**5.9**	**1.1**	**0.0**	**5.9**	**1.2**	**0.0**	**5.6**	**1.1**	**0.0**
Ownership												
For-Profit	6.3	1.4	0.0	6.3	1.4	0.0	6.2	1.5	0.0	6.0	1.4	0.0
Voluntary Non-Profit	4.9	0.4	0.0	4.9	0.0	0.0	4.9	0.4	0.0	4.4	0.0	0.0
Government	6.4	0.9	0.0	6.1	0.7	0.0	6.0	0.7	0.0	5.3	0.5	0.0
Certification												
Medicare and Medicaid	6.0	1.3	0.0	6.0	1.3	0.0	6.0	1.4	0.0	5.7	1.3	0.0
Medicare only	2.0	0.0	0.0	1.8	0.0	0.0	2.0	0.0	0.0	2.0	0.0	0.0
Medicaid only	6.9	0.0	0.0	6.6	0.0	0.0	6.8	0.0	0.0	6.7	0.0	0.0
Bed Size												
Less than 50	4.3	0.0	0.0	4.4	0.0	0.0	4.2	0.0	0.0	3.8	0.0	0.0
50 - 99	6.3	1.3	0.0	6.4	1.3	0.0	6.5	1.3	0.0	5.9	1.2	0.0
100 - 199	6.1	1.5	0.0	6.0	1.5	0.0	5.9	1.6	0.0	5.9	1.5	0.0
200 or more	5.1	1.4	0.0	5.2	1.5	0.0	5.3	1.4	0.0	4.8	1.3	0.0
Chain												
No	5.8	1.0	0.0	6.0	1.1	0.0	6.0	1.1	0.0	5.7	1.0	0.0
Yes	5.7	1.5	0.0	5.5	1.4	0.0	5.7	1.4	0.0	5.6	1.4	0.0

Source: MDS and OSCAR

Table 3.13. Incidence of Physical Restraint Use in Nursing Homes at the 90th, Median, and 10th Percentile: United States, Third Quarter 1999-2001

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**6.1**	**1.2**	**0.0**	**6.1**	**1.1**	**0.0**	**5.5**	**2.1**	**0.0**
Alabama	5.0	0.6	0.0	5.3	0.7	0.0	4.9	2.1	0.0
Alaska	7.7	0.0	0.0	9.5	0.0	0.0	4.6	0.0	0.0
Arizona	6.0	1.3	0.0	5.0	1.4	0.0	4.7	2.0	0.0
Arkansas	10.1	4.0	0.0	8.1	3.5	0.0	6.3	2.4	0.0
California	8.2	2.6	0.0	8.4	2.4	0.0	5.6	2.0	0.0
Colorado	6.3	1.5	0.0	4.8	1.1	0.0	4.8	1.9	0.0
Connecticut	6.5	2.1	0.0	6.5	1.7	0.0	4.5	1.9	0.0
Delaware	2.8	0.0	0.0	2.2	0.0	0.0	5.1	2.1	0.0
District of Columbia	2.5	0.8	0.0	1.9	0.4	0.0	5.9	2.9	0.0
Florida	4.8	1.0	0.0	4.9	1.1	0.0	4.6	2.0	0.0
Georgia	6.9	1.9	0.0	7.8	2.1	0.0	6.3	2.7	0.0
Hawaii	7.6	1.0	0.0	7.5	0.9	0.0	5.3	1.1	0.0
Idaho	4.0	0.0	0.0	4.7	0.0	0.0	4.2	1.5	0.0
Illinois	3.8	0.5	0.0	3.4	0.0	0.0	5.3	2.0	0.0
Indiana	5.1	1.2	0.0	5.6	1.0	0.0	6.4	2.7	0.0
Iowa	2.5	0.0	0.0	2.4	0.0	0.0	4.3	1.3	0.0
Kansas	3.6	0.0	0.0	4.7	0.0	0.0	5.5	1.8	0.0
Kentucky	6.0	1.1	0.0	6.3	1.2	0.0	6.3	2.9	0.0
Louisiana	7.9	2.5	0.0	8.3	2.6	0.0	6.3	2.6	0.0
Maine	3.7	0.0	0.0	3.7	0.0	0.0	6.3	2.1	0.0
Maryland	6.9	1.9	0.0	5.5	1.4	0.0	5.1	2.3	0.0
Massachusetts	4.2	0.8	0.0	4.1	0.9	0.0	5.5	2.3	0.0
Michigan	4.9	1.2	0.0	4.8	1.0	0.0	5.3	2.2	0.0
Minnesota	3.5	0.6	0.0	3.5	0.5	0.0	4.2	1.4	0.0
Mississippi	6.7	2.0	0.0	8.9	2.2	0.0	5.4	1.8	0.0
Missouri	5.4	0.8	0.0	5.1	0.7	0.0	5.3	1.9	0.0
Montana	3.8	0.0	0.0	3.8	0.0	0.0	4.2	1.1	0.0
Nebraska	2.2	0.0	0.0	2.3	0.0	0.0	4.5	1.3	0.0
Nevada	5.7	0.8	0.0	4.8	0.8	0.0	6.2	1.9	0.0
New Hampshire	1.9	0.0	0.0	1.9	0.0	0.0	4.8	1.4	0.0
New Jersey	2.6	0.3	0.0	3.6	0.4	0.0	5.6	2.6	0.0
New Mexico	7.0	1.5	0.0	5.7	1.1	0.0	5.0	1.7	0.0
New York	6.0	1.4	0.0	5.3	1.6	0.0	5.7	2.7	0.6
North Carolina	8.7	1.5	0.0	6.8	1.3	0.0	5.9	2.3	0.0
North Dakota	4.7	0.0	0.0	2.9	0.0	0.0	4.7	1.3	0.0
Ohio	5.3	1.1	0.0	5.7	1.3	0.0	5.5	2.1	0.0
Oklahoma	6.2	1.5	0.0	6.7	1.5	0.0	6.9	2.3	0.0
Oregon	6.8	2.5	0.0	6.3	1.8	0.0	5.3	1.6	0.0
Pennsylvania	6.5	1.1	0.0	5.7	1.0	0.0	6.1	3.0	0.0
Rhode Island	4.1	0.7	0.0	3.9	0.0	0.0	4.9	2.2	0.0
South Carolina	7.6	1.1	0.0	6.8	1.3	0.0	5.1	2.2	0.0
South Dakota	5.0	1.2	0.0	5.1	1.5	0.0	5.4	1.9	0.0
Tennessee	7.5	2.0	0.0	9.1	2.5	0.0	4.9	2.1	0.0
Texas	9.5	2.6	0.0	10.3	2.8	0.0	6.1	2.4	0.0
Utah	5.4	0.0	0.0	4.2	1.0	0.0	3.8	1.4	0.0
Vermont	4.5	0.0	0.0	4.5	0.0	0.0	5.2	2.2	0.0
Virginia	4.9	1.1	0.0	5.3	0.7	0.0	6.7	2.4	0.0
Washington	4.9	0.9	0.0	6.5	1.3	0.0	5.1	1.9	0.0
West Virginia	4.7	0.6	0.0	5.1	0.8	0.0	6.9	2.9	0.0
Wisconsin	3.7	0.6	0.0	3.0	0.0	0.0	4.3	1.8	0.0
Wyoming	5.1	0.4	0.0	4.8	0.0	0.0	5.9	1.8	0.0

Source: MDS

Table 3.14. Prevalence of Tube Feeding in Nursing Homes by Type of Nursing Home at the 90th, Median, and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**13.4**	**4.4**	**0.0**	**13.2**	**4.2**	**0.0**	**12.8**	**4.2**	**0.0**	13.4	4.4	0.0
Ownership												
For-Profit	13.8	5.1	0.0	14.1	5.2	0.0	14.0	5.3	0.0	14.1	5.2	0.0
Voluntary Non-Profit	10.9	3.0	0.0	11.1	3.1	0.0	11.2	3.1	0.0	11.3	3.1	0.0
Government	12.6	3.0	0.0	13.0	3.3	0.0	13.7	3.4	0.0	13.2	3.3	0.0
Certification												
Medicare and Medicaid	13.5	4.8	0.0	13.9	4.9	0.0	13.9	4.9	0.0	13.9	4.9	0.0
Medicare only	8.7	2.5	0.0	9.1	2.8	0.0	9.3	2.8	0.0	9.8	3.0	0.0
Medicaid only	10.8	1.8	0.0	11.1	1.8	0.0	10.8	1.9	0.0	10.9	2.0	0.0
Bed Size												
Less than 50	10.0	2.1	0.0	10.7	2.2	0.0	11.0	2.3	0.0	10.7	2.4	0.0
50 - 99	12.8	3.4	0.0	12.9	3.6	0.0	13.0	3.5	0.0	13.0	3.5	0.0
100 - 199	13.2	5.3	1.1	13.6	5.4	1.1	13.6	5.4	1.1	13.6	5.4	1.1
200 or more	15.2	6.7	1.8	15.9	6.9	1.9	15.6	6.9	1.8	15.5	6.9	1.9

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**13.3**	**4.4**	**0.0**	**13.4**	**4.3**	**0.0**	**13.2**	**4.3**	**0.0**	**13.0**	**4.3**	**0.0**
Ownership												
For-Profit	14.0	5.2	0.0	14.1	5.2	0.0	13.9	5.1	0.0	13.6	5.1	0.0
Voluntary Non-Profit	11.0	3.1	0.0	11.3	3.1	0.0	11.0	3.0	0.0	10.9	3.0	0.0
Government	12.9	3.1	0.0	13.1	3.2	0.0	13.0	3.2	0.0	12.5	3.2	0.0
Certification												
Medicare and Medicaid	13.8	4.9	0.6	13.9	4.9	0.5	13.7	4.8	0.0	13.4	4.8	0.0
Medicare only	9.5	2.9	0.0	9.4	2.9	0.0	8.9	2.9	0.0	8.8	2.8	0.0
Medicaid only	10.9	1.9	0.0	11.1	2.0	0.0	10.8	2.0	0.0	10.6	2.0	0.0
Bed Size												
Less than 50	10.9	2.4	0.0	11.4	2.3	0.0	10.8	2.4	0.0	10.7	2.4	0.0
50 - 99	12.9	3.4	0.0	12.8	3.5	0.0	12.5	3.4	0.0	12.4	3.5	0.0
100 - 199	13.6	5.4	1.1	13.6	5.4	1.2	13.5	5.3	1.1	13.3	5.2	1.1
200 or more	15.6	6.8	1.9	15.8	6.8	1.9	15.6	6.7	1.9	15.3	6.8	1.8

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**13.0**	**4.2**	**0.0**	**12.9**	**4.2**	**0.0**	**12.8**	**4.2**	**0.0**	**12.8**	**4.2**	**0.0**
Ownership												
For-Profit	13.7	5.0	0.0	13.5	5.0	0.0	13.5	5.0	0.0	13.5	4.9	0.0
Voluntary Non-Profit	10.6	2.9	0.0	10.9	2.9	0.0	10.7	2.9	0.0	10.5	2.9	0.0
Government	13.2	3.0	0.0	12.8	3.1	0.0	13.0	3.1	0.0	13.0	3.0	0.0
Certification												
Medicare and Medicaid	13.5	4.8	0.0	13.3	4.7	0.0	13.3	4.7	0.0	13.2	4.6	0.0
Medicare only	8.0	2.6	0.0	7.9	2.5	0.0	8.3	2.6	0.0	8.1	2.6	0.0
Medicaid only	10.4	1.8	0.0	11.0	1.8	0.0	10.6	1.7	0.0	10.7	1.7	0.0
Bed Size												
Less than 50	10.6	2.3	0.0	10.5	2.3	0.0	10.6	2.4	0.0	10.0	2.4	0.0
50 - 99	12.5	3.4	0.0	12.5	3.4	0.0	12.4	3.4	0.0	12.5	3.3	0.0
100 - 199	13.3	5.2	1.1	13.3	5.1	1.1	13.1	5.1	1.1	13.0	5.0	1.0
200 or more	15.4	6.9	2.0	15.0	6.9	1.9	14.7	6.8	2.0	14.7	6.7	1.8

Source: MDS and OSCAR

Table 3.15. Prevalence of Tube Feeding in Nursing Homes at the 90th, Median, and 10th Percentile: United States, Third Quarter 1999 - 2001

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**13.4**	**4.4**	**0.0**	**13.2**	**4.2**	**0.0**	**12.8**	**4.2**	**0.0**
Alabama	20.2	11.6	4.8	19	11.3	3.9	19	10.6	4.3
Alaska	16.2	4.8	0.0	20.2	8.5	0.0	24.3	6.7	0.0
Arizona	8.1	2.8	0.0	7.8	2.9	0.0	7.2	2.2	0.0
Arkansas	12.2	5.3	1.1	12.3	5.0	0.9	12.2	5.2	0.9
California	17.6	6.6	0.0	18.1	6.7	0.0	17.9	6.3	0.0
Colorado	6.1	2.1	0.0	5.1	1.8	0.0	5.9	1.9	0.0
Connecticut	8.5	3.0	0.0	7.9	3.1	0.0	7.0	3.2	0.0
Delaware	14.3	6.6	0.0	11.8	5.5	0.0	12.4	4.8	0.0
District of Columbia	31.1	10.1	1.0	24.0	12.6	2.2	19.7	10.7	0.0
Florida	14.0	6.5	1.8	13.7	6.5	1.8	13.3	5.9	2.2
Georgia	15.2	7.0	2.4	15.0	7.3	2.5	14.5	7.3	2.1
Hawaii	34.8	9.4	0.8	30.2	8.7	1.7	31.3	9.6	1.6
Idaho	5.0	1.2	0.0	5.9	1.9	0.0	4.8	2.3	0.0
Illinois	10.0	3.2	0.0	9.7	3.1	0.0	9.3	3.3	0.0
Indiana	11.6	4.5	0.0	11.1	4.3	0.0	10.0	4.2	0.0
Iowa	4.9	1.1	0.0	5.0	1.0	0.0	4.9	0.7	0.0
Kansas	4.8	1.6	0.0	5.1	1.6	0.0	5.0	1.4	0.0
Kentucky	21.7	7.8	1.5	19.4	7.8	1.5	20.0	7.3	1.6
Louisiana	15.8	8.0	2.3	16.1	8.3	2.3	15.8	8.1	2.9
Maine	5.6	1.9	0.0	4.9	1.9	0.0	4.8	1.7	0.0
Maryland	18.1	6.7	0.0	16.0	6.0	0.0	16.8	5.7	0.0
Massachusetts	6.8	2.6	0.0	7.4	2.5	0.0	6.6	2.3	0.0
Michigan	11.7	4.1	0.0	11.3	4.0	0.0	10.7	3.7	0.0
Minnesota	4.3	1.5	0.0	4.2	1.5	0.0	4.1	1.4	0.0
Mississippi	15.4	8.8	3.2	16.2	8.7	3.3	16.1	9.1	1.9
Missouri	9.2	3.4	0.0	9.2	3.3	0.0	9.1	3.4	0.0
Montana	4.8	1.9	0.0	5.1	1.7	0.0	5.0	1.9	0.0
Nebraska	6.6	1.4	0.0	6.5	1.6	0.0	6.5	1.7	0.0
Nevada	16.3	3.5	0.0	13.2	5.6	0.0	15.6	5.7	0.0
New Hampshire	4.9	1.1	0.0	3.3	1.3	0.0	4.0	1.1	0.0
New Jersey	12.5	5.6	0.0	12.2	5.6	0.9	12.1	5.5	1.0
New Mexico	6.0	2.1	0.0	6.9	3.1	0.0	6.5	2.4	0.0
New York	15.5	6.2	1.2	14.9	6.2	1.7	13.9	6.0	1.5
North Carolina	18.3	7.7	1.7	19.5	7.6	1.3	18.8	7.1	1.4
North Dakota	6.1	2.2	0.0	6.3	2.0	0.0	5.7	2.0	0.0
Ohio	14.6	6.3	1.4	13.7	5.8	0.9	12.8	5.3	0.8
Oklahoma	12.2	4.8	0.0	11.9	5.4	0.0	12.1	5.4	0.0
Oregon	6.9	2.5	0.0	6.5	2.3	0.0	6.0	2.2	0.0
Pennsylvania	13.0	4.8	0.0	12.5	4.8	0.0	11.9	4.4	0.7
Rhode Island	7.9	2.8	0.0	6.7	2.8	0.0	7.0	2.9	0.0
South Carolina	19.0	7.4	1.1	18.3	7.9	1.8	17.8	7.4	1.4
South Dakota	5.1	1.7	0.0	4.4	1.6	0.0	4.7	1.7	0.0
Tennessee	15.1	6.1	0.8	14.2	6.1	0.7	14.5	6.1	1.4
Texas	14.9	5.7	0.0	15.5	5.9	0.0	14.7	5.6	0.0
Utah	4.6	1.5	0.0	4.2	1.8	0.0	4.9	2.0	0.0
Vermont	5.9	2.4	0.0	5.3	2.0	0.0	4.8	2.2	0.0
Virginia	14.3	6.3	0.0	14.6	6.3	1.0	14.2	6.0	0.7
Washington	7.8	3.4	0.0	7.8	2.9	0.0	7.7	3.0	0.0
West Virginia	13.9	5.1	0.0	12.8	4.9	0.0	12.5	4.7	0.0
Wisconsin	5.3	1.8	0.0	5.4	1.8	0.0	4.9	1.7	0.0
Wyoming	4.7	0.8	0.0	2.8	0.9	0.0	2.9	0.9	0.0

Source: MDS

Table 3.16. Prevalence of Weight Loss in Nursing Homes by Type of Nursing Home in the 90th, Median, and 10th Percentile in United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**21.8**	**11.4**	**4.2**	**21.2**	**10.8**	**3.9**	**20.0**	**10.2**	**3.7**	**19.4**	**9.9**	**3.5**
Ownership												
For-Profit	20.8	11.3	4.3	20.2	10.7	4.0	19.0	10.1	3.8	18.3	9.8	3.6
Voluntary Non-Profit	23.8	12.0	4.6	23.4	11.3	4.2	22.2	10.5	3.9	22.0	10.3	4.0
Government	20.6	10.8	3.7	20.0	10.2	3.8	18.3	9.5	3.5	18.2	9.0	3.2
Certification												
Medicare and Medicaid	21.0	11.6	4.8	20.4	10.9	4.5	19.2	10.3	4.2	18.4	10.1	4.1
Medicare only	34.4	16.4	4.3	33.1	15.6	4.4	32.8	15.4	4.2	32.2	14.9	4.0
Medicaid only	17.0	8.3	2.1	16.9	8.2	2.2	15.4	7.5	2.0	14.9	7.1	1.8
Bed Size												
Less than 50	28.3	11.9	2.5	27.7	11.1	2.5	27.8	10.3	2.2	27.3	10.3	2.2
50 - 99	20.4	10.7	3.8	19.6	10.1	3.6	18.6	9.6	3.4	17.8	9.2	3.2
100 - 199	20.9	11.9	5.3	20.3	11.3	5.0	19.2	10.5	4.8	18.3	10.3	4.5
200 or more	19.6	11.6	6.0	19.0	10.8	5.5	18.5	10.4	5.0	17.4	10.1	5.1

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**20.5**	**10.7**	**3.8**	**19.1**	**9.7**	**3.4**	**18.7**	**9.5**	**3.3**	**18.8**	**9.6**	**3.3**
Ownership												
For-Profit	19.5	10.6	4.0	18.2	9.6	3.5	17.7	9.5	3.4	17.8	9.5	3.4
Voluntary Non-Profit	23.0	11.4	4.2	21.6	10.4	3.8	21.0	10.0	3.7	21.1	10.1	3.7
Government	18.8	10.0	3.4	18.3	9.0	3.3	17.3	8.9	3.0	18.3	9.2	3.3
Certification												
Medicare and Medicaid	19.8	10.9	4.5	18.4	9.9	4.0	17.9	9.7	3.9	18.0	9.8	3.9
Medicare only	33.3	15.8	4.1	32.3	14.4	4.0	31.7	14.5	3.8	32.1	14.5	3.7
Medicaid only	16.7	7.7	2.0	15.1	7.0	1.2	14.6	6.7	1.5	14.7	7.1	0.9
Bed Size												
Less than 50	28.0	10.8	2.4	27.2	9.9	1.1	26.1	10.0	2.0	27.0	10.0	0.8
50 - 99	19.4	10.0	3.4	18.1	9.2	3.0	17.7	8.9	2.9	17.6	9.0	2.9
100 - 199	19.5	11.1	4.9	18.2	10.1	4.5	17.5	10.0	4.4	17.8	10.0	4.4
200 or more	18.3	10.9	5.6	16.7	9.8	5.2	16.5	9.5	5.0	17.4	9.9	5.1

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**19.5**	**10.1**	**3.7**	**18.8**	**9.7**	**3.6**	**18.3**	**9.5**	**3.4**	**18.2**	**9.3**	**3.4**
Ownership												
For-Profit	18.4	10.0	3.8	17.7	9.5	3.4	17.5	9.4	3.4	17.4	9.2	3.3
Voluntary Non-Profit	21.8	10.7	3.8	21.6	10.2	4.0	20.7	10.0	3.7	20.7	9.8	3.7
Government	19.4	9.8	3.4	18.8	9.3	3.3	18.2	9.3	3.2	18.8	9.1	3.0
Certification												
Medicare and Medicaid	18.8	10.3	4.2	18.2	9.9	4.1	17.6	9.7	3.9	17.6	9.5	3.8
Medicare only	31.6	14.8	3.7	30.5	14.3	3.7	32.1	14.1	3.4	32.1	13.6	3.5
Medicaid only	15.4	7.3	1.2	14.5	7.0	1.6	14.8	7.0	1.5	14.6	6.6	1.3
Bed Size												
Less than 50	27.3	10.3	0.9	26.7	9.8	1.8	26.3	10.2	2.1	25.4	10.0	0.8
50 - 99	18.2	9.5	3.3	17.8	9.2	3.1	17.6	9.1	3.1	17.4	8.9	3.0
100 - 199	18.6	10.6	4.8	17.7	10.0	4.5	17.1	9.8	4.3	17.2	9.6	4.2
200 or more	17.5	10.0	5.4	16.7	9.7	5.2	15.8	9.3	4.9	16.4	9.3	4.7

Source: MDS and OSCAR

Table 3.17. Prevalence of Weight Loss in Nursing Homes in the 90th, Median, and 10th Percentile in United States, Third Quarter 1999-2001

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**20.0**	**10.2**	**3.7**	**18.8**	**9.5**	**3.4**	**18.3**	**9.5**	**3.4**
Alabama	22.6	11.4	5.4	20.9	11.3	5.4	19.9	10.8	4.9
Alaska	18.8	11.9	0.0	20.0	10.5	5.3	19.4	11.3	0.0
Arizona	20.1	9.4	3.9	20.9	10.0	1.9	17.5	8.3	3.5
Arkansas	22.5	11.3	4.2	20.3	9.5	3.1	20.3	9.7	3.6
California	21.5	9.9	3.1	20.3	9.0	2.6	19.2	9.3	2.6
Colorado	22.2	10.2	3.9	19.2	10.4	4.7	18.5	9.5	4.1
Connecticut	16.2	9.8	4.4	15.6	8.8	3.5	15.9	9.3	4.4
Delaware	19.1	10.6	5.6	18.9	10.3	3.8	19.0	11.5	3.4
District of Columbia	16.4	10.2	5.2	13.9	8.4	2.9	15.5	10.1	3.3
Florida	22.5	11.2	4.8	21.3	11.1	4.8	19.7	10.3	4.3
Georgia	19.0	10.8	4.3	18.0	10.6	4.3	17.8	10.4	4.9
Hawaii	20.4	10.8	3.5	22.7	9.9	2.4	18.5	9.8	3.8
Idaho	25.8	13.5	3.9	21.6	12.4	5.6	22.8	12.5	4.4
Illinois	17.6	9.0	3.3	16.3	8.2	2.3	16.2	8.3	2.4
Indiana	19.0	9.9	3.4	17.7	9.4	2.9	17.7	9.1	3.5
Iowa	14.3	7.5	2.7	13.4	6.8	2.2	14.3	7.6	2.6
Kansas	16.2	8.0	2.6	16.7	7.5	2.1	16.7	7.9	1.9
Kentucky	24.2	11.7	5.0	22.9	10.9	4.5	20.3	10.9	5.0
Louisiana	20.0	9.2	2.6	19.1	8.9	2.8	17.7	9.6	3.5
Maine	15.4	8.3	2.0	16.8	8.9	2.7	19.0	9.3	2.8
Maryland	20.0	11.2	4.4	18.5	10.2	3.6	18.5	9.9	4.3
Massachusetts	20.7	11.8	4.8	17.9	10.4	4.4	17.7	9.8	4.0
Michigan	20.7	11.5	5.0	20.1	10.0	4.2	20.0	11.2	3.9
Minnesota	16.4	8.7	2.8	15.4	8.6	2.9	16.0	9.0	3.7
Mississippi	18.6	9.6	3.5	16.4	8.9	4.0	16.7	9.2	3.1
Missouri	20.8	10.3	3.1	20.0	9.1	2.9	18.5	8.7	3.2
Montana	19.8	11.1	2.5	21.4	11.2	3.9	19.6	9.4	3.9
Nebraska	15.8	8.6	2.8	16.0	8.3	2.7	16.4	8.3	2.9
Nevada	21.9	11.5	5.0	21.0	11.1	6.1	25.0	8.8	1.9
New Hampshire	18.8	10.8	5.1	17.5	10.4	3.8	18.2	11.5	3.9
New Jersey	21.6	11.7	5.6	21.2	11.5	5.9	20.6	11.8	5.3
New Mexico	20.0	10.3	3.7	22.4	9.3	2.9	22.0	10.9	4.9
New York	17.4	9.2	4.3	16.3	8.7	4.4	16.4	8.9	4.1
North Carolina	23.1	11.1	4.9	20.6	10.8	4.0	18.9	10.5	5.0
North Dakota	15.6	8.1	2.6	14.0	7.0	2.7	14.3	8.4	2.9
Ohio	19.5	10.3	4.0	17.9	9.4	4.0	17.5	9.4	4.0
Oklahoma	18.6	8.2	2.4	18.2	8.3	1.8	16.5	7.5	1.5
Oregon	19.9	11.1	4.5	18.8	10.5	3.7	20.6	10.6	3.7
Pennsylvania	21.9	11.3	5.3	20.3	10.6	5.1	19.6	10.4	5.1
Rhode Island	23.0	12.8	4.8	18.1	11.5	4.9	20.2	11.1	4.5
South Carolina	21.6	11.1	4.8	20.2	10.6	5.3	22.2	11.5	4.4
South Dakota	16.1	7.5	2.3	15.0	8.1	2.7	15.5	8.5	2.9
Tennessee	21.6	11.9	5.4	20.2	11.6	5.7	19.4	10.8	4.5
Texas	19.0	9.1	2.4	16.7	8.0	2.4	15.4	7.9	2.2
Utah	21.4	10.5	3.4	18.5	10.5	2.9	18.2	9.9	3.6
Vermont	17.6	10.8	5.9	17.9	10.2	5.4	16.1	12.0	5.8
Virginia	18.7	11.2	5.4	18.2	10.1	4.5	20.0	10.8	4.7
Washington	22.8	13.4	5.6	20.3	11.8	5.3	22.5	12.9	5.7
West Virginia	21.0	11.1	3.4	20.2	10.5	3.8	19.0	10.6	4.5
Wisconsin	21.0	11.6	5.2	18.2	10.2	4.2	18.2	10.4	4.5
Wyoming	31.0	12.3	3.2	20.6	10.4	0.0	21.2	10.9	3.1

Source: MDS

Table 3.18. Prevalence of Dehydration in Nursing Homes by Type of Nursing Home at the 90th, Median, and 10th Percentile: United States, Quarterly 1999-2001

1999	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**3.2**	**0.0**	**0.0**	**2.9**	**0.0**	**0.0**	**2.4**	**0.0**	**0.0**	**2.1**	**0.0**	**0.0**
Ownership												
For-Profit	2.8	0.0	0.0	2.6	0.0	0.0	2.1	0.0	0.0	1.9	0.0	0.0
Voluntary Non-Profit	3.8	0.0	0.0	3.4	0.0	0.0	3.0	0.0	0.0	2.8	0.0	0.0
Government	3.8	0.0	0.0	3.6	0.0	0.0	3.0	0.0	0.0	2.4	0.0	0.0
Certification												
Medicare and Medicaid	2.9	0.0	0.0	2.7	0.0	0.0	2.2	0.0	0.0	2.0	0.0	0.0
Medicare only	10.3	1.4	0.0	9.2	1.1	0.0	8.7	0.8	0.0	8.0	0.6	0.0
Medicaid only	1.7	0.0	0.0	1.5	0.0	0.0	1.1	0.0	0.0	1.0	0.0	0.0
Bed Size												
Less than 50	7.1	0.0	0.0	6.3	0.0	0.0	5.6	0.0	0.0	5.3	0.0	0.0
50 - 99	3.0	0.0	0.0	2.6	0.0	0.0	2.2	0.0	0.0	2.0	0.0	0.0
100 - 199	2.6	0.5	0.0	2.4	0.0	0.0	1.9	0.0	0.0	1.7	0.0	0.0
200 or more	2.1	0.4	0.0	1.8	0.3	0.0	1.6	0.0	0.0	1.4	0.0	0.0

2000	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**2.2**	**0.0**	**0.0**	**1.9**	**0.0**	**0.0**	**1.7**	**0.0**	**0.0**	**1.7**	**0.0**	**0.0**
Ownership												
For-Profit	1.9	0.0	0.0	1.6	0.0	0.0	1.4	0.0	0.0	1.5	0.0	0.0
Voluntary Non-Profit	2.7	0.0	0.0	2.3	0.0	0.0	2.2	0.0	0.0	2.1	0.0	0.0
Government	2.9	0.0	0.0	2.6	0.0	0.0	2.3	0.0	0.0	2.2	0.0	0.0
Certification												
Medicare and Medicaid	2.0	0.0	0.0	1.7	0.0	0.0	1.5	0.0	0.0	1.6	0.0	0.0
Medicare only	7.9	0.5	0.0	6.9	0.0	0.0	7.4	0.0	0.0	7.9	0.0	0.0
Medicaid only	1.1	0.0	0.0	0.8	0.0	0.0	0.7	0.0	0.0	0.0	0.0	0.0
Bed Size												
Less than 50	5.3	0.0	0.0	4.7	0.0	0.0	4.8	0.0	0.0	4.5	0.0	0.0
50 - 99	2.0	0.0	0.0	1.8	0.0	0.0	1.7	0.0	0.0	1.7	0.0	0.0
100 - 199	1.7	0.0	0.0	1.4	0.0	0.0	1.3	0.0	0.0	1.3	0.0	0.0
200 or more	1.4	0.0	0.0	1.2	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0

2001	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**1.7**	**0.0**	**0.0**	**1.6**	**0.0**	**0.0**	**1.5**	**0.0**	**0.0**	**1.5**	**0.0**	**0.0**
Ownership												
For-Profit	1.5	0.0	0.0	1.4	0.0	0.0	1.3	0.0	0.0	1.3	0.0	0.0
Voluntary Non-Profit	2.1	0.0	0.0	2.0	0.0	0.0	1.9	0.0	0.0	1.8	0.0	0.0
Government	2.2	0.0	0.0	1.9	0.0	0.0	2.0	0.0	0.0	1.9	0.0	0.0
Certification												
Medicare and Medicaid	1.6	0.0	0.0	1.4	0.0	0.0	1.4	0.0	0.0	1.4	0.0	0.0
Medicare only	6.8	0.0	0.0	7.0	0.0	0.0	5.5	0.0	0.0	4.9	0.0	0.0
Medicaid only	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Bed Size												
Less than 50	4.2	0.0	0.0	4.2	0.0	0.0	4.1	0.0	0.0	3.4	0.0	0.0
50 - 99	1.7	0.0	0.0	1.6	0.0	0.0	1.5	0.0	0.0	1.6	0.0	0.0
100 - 199	1.3	0.0	0.0	1.1	0.0	0.0	1.1	0.0	0.0	1.1	0.0	0.0
200 or more	0.9	0.0	0.0	0.8	0.0	0.0	0.8	0.0	0.0	0.7	0.0	0.0

Source: MDS and OSCAR

Table 3.19. Prevalence of Dehydration in Nursing Homes at the 90th, Median, and 10th Percentile: United States, Third Quarter 1999-2001

	Percent Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**2.4**	**0.0**	**0.0**	**1.7**	**0.0**	**0.0**	**1.5**	**0.0**	**0.0**
Alabama	2.0	0.0	0.0	1.4	0.0	0.0	1.2	0.0	0.0
Alaska	6.7	0.0	0.0	12.0	0.0	0.0	4.3	0.0	0.0
Arizona	3.6	0.7	0.0	2.2	0.0	0.0	1.4	0.0	0.0
Arkansas	2.5	0.0	0.0	1.7	0.0	0.0	1.4	0.0	0.0
California	2.9	0.0	0.0	1.7	0.0	0.0	1.5	0.0	0.0
Colorado	3.5	0.0	0.0	1.9	0.0	0.0	1.6	0.0	0.0
Connecticut	2.0	0.0	0.0	1.4	0.0	0.0	1.4	0.0	0.0
Delaware	1.5	0.0	0.0	1.3	0.0	0.0	1.3	0.0	0.0
District of Columbia	1.7	0.0	0.0	3.2	0.0	0.0	1.0	0.0	0.0
Florida	2.3	0.0	0.0	1.1	0.0	0.0	1.0	0.0	0.0
Georgia	1.8	0.0	0.0	1.3	0.0	0.0	1.4	0.0	0.0
Hawaii	1.6	0.0	0.0	1.0	0.0	0.0	1.9	0.0	0.0
Idaho	3.9	0.0	0.0	2.4	0.0	0.0	2.9	0.0	0.0
Illinois	1.4	0.0	0.0	0.9	0.0	0.0	0.8	0.0	0.0
Indiana	2.3	0.0	0.0	1.5	0.0	0.0	1.0	0.0	0.0
Iowa	1.7	0.0	0.0	1.3	0.0	0.0	0.7	0.0	0.0
Kansas	2.4	0.0	0.0	1.9	0.0	0.0	1.6	0.0	0.0
Kentucky	2.4	0.0	0.0	1.5	0.0	0.0	1.4	0.0	0.0
Louisiana	3.3	0.0	0.0	2.0	0.0	0.0	2.0	0.0	0.0
Maine	2.7	0.0	0.0	2.4	0.0	0.0	2.2	0.0	0.0
Maryland	2.2	0.0	0.0	1.6	0.0	0.0	1.4	0.0	0.0
Massachusetts	3.2	0.2	0.0	1.9	0.0	0.0	1.9	0.0	0.0
Michigan	2.4	0.0	0.0	1.5	0.0	0.0	1.3	0.0	0.0
Minnesota	1.8	0.0	0.0	1.4	0.0	0.0	1.2	0.0	0.0
Mississippi	1.6	0.0	0.0	1.6	0.0	0.0	0.8	0.0	0.0
Missouri	3.1	0.0	0.0	2.2	0.0	0.0	1.9	0.0	0.0
Montana	4.6	0.0	0.0	3.2	0.0	0.0	3.0	0.0	0.0
Nebraska	2.1	0.0	0.0	1.8	0.0	0.0	1.5	0.0	0.0
Nevada	2.8	0.0	0.0	2.0	0.0	0.0	1.0	0.0	0.0
New Hampshire	2.9	0.0	0.0	1.7	0.0	0.0	1.5	0.0	0.0
New Jersey	1.7	0.0	0.0	1.3	0.0	0.0	1.4	0.0	0.0
New Mexico	3.1	0.0	0.0	1.5	0.0	0.0	1.1	0.0	0.0
New York	1.6	0.0	0.0	1.2	0.0	0.0	1.1	0.0	0.0
North Carolina	2.4	0.0	0.0	1.9	0.0	0.0	1.6	0.0	0.0
North Dakota	2.3	0.0	0.0	1.3	0.0	0.0	2.0	0.0	0.0
Ohio	2.2	0.0	0.0	1.4	0.0	0.0	1.1	0.0	0.0
Oklahoma	2.8	0.0	0.0	2.5	0.0	0.0	1.9	0.0	0.0
Oregon	3.6	0.0	0.0	2.6	0.0	0.0	2.1	0.0	0.0
Pennsylvania	2.4	0.0	0.0	1.4	0.0	0.0	1.2	0.0	0.0
Rhode Island	2.2	0.0	0.0	1.6	0.0	0.0	1.7	0.0	0.0
South Carolina	2.1	0.0	0.0	2.3	0.0	0.0	2.0	0.0	0.0
South Dakota	2.3	0.0	0.0	2.3	0.0	0.0	1.9	0.0	0.0
Tennessee	2.9	0.0	0.0	1.5	0.0	0.0	1.6	0.0	0.0
Texas	2.3	0.0	0.0	1.4	0.0	0.0	1.2	0.0	0.0
Utah	3.0	0.0	0.0	2.8	0.0	0.0	2.8	0.0	0.0
Vermont	3.0	0.0	0.0	2.4	0.0	0.0	3.2	0.0	0.0
Virginia	1.9	0.0	0.0	2.2	0.0	0.0	1.5	0.0	0.0
Washington	6.6	1.4	0.0	4.4	1.0	0.0	4.9	1.1	0.0
West Virginia	3.2	0.0	0.0	3.2	0.0	0.0	2.0	0.0	0.0
Wisconsin	2.0	0.0	0.0	1.8	0.0	0.0	1.5	0.0	0.0
Wyoming	2.5	0.0	0.0	3.4	0.0	0.0	2.0	0.0	0.0

Source: MDS

Table 3.20. Prevalence of Severe Bowel or Bladder Incontinence by Type of Nursing Home at the 90th, Median, and 10th Percentile: United States, Quarterly 1999-2001

1999

	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10t
Nation	**56.1**	**35.7**	**13.6**	**56.3**	**35.6**	**13.5**	**56.4**	**36.0**	**13.8**	**56.3**	**35.9**	**13.**
Ownership												
For-Profit	57.0	38.1	18.6	57.0	38.2	18.5	57.1	38.3	18.8	57.1	38.2	18.
Voluntary Non-Profit	52.9	30.1	9.1	52.8	30.0	9.1	53.3	30.4	8.5	53.3	30.4	8.
Government	56.6	33.3	13.1	56.8	33.3	13.2	57.7	33.8	13.1	57.6	33.3	12.
Certification												
Medicare and Medicaid	56.8	37.5	18.1	56.7	37.4	18.0	56.9	37.7	18.3	56.9	37.7	17.
Medicare only	44.1	18.1	3.7	43.5	17.2	3.6	43.2	18.3	3.4	44.0	18.1	3.
Medicaid only	54.2	31.7	9.5	55.0	31.6	9.7	54.8	32.1	10.0	54.1	31.9	9.
Bed Size												
Less than 50	52.0	23.1	4.7	52.0	22.9	4.8	51.7	23.1	4.3	52.1	23.2	4.
50 - 99	57.0	34.8	15.0	56.9	34.7	14.9	57.1	34.8	15.1	57.1	34.6	14.
100 - 199	55.8	38.5	21.0	55.8	38.6	20.8	56.0	38.9	21.3	56.0	38.8	21.
200 or more	58.0	40.5	19.8	58.8	40.5	19.0	58.4	40.7	19.3	57.9	41.1	19.

2000

	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10t
Nation	**55.9**	**35.3**	**13.6**	**55.8**	**35.2**	**13.4**	**56.3**	**35.7**	**13.5**	**56.4**	**35.6**	**13.**
Ownership												
For-Profit	56.8	37.6	17.9	56.7	37.6	17.8	57.1	38.2	18.1	57.1	38.2	17.
Voluntary Non-Profit	52.8	29.7	8.3	52.6	29.5	8.2	53.3	30.0	8.2	53.3	30.0	8.
Government	56.7	32.4	11.9	57.1	32.6	11.6	56.6	33.0	11.8	57.4	32.7	10.
Certification									11.5			
Medicare and Medicaid	56.5	37.0	17.4	56.5	36.8	17.2	56.9	37.6	17.5	56.9	37.5	17.
Medicare only	43.0	17.1	3.1	43.1	16.7	2.9	45.0	16.7	3.1	45.2	16.0	2.
Medicaid only	53.8	31.0	9.4	54.2	31.1	9.3	54.3	31.6	10.0	54.9	31.5	9.
Bed Size												
Less than 50	51.9	22.9	4.1	51.7	22.2	3.9	52.8	22.7	3.8	52.7	23.3	3.
50 - 99	56.2	33.8	14.3	55.8	33.3	14.3	56.4	34.1	14.5	56.7	34.1	14.
100 - 199	55.9	38.3	20.5	55.9	38.3	20.5	56.3	38.8	20.8	56.3	38.8	20.
200 or more	57.5	40.4	18.9	57.7	40.4	18.1	57.9	40.7	18.5	57.6	40.7	17.

2001

	Percent of Residents											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th	90th	Median	10t
Nation	**55.9**	**35.1**	**13.3**	**56.0**	**35.1**	**13.2**	**56.4**	**35.5**	**13.3**	**56.7**	**35.6**	**13.**
Ownership												
For-Profit	56.9	37.7	17.4	57.1	37.5	17.3	57.4	37.9	17.4	57.5	38.1	17.
Voluntary Non-Profit	52.5	29.7	7.7	52.8	29.1	7.7	53.1	29.7	7.7	52.9	29.7	7.
Government	56.9	31.5	10.5	56.5	31.6	11.1	57.5	32.0	10.3	57.1	32.0	9.
Certification												
Medicare and Medicaid	56.6	36.9	16.9	56.6	36.8	16.8	57.1	37.1	16.9	57.1	37.1	16.
Medicare only	42.6	16.0	2.5	43.1	15.2	2.9	43.6	15.6	2.7	43.9	15.0	2.
Medicaid only	54.0	30.6	7.5	54.7	30.3	7.1	54.9	30.8	7.7	55.4	30.6	8.
Bed Size												
Less than 50	51.7	22.0	3.1	52.9	21.6	3.6	53.2	21.6	3.4	53.5	22.0	2.
50 - 99	55.8	33.3	14.0	55.8	33.8	14.0	56.3	33.9	13.8	56.5	34.0	13.
100 - 199	56.1	38.3	20.0	56.0	38.3	19.9	56.4	38.5	20.2	56.6	38.7	19.
200 or more	58.3	40.9	21.8	58.6	40.6	22.0	58.8	41.5	21.9	59.0	41.1	22.

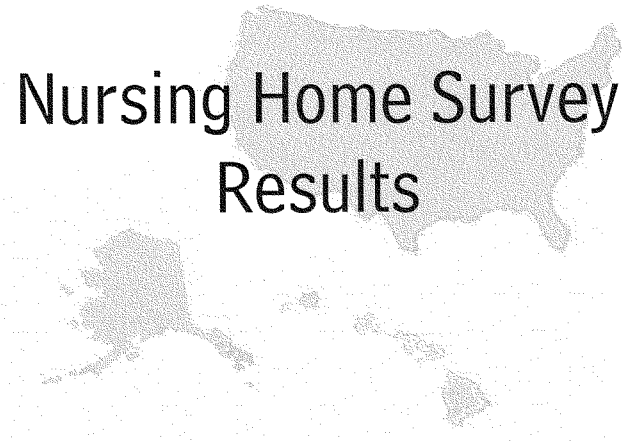
Source: MDS and OSCAR

Table 3.21. Prevalence of Severe Bowel or Bladder Incontinence by State at the 90th, Median, and 10th Percentile: United States, Third Quarter 1999-2001.

	Percent of Residents								
	1999 Quarter 3			2000 Quarter 3			2001 Quarter 3		
Percentile	90th	Median	10th	90th	Median	10th	90th	Median	10th
Nation	**56.4**	**36.0**	**13.8**	**56.3**	**35.7**	**13.5**	**56.4**	**35.5**	**13.3**
Alabama	57.4	43.3	29.4	54.9	42.1	26.9	56.5	42.0	28.9
Alaska	51.7	23.5	11.9	59.8	18.0	10.0	57.4	25.0	2.2
Arizona	52.3	36.8	15.4	47.8	35.7	16.5	48.3	35.7	15.9
Arkansas	52.2	37.8	21.9	52.0	38.8	22.9	50.8	38.6	21.1
California	66.2	47.6	19.2	67.5	47.2	18.6	68.3	47.8	17.9
Colorado	42.0	27.1	9.7	43.1	27.0	10.5	42.4	27.3	10.2
Connecticut	43.5	30.5	16.5	44.5	30.3	15.5	46.0	30.5	13.6
Delaware	56.1	40.4	21.8	50.9	39.8	22.0	56.3	40.4	21.6
District of Columbia	64.8	52.1	23.0	65.7	49.2	30.4	63.1	47.0	29.9
Florida	53.9	38.6	16.3	54.0	38.8	18.0	54.0	38.2	18.8
Georgia	58.5	44.2	29.5	57.9	44.9	30.1	59.7	45.5	31.0
Hawaii	73.8	49.5	22.2	77.8	50.5	17.7	71.6	50.3	27.8
Idaho	44.3	27.0	9.1	43.1	28.9	11.4	41.8	28.6	9.3
Illinois	41.1	24.5	7.7	40.6	24.2	7.2	41.3	23.9	6.7
Indiana	47.8	32.9	14.3	48.5	31.9	13.3	50.0	32.1	12.7
Iowa	33.9	18.2	6.7	34.5	18.2	7.5	37.1	18.3	7.3
Kansas	40.0	23.2	9.4	38.6	23.4	8.3	38.5	24.4	7.0
Kentucky	60.6	46.6	16.0	60.4	45.9	16.8	59.7	45.1	18.5
Louisiana	51.0	37.9	25.6	52.1	38.1	23.8	53.0	39.1	26.1
Maine	57.3	36.6	10.2	58.5	34.5	12.9	57.1	31.6	11.0
Maryland	63.6	47.4	12.5	61.1	46.0	13.2	60.3	44.4	16.3
Massachusetts	58.2	41.7	14.8	59.3	41.1	17.1	58.0	40.9	14.6
Michigan	50.5	32.7	17.6	48.6	31.1	15.4	48.7	30.8	14.9
Minnesota	44.2	27.2	12.8	43.3	26.6	11.6	42.5	24.9	9.5
Mississippi	58.7	44.2	22.6	57.6	45.2	23.8	58.0	45.5	27.3
Missouri	44.0	29.6	12.8	43.3	27.1	11.8	44.3	26.3	10.7
Montana	41.7	26.2	9.1	39.6	23.3	10.3	41.1	23.7	8.0
Nebraska	34.8	19.4	6.1	35.9	20.1	6.6	37.3	20.0	6.8
Nevada	58.8	37.8	13.0	57.4	40.2	11.6	58.4	47.9	16.7
New Hampshire	39.5	25.4	14.8	38.2	24.0	11.2	38.1	21.7	10.9
New Jersey	50.0	37.0	18.6	51.3	36.8	17.7	51.6	37.0	19.9
New Mexico	48.3	36.2	15.9	48.2	35.8	20.0	48.9	36.2	15.3
New York	59.7	41.9	22.7	58.8	42.2	23.0	59.6	40.9	23.1
North Carolina	61.6	47.3	28.0	63.5	48.0	26.4	62.1	47.3	27.7
North Dakota	37.5	24.1	9.1	38.6	23.0	7.1	33.3	21.0	7.8
Ohio	45.5	29.5	13.1	43.7	28.6	13.0	43.5	28.3	12.3
Oklahoma	46.9	33.3	18.6	45.5	31.6	20.3	45.9	31.9	17.2
Oregon	52.4	35.2	19.7	53.2	35.5	21.3	52.9	35.0	19.3
Pennsylvania	60.4	43.2	10.4	60.6	43.4	12.0	61.0	43.3	14.7
Rhode Island	44.0	27.6	13.8	42.2	28.0	12.1	47.7	28.3	11.5
South Carolina	66.3	54.4	24.3	65.2	52.3	21.0	66.7	52.7	23.3
South Dakota	36.8	21.8	6.8	38.3	22.6	10.2	38.0	24.7	8.3
Tennessee	58.7	44.0	24.0	59.3	43.9	20.8	59.6	43.8	22.0
Texas	60.4	45.2	25.6	60.7	45.9	27.3	61.4	46.1	27.0
Utah	44.6	29.1	7.9	44.4	30.1	9.0	46.0	27.7	8.3
Vermont	40.3	30.4	18.9	45.5	28.6	20.6	50.0	30.2	20.6
Virginia	64.7	50.8	29.0	64.7	48.8	26.1	62.9	49.3	27.5
Washington	48.5	31.0	13.8	48.4	32.3	16.8	48.2	31.8	16.2
West Virginia	54.3	38.3	13.3	54.1	38.6	10.8	53.2	37.7	8.3
Wisconsin	37.5	23.5	9.1	37.8	23.5	8.5	37.0	22.2	8.3
Wyoming	28.6	14.7	2.6	30.6	17.3	2.8	30.0	19.2	4.3

Source: MDS

Nursing Home Survey Results



Nursing Home Survey Results

Mean Number of Health Deficiencies

- Nationally, the average number of health deficiencies per nursing home survey increased from 5.1 in 1996 to 6.3 in 2001. In 2001, the mean number of deficiencies varied from 3.2 in Vermont to 11.3 in California.

  Figure 4.3; Tables 4.1(f) and 4.2(f)

- Since 1997, the percentage of nursing home surveys that do not result in health deficiencies has decreased by almost half. While 22 percent of nursing home surveys did not result in health deficiencies in 1997, slightly more than 11 percent were without deficiencies 2001.

  Figure 4.6; Tables 4.3(a)-4.3(f) and 4.4(a)-4.4(f)

Technical Notes:

These data are from the CMS's Online Survey Certification and Reporting (OSCAR) System, an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by survey teams.

Note that for all of the calendar year calculations of health deficiencies, the weighting scheme is unique. The facility that was not surveyed during the particular calendar year is not counted and the facility that was surveyed twice during the year is doubly counted, giving it a weight of 2.

The percentage of surveys resulting in zero deficiencies is defined as the number of nursing home surveys that received zero deficiencies divided by the number of surveys conducted that year.

Scope and Severity of Health Deficiencies

- More citations are for isolated deficiencies that caused minimal harm to residents than for any other level of scope and severity. The percentage of deficiencies cited at that level of scope and severity (D-level) increased from 31 to 50 percent from 1996 to 2001.

  Figures 4.2(a) – 4.2(c) and 4.9; Tables 4.5(a)-4.5(f)

- The percentage of nursing home surveys resulting in a health deficiency of actual harm or immediate jeopardy increased each year from 1996 to 1999. Since 1999, however, the percentage has dropped to the lowest level of that time period. In 1999, more than 31 percent of facilities were cited at these levels. In 2001, about 21 percent of facilities were cited for deficiencies at actual harm, well below the1996 rate of 26.3 percent.

  Figure 4.10; Tables 4.6(a)-4.6(f) and 4.7(a)-4.7(f)

- The percentage of deficiencies with the highest level of severity, immediate jeopardy, has increased by four-fold since 1996. However, only a small proportion of surveys result in citations at this level: in 2001, the citation rate was 2.4 percent.

  Figures 4.13, Tables 4.8(a)-4.8(f) and 4.9(a)-4.9(f)

Technical Notes:

Data in this report are from the CMS's Online Survey Certification and Reporting (OSCAR) System, an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by state and federal compliance survey teams.

In distributions of the scope and severity by year, the denominator is the number of citations, not nursing homes or surveys.

Note that for all of the calendar year calculations of health deficiencies, the weighting scheme is unique. The facility that was not surveyed during the particular calendar year is not counted and the facility that was surveyed twice during the year is doubly counted, giving it a weight of 2.

An "actual harm" deficiency is defined as a deficiency citation that is rated at scope and severity 'G' or more severe.

Immediate jeopardy is a deficiency that constitutes an immediate threat to the health or life of one or more nursing home residents. Immediate jeopardy is determined when a deficiency is scored by Federal or state surveyors at the scope and severity of "J", "K" or "L".

Substandard Quality of Care Citations

- The percentage of nursing home surveys resulting in citations for substandard quality of care decreased from 5.5 percent in 1998 to 4.3 percent in 2001.

  Figure 4.15; Tables 4.10(a)-4.10(f) and 4.11(a)-4.11(f)

- The number of states citing one percent or fewer facilities for substandard quality of care has fluctuated between 1 and 7 over time. It was greatest in 1996 and 1997 and lowest in 1999.

  Figures 4.16 and 4.17; Tables 4.10(a)-4.10(f) and 4.11(a)-4.11(f)

Technical Notes:

These data are from the CMS's Online Survey Certification and Reporting (OSCAR) System, an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by survey teams.

Note that for all of the calendar year calculations of health deficiencies, the weighting scheme is unique. The facility that was not surveyed during the particular calendar year is not counted and the facility that was surveyed twice during the year is doubly counted, giving it a weight of 2.

Substandard Quality of Care (SQC) is defined as any deficiency in the Code of Federal Regulations (42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42CFR 483.25 Quality of Care), at a scope and severity level of F, H, I, J, K, or L.

Abuse, Restraint Use, and Pressure Ulcer Citations

- During the four-year period (1996 to 2001), no more than 2.1 percent of surveys per year resulted in citations related to abuse of nursing home residents. The rate fluctuates from year to year, but has declined steadily since 1999, when it was 2.1 percent. In 2001, 14 states cited no instances of abuse in nursing homes, while 3 states cited this deficiency in 5 percent or more of its surveys.

  Figures 4.18, 4.19, and 4.20; Tables 4.12(a)-4.12(f) and 4.13(a)-4.13(f)

- The proportion of nursing home surveys resulting in citations for the improper use of physical and chemical restraints has declined since 1996, but remained constant from 2000 to 2001.

  Figures 4.21 and 4.22, Tables 4.14(a)-4.14(f) and 4.15(a)-4.15(f)

- The pressure ulcer citation rate declined from a high of 18.9 percent in 1999. The rate further declined to 17.2 percent in 2001.

  Figures 4.23 and 4.24, Tables 4.16(a) - 4.16(f) and 4.17(a)-4.17(f)

Technical Notes:

These data are from the CMS's Online Survey Certification and Reporting (OSCAR) System, an administrative database that captures data about the survey and certification process. Data from OSCAR are a combination of self-reported data from nursing facilities and compliance data gathered by state survey teams.

Note that for all of the calendar year calculations of health deficiencies, the weighting scheme is unique. The facility that was not surveyed during the particular calendar year is not counted and the facility that was surveyed twice during the year is doubly counted, giving it a weight of 2.

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification"

Restraint use citations are those deficiencies cited under tags F221-F222 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification"

Pressure ulcer citations are those deficiencies cited under tag F314 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification"

Figure 4.1. Scope and Severity Grid for Rating Nursing Home Deficiencies

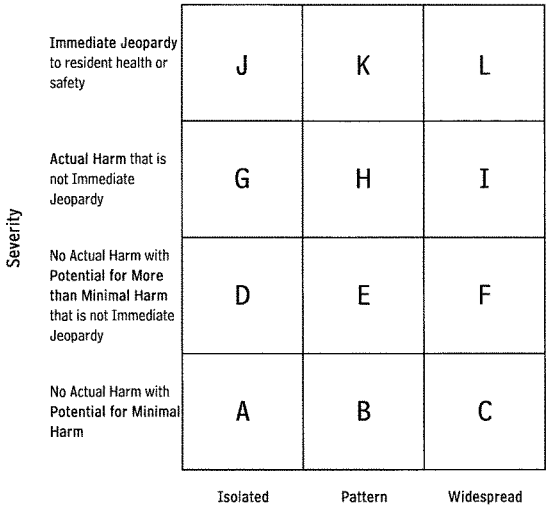


Figure 4.2 (a). Percent Distribution of Scope and Severity of Health Deficiency Citations by Year: United States, 1996-2001

1996

	Isolated	Pattern	Widespread
Immediate Jeopardy	0.1 J	0.1 K	0.1 L
Actual Harm	9.8 G	2.5 H	0.4 I
Greater Than Minimal Harm	31.0 D	23.6 E	5.6 F
Minimal Harm	N/A A	16.7 B	10.0 C

1997

	Isolated	Pattern	Widespread
Immediate Jeopardy	0.2 J	0.2 K	0.1 L
Actual Harm	11.1 G	1.7 H	0.2 I
Greater Than Minimal Harm	38.2 D	22.0 E	5.0 F
Minimal Harm	N/A A	13.7 B	7.9 C

Source: OSCAR

Figure 4.2 (b). Percent Distribution of Scope and Severity of Health Deficiency Citations by Year: United States, 1996-2001

1998

	Isolated	Pattern	Widespread
Immediate Jeopardy	0.3 J	0.3 K	0.1 L
Actual Harm	11.3 G	1.7 H	0.1 I
Greater Than Minimal Harm	40.7 D	22.1 E	5.1 F
Minimal Harm	N/A A	10.8 B	6.8 C

1999

	Isolated	Pattern	Widespread
Immediate Jeopardy	0.3 J	0.2 K	0.1 L
Actual Harm	10.6 G	1.3 H	0.1 I
Greater Than Minimal Harm	43.7 D	23.1 E	5.5 F
Minimal Harm	N/A A	8.6 B	6.4 C

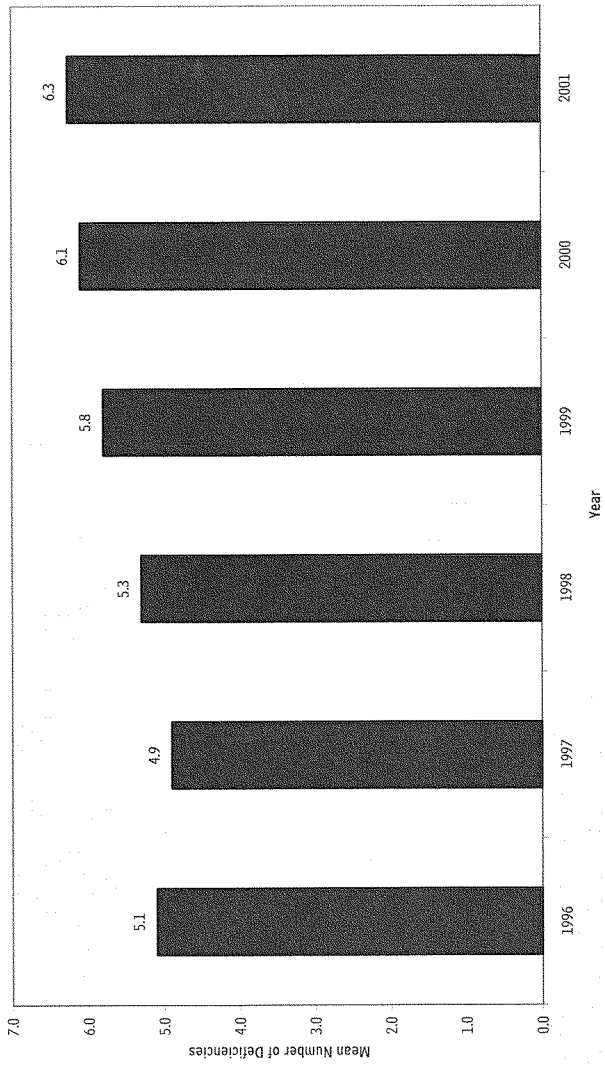
Figure 4.2 (c). Percent Distribution of Scope and Severity of Health Deficiency Citations by Year: United States, 1996-2001

		Isolated	Pattern	Widespread
2000	Immediate Jeopardy	0.3 J	0.3 K	0.1 L
	Actual Harm	7.4 G	0.8 H	0.1 I
	Greater Than Minimal Harm	46.2 D	24.1 E	5.5 F
	Minimal Harm	N/A A	9.0 B	6.3 C

		Isolated	Pattern	Widespread
2001	Immediate Jeopardy	0.3 J	0.4 K	0.1 L
	Actual Harm	5.6 G	0.5 H	0.0 I
	Greater Than Minimal Harm	49.7 D	22.9 E	5.1 F
	Minimal Harm	N/A A	9.7 B	5.7 C

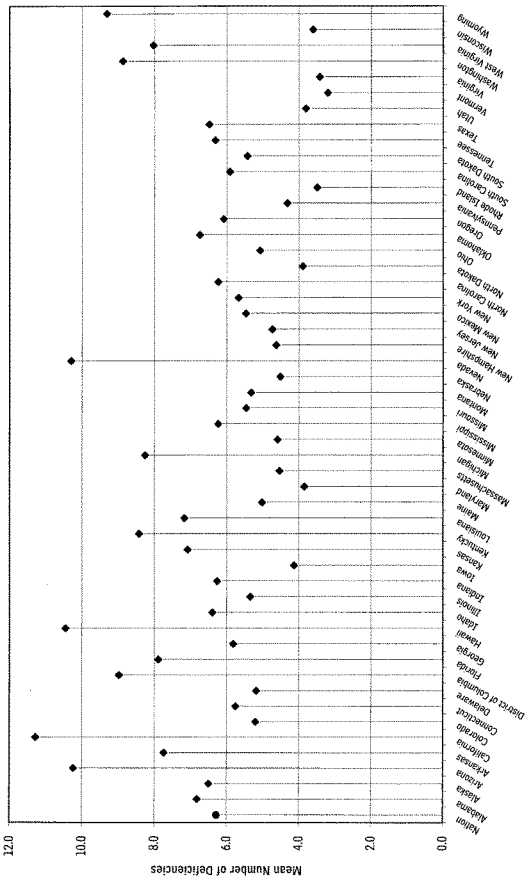
SOURCE: OSCAR

Figure 4.3. Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Year: United States, 1996-2001



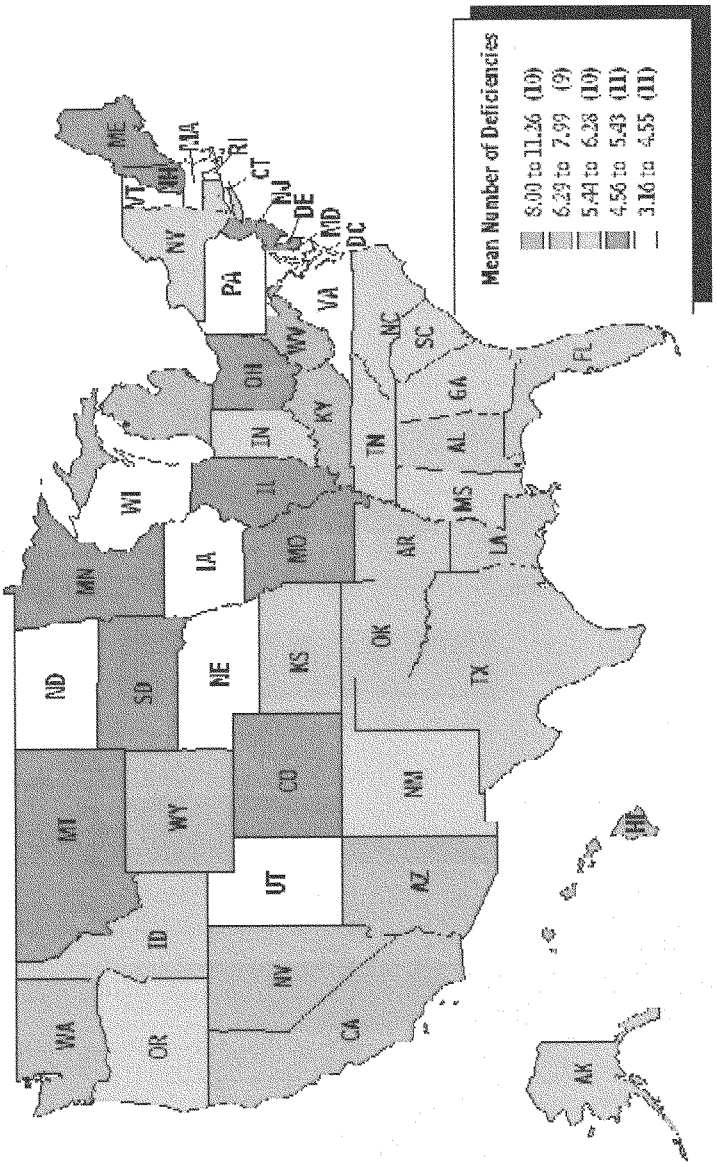
SOURCE: OSCAR

Figure 4.4. Mean Number of Health Deficiencies Cited in Nursing Home Surveys by State: United States, 2001



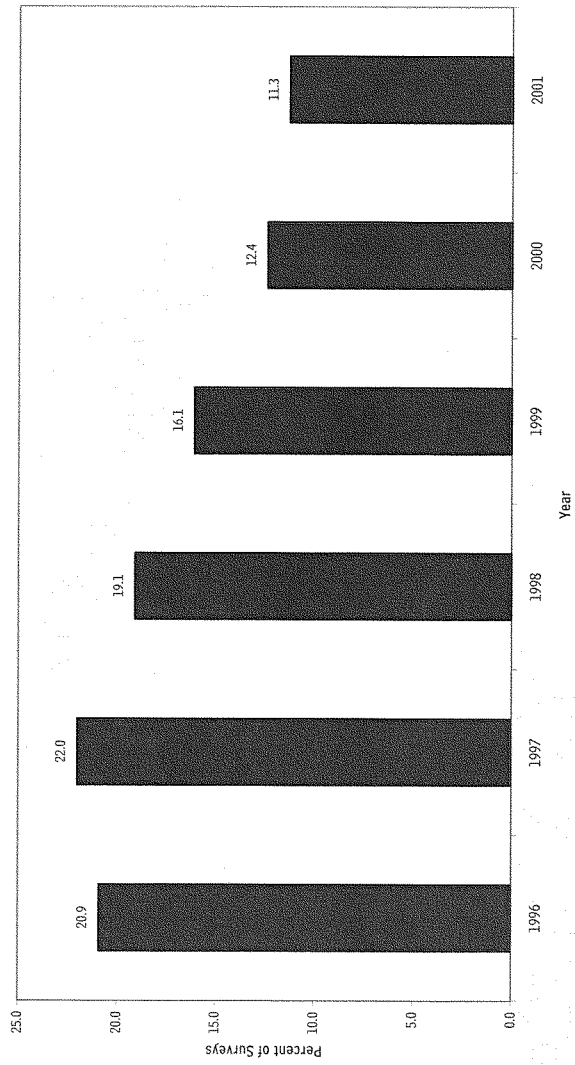
SOURCE: OSCAR

Figure 4.5. Mean Number of Health Deficiencies Cited in Nursing Home Surveys by State: United States, 2001



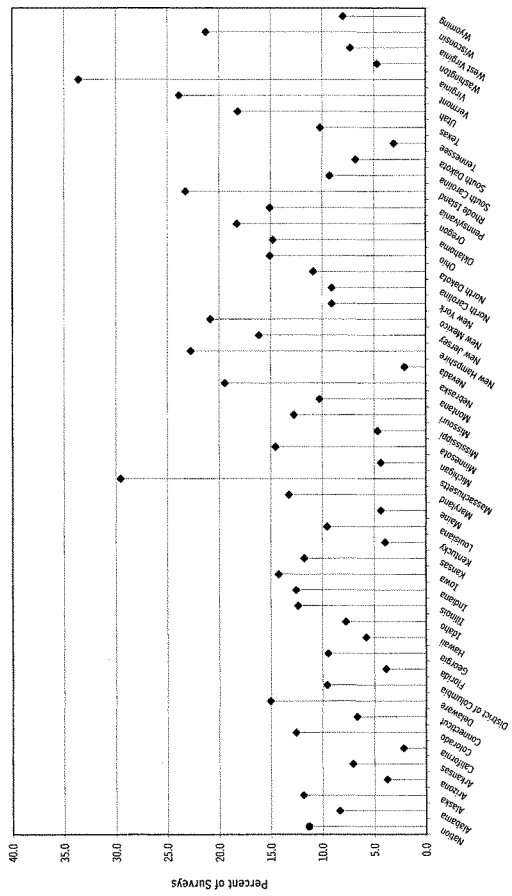
SOURCE: OSCAR

Figure 4.6. Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Year: United States, 1996-2001



SOURCE: OSCAR

Figure 4.7. Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by State: United States, 2001



SOURCE: OSCAR

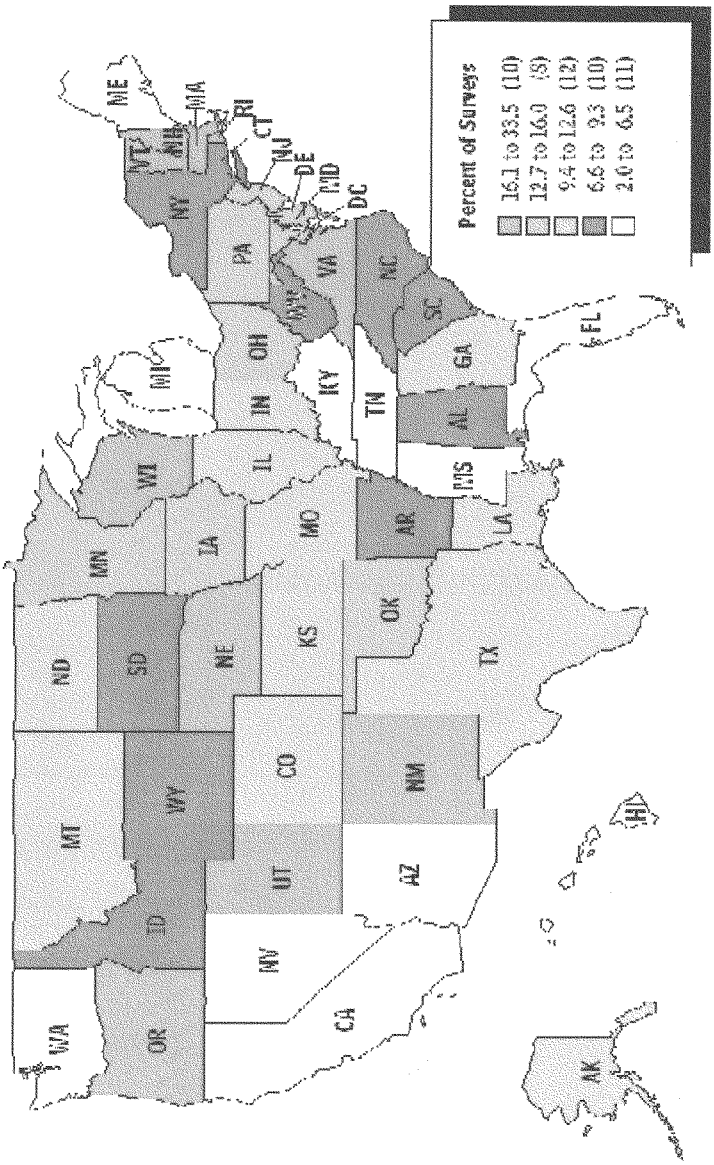
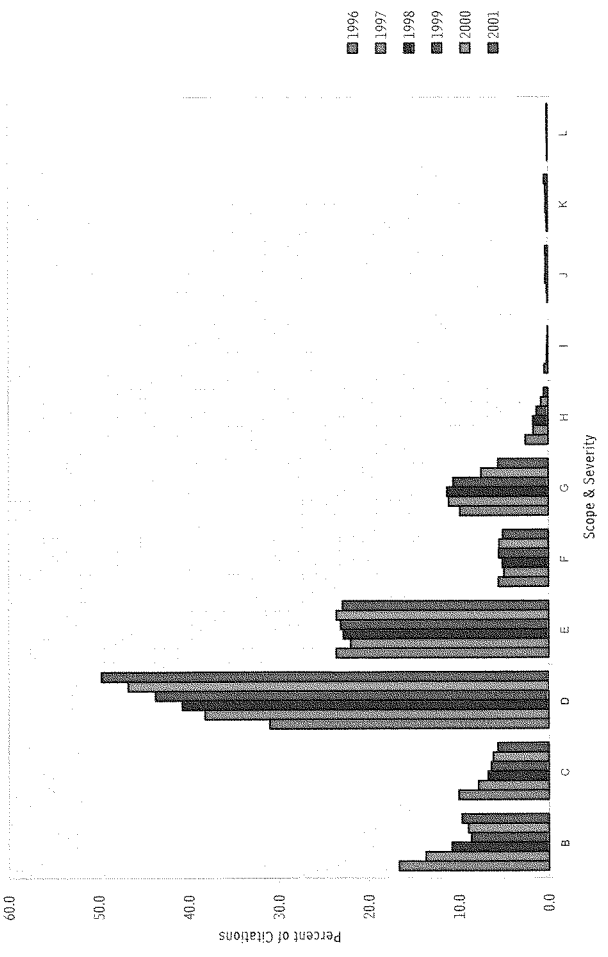


Figure 4.8. Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by State: United States, 2001

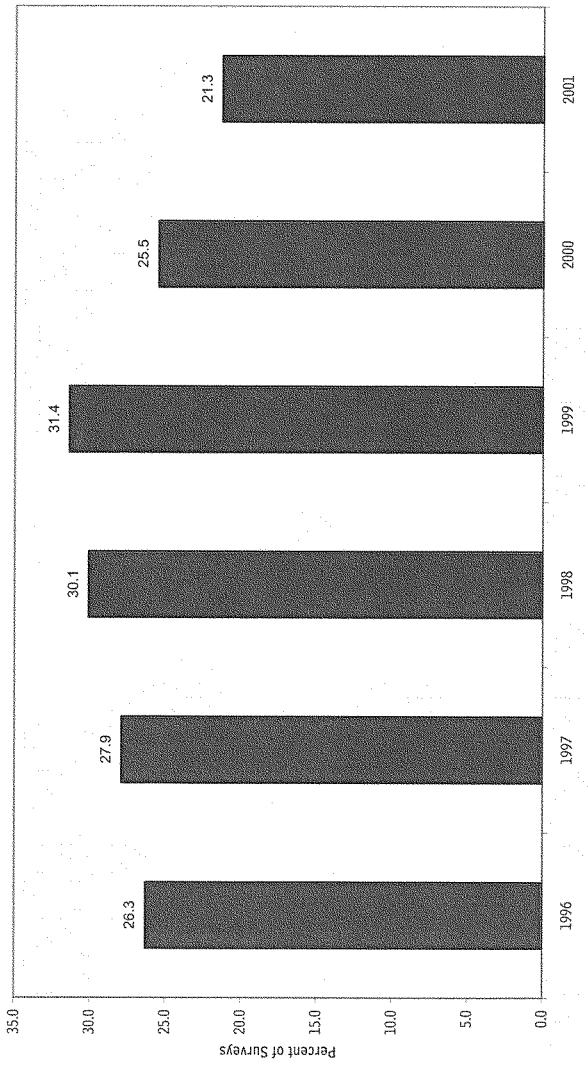
SOURCE: OSCAR

Figure 4.9. Distribution of Scope and Severity of Health Deficiency Citations by Year: United States, 1996-2001



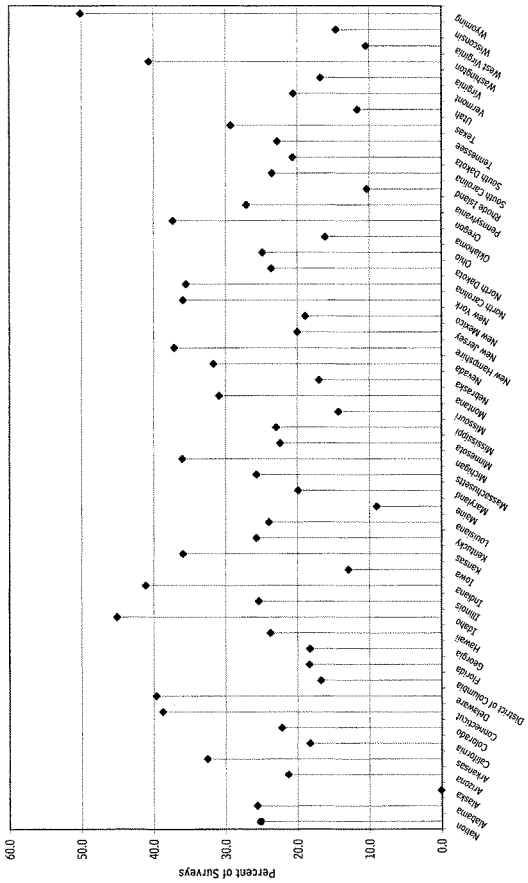
SOURCE: OSCAR

Figure 4.10. Nursing Home Surveys Resulting in a Citation for Actual Harm or Immediate Jeopardy to Nursing Home Residents by Year: United States, 1996-2001



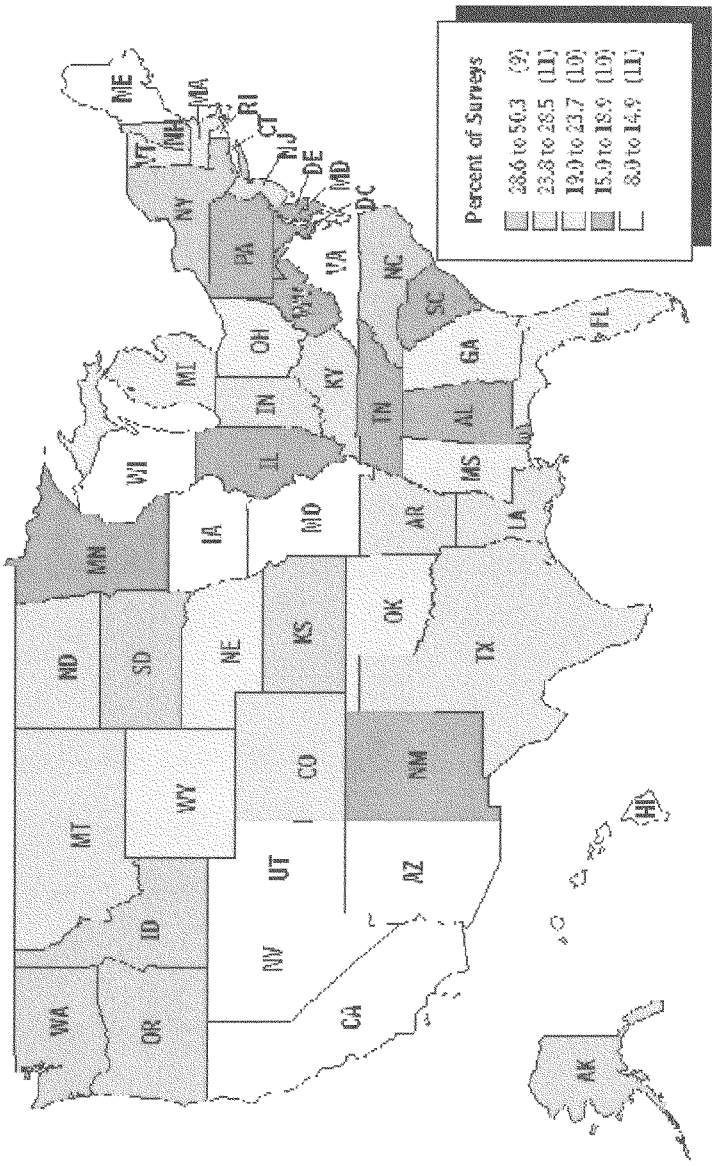
SOURCE: OSCAR

Figure 4.11. Percent of Nursing Home Surveys Resulting in a Citation for Actual Harm or Immediate Jeopardy to Nursing Home Residents by State: United States, 2001



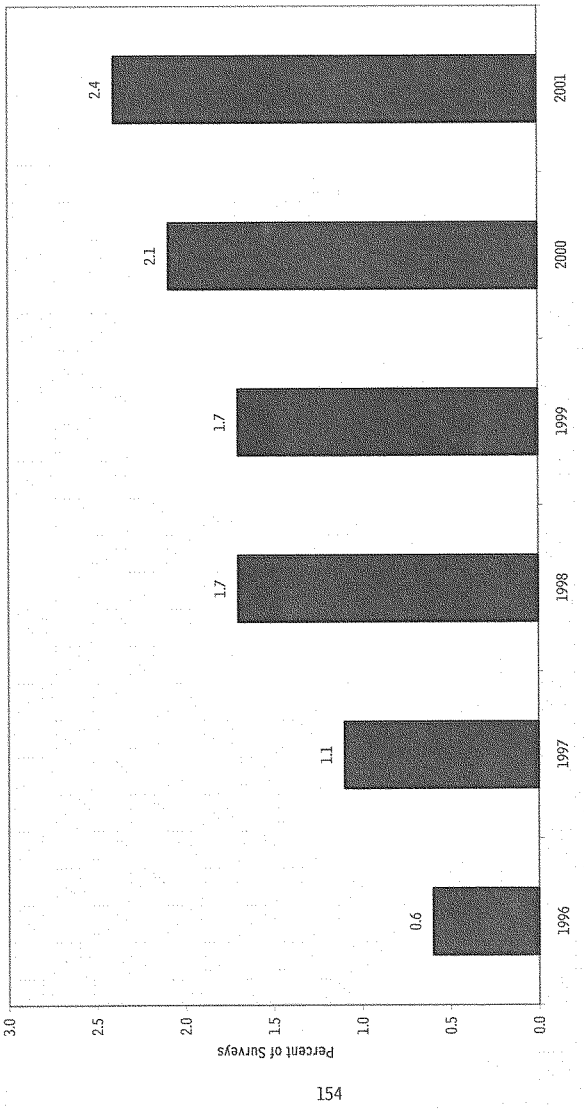
SOURCE: OSCAR

Figure 4.12. Percent of Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Nursing Home Residents by State: United States, 2001



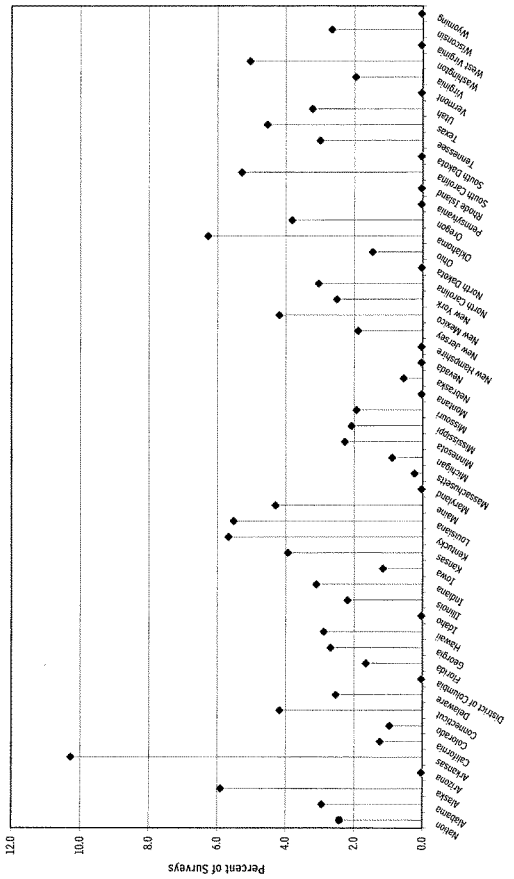
SOURCE: OSCAR

Figure 4.13. Percent of Nursing Home Surveys Resulting in a Citation for Immediate Jeopardy to Nursing Home Residents by Year: United States, 1996-2001



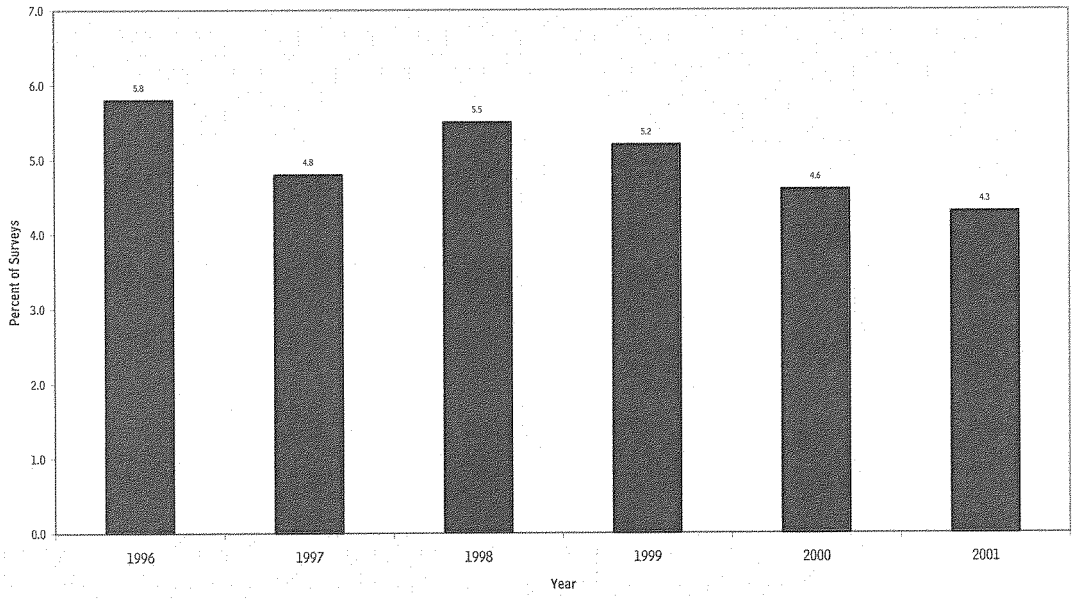
SOURCE: OSCAR

Figure 4.14. Percent of Nursing Home Surveys Resulting in a Citation for Immediate Jeopardy to Nursing Home Residents by State: United States, 2001



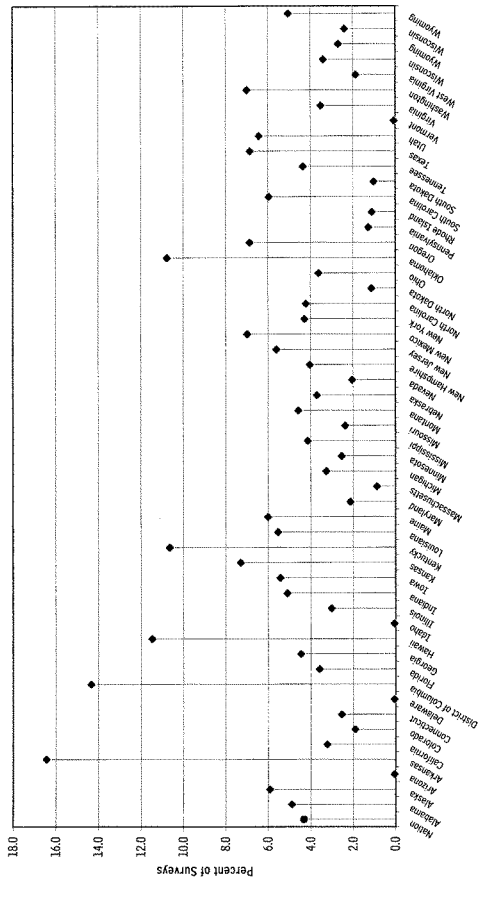
SOURCE: OSCAR

Figure 4.15. Percent of Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Year: United States, 1996-2001



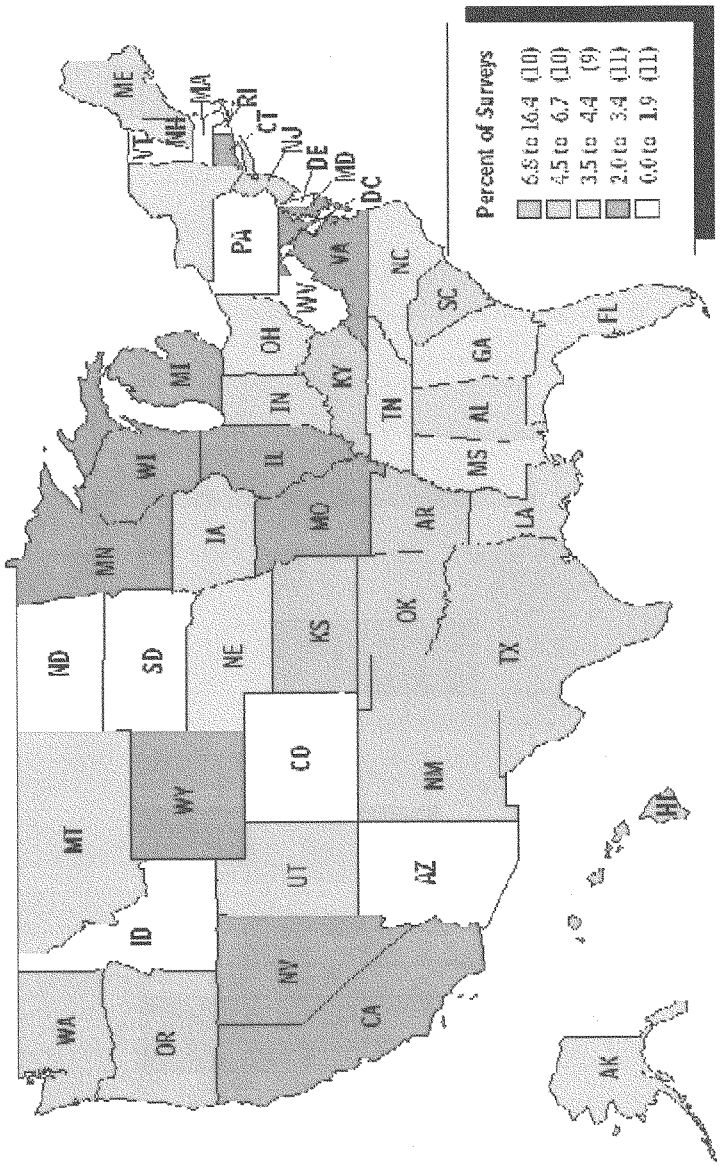
SOURCE: OSCAR

Figure 4.16. Percent of Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by State: United States, 2001



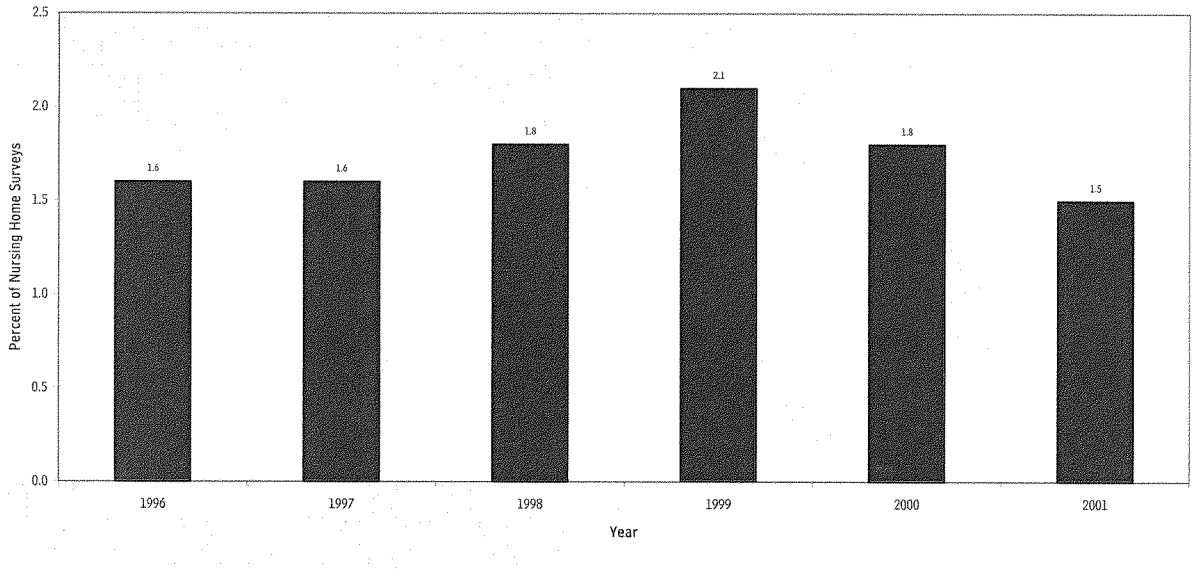
SOURCE: OSCAR

Figure 4.17. Percent of Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by State: United States, 2001



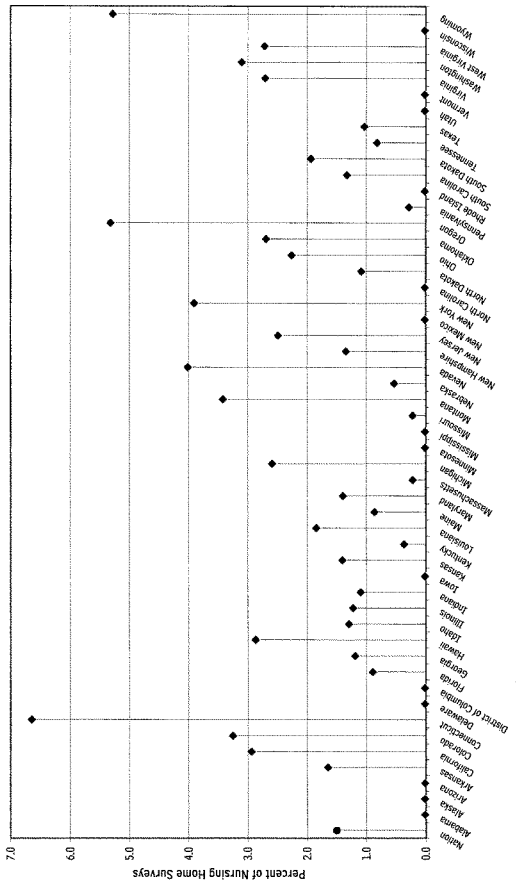
SOURCE: OSCAR

Figure 4.18. Percent of Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Year: United States, 1996-2001



SOURCE: OSCAR

Figure 4.19. Percent of Nursing Home Surveys Resulting in a Citation for Abuse of Residents by State: United States, 2001



SOURCE: OSCAR

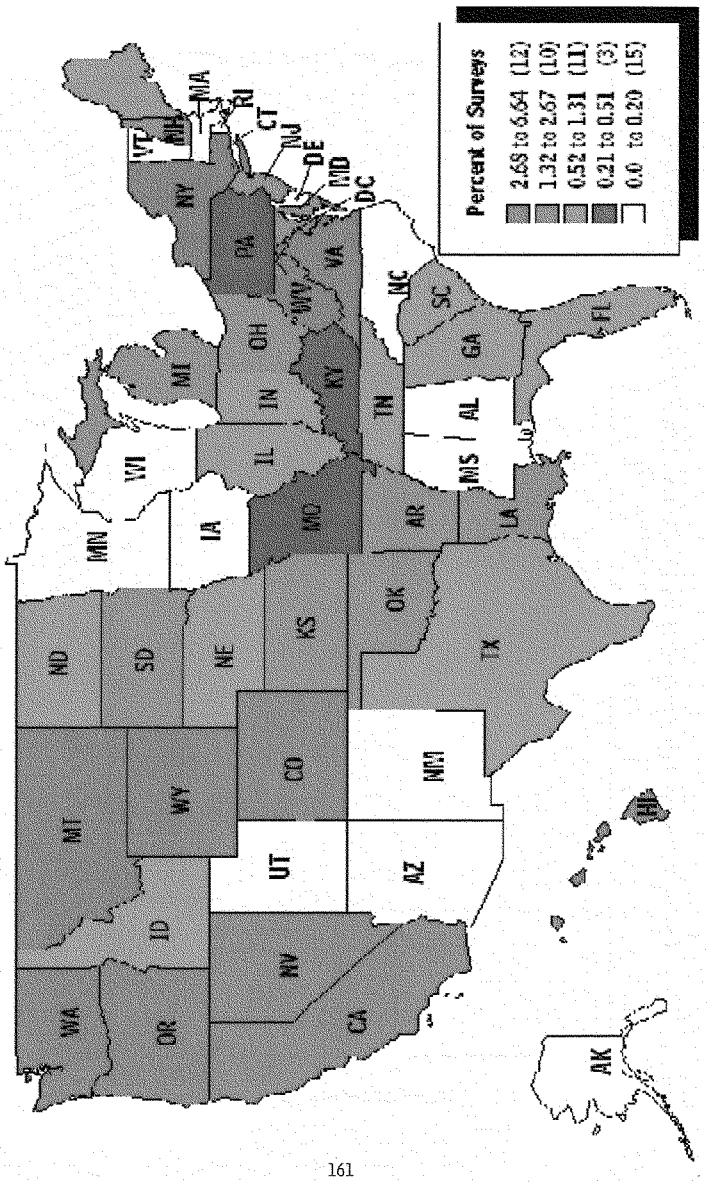
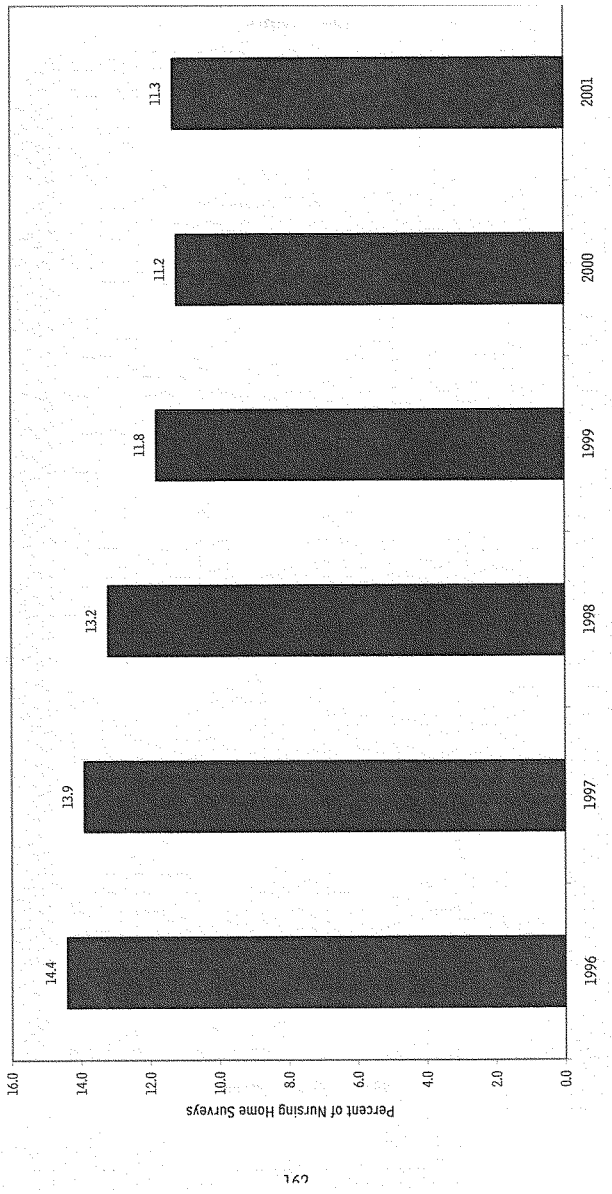


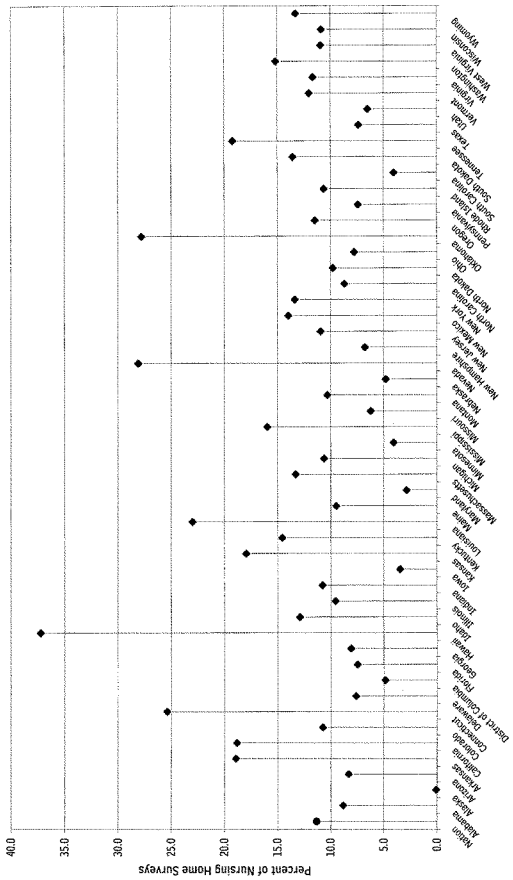
Figure 4.20. Percent of Nursing Homes Cited for Abuse of Residents by State: United States, 2001

Figure 4.21. Percent of Nursing Home Surveys Resulting in a Citation for Improper Use of Restraints by Year: United States, 1996-2001



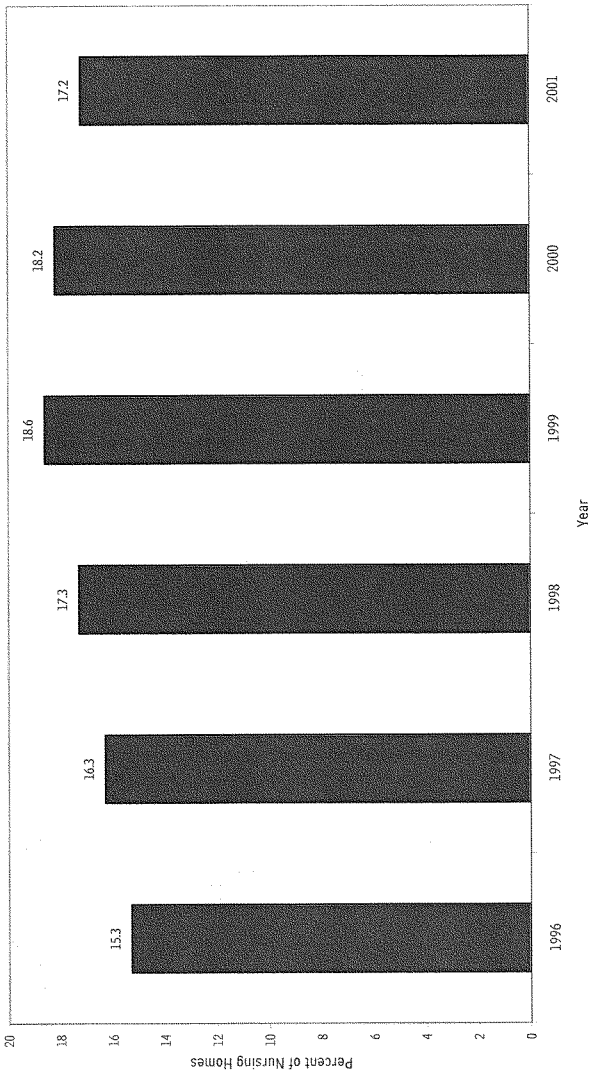
SOURCE: OSCAR

Figure 4.22. Percent of Nursing Home Surveys Resulting in a Citation for Improper Use of Restraints by State: United States, 2001



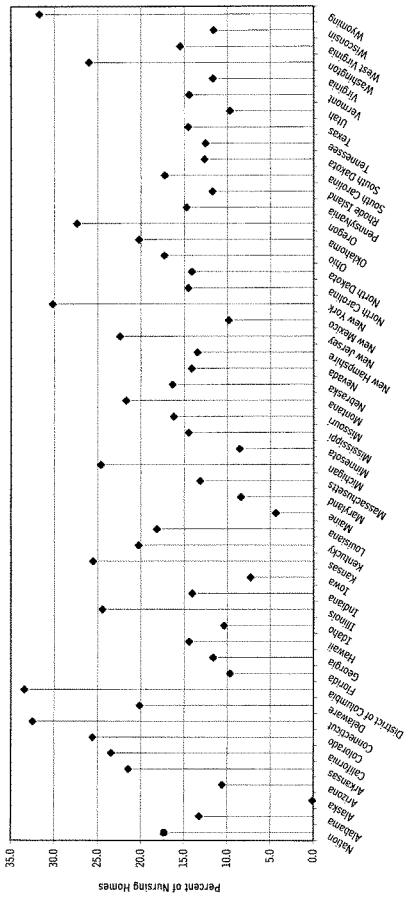
SOURCE: OSCAR

Figure 4.23. Percent of Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Year: United States, 1996-2001



SOURCE: OSCAR

Figure 4.24. Percent of Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by State: United States, 2000



SOURCE: OSCAR

Table 4.1 (a). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 1996

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.5**	**5.1**	**5.7**	**6.1**	**5.1**
Alabama	3.3	5.1	7.5	9.7	6.3
Alaska	1.8	4.0	n/a	0.0	2.1
Arizona	4.0	5.7	6.0	8.7	5.7
Arkansas	8.5	7.7	8.6	10.0	8.3
California	7.1	10.7	13.3	16.2	10.8
Colorado	1.5	2.0	3.4	3.1	2.4
Connecticut	1.1	1.0	1.8	1.7	1.5
Delaware	4.0	7.4	11.3	n/a	9.5
District of Columbia	7.0	4.9	10.3	4.2	6.0
Florida	3.4	5.0	7.0	9.2	6.2
Georgia	1.6	3.2	3.8	5.3	3.5
Hawaii	4.7	5.3	4.4	4.0	4.7
Idaho	4.5	6.6	7.8	7.0	6.1
Illinois	4.2	6.2	6.4	7.4	6.2
Indiana	4.4	5.6	7.9	8.8	6.5
Iowa	3.1	3.9	4.9	5.7	4.0
Kansas	4.9	7.2	8.9	16.6	7.0
Kentucky	1.0	2.1	2.9	4.9	2.1
Louisiana	1.7	4.3	5.5	5.2	4.7
Maine	1.9	2.6	2.2	2.3	2.3
Maryland	1.7	2.3	2.6	3.7	2.5
Massachusetts	2.2	3.2	3.5	4.5	3.2
Michigan	6.1	7.9	11.5	10.8	9.8
Minnesota	2.6	2.5	3.5	3.5	2.9
Mississippi	2.6	4.1	6.4	5.8	4.7
Missouri	2.7	3.9	5.0	5.3	4.2
Montana	4.5	5.5	7.8	11.5	5.7
Nebraska	3.7	2.9	5.0	6.4	3.6
Nevada	8.1	15.4	16.8	21.8	13.3
New Hampshire	4.0	5.1	3.0	3.4	4.1
New Jersey	2.9	1.6	2.5	3.6	2.6
New Mexico	0.5	1.7	3.1	0.0	2.0
New York	2.4	2.7	3.2	2.8	2.9
North Carolina	1.4	3.9	5.0	6.6	4.2
North Dakota	3.9	6.1	9.0	16.0	6.5
Ohio	4.2	3.9	5.4	5.3	4.8
Oklahoma	2.4	3.7	4.6	7.0	3.9
Oregon	3.6	5.5	5.6	6.0	5.1
Pennsylvania	1.6	2.5	3.7	4.6	3.1
Rhode Island	2.4	2.3	4.0	3.3	3.1
South Carolina	4.7	7.0	8.7	5.8	7.1
South Dakota	3.5	4.3	5.1	4.0	4.2
Tennessee	3.8	5.2	6.3	11.0	5.9
Texas	1.4	4.4	4.9	5.7	4.2
Utah	2.2	4.1	5.6	1.5	4.0
Vermont	2.9	1.1	2.7	n/a	2.3
Virginia	1.1	3.0	4.5	7.4	3.7
Washington	5.0	8.2	8.1	6.4	7.6
West Virginia	2.5	4.0	6.2	42.0	4.8
Wisconsin	1.9	3.0	3.5	4.7	3.3
Wyoming	1.4	2.8	4.9	1.0	3.1

Source: OSCAR

n/a: Data unavailable

Table 4.1 (b). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 1997

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.3**	**5.0**	**5.4**	**5.7**	**4.9**
Alabama	3.5	4.6	7.3	9.4	6.1
Alaska	2.0	7.5	n/a	14.0	3.4
Arizona	3.6	5.5	5.4	5.7	5.1
Arkansas	6.1	7.0	7.8	9.9	7.4
California	7.7	10.7	13.3	16.2	10.8
Colorado	1.2	2.2	3.1	3.4	2.3
Connecticut	0.8	1.2	2.4	2.6	2.0
Delaware	2.4	4.7	8.9	10.0	7.0
District of Columbia	3.6	2.5	6.9	6.1	5.0
Florida	3.2	5.6	7.3	9.4	6.5
Georgia	0.8	1.6	3.6	2.8	2.7
Hawaii	6.4	6.0	8.1	6.3	6.6
Idaho	5.2	7.2	7.7	n/a	6.6
Illinois	3.6	6.0	6.2	7.5	6.0
Indiana	5.4	6.5	7.6	7.1	6.8
Iowa	2.4	4.6	6.4	8.1	4.7
Kansas	4.6	6.5	9.4	5.0	6.5
Kentucky	1.5	2.8	3.7	19.8	3.1
Louisiana	1.3	4.1	5.2	3.9	4.3
Maine	2.0	2.7	3.3	5.0	2.6
Maryland	1.4	1.3	2.7	3.1	2.2
Massachusetts	1.6	2.1	3.2	3.2	2.6
Michigan	6.4	7.4	9.5	10.1	8.6
Minnesota	2.9	2.1	3.5	4.1	2.8
Mississippi	2.0	3.8	4.8	7.0	3.8
Missouri	2.1	3.4	4.2	4.6	3.6
Montana	3.2	2.8	4.7	3.0	3.4
Nebraska	2.2	2.6	3.0	2.2	2.6
Nevada	8.9	18.3	21.4	13.5	15.2
New Hampshire	3.8	3.8	3.8	3.6	3.8
New Jersey	1.5	1.8	2.3	3.6	2.4
New Mexico	1.1	2.1	2.5	0.0	2.0
New York	1.9	2.1	2.4	2.1	2.2
North Carolina	0.8	2.9	4.7	4.8	3.6
North Dakota	5.1	7.7	11.3	4.0	7.9
Ohio	3.0	3.9	4.4	5.4	4.1
Oklahoma	2.7	4.5	4.7	5.4	4.3
Oregon	3.5	5.1	4.9	2.0	4.7
Pennsylvania	1.8	2.9	3.8	3.6	3.2
Rhode Island	1.7	2.6	4.4	4.0	3.2
South Carolina	5.6	6.9	9.9	8.2	7.8
South Dakota	3.5	2.8	5.1	3.0	3.2
Tennessee	1.6	2.5	2.7	3.7	2.5
Texas	1.6	4.6	5.0	5.5	4.3
Utah	1.8	3.6	4.4	3.5	3.4
Vermont	1.7	1.2	2.6	n/a	1.9
Virginia	0.9	2.4	4.6	4.6	3.3
Washington	6.3	8.2	9.0	13.0	8.4
West Virginia	4.1	5.5	6.7	22.3	6.1
Wisconsin	1.5	3.7	3.9	5.4	3.7
Wyoming	6.1	6.6	5.5	8.0	6.2

Source: OSCAR
n/a: Data unavailable

Table 4.1 (c). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 1998

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.4**	**5.2**	**5.9**	**6.0**	**5.3**
Alabama	3.1	4.8	6.8	7.7	5.8
Alaska	2.1	5.0	n/a	10.0	3.8
Arizona	3.6	4.5	6.9	8.3	5.9
Arkansas	5.7	6.6	8.7	8.3	7.5
California	7.3	10.6	13.1	17.7	10.8
Colorado	1.6	2.2	2.6	4.1	2.3
Connecticut	1.9	2.3	3.0	3.2	2.8
Delaware	1.0	4.6	13.8	18.0	10.3
District of Columbia	4.7	3.3	9.0	4.4	5.5
Florida	3.5	6.5	8.2	10.2	7.3
Georgia	1.2	3.2	4.0	4.6	3.6
Hawaii	6.4	10.4	7.5	8.3	7.8
Idaho	5.2	7.0	9.6	n/a	7.3
Illinois	3.8	5.9	6.1	6.1	5.7
Indiana	5.4	7.2	9.3	9.3	7.8
Iowa	2.6	4.4	6.9	5.7	4.7
Kansas	3.8	5.5	8.6	2.8	5.5
Kentucky	3.9	6.1	7.1	11.5	5.9
Louisiana	1.1	3.8	4.6	4.9	3.9
Maine	2.9	3.3	4.7	7.5	3.5
Maryland	0.8	1.6	3.2	3.6	2.4
Massachusetts	1.2	3.2	3.0	5.9	2.8
Michigan	6.3	8.3	10.5	11.3	9.4
Minnesota	3.9	2.9	4.7	5.2	3.8
Mississippi	1.8	4.8	5.3	10.4	4.4
Missouri	2.3	4.3	5.0	6.0	4.4
Montana	4.6	4.6	7.8	16.0	5.6
Nebraska	2.7	2.6	3.9	5.0	2.9
Nevada	7.2	17.0	20.4	25.3	15.3
New Hampshire	1.7	2.4	4.1	1.4	2.7
New Jersey	1.3	1.3	2.4	2.7	2.1
New Mexico	3.6	3.8	5.5	4.0	4.4
New York	1.6	2.2	2.3	1.5	1.9
North Carolina	1.2	3.3	5.7	8.7	4.4
North Dakota	5.8	5.8	11.4	7.0	7.2
Ohio	4.1	4.4	4.9	6.2	4.7
Oklahoma	2.8	4.1	4.5	4.0	4.0
Oregon	3.9	4.6	4.6	7.0	4.5
Pennsylvania	2.2	2.9	4.7	4.7	3.8
Rhode Island	1.1	2.1	4.7	5.9	3.4
South Carolina	6.6	7.9	8.9	9.0	8.0
South Dakota	1.8	3.9	5.5	5.0	3.7
Tennessee	2.2	4.1	4.1	4.5	3.9
Texas	1.6	4.4	5.1	6.2	4.3
Utah	2.4	3.8	6.2	4.0	4.1
Vermont	1.7	1.6	2.3	n/a	1.9
Virginia	1.1	2.3	4.8	4.8	3.4
Washington	5.7	8.6	9.9	8.9	8.6
West Virginia	3.2	4.6	9.1	n/a	5.9
Wisconsin	1.4	3.9	3.7	7.2	4.0
Wyoming	2.6	3.6	7.3	6.0	4.4

Source: OSCAR

n/a: Data unavailable

Table 4.1 (d). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 1999

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.8**	**5.7**	**6.6**	**6.9**	**5.8**
Alabama	5.4	5.8	8.8	11.0	7.6
Alaska	4.5	9.0	n/a	11.0	6.0
Arizona	3.4	7.2	8.3	6.8	7.2
Arkansas	5.4	7.9	8.9	3.5	8.0
California	7.4	11.5	14.6	17.0	11.6
Colorado	1.5	2.5	4.0	4.4	2.9
Connecticut	2.5	2.8	4.5	5.4	4.0
Delaware	1.0	4.1	10.1	9.0	7.6
District of Columbia	1.0	3.3	8.8	12.5	7.1
Florida	3.3	5.4	7.4	7.6	6.5
Georgia	1.7	3.9	4.9	8.0	4.6
Hawaii	5.4	8.0	7.4	8.7	6.8
Idaho	5.3	7.7	10.1	n/a	7.7
Illinois	3.5	6.7	6.7	6.5	6.2
Indiana	6.2	6.1	8.7	11.1	7.4
Iowa	2.7	4.4	5.2	5.0	4.3
Kansas	3.9	6.4	11.2	9.4	6.6
Kentucky	4.6	7.1	9.4	11.2	7.3
Louisiana	1.1	4.8	5.2	5.9	4.6
Maine	3.9	3.8	2.7	7.0	3.7
Maryland	1.2	2.8	4.3	5.9	3.6
Massachusetts	1.7	3.4	5.0	6.4	4.0
Michigan	5.0	10.0	10.8	11.9	10.0
Minnesota	3.2	3.3	4.2	4.9	3.7
Mississippi	3.3	5.5	7.1	11.0	5.8
Missouri	4.0	4.3	6.8	8.0	5.5
Montana	4.5	6.3	5.2	10.0	5.3
Nebraska	3.3	3.1	4.7	2.5	3.5
Nevada	7.1	10.4	16.3	12.0	12.6
New Hampshire	2.2	3.8	4.9	5.2	3.9
New Jersey	1.3	2.3	3.8	4.6	3.4
New Mexico	2.2	5.8	5.6	5.0	5.1
New York	3.2	3.6	3.8	3.5	3.6
North Carolina	1.6	4.8	7.0	12.1	5.8
North Dakota	3.3	5.2	7.0	11.5	5.2
Ohio	4.0	4.9	5.7	8.5	5.4
Oklahoma	2.6	4.6	6.2	9.4	5.0
Oregon	4.3	6.9	7.7	19.0	6.9
Pennsylvania	2.2	3.8	5.1	5.4	4.3
Rhode Island	2.8	3.2	3.6	2.6	3.3
South Carolina	5.8	8.3	9.4	10.7	8.3
South Dakota	4.0	4.2	8.8	n/a	4.7
Tennessee	2.9	4.7	5.4	7.0	4.9
Texas	2.0	4.7	5.4	6.7	4.8
Utah	0.9	4.5	5.3	n/a	3.4
Vermont	2.9	2.9	1.2	n/a	2.3
Virginia	1.5	2.8	4.8	4.4	3.7
Washington	7.3	9.2	11.2	12.4	9.8
West Virginia	4.8	5.5	7.0	8.5	5.9
Wisconsin	1.7	3.1	3.3	5.9	3.4
Wyoming	6.1	4.1	7.8	4.0	5.9

Source: OSCAR

n/a: Data unavailable

Table 4.1 (e). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 2000

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**4.0**	**5.9**	**6.9**	**7.0**	**6.1**
Alabama	4.4	6.5	8.7	7.3	7.5
Alaska	3.6	5.4	n/a	0.0	4.0
Arizona	2.4	6.3	9.9	7.6	7.9
Arkansas	6.9	6.5	8.7	3.5	7.6
California	7.7	11.3	14.0	16.8	11.5
Colorado	2.1	4.2	5.8	5.3	4.3
Connecticut	3.4	3.4	4.7	5.9	4.4
Delaware	2.2	5.3	9.3	1.0	7.3
District of Columbia	3.8	6.7	15.0	9.3	7.8
Florida	3.3	5.5	7.3	7.6	6.5
Georgia	3.2	4.0	5.9	7.0	5.1
Hawaii	6.4	6.1	9.9	1.0	7.2
Idaho	5.3	8.6	7.2	n/a	6.9
Illinois	3.9	6.2	6.5	5.8	6.0
Indiana	6.2	6.2	8.3	11.3	7.4
Iowa	3.2	3.9	5.1	3.3	4.1
Kansas	4.7	7.7	9.7	9.0	7.2
Kentucky	5.6	6.8	11.0	13.0	8.1
Louisiana	2.3	7.1	6.3	8.7	6.1
Maine	3.2	4.0	3.6	4.5	3.7
Maryland	1.1	2.0	3.6	4.3	3.0
Massachusetts	2.6	3.8	5.0	6.8	4.3
Michigan	6.4	9.1	10.6	10.7	9.7
Minnesota	4.3	4.2	6.0	7.2	5.0
Mississippi	4.8	6.7	9.6	16.7	7.9
Missouri	4.0	5.1	6.5	7.8	5.6
Montana	3.9	5.4	3.8	7.0	4.4
Nebraska	2.9	3.8	8.2	3.0	4.4
Nevada	6.0	17.2	12.3	6.0	11.3
New Hampshire	2.2	4.1	5.0	5.0	4.2
New Jersey	1.8	1.9	4.6	4.8	3.8
New Mexico	1.8	5.2	5.4	3.0	4.6
New York	3.1	4.0	5.0	4.9	4.6
North Carolina	2.3	4.4	7.3	10.1	5.8
North Dakota	5.0	3.6	4.2	1.0	4.1
Ohio	3.5	4.7	6.0	6.7	5.4
Oklahoma	3.5	5.3	6.8	7.5	5.5
Oregon	4.2	5.1	6.6	4.5	5.5
Pennsylvania	2.6	3.5	5.0	5.7	4.3
Rhode Island	2.1	2.1	2.9	3.0	2.5
South Carolina	5.2	8.2	9.6	6.2	7.9
South Dakota	4.0	3.8	5.2	n/a	4.0
Tennessee	3.7	6.1	6.9	8.3	6.3
Texas	2.8	6.3	6.9	8.0	6.3
Utah	1.2	3.4	4.8	2.0	3.2
Vermont	2.8	2.9	3.3	n/a	3.1
Virginia	1.1	2.4	4.4	4.7	3.3
Washington	8.1	9.6	9.3	14.0	9.3
West Virginia	4.0	6.5	7.4	12.0	6.3
Wisconsin	1.2	2.9	3.3	5.1	3.2
Wyoming	7.1	6.8	9.1	3.0	7.6

Source: OSCAR

n/a: Data unavailable

Table 4.1 (f). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Bed Size Category: United States, 2001

	Mean Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**4.0**	**5.9**	**6.9**	**7.0**	**6.3**
Alabama	4.4	6.5	8.7	7.3	6.8
Alaska	3.6	5.4	n/a	0.0	6.5
Arizona	2.4	6.3	9.9	7.6	10.2
Arkansas	6.9	6.5	8.7	3.5	7.7
California	7.7	11.3	14.0	16.8	11.3
Colorado	2.1	4.2	5.8	5.3	5.2
Connecticut	3.4	3.4	4.7	5.9	5.7
Delaware	2.2	5.3	9.3	1.0	5.2
District of Columbia	3.8	6.7	15.0	9.3	9.0
Florida	3.3	5.5	7.3	7.6	7.9
Georgia	3.2	4.0	5.9	7.0	5.8
Hawaii	6.4	6.1	9.9	1.0	10.4
Idaho	5.3	8.6	7.2	n/a	6.4
Illinois	3.9	6.2	6.5	5.8	5.3
Indiana	6.2	6.2	8.3	11.3	6.2
Iowa	3.2	3.9	5.1	3.3	4.1
Kansas	4.7	7.7	9.7	9.0	7.1
Kentucky	5.6	6.8	11.0	13.0	8.4
Louisiana	2.3	7.1	6.3	8.7	7.1
Maine	3.2	4.0	3.6	4.5	5.0
Maryland	1.1	2.0	3.6	4.3	3.8
Massachusetts	2.6	3.8	5.0	6.8	4.5
Michigan	6.4	9.1	10.6	10.7	8.2
Minnesota	4.3	4.2	6.0	7.2	4.6
Mississippi	4.8	6.7	9.6	16.7	6.2
Missouri	4.0	5.1	6.5	7.8	5.4
Montana	3.9	5.4	3.8	7.0	5.3
Nebraska	2.9	3.8	8.2	3.0	4.5
Nevada	6.0	17.2	12.3	6.0	10.3
New Hampshire	2.2	4.1	5.0	5.0	4.6
New Jersey	1.8	1.9	4.6	4.8	4.7
New Mexico	1.8	5.2	5.4	3.0	5.4
New York	3.1	4.0	5.0	4.9	5.6
North Carolina	2.3	4.4	7.3	10.1	6.2
North Dakota	5.0	3.6	4.2	1.0	3.9
Ohio	3.5	4.7	6.0	6.7	5.0
Oklahoma	3.5	5.3	6.8	7.5	6.7
Oregon	4.2	5.1	6.6	4.5	6.1
Pennsylvania	2.6	3.5	5.0	5.7	4.3
Rhode Island	2.1	2.1	2.9	3.0	3.5
South Carolina	5.2	8.2	9.6	6.2	5.9
South Dakota	4.0	3.8	5.2	n/a	5.4
Tennessee	3.7	6.1	6.9	8.3	6.3
Texas	2.8	6.3	6.9	8.0	6.5
Utah	1.2	3.4	4.8	2.0	3.8
Vermont	2.8	2.9	3.3	n/a	3.2
Virginia	1.1	2.4	4.4	4.7	3.4
Washington	8.1	9.6	9.3	14.0	8.9
West Virginia	4.0	6.5	7.4	12.0	8.0
Wisconsin	1.2	2.9	3.3	5.1	3.6
Wyoming	7.1	6.8	9.1	3.0	9.3

Source: OSCAR
n/a: Data unavailable

Table 4.2 (a). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 1996

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**5.7**	**4.0**	**4.4**	**5.1**
Alabama	6.5	5.7	6.0	6.3
Alaska	0.0	1.9	2.7	2.1
Arizona	6.5	4.5	5.8	5.7
Arkansas	8.5	7.4	7.1	8.3
California	11.4	8.5	11.0	10.8
Colorado	2.8	1.5	2.2	2.4
Connecticut	1.7	1.0	1.5	1.5
Delaware	8.7	9.4	15.0	9.5
District of Columbia	9.8	4.5	1.0	6.0
Florida	6.6	4.9	5.9	6.2
Georgia	3.6	4.1	1.4	3.5
Hawaii	4.4	4.7	5.1	4.7
Idaho	6.7	4.1	5.9	6.1
Illinois	6.7	5.4	5.2	6.2
Indiana	7.0	5.1	4.7	6.5
Iowa	4.4	3.5	3.9	4.0
Kansas	7.8	6.2	5.3	7.0
Kentucky	2.6	1.1	2.0	2.1
Louisiana	4.8	4.8	3.3	4.7
Maine	2.5	1.7	2.0	2.3
Maryland	2.7	2.3	3.1	2.5
Massachusetts	3.5	2.2	3.4	3.2
Michigan	10.7	9.2	6.0	9.8
Minnesota	3.5	2.6	2.7	2.9
Mississippi	5.3	2.9	3.9	4.7
Missouri	4.6	3.4	3.7	4.2
Montana	6.9	4.8	4.9	5.7
Nebraska	3.7	3.3	3.8	3.6
Nevada	14.4	8.3	12.8	13.3
New Hampshire	5.8	2.1	2.7	4.1
New Jersey	2.9	1.8	2.8	2.6
New Mexico	2.6	1.3	0.8	2.0
New York	2.6	3.0	3.9	2.9
North Carolina	4.8	2.5	2.2	4.2
North Dakota	6.5	6.5	9.0	6.5
Ohio	5.1	3.9	5.0	4.8
Oklahoma	4.2	2.3	3.4	3.9
Oregon	5.7	3.9	1.0	5.1
Pennsylvania	3.8	2.5	4.0	3.1
Rhode Island	3.5	1.9	n/a	3.1
South Carolina	7.5	6.1	6.2	7.1
South Dakota	5.1	3.9	2.4	4.2
Tennessee	6.1	5.4	5.4	5.9
Texas	4.6	2.3	1.8	4.2
Utah	4.2	3.3	3.0	4.0
Vermont	2.3	1.4	6.0	2.3
Virginia	4.3	2.3	5.3	3.7
Washington	8.2	6.2	6.3	7.6
West Virginia	5.2	4.0	3.5	4.8
Wisconsin	3.4	3.4	2.7	3.3
Wyoming	3.2	3.0	3.0	3.1

Source: OSCAR

n/a: Data unavailable

Table 4.2 (b). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 1997

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**5.5**	**3.7**	**4.2**	**4.9**
Alabama	6.4	4.6	6.1	6.1
Alaska	4.0	5.1	1.4	3.4
Arizona	5.4	4.5	12.0	5.1
Arkansas	7.7	6.0	6.1	7.4
California	11.6	8.2	10.8	10.8
Colorado	2.8	1.4	2.0	2.3
Connecticut	2.1	1.3	6.5	2.0
Delaware	6.7	7.2	7.8	7.0
District of Columbia	4.7	4.5	8.0	5.0
Florida	7.2	4.2	4.6	6.5
Georgia	2.9	2.3	1.6	2.7
Hawaii	6.1	4.9	10.2	6.6
Idaho	6.6	4.0	8.3	6.6
Illinois	6.6	4.9	5.7	6.0
Indiana	7.3	4.9	7.1	6.8
Iowa	5.2	4.4	2.7	4.7
Kansas	7.6	5.5	4.1	6.5
Kentucky	3.5	2.4	3.0	3.1
Louisiana	4.7	3.7	1.6	4.3
Maine	2.7	2.6	2.0	2.6
Maryland	2.5	2.0	0.7	2.2
Massachusetts	2.9	1.9	1.1	2.6
Michigan	9.3	7.7	6.9	8.6
Minnesota	3.3	2.6	2.5	2.8
Mississippi	4.1	3.5	2.8	3.8
Missouri	4.1	2.6	2.2	3.6
Montana	3.7	3.3	3.3	3.4
Nebraska	2.8	2.3	2.7	2.6
Nevada	16.0	10.3	13.8	15.2
New Hampshire	4.2	3.2	3.3	3.8
New Jersey	2.7	1.8	2.2	2.4
New Mexico	2.2	2.1	0.1	2.0
New York	2.2	2.1	3.1	2.2
North Carolina	4.2	1.7	1.8	3.6
North Dakota	10.1	7.7	3.5	7.9
Ohio	4.4	3.3	3.7	4.1
Oklahoma	4.6	2.8	3.4	4.3
Oregon	4.7	4.5	5.6	4.7
Pennsylvania	4.1	2.5	3.4	3.2
Rhode Island	3.7	1.6	n/a	3.2
South Carolina	8.0	7.6	6.8	7.8
South Dakota	2.8	3.5	3.3	3.2
Tennessee	2.6	2.3	2.9	2.5
Texas	4.6	2.9	1.9	4.3
Utah	3.4	2.5	4.3	3.4
Vermont	2.0	1.7	n/a	1.9
Virginia	4.0	1.6	7.5	3.3
Washington	9.2	6.5	6.6	8.4
West Virginia	6.9	4.6	5.9	6.1
Wisconsin	4.0	3.8	3.0	3.7
Wyoming	5.5	6.2	6.9	6.2

Source: OSCAR

n/a: Data unavailable

Table 4.2 (c). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 1998

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**5.9**	**4.0**	**4.2**	**5.3**
Alabama	6.0	5.3	5.1	5.8
Alaska	0.0	5.1	2.0	3.8
Arizona	6.5	4.8	6.7	5.9
Arkansas	7.9	6.5	5.1	7.5
California	11.6	8.1	10.9	10.8
Colorado	2.9	1.0	2.1	2.3
Connecticut	2.9	2.2	3.0	2.8
Delaware	13.5	7.5	10.3	10.3
District of Columbia	7.0	5.0	5.5	5.5
Florida	7.8	5.4	6.8	7.3
Georgia	3.8	3.2	1.8	3.6
Hawaii	9.1	6.9	6.8	7.8
Idaho	8.0	5.0	7.1	7.3
Illinois	6.3	4.7	5.0	5.7
Indiana	8.5	5.7	4.9	7.8
Iowa	5.2	4.1	3.2	4.7
Kansas	7.1	3.7	3.7	5.5
Kentucky	6.1	5.3	10.4	5.9
Louisiana	4.4	3.3	1.4	3.9
Maine	3.5	3.3	3.2	3.5
Maryland	2.8	2.0	0.3	2.4
Massachusetts	3.0	2.4	1.3	2.8
Michigan	10.4	7.9	7.5	9.4
Minnesota	4.1	3.7	3.1	3.8
Mississippi	4.9	3.1	3.8	4.4
Missouri	5.2	2.8	3.4	4.4
Montana	7.9	4.3	4.8	5.6
Nebraska	3.1	2.4	3.2	2.9
Nevada	16.4	6.0	13.1	15.3
New Hampshire	3.2	1.8	2.8	2.7
New Jersey	2.6	1.3	1.7	2.1
New Mexico	4.8	3.4	5.4	4.4
New York	1.9	1.9	2.3	1.9
North Carolina	5.2	2.3	1.7	4.4
North Dakota	6.5	7.3	7.0	7.2
Ohio	5.0	4.0	3.3	4.7
Oklahoma	4.3	2.9	1.9	4.0
Oregon	4.8	3.5	3.4	4.5
Pennsylvania	4.7	3.0	4.7	3.8
Rhode Island	3.9	1.3	n/a	3.4
South Carolina	8.2	8.1	7.2	8.0
South Dakota	3.3	4.1	3.2	3.7
Tennessee	4.0	3.2	4.6	3.9
Texas	4.7	3.1	1.8	4.3
Utah	4.5	2.8	1.3	4.1
Vermont	1.8	2.3	0.0	1.9
Virginia	4.1	2.1	5.0	3.4
Washington	9.6	6.5	5.7	8.6
West Virginia	6.5	4.6	5.3	5.9
Wisconsin	5.0	3.2	2.7	4.0
Wyoming	5.1	5.0	3.4	4.4

Source: OSCAR

n/a: Data unavailable

Table 4.2 (d). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 1999

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**6.6**	**4.3**	**4.6**	**5.8**
Alabama	7.7	6.3	8.1	7.6
Alaska	12.0	6.2	4.4	6.0
Arizona	8.0	5.6	6.0	7.2
Arkansas	8.7	5.9	3.7	8.0
California	12.6	8.3	10.7	11.6
Colorado	3.4	1.9	2.2	2.9
Connecticut	4.2	3.3	2.5	4.0
Delaware	8.8	6.3	7.7	7.6
District of Columbia	6.5	5.5	25.0	7.1
Florida	6.9	5.3	3.4	6.5
Georgia	4.7	4.6	3.6	4.6
Hawaii	6.4	7.7	6.7	6.8
Idaho	8.5	5.1	7.4	7.7
Illinois	7.1	4.4	5.4	6.2
Indiana	8.2	5.3	4.5	7.4
Iowa	5.1	3.5	2.9	4.3
Kansas	8.7	5.0	2.7	6.6
Kentucky	8.1	5.7	8.3	7.3
Louisiana	5.0	3.1	4.1	4.6
Maine	3.7	3.6	4.7	3.7
Maryland	4.7	2.3	3.2	3.6
Massachusetts	4.7	2.4	1.1	4.0
Michigan	11.1	8.5	6.6	10.0
Minnesota	3.7	3.8	2.9	3.7
Mississippi	6.2	5.6	3.9	5.8
Missouri	6.1	4.5	3.6	5.5
Montana	6.0	4.9	4.8	5.3
Nebraska	3.5	3.4	3.5	3.5
Nevada	14.0	3.4	18.8	12.6
New Hampshire	5.1	2.0	4.1	3.9
New Jersey	4.0	2.3	3.2	3.4
New Mexico	5.7	4.1	4.2	5.1
New York	3.5	3.5	5.0	3.6
North Carolina	6.6	3.8	3.2	5.8
North Dakota	6.3	5.1	4.3	5.2
Ohio	5.8	4.4	5.3	5.4
Oklahoma	5.3	4.1	3.3	5.0
Oregon	7.2	5.9	5.3	6.9
Pennsylvania	5.2	3.5	5.2	4.3
Rhode Island	3.9	1.7	n/a	3.3
South Carolina	8.9	6.3	6.6	8.3
South Dakota	4.8	4.7	3.5	4.7
Tennessee	5.1	4.2	5.7	4.9
Texas	5.1	3.4	2.0	4.8
Utah	3.9	2.1	1.5	3.4
Vermont	1.9	2.2	7.5	2.3
Virginia	4.3	2.4	3.0	3.7
Washington	10.8	7.3	7.6	9.8
West Virginia	6.3	5.4	4.5	5.9
Wisconsin	4.2	2.8	2.3	3.4
Wyoming	5.3	3.0	7.2	5.9

Source: OSCAR n/a: Data unavailable

Table 4.2 (e). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 2000

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**7.0**	**4.8**	**5.1**	**6.3**
Alabama	7.7	6.9	7.5	7.6
Alaska	n/a	4.1	3.8	4.0
Arizona	9.6	5.4	6.8	8.2
Arkansas	8.2	7.2	5.4	7.9
California	12.5	9.2	10.3	11.8
Colorado	5.6	3.6	1.7	4.7
Connecticut	4.8	3.5	4.0	4.5
Delaware	9.2	6.1	3.6	7.2
District of Columbia	12.0	6.5	3.5	7.8
Florida	6.9	5.1	5.4	6.5
Georgia	5.4	4.7	5.7	5.3
Hawaii	6.0	8.2	7.4	7.1
Idaho	7.1	6.3	6.3	6.8
Illinois	6.7	4.4	5.7	6.0
Indiana	8.1	5.6	4.1	7.4
Iowa	4.1	3.7	3.9	3.9
Kansas	9.9	5.3	4.1	7.5
Kentucky	9.0	6.4	9.4	8.1
Louisiana	6.8	4.8	1.2	6.2
Maine	3.7	3.6	4.5	3.7
Maryland	3.5	2.4	3.6	3.1
Massachusetts	5.2	2.7	3.3	4.4
Michigan	10.7	8.9	5.5	9.8
Minnesota	5.5	5.1	4.0	5.1
Mississippi	8.3	6.1	6.9	7.8
Missouri	6.4	5.2	6.2	6.1
Montana	5.8	4.4	4.0	4.8
Nebraska	5.4	4.2	3.4	4.5
Nevada	14.0	3.3	11.0	11.8
New Hampshire	4.9	3.9	4.1	4.4
New Jersey	5.3	3.0	5.1	4.5
New Mexico	5.6	3.1	3.4	4.7
New York	4.8	4.6	5.4	4.8
North Carolina	6.6	3.9	3.0	5.8
North Dakota	3.2	4.4	8.7	4.3
Ohio	5.9	4.9	5.2	5.6
Oklahoma	7.3	4.5	4.9	6.8
Oregon	6.1	4.2	4.3	5.7
Pennsylvania	5.3	3.7	5.8	4.5
Rhode Island	3.0	1.6	n/a	2.7
South Carolina	8.6	5.8	6.7	8.0
South Dakota	4.0	4.2	3.3	4.0
Tennessee	6.3	5.9	6.7	6.2
Texas	6.9	5.6	2.4	6.6
Utah	3.7	2.1	2.3	3.4
Vermont	2.8	3.8	3.0	3.1
Virginia	4.2	1.9	1.1	3.4
Washington	10.4	6.8	8.1	9.4
West Virginia	7.4	5.9	6.1	6.9
Wisconsin	3.8	2.4	2.8	3.1
Wyoming	8.7	9.5	4.8	7.5

Source: OSCAR

n/a: Data unavailable

Table 4.2 (f). Mean Number of Health Deficiencies Cited in Nursing Home Surveys by Type of Ownership: United States, 2001

	Mean Number by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**7.1**	**4.7**	**4.9**	**6.3**
Alabama	7.2	5.6	5.0	6.8
Alaska	2.5	8.0	5.0	6.5
Arizona	11.4	7.5	6.5	10.2
Arkansas	7.9	6.7	8.3	7.7
California	12.0	8.2	12.0	11.3
Colorado	5.9	3.7	4.2	5.2
Connecticut	6.1	4.5	6.0	5.7
Delaware	6.1	4.2	5.3	5.2
District of Columbia	9.7	9.7	2.0	9.0
Florida	8.5	5.9	7.0	7.9
Georgia	6.0	5.0	5.4	5.8
Hawaii	13.7	7.5	8.2	10.4
Idaho	6.4	4.8	7.4	6.4
Illinois	6.1	3.6	4.5	5.3
Indiana	6.9	5.0	2.6	6.2
Iowa	4.4	3.8	4.0	4.1
Kansas	9.4	4.7	4.4	7.1
Kentucky	9.1	7.1	5.9	8.4
Louisiana	7.2	8.0	4.5	7.1
Maine	4.8	5.4	5.7	5.0
Maryland	4.7	2.8	2.2	3.8
Massachusetts	5.0	3.5	1.8	4.5
Michigan	9.3	7.0	5.0	8.2
Minnesota	5.5	4.4	3.6	4.6
Mississippi	6.5	5.4	5.5	6.2
Missouri	5.9	4.5	4.6	5.4
Montana	4.7	5.4	6.1	5.3
Nebraska	5.2	4.1	3.4	4.5
Nevada	11.2	7.1	8.4	10.3
New Hampshire	4.6	4.8	4.2	4.6
New Jersey	5.4	3.5	3.8	4.7
New Mexico	6.7	3.1	2.6	5.4
New York	5.8	5.5	5.5	5.6
North Carolina	7.0	4.3	3.5	6.2
North Dakota	5.0	3.8	3.5	3.9
Ohio	5.5	3.9	3.8	5.0
Oklahoma	7.3	3.0	4.8	6.7
Oregon	7.1	3.8	3.3	6.1
Pennsylvania	5.3	3.4	4.3	4.3
Rhode Island	3.6	3.0	n/a	3.5
South Carolina	6.2	4.8	5.2	5.9
South Dakota	3.9	6.2	5.5	5.4
Tennessee	6.5	5.6	6.2	6.3
Texas	7.0	4.4	3.0	6.5
Utah	4.0	3.1	0.0	3.8
Vermont	3.9	1.8	0.0	3.2
Virginia	3.9	2.5	2.3	3.4
Washington	10.1	6.3	6.4	8.9
West Virginia	9.3	5.6	5.1	8.0
Wisconsin	4.2	3.3	2.3	3.6
Wyoming	12.4	9.0	7.1	9.3

Source: OSCAR n/a: Data unavailable

Table 4.3 (a). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**31.3**	**20.9**	**17.4**	**16.0**	**20.9**
Alabama	5.9	17.1	6.5	0.0	10.2
Alaska	38.5	0.0	n/a	100.0	35.3
Arizona	13.3	5.9	0.0	0.0	4.1
Arkansas	9.1	2.5	1.4	0.0	2.6
California	7.0	3.4	1.6	1.6	3.7
Colorado	51.8	47.1	22.2	0.0	37.3
Connecticut	55.6	59.7	43.4	28.0	47.3
Delaware	20.0	0.0	0.0	n/a	2.7
District of Columbia	0.0	0.0	0.0	20.0	5.0
Florida	28.9	19.7	11.1	9.1	15.0
Georgia	60.0	36.0	24.2	21.9	30.7
Hawaii	0.0	0.0	9.1	0.0	2.4
Idaho	24.2	4.0	13.0	0.0	14.6
Illinois	15.9	7.6	8.1	4.5	8.3
Indiana	22.8	11.6	5.9	9.3	11.7
Iowa	33.3	26.7	17.4	18.2	25.5
Kansas	9.2	7.9	10.3	0.0	8.6
Kentucky	69.4	56.1	54.5	28.6	58.5
Louisiana	44.8	18.1	15.5	19.0	20.7
Maine	59.0	27.3	10.7	0.0	32.4
Maryland	53.8	34.7	32.4	22.6	35.2
Massachusetts	50.0	39.6	31.2	9.5	36.7
Michigan	11.1	3.7	1.3	0.0	2.9
Minnesota	25.0	30.9	19.7	15.4	25.4
Mississippi	40.5	25.6	17.3	20.0	25.5
Missouri	27.6	29.6	25.9	17.9	27.2
Montana	16.7	9.1	14.3	0.0	13.3
Nebraska	33.9	31.9	25.5	0.0	30.4
Nevada	5.0	0.0	0.0	0.0	2.1
New Hampshire	33.3	23.1	41.9	14.3	30.4
New Jersey	31.4	51.7	40.3	28.4	39.1
New Mexico	78.9	48.3	16.2	100.0	42.5
New York	48.9	22.2	27.5	31.7	29.5
North Carolina	47.8	23.4	15.4	8.3	21.9
North Dakota	4.3	7.7	8.3	0.0	6.8
Ohio	22.8	21.1	13.5	11.1	16.9
Oklahoma	38.2	21.4	29.8	14.3	26.9
Oregon	40.5	21.1	20.3	0.0	25.0
Pennsylvania	50.6	34.1	19.7	16.3	28.5
Rhode Island	26.3	21.9	24.4	33.3	24.5
South Carolina	15.0	4.6	1.5	16.7	6.2
South Dakota	25.9	18.2	6.7	0.0	18.3
Tennessee	17.3	16.3	8.6	4.8	11.9
Texas	48.0	21.2	17.7	19.6	24.3
Utah	25.9	14.7	10.0	50.0	17.2
Vermont	7.1	45.5	22.2	n/a	23.3
Virginia	57.5	45.3	30.4	23.8	38.6
Washington	23.3	5.5	9.7	10.0	10.1
West Virginia	17.4	17.0	10.3	0.0	14.7
Wisconsin	35.7	27.3	21.3	16.1	24.6
Wyoming	50.0	36.8	9.1	0.0	30.8

Source: OSCAR

n/a: Data unavailable

Table 4.3 (b). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**33.1**	**21.5**	**18.5**	**17.8**	**22.0**
Alabama	9.1	11.5	3.9	0.0	7.0
Alaska	30.8	0.0	n/a	0.0	25.0
Arizona	4.8	7.7	6.5	0.0	5.9
Arkansas	5.7	4.0	4.3	0.0	4.3
California	6.5	2.2	2.0	0.0	3.1
Colorado	54.7	41.3	34.9	14.3	41.8
Connecticut	68.8	48.8	28.5	22.2	36.2
Delaware	40.0	33.3	3.7	0.0	15.6
District of Columbia	20.0	16.7	0.0	12.5	11.5
Florida	30.4	11.7	7.8	0.0	11.4
Georgia	52.2	44.6	26.9	20.0	33.6
Hawaii	7.1	14.3	0.0	25.0	9.5
Idaho	18.8	4.0	14.8	n/a	13.1
Illinois	16.1	6.0	7.6	2.6	7.3
Indiana	16.4	8.3	6.8	10.5	9.8
Iowa	38.9	17.5	7.4	11.1	18.4
Kansas	18.3	8.4	6.7	0.0	10.3
Kentucky	62.1	50.0	43.3	0.0	49.8
Louisiana	56.9	15.4	17.7	16.7	23.1
Maine	47.7	26.5	23.8	0.0	32.4
Maryland	50.0	53.5	31.4	29.0	38.5
Massachusetts	65.5	51.3	40.1	38.1	48.0
Michigan	0.0	1.6	4.0	5.7	3.0
Minnesota	31.9	39.0	16.7	11.1	28.6
Mississippi	45.7	27.5	21.3	0.0	28.6
Missouri	35.2	33.3	26.3	0.0	30.1
Montana	23.8	28.6	12.0	50.0	23.1
Nebraska	51.7	42.0	33.3	60.0	43.0
Nevada	0.0	0.0	0.0	0.0	0.0
New Hampshire	33.3	29.3	30.3	40.0	30.8
New Jersey	41.9	53.2	43.9	28.3	42.2
New Mexico	56.3	48.4	42.9	100.0	49.4
New York	29.5	32.7	28.3	45.0	34.8
North Carolina	58.3	41.3	25.9	8.3	34.9
North Dakota	5.0	3.0	4.8	0.0	3.9
Ohio	30.9	24.1	19.3	12.0	21.9
Oklahoma	38.7	19.0	26.4	14.3	24.8
Oregon	33.3	24.2	27.8	50.0	27.7
Pennsylvania	42.5	28.1	17.5	20.7	25.5
Rhode Island	25.0	29.4	21.6	16.7	24.7
South Carolina	7.7	4.7	5.7	16.7	6.1
South Dakota	18.2	25.7	0.0	0.0	21.0
Tennessee	32.1	38.1	29.8	0.0	31.0
Texas	50.2	21.1	17.2	9.8	23.9
Utah	50.0	11.8	12.5	50.0	24.0
Vermont	30.0	46.2	31.3	n/a	35.9
Virginia	66.7	42.0	24.8	30.0	37.0
Washington	14.3	4.2	3.4	0.0	5.4
West Virginia	10.0	8.1	11.1	0.0	9.2
Wisconsin	56.8	19.0	17.7	8.0	21.1
Wyoming	11.1	0.0	0.0	0.0	2.7

Source: OSCAR

n/a: Data unavailable

Table 4.3 (c.) Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**28.2**	**18.4**	**16.2**	**17.3**	**19.1**
Alabama	21.4	10.5	6.8	0.0	8.8
Alaska	30.0	0.0	n/a	0.0	18.8
Arizona	11.1	7.7	6.3	0.0	6.8
Arkansas	3.3	9.7	1.6	0.0	4.9
California	3.2	1.7	1.0	0.0	1.8
Colorado	47.3	38.2	27.4	11.1	35.3
Connecticut	46.7	27.1	17.5	22.7	22.5
Delaware	66.7	0.0	0.0	0.0	7.1
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	23.8	9.1	8.8	0.0	10.5
Georgia	39.4	26.0	20.6	15.4	23.6
Hawaii	5.9	0.0	0.0	0.0	2.3
Idaho	10.7	3.8	3.3	n/a	6.0
Illinois	19.7	6.1	7.4	8.6	8.8
Indiana	8.7	10.7	4.8	3.6	7.3
Iowa	28.8	16.4	4.7	0.0	15.5
Kansas	27.0	15.6	16.0	25.0	18.8
Kentucky	27.6	10.7	9.5	0.0	14.7
Louisiana	56.4	23.1	23.2	28.0	28.3
Maine	23.4	10.8	0.0	0.0	13.5
Maryland	54.8	50.0	30.9	22.2	38.5
Massachusetts	63.4	45.2	36.7	19.0	43.5
Michigan	8.9	4.8	0.5	3.1	3.0
Minnesota	19.0	30.9	17.9	8.0	23.6
Mississippi	32.7	16.0	9.3	20.0	17.6
Missouri	30.6	24.3	19.5	18.5	23.0
Montana	15.8	12.9	4.3	0.0	11.7
Nebraska	25.0	40.5	28.6	25.0	34.2
Nevada	5.6	0.0	11.1	0.0	6.3
New Hampshire	52.9	38.2	29.6	60.0	39.8
New Jersey	42.2	60.7	45.4	35.2	46.1
New Mexico	28.6	21.4	17.2	50.0	21.9
New York	39.0	35.7	32.2	49.8	39.5
North Carolina	56.6	33.1	17.5	0.0	27.5
North Dakota	14.8	10.0	4.3	0.0	9.8
Ohio	26.6	24.0	23.1	9.7	22.9
Oklahoma	37.9	23.7	25.7	20.0	26.4
Oregon	34.3	20.3	20.8	0.0	23.3
Pennsylvania	36.0	21.2	14.1	8.2	19.5
Rhode Island	50.0	33.3	7.0	25.0	24.2
South Carolina	2.8	6.5	3.0	20.0	4.7
South Dakota	15.8	10.5	7.7	0.0	11.1
Tennessee	25.4	25.8	17.6	16.7	21.0
Texas	42.7	17.0	16.6	6.4	20.7
Utah	40.6	17.2	9.7	0.0	22.3
Vermont	40.0	21.4	42.9	n/a	34.2
Virginia	60.0	35.9	22.7	26.7	32.8
Washington	7.7	4.4	4.6	0.0	4.9
West Virginia	5.6	8.8	6.9	n/a	7.4
Wisconsin	42.5	22.4	19.9	5.7	21.3
Wyoming	30.8	17.6	0.0	0.0	16.3

Source: OSCAR

n/a: Data unavailable

Table 4.3 (d). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**26.6**	**15.9**	**12.7**	**13.4**	**16.1**
Alabama	12.5	12.0	4.0	0.0	7.4
Alaska	9.1	0.0	n/a	0.0	6.3
Arizona	15.4	10.0	6.3	0.0	8.0
Arkansas	6.5	7.1	3.3	25.0	5.4
California	7.7	1.8	1.4	1.9	3.0
Colorado	49.1	27.1	14.3	0.0	26.4
Connecticut	38.5	21.3	7.9	4.0	13.1
Delaware	66.7	20.0	0.0	0.0	11.4
District of Columbia	0.0	16.7	0.0	0.0	6.7
Florida	25.5	17.6	7.0	13.5	11.8
Georgia	43.3	19.5	16.1	4.0	18.6
Hawaii	0.0	0.0	8.3	33.3	4.7
Idaho	17.2	11.5	0.0	n/a	9.5
Illinois	19.5	10.5	7.4	7.6	10.0
Indiana	14.2	10.7	8.2	2.9	10.1
Iowa	30.0	15.2	15.5	14.3	17.9
Kansas	26.1	7.7	7.8	14.3	13.0
Kentucky	12.7	11.2	5.2	0.0	9.3
Louisiana	62.7	25.0	21.6	3.7	26.6
Maine	23.9	15.2	16.7	0.0	18.3
Maryland	46.7	20.8	25.7	10.5	27.3
Massachusetts	48.1	36.2	25.9	20.0	32.4
Michigan	11.1	2.6	1.9	0.0	2.9
Minnesota	28.8	25.5	14.0	12.5	21.5
Mississippi	25.0	9.2	5.3	33.3	11.1
Missouri	16.0	23.3	13.4	0.0	17.0
Montana	14.0	0.0	10.7	0.0	8.6
Nebraska	11.7	29.4	27.1	50.0	24.6
Nevada	0.0	0.0	10.0	20.0	6.8
New Hampshire	46.2	28.1	21.1	40.0	30.4
New Jersey	45.5	39.6	23.7	18.9	27.8
New Mexico	38.5	18.2	15.6	0.0	20.0
New York	20.5	19.6	18.3	32.8	23.7
North Carolina	45.2	21.7	10.4	7.7	18.0
North Dakota	20.7	17.5	4.3	0.0	14.9
Ohio	30.6	23.7	15.3	4.9	19.2
Oklahoma	33.3	24.9	22.1	22.2	24.9
Oregon	32.1	14.5	16.7	0.0	18.5
Pennsylvania	36.5	15.0	11.9	12.8	17.2
Rhode Island	52.9	29.4	14.0	20.0	26.3
South Carolina	2.9	6.5	4.3	0.0	4.6
South Dakota	25.0	7.4	0.0	n/a	11.4
Tennessee	20.4	8.4	8.6	9.1	10.4
Texas	43.5	16.7	15.5	10.4	19.7
Utah	63.3	11.1	0.0	n/a	26.8
Vermont	26.7	28.6	72.2	n/a	44.7
Virginia	54.1	32.6	20.0	25.0	29.1
Washington	2.0	2.9	0.0	0.0	1.5
West Virginia	3.4	1.6	6.3	0.0	3.5
Wisconsin	44.1	27.7	27.5	15.1	27.4
Wyoming	30.8	7.1	8.3	0.0	15.0

Source: OSCAR
n/a: Data unavailable

Table 4.3 (e). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**21.8**	**13.1**	**8.7**	**9.9**	**12.4**
Alabama	8.3	4.1	1.1	0.0	2.7
Alaska	25.0	0.0	n/a	100.0	21.4
Arizona	5.3	6.7	1.3	0.0	2.8
Arkansas	0.0	4.3	3.5	0.0	3.3
California	5.4	2.1	1.1	1.9	2.5
Colorado	29.4	20.0	9.3	0.0	17.4
Connecticut	20.0	22.1	7.1	0.0	11.5
Delaware	20.0	18.2	3.7	0.0	9.1
District of Columbia	0.0	12.5	0.0	0.0	4.8
Florida	19.8	9.6	5.8	15.0	8.6
Georgia	29.2	19.6	8.1	4.3	13.0
Hawaii	5.9	0.0	7.7	50.0	7.3
Idaho	3.2	16.0	4.2	n/a	7.5
Illinois	17.3	10.8	8.0	8.0	10.0
Indiana	15.6	15.2	5.3	4.9	10.7
Iowa	27.8	18.2	7.2	16.7	17.5
Kansas	22.2	8.4	8.5	14.3	12.2
Kentucky	18.8	14.5	4.2	0.0	11.7
Louisiana	50.0	9.6	12.3	8.3	16.2
Maine	19.5	13.6	17.6	0.0	15.9
Maryland	42.2	28.8	17.1	20.0	24.1
Massachusetts	36.8	28.0	16.9	10.5	23.1
Michigan	10.2	3.5	1.2	2.5	2.9
Minnesota	17.5	12.9	10.8	0.0	12.2
Mississippi	16.1	9.2	2.6	0.0	7.5
Missouri	13.2	16.9	6.3	6.3	11.4
Montana	20.0	21.4	13.0	0.0	18.3
Nebraska	26.4	18.4	5.1	66.7	18.7
Nevada	0.0	8.3	5.3	0.0	4.2
New Hampshire	25.0	6.3	20.0	20.0	15.2
New Jersey	43.2	29.1	11.2	8.9	17.3
New Mexico	53.8	18.8	15.6	0.0	23.1
New York	25.0	12.5	12.0	15.1	14.2
North Carolina	34.6	17.1	8.5	5.9	14.5
North Dakota	14.8	19.4	0.0	0.0	12.6
Ohio	23.1	17.1	8.2	9.1	12.8
Oklahoma	26.9	10.6	8.1	0.0	12.0
Oregon	13.0	17.1	9.1	50.0	14.1
Pennsylvania	24.8	16.2	11.4	12.0	14.8
Rhode Island	47.1	41.4	26.2	33.3	35.1
South Carolina	9.3	0.0	4.3	16.7	4.6
South Dakota	5.6	8.2	0.0	n/a	6.5
Tennessee	6.3	6.5	3.6	0.0	4.6
Texas	29.5	9.8	9.3	8.3	11.8
Utah	43.3	0.0	3.0	0.0	14.4
Vermont	14.3	16.7	15.8	n/a	15.6
Virginia	68.4	43.4	28.1	25.0	37.9
Washington	8.2	5.5	4.8	0.0	5.5
West Virginia	6.1	7.4	1.8	0.0	5.1
Wisconsin	52.6	28.2	22.7	18.8	27.5
Wyoming	18.2	12.5	0.0	0.0	9.5

Source: OSCAR

n/a: Data unavailable

Table 4.3 (f). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**20.6**	**11.9**	**7.9**	**8.0**	**11.3**
Alabama	27.3	9.2	5.7	7.7	8.3
Alaska	10.0	20.0	n/a	0.0	11.8
Arizona	14.3	7.1	1.3	0.0	3.7
Arkansas	17.4	4.1	6.7	25.0	7.0
California	3.9	1.7	1.8	0.0	2.1
Colorado	28.3	12.7	4.7	0.0	12.5
Connecticut	38.5	11.3	1.5	4.8	6.6
Delaware	25.0	40.0	4.0	0.0	15.0
District of Columbia	0.0	0.0	16.7	16.7	9.5
Florida	16.0	3.9	2.1	0.0	3.8
Georgia	22.2	14.4	5.6	0.0	9.4
Hawaii	8.3	9.1	0.0	0.0	5.7
Idaho	17.2	4.3	0.0	n/a	7.7
Illinois	28.2	12.5	8.6	9.7	12.3
Indiana	18.3	15.9	7.8	5.6	12.5
Iowa	15.9	16.0	6.5	25.0	14.2
Kansas	14.0	10.9	11.3	0.0	11.7
Kentucky	7.6	2.7	3.0	0.0	3.9
Louisiana	41.7	4.6	5.8	5.0	9.5
Maine	7.1	3.3	0.0	0.0	4.3
Maryland	17.9	26.9	6.7	13.3	13.2
Massachusetts	50.6	32.5	23.0	5.9	29.5
Michigan	14.0	2.7	2.6	8.6	4.3
Minnesota	15.8	14.5	15.7	4.3	14.5
Mississippi	6.7	4.7	3.9	0.0	4.6
Missouri	22.9	13.9	10.2	0.0	12.7
Montana	16.2	8.7	3.8	0.0	10.2
Nebraska	31.5	17.3	8.1	0.0	19.4
Nevada	0.0	0.0	4.5	0.0	2.0
New Hampshire	30.8	20.7	23.3	0.0	22.7
New Jersey	42.1	26.3	9.8	7.3	16.1
New Mexico	35.7	27.6	7.1	0.0	20.8
New York	15.9	8.8	7.9	8.9	9.0
North Carolina	25.5	10.9	4.4	6.7	9.0
North Dakota	19.2	7.3	8.7	0.0	10.8
Ohio	24.6	18.8	10.6	7.8	15.0
Oklahoma	31.4	12.2	11.5	0.0	14.7
Oregon	26.1	23.0	8.7	0.0	18.2
Pennsylvania	21.0	15.9	12.5	15.4	15.0
Rhode Island	30.0	21.9	21.1	20.0	23.2
South Carolina	8.1	17.0	4.8	0.0	9.2
South Dakota	5.6	7.4	7.1	n/a	6.7
Tennessee	7.0	3.8	1.6	0.0	3.0
Texas	30.2	7.8	7.6	5.9	10.1
Utah	36.7	14.3	6.1	0.0	18.1
Vermont	41.7	16.7	16.7	n/a	23.8
Virginia	57.6	40.9	22.3	27.8	33.5
Washington	4.3	6.9	2.9	0.0	4.6
West Virginia	18.2	8.2	0.0	0.0	7.2
Wisconsin	37.1	22.3	16.8	20.0	21.2
Wyoming	25.0	0.0	0.0	n/a	7.9

Source: OSCAR

n/a: Data unavailable

Table 4.4 (a). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 1996

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**18.1**	**27.7**	**20.4**	**20.9**
Alabama	9.2	19.4	4.5	10.2
Alaska	100.0	40.0	16.7	35.3
Arizona	4.5	3.6	0.0	4.1
Arkansas	2.0	6.8	0.0	2.6
California	3.2	5.0	5.3	3.7
Colorado	34.1	44.1	38.1	37.3
Connecticut	44.3	60.4	0.0	47.3
Delaware	0.0	7.1	0.0	2.7
District of Columbia	0.0	7.7	0.0	5.0
Florida	12.9	22.1	20.0	15.0
Georgia	29.7	28.8	48.1	30.7
Hawaii	6.3	0.0	0.0	2.4
Idaho	10.2	38.5	10.0	14.6
Illinois	6.2	13.0	7.3	8.3
Indiana	7.0	26.5	13.3	11.7
Iowa	24.3	27.4	25.0	25.5
Kansas	8.4	10.4	5.0	8.6
Kentucky	53.1	70.4	54.5	58.5
Louisiana	20.1	19.1	32.0	20.7
Maine	31.6	37.5	16.7	32.4
Maryland	28.8	45.5	28.6	35.2
Massachusetts	32.3	51.9	28.6	36.7
Michigan	2.5	4.0	2.4	2.9
Minnesota	18.6	29.0	29.6	25.4
Mississippi	20.9	33.3	38.7	25.5
Missouri	25.6	31.1	28.0	27.2
Montana	13.2	14.3	11.1	13.3
Nebraska	28.7	33.7	28.8	30.4
Nevada	2.9	0.0	0.0	2.1
New Hampshire	22.9	46.7	21.4	30.4
New Jersey	33.8	51.4	34.6	39.1
New Mexico	34.6	48.1	75.0	42.5
New York	33.0	28.2	15.7	29.5
North Carolina	19.3	28.7	31.3	21.9
North Dakota	0.0	7.9	0.0	6.8
Ohio	14.7	24.6	9.8	16.9
Oklahoma	25.2	35.6	30.0	26.9
Oregon	20.3	35.3	66.7	25.0
Pennsylvania	20.1	37.3	10.2	28.5
Rhode Island	18.1	42.3	n/a	24.5
South Carolina	4.7	16.1	0.0	6.2
South Dakota	18.4	19.7	0.0	18.3
Tennessee	11.0	15.2	10.3	11.9
Texas	20.3	42.1	54.1	24.3
Utah	16.4	25.0	0.0	17.2
Vermont	24.2	25.0	0.0	23.3
Virginia	33.7	51.8	16.7	38.6
Washington	6.4	21.0	13.6	10.1
West Virginia	15.2	16.0	8.3	14.7
Wisconsin	22.7	26.0	27.3	24.6
Wyoming	26.3	16.7	42.9	30.8

Source: OSCAR

n/a: Data unavailable

Table 4.4 (b). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 1997

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**19.2**	**28.5**	**22.9**	**22.0**
Alabama	5.8	14.3	5.6	7.0
Alaska	0.0	0.0	57.1	25.0
Arizona	6.5	4.9	0.0	5.9
Arkansas	3.1	9.3	6.7	4.3
California	2.2	5.2	6.9	3.1
Colorado	38.8	49.3	39.1	41.8
Connecticut	33.3	47.5	0.0	36.2
Delaware	15.0	19.0	0.0	15.6
District of Columbia	20.0	7.7	0.0	11.5
Florida	9.6	17.6	18.2	11.4
Georgia	34.2	34.4	23.8	33.6
Hawaii	11.1	14.3	0.0	9.5
Idaho	11.5	15.4	15.8	13.1
Illinois	5.0	13.5	0.0	7.3
Indiana	6.3	21.1	12.5	9.8
Iowa	17.7	18.4	26.1	18.4
Kansas	5.7	16.6	14.5	10.3
Kentucky	46.2	54.7	70.0	49.8
Louisiana	19.2	31.0	41.4	23.1
Maine	32.3	31.3	40.0	32.4
Maryland	30.7	47.4	71.4	38.5
Massachusetts	44.0	58.2	60.0	48.0
Michigan	2.2	4.5	4.9	3.0
Minnesota	26.6	26.4	40.3	28.6
Mississippi	24.1	34.3	43.3	28.6
Missouri	24.6	43.0	35.4	30.1
Montana	18.4	30.4	15.0	23.1
Nebraska	45.9	46.3	32.7	43.0
Nevada	0.0	0.0	0.0	0.0
New Hampshire	30.6	34.5	23.1	30.8
New Jersey	39.0	50.0	35.3	42.2
New Mexico	44.2	48.1	85.7	49.4
New York	38.0	35.4	16.4	34.8
North Carolina	30.4	47.7	50.0	34.9
North Dakota	0.0	3.1	50.0	3.9
Ohio	19.3	31.1	13.3	21.9
Oklahoma	21.8	44.6	22.2	24.8
Oregon	23.7	40.6	40.0	27.7
Pennsylvania	17.3	32.2	20.0	25.5
Rhode Island	19.4	40.0	n/a	24.7
South Carolina	8.1	0.0	0.0	6.1
South Dakota	21.1	19.0	50.0	21.0
Tennessee	30.4	33.3	29.6	31.0
Texas	20.9	37.8	31.6	23.9
Utah	19.0	61.5	0.0	24.0
Vermont	37.9	30.0	n/a	35.9
Virginia	32.9	48.8	0.0	37.0
Washington	5.0	8.5	0.0	5.4
West Virginia	9.3	8.0	12.5	9.2
Wisconsin	20.6	21.2	22.6	21.1
Wyoming	5.9	0.0	0.0	2.7

Source: OSCAR

n/a: Data unavailable

Table 4.4 (c). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 1998

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**16.3**	**25.1**	**21.1**	**19.1**
Alabama	5.7	9.7	31.8	8.8
Alaska	100.0	10.0	20.0	18.8
Arizona	8.3	4.4	0.0	6.8
Arkansas	4.3	4.8	14.3	4.9
California	1.5	3.2	0.0	1.8
Colorado	31.4	42.6	39.1	35.3
Connecticut	19.8	34.0	0.0	22.5
Delaware	9.1	7.7	0.0	7.1
District of Columbia	0.0	0.0	0.0	0.0
Florida	9.6	13.7	14.3	10.5
Georgia	22.4	24.3	34.6	23.6
Hawaii	5.3	0.0	0.0	2.3
Idaho	5.9	0.0	10.5	6.0
Illinois	6.0	13.7	14.3	8.8
Indiana	4.3	15.4	20.0	7.3
Iowa	13.5	16.4	33.3	15.5
Kansas	12.2	25.7	27.3	18.8
Kentucky	15.8	13.9	0.0	14.7
Louisiana	23.6	38.2	50.0	28.3
Maine	13.3	16.7	0.0	13.5
Maryland	29.9	48.8	75.0	38.5
Massachusetts	39.5	51.4	61.5	43.5
Michigan	2.0	4.5	4.8	3.0
Minnesota	23.9	24.2	20.0	23.6
Mississippi	16.2	30.6	9.4	17.6
Missouri	20.2	31.8	17.0	23.0
Montana	8.8	15.9	6.3	11.7
Nebraska	33.0	33.8	37.0	34.2
Nevada	7.9	0.0	0.0	6.3
New Hampshire	41.3	41.7	30.8	39.8
New Jersey	38.6	58.8	47.1	46.1
New Mexico	19.1	28.6	20.0	21.9
New York	42.9	40.5	16.0	39.5
North Carolina	21.0	45.9	40.0	27.5
North Dakota	0.0	11.3	0.0	9.8
Ohio	20.7	29.6	25.0	22.9
Oklahoma	24.4	34.0	40.9	26.4
Oregon	22.0	27.8	20.0	23.3
Pennsylvania	14.2	24.9	8.5	19.5
Rhode Island	15.4	57.1	n/a	24.2
South Carolina	6.3	0.0	0.0	4.7
South Dakota	12.9	9.3	20.0	11.1
Tennessee	22.8	19.5	11.4	21.0
Texas	17.4	32.8	43.9	20.7
Utah	14.9	50.0	50.0	22.3
Vermont	32.0	33.3	100.0	34.2
Virginia	26.7	47.6	0.0	32.8
Washington	5.2	5.9	0.0	4.9
West Virginia	7.4	4.8	16.7	7.4
Wisconsin	16.6	28.4	19.7	21.3
Wyoming	15.8	0.0	22.2	16.3

Source: OSCAR

n/a: Data unavailable

Table 4.4 (d). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 1999

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**13.5**	**15.9**	**19.1**	**16.1**
Alabama	7.1	12.0	4.8	7.4
Alaska	0.0	0.0	0.0	6.3
Arizona	8.8	10.0	0.0	8.0
Arkansas	3.7	7.1	15.4	5.4
California	1.9	1.8	2.3	3.0
Colorado	20.8	27.1	28.0	26.4
Connecticut	11.5	21.3	50.0	13.1
Delaware	6.3	20.0	0.0	11.4
District of Columbia	0.0	16.7	0.0	6.7
Florida	9.2	17.6	38.5	11.8
Georgia	18.5	19.5	20.0	18.6
Hawaii	9.5	0.0	0.0	4.7
Idaho	3.8	11.5	10.5	9.5
Illinois	6.5	10.5	15.6	10.0
Indiana	5.5	10.7	17.6	10.1
Iowa	18.2	15.2	31.8	17.9
Kansas	6.3	7.7	25.5	13.0
Kentucky	7.2	11.2	0.0	9.3
Louisiana	22.2	25.0	40.7	26.6
Maine	18.5	15.2	16.7	18.3
Maryland	20.5	20.8	33.3	27.3
Massachusetts	28.9	36.2	46.2	32.4
Michigan	3.5	2.6	2.6	2.9
Minnesota	22.4	25.5	31.0	21.5
Mississippi	8.1	9.2	15.4	11.1
Missouri	15.2	23.3	22.4	17.0
Montana	5.4	0.0	0.0	8.6
Nebraska	28.3	29.4	14.3	24.6
Nevada	6.5	0.0	0.0	6.8
New Hampshire	19.4	28.1	30.0	30.4
New Jersey	22.1	39.6	22.2	27.8
New Mexico	12.5	18.2	20.0	20.0
New York	27.0	19.6	8.7	23.7
North Carolina	14.1	21.7	47.1	18.0
North Dakota	8.3	17.5	0.0	14.9
Ohio	17.2	23.7	16.7	19.2
Oklahoma	24.2	24.9	23.5	24.9
Oregon	16.7	14.5	0.0	18.5
Pennsylvania	13.8	15.0	11.1	17.2
Rhode Island	17.6	29.4	n/a	26.3
South Carolina	3.4	6.5	11.8	4.6
South Dakota	15.2	7.4	33.3	11.4
Tennessee	8.7	8.4	11.4	10.4
Texas	16.7	16.7	47.5	19.7
Utah	22.6	11.1	25.0	26.8
Vermont	43.3	28.6	0.0	44.7
Virginia	23.6	32.6	0.0	29.1
Washington	1.6	2.9	4.3	1.5
West Virginia	3.3	1.6	6.7	3.5
Wisconsin	21.3	27.7	31.7	27.4
Wyoming	16.7	7.1	17.6	15.0

Source: OSCAR

n/a: Data unavailable

Table 4.4 (e). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 2000

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**10.1**	**17.1**	**14.6**	**12.4**
Alabama	3.5	0.0	0.0	2.7
Alaska	n/a	22.2	20.0	21.4
Arizona	1.1	6.8	0.0	2.8
Arkansas	4.2	0.0	0.0	3.3
California	2.1	4.1	2.3	2.5
Colorado	13.8	19.0	36.4	17.4
Connecticut	10.1	16.9	0.0	11.5
Delaware	0.0	15.8	20.0	9.1
District of Columbia	0.0	7.7	0.0	4.8
Florida	7.2	13.6	7.1	8.6
Georgia	12.2	16.4	14.8	13.0
Hawaii	17.6	0.0	0.0	7.3
Idaho	4.3	6.7	15.8	7.5
Illinois	8.1	14.0	12.2	10.0
Indiana	7.3	19.0	28.6	10.7
Iowa	20.3	14.7	10.5	17.5
Kansas	8.5	16.3	15.4	12.2
Kentucky	10.0	16.1	0.0	11.7
Louisiana	12.8	18.6	54.5	16.2
Maine	14.9	21.4	0.0	15.9
Maryland	17.2	34.7	22.2	24.1
Massachusetts	18.3	34.0	28.6	23.1
Michigan	2.0	4.6	4.8	2.9
Minnesota	7.0	14.3	14.1	12.2
Mississippi	6.2	13.3	8.3	7.5
Missouri	11.3	11.3	12.7	11.4
Montana	17.1	18.6	20.0	18.3
Nebraska	17.9	16.9	23.3	18.7
Nevada	5.9	0.0	0.0	4.2
New Hampshire	10.0	14.8	33.3	15.2
New Jersey	12.4	28.2	6.7	17.3
New Mexico	20.4	27.3	28.6	23.1
New York	14.3	16.0	3.9	14.2
North Carolina	10.8	24.2	26.3	14.5
North Dakota	25.0	11.1	0.0	12.6
Ohio	11.2	18.5	9.4	12.8
Oklahoma	9.1	29.5	14.3	12.0
Oregon	12.8	18.2	16.7	14.1
Pennsylvania	10.7	19.1	6.8	14.8
Rhode Island	31.6	50.0	n/a	35.1
South Carolina	3.9	4.0	9.1	4.6
South Dakota	10.9	2.8	16.7	6.5
Tennessee	4.0	7.1	3.1	4.6
Texas	10.5	14.2	37.1	11.8
Utah	13.0	25.0	0.0	14.4
Vermont	17.2	13.3	0.0	15.6
Virginia	29.6	51.6	62.5	37.9
Washington	5.9	6.3	0.0	5.5
West Virginia	4.8	5.3	6.3	5.1
Wisconsin	21.9	36.1	24.1	27.5
Wyoming	9.1	0.0	14.3	9.5

Source: OSCAR

n/a: Data unavailable

Table 4.4 (f). Percent of Nursing Home Surveys Resulting in Zero Health Deficiency Citations by Type of Ownership: United States 2001

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**8.8**	**16.2**	**14.8**	**11.3**
Alabama	7.5	11.1	10.5	8.3
Alaska	50.0	10.0	0.0	11.8
Arizona	2.1	8.1	0.0	3.7
Arkansas	6.2	9.8	11.1	7.0
California	1.8	3.5	0.0	2.1
Colorado	8.4	19.2	23.8	12.5
Connecticut	2.2	21.4	0.0	6.6
Delaware	5.3	22.2	33.3	15.0
District of Columbia	16.7	0.0	50.0	9.5
Florida	2.3	7.7	15.4	3.8
Georgia	8.6	15.5	4.0	9.4
Hawaii	6.3	7.7	0.0	5.7
Idaho	13.3	0.0	0.0	7.7
Illinois	8.0	20.8	22.9	12.3
Indiana	8.7	18.4	43.8	12.5
Iowa	15.5	13.2	8.3	14.2
Kansas	7.7	13.8	20.8	11.7
Kentucky	2.2	7.9	0.0	3.9
Louisiana	7.3	13.1	23.8	9.5
Maine	3.6	3.6	16.7	4.3
Maryland	7.5	20.7	16.7	13.2
Massachusetts	25.8	37.0	50.0	29.5
Michigan	1.7	7.6	10.4	4.3
Minnesota	11.3	16.1	13.6	14.5
Mississippi	5.7	3.7	0.0	4.6
Missouri	10.1	18.1	17.2	12.7
Montana	7.1	12.2	10.5	10.2
Nebraska	17.5	20.0	23.1	19.4
Nevada	0.0	12.5	0.0	2.0
New Hampshire	27.5	21.7	8.3	22.7
New Jersey	11.4	25.2	15.8	16.1
New Mexico	17.0	30.0	20.0	20.8
New York	10.8	8.5	2.0	9.0
North Carolina	6.1	16.5	17.4	9.0
North Dakota	22.2	10.0	0.0	10.8
Ohio	12.1	22.9	16.7	15.0
Oklahoma	11.0	42.9	25.0	14.7
Oregon	17.6	17.1	33.3	18.2
Pennsylvania	10.6	19.2	12.8	15.0
Rhode Island	23.6	21.7	n/a	n/a
South Carolina	10.2	9.5	4.3	9.2
South Dakota	8.8	4.7	16.7	6.7
Tennessee	2.7	2.3	6.9	3.0
Texas	8.4	15.6	26.3	10.1
Utah	15.8	23.5	100.0	18.1
Vermont	10.7	46.2	100.0	23.8
Virginia	27.6	45.5	22.2	33.5
Washington	5.1	5.3	0.0	4.6
West Virginia	4.1	7.1	30.0	7.2
Wisconsin	16.3	26.0	25.8	21.2
Wyoming	0.0	0.0	15.8	7.9

Source: OSCAR

n/a: Data unavailable

Table 4.5 (a). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 1996

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	**16.7**	**10.0**	**31.0**	**23.6**	**5.6**	**9.8**	**2.5**	**0.4**	**0.1**	**0.1**	**0.1**
Alabama	13.6	9.3	41.5	25.3	2.4	6.9	0.6	0.3	0.1	0.1	0.0
Alaska	0.0	0.0	71.4	28.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Arizona	30.8	8.2	21.4	33.0	1.4	3.4	1.8	0.0	0.0	0.0	0.0
Arkansas	55.2	7.1	23.4	10.6	1.2	1.8	0.6	0.0	0.0	0.0	0.0
California	23.0	6.7	35.8	24.0	2.5	5.2	2.4	0.2	0.0	0.2	0.0
Colorado	11.6	0.4	52.1	25.9	1.2	6.3	2.6	0.0	0.0	0.0	0.0
Connecticut	1.5	1.3	44.6	15.4	4.9	29.5	2.8	0.0	0.0	0.0	0.0
Delaware	18.1	3.2	42.4	24.4	2.6	8.3	1.2	0.0	0.0	0.0	0.0
District of Columbia	56.7	20.0	11.1	5.6	0.0	6.7	0.0	0.0	0.0	0.0	0.0
Florida	6.6	13.6	21.9	32.7	11.6	8.6	3.3	1.6	0.0	0.1	0.1
Georgia	18.8	14.0	13.7	17.5	9.3	13.4	10.4	2.9	0.0	0.0	0.1
Hawaii	26.7	12.3	30.8	8.9	8.2	11.0	0.7	1.4	0.0	0.0	0.0
Idaho	5.4	4.6	22.5	29.1	9.8	24.3	4.4	0.0	0.0	0.0	0.0
Illinois	22.5	15.4	33.1	20.9	2.6	4.8	0.6	0.0	0.0	0.0	0.0
Indiana	14.1	6.2	36.4	22.0	3.8	12.7	4.1	0.4	0.1	0.2	0.0
Iowa	8.2	8.1	32.3	21.2	5.0	24.0	1.2	0.1	0.0	0.0	0.0
Kansas	9.0	11.3	25.0	19.7	8.1	19.0	6.7	1.0	0.1	0.1	0.0
Kentucky	9.0	17.2	19.0	26.7	10.9	7.0	6.3	2.4	0.8	0.6	0.2
Louisianna	47.6	24.6	13.3	9.6	0.9	3.9	0.1	0.1	0.0	0.0	0.0
Maine	15.1	22.7	29.4	15.1	8.4	6.4	1.0	2.0	0.0	0.0	0.0
Maryland	15.0	8.3	26.3	25.6	3.0	6.8	13.5	1.5	0.0	0.0	0.0
Massachusetts	5.4	6.3	27.1	26.0	5.5	25.3	3.8	0.4	0.0	0.3	0.1
Michigan	12.4	4.0	40.5	25.9	5.1	10.4	1.7	0.0	0.1	0.0	0.1
Minnesota	14.6	6.3	32.3	28.0	2.3	15.5	1.0	0.0	0.0	0.0	0.0
Mississippi	21.4	15.6	27.9	17.0	5.2	8.9	2.3	1.0	0.1	0.5	0.0
Missouri	3.6	4.8	26.8	37.0	10.1	11.4	5.1	0.3	0.4	0.5	0.0
Montana	16.4	9.7	25.7	32.0	2.2	12.4	1.4	0.0	0.2	0.0	0.0
Nebraska	5.0	7.2	20.7	27.5	10.2	22.2	6.7	0.1	0.0	0.2	0.1
Nevada	12.5	5.5	32.3	32.8	2.3	12.8	1.3	0.5	0.0	0.0	0.0
New Hampshire	9.8	6.3	42.0	18.7	6.3	11.2	3.2	0.3	1.7	0.0	0.6
New Jersey	18.2	10.6	25.3	21.7	7.3	13.1	3.5	0.3	0.0	0.0	0.0
New Mexico	8.6	6.0	14.7	42.2	15.5	10.3	1.7	0.9	0.0	0.0	0.0
New York	22.5	6.7	40.5	17.5	2.4	9.2	1.2	0.1	0.0	0.0	0.0
North Carolina	16.1	7.0	36.1	16.7	4.7	16.6	2.2	0.3	0.1	0.1	0.0
North Dakota	15.8	6.3	38.2	19.3	2.6	16.5	1.4	0.0	0.0	0.0	0.0
Ohio	7.3	5.7	40.6	28.2	7.8	8.0	1.7	0.5	0.0	0.1	0.2
Oklahoma	15.0	23.1	12.3	37.9	7.5	3.3	0.9	0.0	0.0	0.0	0.0
Oregon	14.0	2.3	26.4	30.4	5.4	12.0	5.7	0.9	0.7	1.6	0.8
Pennsylvania	12.3	8.9	36.2	22.6	4.4	12.8	1.4	0.7	0.0	0.1	0.6
Rhode Island	7.6	24.0	38.0	9.2	13.6	7.6	0.0	0.0	0.0	0.0	0.0
South Carolina	6.9	5.0	52.4	16.8	5.8	11.8	1.0	0.1	0.2	0.0	0.0
South Dakota	2.8	2.8	39.0	7.3	5.1	41.8	1.1	0.0	0.0	0.0	0.0
Tennessee	4.0	12.3	32.5	29.0	16.5	3.9	1.3	0.4	0.1	0.1	0.1
Texas	25.2	22.8	14.5	20.0	7.0	7.0	2.6	0.6	0.1	0.2	0.1
Utah	20.7	1.2	32.7	28.1	1.2	9.0	4.2	1.0	0.0	2.0	0.0
Vermont	11.3	9.4	45.3	16.0	0.0	17.0	0.0	0.0	0.9	0.0	0.0
Virginia	6.1	5.8	30.9	18.7	20.7	9.3	5.3	3.0	0.0	0.1	0.0
Washington	10.3	8.3	33.5	22.5	4.6	18.0	2.4	0.2	0.1	0.1	0.0
West Virginia	12.3	32.3	21.1	13.1	13.3	3.7	2.4	1.7	0.0	0.0	0.0
Wisconsin	11.8	10.3	39.2	25.7	4.0	8.3	0.7	0.0	0.0	0.2	0.0
Wyoming	9.2	5.0	33.3	31.7	7.5	11.7	1.7	0.0	0.0	0.0	0.0

Source: OSCAR

Table 4.5 (b). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 1997

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	**13.7**	**7.9**	**38.2**	**22.0**	**5.0**	**11.1**	**1.7**	**0.2**	**0.2**	**0.2**	**0.1**
Alabama	10.8	10.9	48.6	13.2	1.5	14.2	0.8	0.0	0.0	0.0	0.0
Alaska	9.1	1.8	41.8	18.2	1.8	25.5	1.8	0.0	0.0	0.0	0.0
Arizona	28.9	4.5	27.1	34.4	1.0	2.8	0.2	0.0	0.0	0.7	0.5
Arkansas	55.5	4.1	24.9	11.0	1.5	2.5	0.5	0.0	0.1	0.0	0.0
California	16.7	4.4	47.4	22.1	2.1	5.3	1.5	0.1	0.2	0.2	0.1
Colorado	10.5	2.4	58.8	18.4	1.5	8.1	0.4	0.0	0.0	0.0	0.0
Connecticut	0.8	1.9	39.8	9.4	3.0	44.2	0.9	0.0	0.0	0.0	0.0
Delaware	14.1	4.3	55.6	14.7	1.6	9.8	0.0	0.0	0.0	0.0	0.0
District of Columbia	64.1	12.2	10.7	3.1	2.3	6.1	0.0	1.5	0.0	0.0	0.0
Florida	5.5	10.5	28.8	32.1	10.2	9.9	2.5	0.2	0.1	0.0	0.0
Georgia	22.8	12.6	24.4	18.1	6.1	11.9	3.4	0.7	0.0	0.0	0.0
Hawaii	9.1	10.6	35.9	14.7	10.1	17.2	0.5	2.0	0.0	0.0	0.0
Idaho	3.2	2.8	26.1	27.5	11.8	25.2	2.8	0.0	0.5	0.0	0.0
Illinois	17.4	12.5	43.8	14.7	1.9	8.4	0.7	0.1	0.1	0.3	0.1
Indiana	10.3	3.7	46.7	23.8	2.7	11.3	1.3	0.1	0.0	0.1	0.0
Iowa	4.7	4.2	42.9	19.1	4.3	22.5	2.1	0.0	0.2	0.0	0.0
Kansas	3.2	5.3	28.6	20.5	9.5	26.2	5.1	0.7	0.3	0.4	0.1
Kentucky	7.2	8.9	31.1	22.8	9.0	13.7	2.6	1.1	2.8	0.0	0.7
Louisianna	38.3	19.9	22.5	14.6	0.6	3.6	0.1	0.0	0.0	0.3	0.1
Maine	10.6	20.7	41.2	8.8	12.0	4.5	0.8	0.8	0.0	0.5	0.0
Maryland	19.3	10.6	31.3	21.4	2.0	12.7	2.7	0.0	0.0	0.0	0.0
Massachusetts	4.3	4.2	35.7	23.5	4.1	21.8	5.7	0.0	0.1	0.7	0.0
Michigan	12.2	3.7	42.7	26.3	5.9	8.7	0.4	0.0	0.0	0.1	0.1
Minnesota	10.0	6.2	37.7	28.9	3.0	12.5	1.4	0.1	0.2	0.1	0.0
Mississippi	15.7	15.5	37.0	16.7	4.1	9.9	1.1	0.0	0.0	0.0	0.0
Missouri	1.3	3.0	36.0	32.5	10.3	14.4	2.0	0.1	0.2	0.2	0.0
Montana	12.9	2.3	31.2	30.1	0.6	20.8	2.3	0.0	0.0	0.0	0.0
Nebraska	2.9	6.7	35.1	25.5	9.6	18.8	1.1	0.0	0.0	0.3	0.0
Nevada	15.5	4.9	38.3	27.9	1.9	9.6	1.9	0.0	0.0	0.0	0.0
New Hampshire	11.9	3.8	43.2	19.4	2.6	14.2	4.4	0.6	0.0	0.0	0.0
New Jersey	17.1	14.0	19.8	19.7	14.1	11.5	3.5	0.4	0.0	0.0	0.0
New Mexico	25.8	11.8	21.5	29.0	5.4	2.7	2.7	0.0	0.0	1.1	0.0
New York	19.7	4.4	45.8	17.3	1.6	10.9	0.3	0.0	0.0	0.0	0.0
North Carolina	16.3	4.1	39.0	15.3	3.3	20.3	1.7	0.0	0.0	0.0	0.0
North Dakota	10.4	3.7	37.4	20.6	2.3	23.0	2.4	0.3	0.0	0.0	0.0
Ohio	6.4	4.0	45.3	25.6	6.6	9.4	1.8	0.2	0.6	0.2	0.0
Oklahoma	12.0	26.3	13.1	40.5	5.9	2.2	0.1	0.0	0.0	0.0	0.0
Oregon	8.6	2.2	31.2	32.7	3.0	18.0	3.6	0.0	0.3	0.3	0.3
Pennsylvania	7.4	7.4	43.7	21.1	4.7	14.7	0.9	0.0	0.0	0.1	0.0
Rhode Island	4.5	20.8	52.8	8.3	8.7	4.9	0.0	0.0	0.0	0.0	0.0
South Carolina	6.2	2.5	62.2	13.0	8.3	6.4	1.0	0.1	0.1	0.0	0.2
South Dakota	1.5	9.2	39.9	14.2	4.4	29.9	0.9	0.0	0.0	0.0	0.0
Tennessee	4.3	7.0	45.4	26.1	10.7	6.1	0.2	0.0	0.2	0.0	0.0
Texas	23.2	18.5	20.7	19.1	7.3	8.6	1.4	0.2	0.2	0.4	0.3
Utah	14.2	1.5	34.3	40.7	2.2	7.1	0.0	0.0	0.0	0.0	0.0
Vermont	9.2	7.9	42.1	11.8	0.0	22.4	6.6	0.0	0.0	0.0	0.0
Virginia	6.1	5.4	40.7	14.7	16.2	12.1	3.2	1.2	0.2	0.2	0.0
Washington	8.9	5.8	36.9	19.2	4.8	20.7	3.2	0.3	0.1	0.1	0.0
West Virginia	19.3	24.4	34.0	10.4	6.5	3.3	2.0	0.2	0.0	0.0	0.0
Wisconson	6.8	6.6	41.9	29.6	3.9	10.3	1.0	0.0	0.0	0.0	0.0
Wyoming	3.5	2.2	40.8	25.9	10.5	12.3	4.4	0.4	0.0	0.0	0.0

Source: OSCAR

Table 4.5 (c). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 1998

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	**10.8**	**6.8**	**40.7**	**22.8**	**5.1**	**11.3**	**1.7**	**0.1**	**0.3**	**0.3**	**0.1**
Alabama	10.9	13.8	54.2	9.3	1.8	10.1	0.0	0.0	0.0	0.0	0.0
Alaska	4.9	14.8	34.4	21.3	4.9	18.0	0.0	0.0	1.6	0.0	0.0
Arizona	14.7	3.7	39.2	30.6	0.6	7.6	0.5	0.0	1.0	0.3	1.8
Arkansas	34.5	4.5	38.2	15.6	2.1	3.5	0.9	0.0	0.4	0.4	0.1
California	14.4	4.6	49.8	19.8	2.4	6.8	1.7	0.1	0.2	0.3	0.1
Colorado	10.6	2.7	59.5	18.9	0.8	5.6	1.7	0.0	0.0	0.2	0.0
Connecticut	0.3	1.6	47.1	7.0	3.6	38.5	1.9	0.0	0.0	0.0	0.0
Delaware	13.9	5.2	52.3	15.3	0.7	11.9	0.7	0.0	0.0	0.0	0.0
District of Columbia	50.6	8.9	22.8	3.8	5.1	7.6	0.0	1.3	0.0	0.0	0.0
Florida	4.0	7.1	35.7	27.8	11.3	10.7	2.6	0.5	0.1	0.1	0.1
Georgia	26.5	11.1	26.9	19.6	5.3	7.9	1.7	0.2	0.0	0.7	0.0
Hawaii	14.6	9.2	33.6	20.0	10.2	8.8	1.7	0.7	1.4	0.0	0.0
Idaho	2.0	1.8	34.3	29.1	9.5	19.3	4.1	0.0	0.0	0.0	0.0
Illinois	12.9	11.9	43.9	16.8	3.1	10.3	0.6	0.0	0.4	0.2	0.0
Indiana	8.3	2.6	44.4	25.0	2.6	13.2	2.3	0.2	0.8	0.5	0.2
Iowa	4.3	5.0	53.2	19.0	3.7	13.5	0.6	0.0	0.6	0.2	0.0
Kansas	1.0	2.9	33.5	21.2	9.2	26.9	4.2	0.2	0.6	0.3	0.0
Kentucky	4.3	10.5	36.2	23.3	8.8	10.0	5.4	0.5	0.8	0.2	0.2
Louisianna	29.0	13.7	26.4	21.5	2.8	5.9	0.7	0.0	0.0	0.1	0.0
Maine	6.6	14.9	50.1	15.7	7.5	4.8	0.0	0.0	0.4	0.0	0.0
Maryland	17.7	6.4	41.7	18.7	1.4	12.1	2.1	0.0	0.0	0.0	0.0
Massachusetts	2.9	3.6	37.0	25.1	4.1	21.8	4.3	0.3	0.6	0.2	0.1
Michigan	9.9	2.7	37.1	31.4	6.8	10.8	1.0	0.0	0.1	0.1	0.1
Minnesota	6.0	5.5	37.7	24.2	3.0	17.3	2.9	0.4	2.1	1.0	0.0
Mississippi	17.2	18.9	33.9	17.4	3.0	7.6	1.2	0.1	0.2	0.6	0.0
Missouri	1.8	2.2	34.1	38.9	9.4	10.8	1.6	0.1	0.7	0.3	0.2
Montana	5.8	3.6	33.0	36.4	2.5	15.4	3.2	0.0	0.2	0.0	0.0
Nebraska	2.9	3.0	29.6	29.4	10.6	23.4	1.0	0.0	0.1	0.0	0.0
Nevada	12.4	2.1	41.9	28.6	2.7	10.0	1.9	0.0	0.0	0.5	0.0
New Hampshire	7.5	4.9	47.4	14.2	6.2	15.9	2.2	1.8	0.0	0.0	0.0
New Jersey	13.6	12.4	23.8	21.8	13.0	13.8	1.6	0.0	0.0	0.0	0.0
New Mexico	13.8	13.2	20.0	37.9	7.1	5.9	0.0	0.3	0.9	0.0	0.9
New York	19.1	5.5	41.0	20.6	1.4	11.1	1.0	0.0	0.0	0.4	0.0
North Carolina	13.7	4.7	44.1	14.9	3.7	18.1	0.7	0.0	0.1	0.0	0.0
North Dakota	8.8	4.8	48.4	16.9	2.9	16.0	2.1	0.0	0.0	0.0	0.0
Ohio	7.1	3.3	41.0	29.2	6.8	9.7	1.8	0.2	0.4	0.5	0.0
Oklahoma	8.7	20.4	13.9	47.8	4.1	4.3	0.7	0.0	0.0	0.0	0.0
Oregon	4.7	3.3	33.8	27.1	3.4	21.5	4.5	0.3	0.4	0.6	0.6
Pennsylvania	6.1	5.6	43.8	21.5	5.7	15.6	1.3	0.2	0.1	0.1	0.0
Rhode Island	8.6	14.0	50.0	8.0	13.4	4.6	1.1	0.3	0.0	0.0	0.0
South Carolina	5.7	1.6	68.6	10.0	7.9	5.7	0.4	0.1	0.0	0.1	0.0
South Dakota	0.9	4.8	39.0	20.5	3.3	31.3	0.0	0.3	0.0	0.0	0.0
Tennessee	1.1	3.2	50.3	26.9	10.1	5.4	1.3	0.0	0.9	0.9	0.1
Texas	22.0	17.1	26.3	18.2	6.3	8.5	1.0	0.1	0.2	0.3	0.1
Utah	7.3	0.8	30.1	42.1	4.9	8.8	4.9	1.0	0.0	0.0	0.0
Vermont	5.2	7.8	41.6	22.1	2.6	14.3	6.5	0.0	0.0	0.0	0.0
Virginia	3.9	2.7	59.1	13.1	6.7	12.2	2.2	0.1	0.0	0.0	0.0
Washington	8.1	4.6	37.7	20.8	4.6	20.9	2.9	0.2	0.1	0.1	0.0
West Virginia	10.4	23.9	40.8	13.1	7.3	4.6	0.0	0.0	0.0	0.0	0.0
Wisconsin	5.5	6.2	45.7	31.0	3.1	7.9	0.4	0.0	0.1	0.1	0.0
Wyoming	9.0	2.7	39.9	34.0	8.5	5.9	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

Table 4.5 (d). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 1999

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	8.6	6.4	43.7	23.1	5.5	10.6	1.3	0.1	0.3	0.2	0.1
Alabama	5.5	11.7	59.8	8.9	4.1	8.7	0.5	0.3	0.1	0.0	0.5
Alaska	3.1	9.4	41.7	24.0	8.3	13.5	0.0	0.0	0.0	0.0	0.0
Arizona	9.0	3.3	48.7	25.1	0.6	11.1	1.0	0.0	1.3	0.0	0.0
Arkansas	18.0	5.4	37.8	23.5	3.7	5.8	2.1	0.1	1.3	1.6	0.7
California	13.7	4.7	52.1	19.6	2.3	6.4	0.9	0.1	0.1	0.1	0.0
Colorado	11.7	2.0	60.8	19.4	0.9	4.3	0.9	0.0	0.0	0.0	0.0
Connecticut	1.3	2.3	52.0	7.6	1.6	34.0	1.1	0.1	0.0	0.0	0.0
Delaware	12.8	4.0	50.7	11.7	4.0	15.7	1.1	0.0	0.0	0.0	0.0
District of Columbia	38.5	18.4	33.0	6.4	3.7	0.0	0.0	0.0	0.0	0.0	0.0
Florida	2.7	6.6	41.6	27.5	11.8	8.1	1.3	0.1	0.1	0.0	0.1
Georgia	16.8	9.3	39.0	16.0	5.7	11.6	1.0	0.0	0.2	0.4	0.0
Hawaii	15.0	7.5	47.6	15.3	8.8	5.4	0.3	0.0	0.0	0.0	0.0
Idaho	3.4	2.8	42.5	24.5	8.8	16.3	0.9	0.0	0.5	0.2	0.2
Illinois	12.6	10.1	45.7	18.1	2.8	9.7	0.7	0.0	0.2	0.1	0.0
Indiana	6.3	2.1	44.8	26.0	3.6	14.6	1.8	0.1	0.2	0.3	0.2
Iowa	7.5	5.2	51.5	20.4	5.3	9.6	0.5	0.0	0.2	0.0	0.0
Kansas	0.6	3.3	46.4	23.2	8.7	15.7	1.8	0.0	0.2	0.1	0.0
Kentucky	3.7	8.4	41.6	20.4	12.2	10.7	1.8	0.1	0.5	0.6	0.0
Louisianna	11.0	11.7	32.7	30.6	5.3	8.0	0.3	0.0	0.1	0.3	0.0
Maine	3.9	11.0	51.3	18.1	8.1	6.5	0.4	0.0	0.2	0.6	0.0
Maryland	8.9	4.4	39.0	24.2	4.9	13.8	4.7	0.0	0.0	0.0	0.0
Massachusetts	2.1	3.3	42.5	22.6	5.1	22.5	1.8	0.0	0.1	0.0	0.0
Michigan	8.8	2.8	40.2	30.6	6.7	9.7	0.8	0.0	0.2	0.2	0.1
Minnesota	6.5	7.2	43.7	20.5	4.1	16.0	1.3	0.0	0.4	0.3	0.0
Mississippi	15.3	16.2	35.9	17.1	3.9	9.0	1.5	0.0	0.2	0.9	0.0
Missouri	2.5	4.0	33.2	35.8	9.4	11.1	2.6	0.2	0.7	0.4	0.1
Montana	7.5	3.6	46.0	28.7	0.9	12.9	0.4	0.0	0.0	0.0	0.0
Nebraska	3.9	2.5	40.2	27.5	9.2	15.7	1.1	0.0	0.0	0.0	0.0
Nevada	9.9	1.6	51.8	25.9	4.0	6.5	0.2	0.0	0.0	0.0	0.2
New Hampshire	8.5	5.9	39.5	16.6	5.5	17.0	4.1	2.6	0.0	0.0	0.4
New Jersey	12.8	9.2	27.0	22.0	8.4	17.3	3.2	0.0	0.1	0.0	0.0
New Mexico	3.7	6.4	26.5	38.1	12.5	7.1	3.4	0.5	0.3	1.0	0.5
New York	13.0	3.7	42.1	21.9	1.2	13.2	3.3	0.0	0.6	0.8	0.1
North Carolina	7.7	3.8	53.7	14.2	2.4	16.8	0.6	0.0	0.2	0.5	0.1
North Dakota	11.1	5.5	50.3	13.8	0.6	16.6	2.1	0.0	0.0	0.0	0.0
Ohio	6.8	3.2	42.0	31.5	7.3	7.3	1.5	0.0	0.1	0.2	0.1
Oklahoma	7.5	17.9	11.2	52.9	5.8	3.9	0.5	0.0	0.3	0.0	0.0
Oregon	2.8	2.8	31.5	26.2	3.2	24.9	5.2	0.2	0.8	1.7	0.7
Pennsylvania	6.3	5.1	47.9	21.8	5.5	12.2	0.6	0.1	0.1	0.2	0.3
Rhode Island	7.0	18.0	47.1	9.8	11.9	5.5	0.6	0.0	0.0	0.0	0.0
South Carolina	3.9	3.1	64.4	12.0	9.5	5.3	0.8	0.0	0.4	0.6	0.2
South Dakota	6.1	7.3	37.8	21.3	5.8	21.8	0.0	0.0	0.0	0.0	0.0
Tennessee	0.4	2.9	52.9	22.1	10.0	9.0	0.7	0.2	1.1	0.6	0.1
Texas	14.7	15.4	29.2	22.5	7.3	8.6	1.2	0.2	0.4	0.2	0.4
Utah	2.5	0.0	32.6	52.3	1.8	6.8	2.9	0.0	1.1	0.0	0.0
Vermont	2.7	5.4	45.1	27.9	1.8	9.0	8.1	0.0	0.0	0.0	0.0
Virginia	6.3	5.3	64.9	7.6	5.2	8.2	1.3	1.0	0.0	0.0	0.1
Washington	7.0	3.4	42.2	23.5	6.3	15.8	1.5	0.0	0.3	0.1	0.0
West Virginia	7.6	20.2	41.8	14.1	7.6	8.0	0.5	0.0	0.2	0.0	0.0
Wisconsin	5.7	7.4	52.1	22.9	3.1	8.0	0.3	0.0	0.4	0.1	0.0
Wyoming	4.7	3.0	26.9	32.9	11.1	12.4	9.0	0.0	0.0	0.0	0.0

Source: OSCAR

Table 4.5 (e). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 2000

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	**9.0**	**6.3**	**46.2**	**24.1**	**5.5**	**7.4**	**0.8**	**0.1**	**0.3**	**0.3**	**0.1**
Alabama	4.4	14.4	57.6	10.8	6.5	4.3	0.4	0.0	1.1	0.5	0.0
Alaska	9.3	14.7	41.3	28.0	5.3	1.3	0.0	0.0	0.0	0.0	0.0
Arizona	12.6	5.0	45.1	29.3	0.8	5.2	2.0	0.0	0.0	0.0	0.0
Arkansas	11.8	3.3	41.7	27.8	3.0	6.2	2.3	0.1	1.0	2.6	0.3
California	17.4	4.8	53.4	18.0	2.4	3.3	0.5	0.0	0.0	0.1	0.1
Colorado	10.9	1.8	59.3	17.1	1.5	7.0	1.6	0.2	0.3	0.5	0.0
Connecticut	1.3	2.1	74.3	7.5	2.0	12.5	0.3	0.0	0.0	0.0	0.0
Delaware	14.2	5.7	56.5	7.6	4.1	10.1	1.9	0.0	0.0	0.0	0.0
District of Columbia	32.9	29.3	22.6	6.1	6.1	3.1	0.0	0.0	0.0	0.0	0.0
Florida	2.4	4.8	47.6	27.1	12.4	4.9	0.4	0.1	0.1	0.0	0.2
Georgia	18.3	9.7	44.5	15.7	5.0	5.6	0.6	0.0	0.0	0.6	0.0
Hawaii	13.4	8.6	46.9	15.4	7.2	8.6	0.0	0.0	0.0	0.0	0.0
Idaho	4.6	2.2	49.5	24.7	5.9	12.7	0.4	0.0	0.0	0.0	0.0
Illinois	13.2	10.2	47.3	18.5	2.7	7.4	0.3	0.1	0.2	0.1	0.0
Indiana	6.6	1.6	47.1	28.7	2.6	10.7	2.3	0.0	0.2	0.2	0.0
Iowa	10.4	8.6	48.8	21.0	6.0	4.7	0.2	0.0	0.3	0.0	0.0
Kansas	0.6	2.4	49.7	23.6	9.7	12.1	1.3	0.0	0.3	0.4	0.0
Kentucky	2.9	5.7	45.1	23.0	12.3	7.5	2.0	0.0	1.1	0.5	0.0
Louisianna	4.4	5.6	39.2	33.5	9.9	5.8	0.4	0.0	0.2	0.9	0.2
Maine	3.5	14.1	57.0	15.2	6.2	3.1	0.4	0.2	0.2	0.0	0.0
Maryland	11.7	4.2	45.8	26.5	1.5	9.2	1.2	0.0	0.0	0.0	0.0
Massachusetts	4.9	2.5	49.4	22.9	2.9	16.0	1.1	0.0	0.3	0.1	0.0
Michigan	10.1	2.5	43.0	29.9	6.9	6.9	0.6	0.0	0.0	0.2	0.0
Minnesota	4.8	8.4	49.6	21.8	4.4	10.0	0.6	0.0	0.2	0.2	0.0
Mississippi	18.9	16.5	40.4	13.9	3.0	4.4	0.5	0.1	1.5	0.8	0.1
Missouri	4.8	5.6	39.3	37.6	7.3	4.7	0.5	0.0	0.1	0.0	0.0
Montana	4.7	3.1	44.4	30.4	4.4	11.5	1.3	0.0	0.0	0.2	0.0
Nebraska	7.6	9.7	43.3	24.7	7.7	6.6	0.3	0.0	0.0	0.0	0.0
Nevada	10.7	2.8	54.4	21.0	2.3	7.8	0.4	0.0	0.2	0.2	0.4
New Hampshire	2.0	3.1	56.0	19.1	5.7	13.1	0.9	0.0	0.0	0.0	0.0
New Jersey	10.1	4.7	33.3	25.7	9.4	12.7	3.2	0.1	0.3	0.5	0.0
New Mexico	4.6	4.6	28.0	37.5	11.7	6.3	3.3	1.4	0.5	2.2	0.0
New York	11.3	4.6	43.8	23.6	1.1	12.8	1.8	0.0	0.2	0.8	0.0
North Carolina	9.3	4.3	54.2	15.0	2.5	13.7	0.3	0.0	0.2	0.4	0.1
North Dakota	14.3	9.3	51.0	12.4	3.4	8.3	1.0	0.0	0.3	0.0	0.0
Ohio	6.2	3.3	45.6	31.9	6.0	6.0	0.8	0.1	0.1	0.1	0.0
Oklahoma	4.6	11.1	13.6	60.3	4.9	3.7	0.7	0.0	0.3	0.4	0.4
Oregon	2.7	2.1	48.5	25.8	2.7	15.4	1.1	0.0	0.5	0.7	0.5
Pennsylvania	5.7	5.2	52.7	19.8	5.0	10.1	1.0	0.4	0.0	0.1	0.1
Rhode Island	5.5	14.0	50.6	14.8	9.7	5.1	0.4	0.0	0.0	0.0	0.0
South Carolina	5.5	4.3	64.1	13.7	7.3	5.0	0.1	0.0	0.0	0.0	0.0
South Dakota	10.2	6.6	52.2	21.1	3.6	6.2	0.0	0.0	0.0	0.0	0.0
Tennessee	1.3	4.8	56.3	20.5	6.8	7.2	0.2	0.0	1.3	1.0	0.8
Texas	10.8	13.7	28.9	27.6	9.2	7.4	0.9	0.1	0.3	0.7	0.4
Utah	5.2	0.0	33.4	48.5	2.2	5.5	1.5	0.0	0.0	0.6	3.1
Vermont	7.8	3.6	52.5	29.1	0.0	7.1	0.0	0.0	0.0	0.0	0.0
Virginia	12.0	6.9	57.6	8.7	5.3	8.1	0.5	0.5	0.0	0.3	0.0
Washington	10.8	3.8	45.0	23.4	5.9	9.5	0.8	0.0	0.4	0.2	0.1
West Virginia	6.5	19.4	50.1	16.3	5.0	2.6	0.0	0.0	0.3	0.0	0.0
Wisconsin	5.0	6.7	54.4	24.5	2.9	5.5	0.3	0.0	0.5	0.3	0.0
Wyoming	5.7	1.3	46.7	20.3	4.1	18.1	3.8	0.0	0.0	0.0	0.0

Source: OSCAR

Table 4.5 (f). Percent Distribution of Scope and Severity of Health Deficiency Citations: United States, 2001

	Percent Distribution of Scope/Severity										
	B	C	D	E	F	G	H	I	J	K	L
Nation	**9.7**	**5.7**	**49.7**	**22.9**	**5.1**	**5.6**	**0.5**	**0.0**	**0.3**	**0.4**	**0.1**
Alabama	4.6	11.4	60.1	12.5	6.3	4.0	0.3	0.0	0.4	0.4	0.0
Alaska	5.5	11.8	49.1	20.9	2.7	9.1	0.0	0.0	0.0	0.0	0.9
Arizona	15.6	5.3	49.5	26.5	1.1	1.8	0.2	0.0	0.0	0.0	0.0
Arkansas	13.3	3.8	35.8	29.9	4.6	5.2	2.0	0.0	1.0	3.7	0.9
California	19.4	4.3	55.4	16.7	2.4	1.5	0.2	0.0	0.0	0.1	0.1
Colorado	7.6	2.1	61.2	21.0	0.7	6.7	0.5	0.0	0.1	0.2	0.0
Connecticut	0.6	2.9	73.2	8.6	1.2	12.6	0.2	0.0	0.5	0.2	0.0
Delaware	25.7	12.1	44.2	9.2	4.9	3.4	0.0	0.0	0.0	0.5	0.0
District of Columbia	30.7	22.7	28.0	5.8	6.7	5.8	0.4	0.0	0.0	0.0	0.0
Florida	2.7	3.8	55.4	23.3	10.0	3.9	0.3	0.1	0.1	0.2	0.2
Georgia	14.7	10.7	46.2	15.3	5.5	5.6	0.0	0.0	0.3	1.5	0.2
Hawaii	13.7	9.6	46.3	19.2	8.0	1.6	0.0	0.6	1.1	0.0	0.0
Idaho	12.7	4.0	50.1	20.3	4.8	8.1	0.0	0.0	0.0	0.0	0.0
Illinois	11.7	10.9	51.1	17.9	2.6	5.2	0.1	0.0	0.3	0.1	0.0
Indiana	10.7	1.9	50.5	26.3	2.0	6.9	0.8	0.0	0.4	0.4	0.1
Iowa	5.1	5.0	49.3	24.4	12.2	3.3	0.2	0.0	0.4	0.0	0.0
Kansas	0.8	2.9	47.8	29.1	10.5	7.3	1.0	0.0	0.4	0.4	0.0
Kentucky	3.2	4.7	55.3	18.8	8.9	6.8	0.8	0.1	0.8	0.4	0.3
Louisianna	3.6	5.5	36.1	39.9	8.7	4.8	0.2	0.0	0.3	0.6	0.3
Maine	7.0	14.5	50.9	16.9	7.0	1.7	1.2	0.0	0.2	0.0	0.7
Maryland	11.1	3.6	49.6	28.7	1.1	5.4	0.5	0.0	0.0	0.0	0.0
Massachusetts	3.8	2.4	57.4	21.5	2.5	11.8	0.5	0.0	0.0	0.1	0.0
Michigan	12.9	3.6	45.5	27.8	6.0	4.0	0.1	0.0	0.1	0.0	0.0
Minnesota	5.4	6.6	54.8	22.2	2.0	7.8	0.2	0.0	0.7	0.2	0.1
Mississippi	15.0	13.4	48.4	13.9	4.0	4.2	0.1	0.0	0.7	0.4	0.0
Missouri	5.5	3.9	46.5	33.9	7.2	2.4	0.1	0.0	0.6	0.0	0.0
Montana	10.5	5.4	37.3	36.1	2.4	6.4	1.9	0.0	0.0	0.0	0.0
Nebraska	3.7	4.3	47.4	29.2	9.0	6.2	0.1	0.0	0.1	0.0	0.0
Nevada	14.2	2.7	63.8	14.4	3.3	1.2	0.4	0.0	0.0	0.0	0.0
New Hampshire	3.9	6.7	58.8	12.9	7.0	10.1	0.6	0.0	0.0	0.0	0.0
New Jersey	7.9	3.0	40.3	26.9	8.2	10.9	2.2	0.0	0.6	0.1	0.0
New Mexico	1.3	1.5	31.6	47.2	7.9	6.1	2.6	0.0	0.0	1.8	0.0
New York	10.3	3.2	49.5	20.4	1.8	11.8	1.5	0.0	0.8	0.8	0.0
North Carolina	8.8	4.5	58.2	16.3	2.8	8.5	0.2	0.0	0.6	0.1	0.1
North Dakota	14.8	6.7	52.1	16.2	0.3	9.5	0.6	0.0	0.0	0.0	0.0
Ohio	8.4	3.4	49.6	27.6	4.7	5.3	0.7	0.0	0.2	0.1	0.0
Oklahoma	8.4	7.0	19.4	53.4	3.7	4.2	1.8	0.0	0.9	1.0	0.3
Oregon	4.0	1.4	48.4	27.8	3.9	13.1	0.9	0.0	0.1	0.5	0.0
Pennsylvania	7.1	4.9	57.9	18.5	5.9	5.6	0.0	0.0	0.0	0.0	0.0
Rhode Island	4.8	19.8	55.9	8.7	6.3	4.5	0.0	0.0	0.0	0.0	0.0
South Carolina	7.9	4.4	63.7	12.2	4.5	3.8	0.7	0.0	0.9	1.5	0.6
South Dakota	10.1	6.6	47.0	22.1	2.5	10.3	1.4	0.0	0.0	0.0	0.0
Tennessee	0.9	5.4	60.3	18.9	7.2	6.0	0.0	0.0	0.6	0.2	0.4
Texas	12.1	13.5	31.2	25.8	8.1	7.3	0.7	0.1	0.2	0.8	0.4
Utah	0.9	1.1	35.8	51.6	2.3	4.5	1.1	0.0	0.6	1.7	0.6
Vermont	18.8	0.8	45.9	24.8	0.0	9.8	0.0	0.0	0.0	0.0	0.0
Virginia	11.2	5.1	63.9	9.2	4.7	4.5	0.5	0.0	0.3	0.2	0.3
Washington	10.6	3.9	46.1	25.3	3.4	9.3	0.9	0.0	0.4	0.1	0.0
West Virginia	7.9	14.0	50.1	18.4	5.9	3.7	0.0	0.0	0.0	0.0	0.0
Wisconsin	5.7	6.7	53.7	25.9	2.3	4.5	0.3	0.0	0.7	0.2	0.1
Wyoming	4.5	2.3	66.6	17.6	2.3	5.7	1.1	0.0	0.0	0.0	0.0

Source: OSCAR

Table 4.6 (a). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**13.9**	**25.9**	**30.9**	**31.2**	**26.3**
Alabama	11.8	22.0	32.7	40.0	27.3
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	13.3	14.7	17.1	15.4	15.6
Arkansas	3.0	8.2	11.3	33.3	9.6
California	13.7	29.0	34.0	50.8	27.7
Colorado	5.4	16.2	16.0	28.6	13.7
Connecticut	22.2	23.6	30.8	36.0	28.7
Delaware	20.0	37.5	41.7	n/a	37.8
District of Columbia	0.0	0.0	66.7	0.0	10.0
Florida	10.8	25.8	36.0	36.4	30.8
Georgia	6.7	39.3	43.1	34.4	38.5
Hawaii	26.7	9.1	9.1	25.0	17.1
Idaho	24.2	64.0	47.8	100.0	43.9
Illinois	9.7	19.7	20.5	23.1	19.3
Indiana	28.3	36.6	49.1	50.0	40.8
Iowa	23.5	39.1	44.0	63.6	38.2
Kansas	37.8	57.4	70.1	80.0	55.1
Kentucky	4.7	8.9	13.9	42.9	10.1
Louisiana	1.7	5.6	13.7	23.8	10.9
Maine	5.1	6.1	7.1	33.3	6.6
Maryland	0.0	6.1	8.3	9.7	6.6
Massachusetts	11.3	28.2	33.3	47.6	27.7
Michigan	22.2	37.5	56.6	50.0	46.8
Minnesota	11.5	25.8	35.0	26.9	27.1
Mississippi	4.8	23.1	46.7	40.0	28.5
Missouri	8.0	25.3	29.3	25.0	24.3
Montana	21.4	45.5	52.4	50.0	36.7
Nebraska	30.4	36.2	51.0	80.0	38.8
Nevada	30.0	62.5	75.0	75.0	54.2
New Hampshire	6.7	38.5	29.0	0.0	27.2
New Jersey	14.3	10.0	18.9	32.8	19.6
New Mexico	5.3	6.9	16.2	0.0	10.3
New York	13.3	17.9	18.7	17.0	17.6
North Carolina	8.7	34.5	40.5	50.0	34.9
North Dakota	30.4	51.3	66.7	50.0	50.0
Ohio	19.3	17.5	33.8	35.6	27.2
Oklahoma	1.5	9.2	18.5	14.3	11.3
Oregon	13.5	40.8	45.8	100.0	36.9
Pennsylvania	8.2	22.2	29.1	34.7	24.2
Rhode Island	15.8	9.4	12.2	16.7	12.2
South Carolina	25.0	43.1	55.2	50.0	43.8
South Dakota	25.9	19.7	40.0	0.0	23.9
Tennessee	9.6	14.3	16.1	38.1	15.9
Texas	5.3	18.3	25.2	23.9	19.4
Utah	14.8	11.8	30.0	0.0	18.3
Vermont	28.6	0.0	22.2	n/a	18.6
Virginia	0.0	15.1	28.8	42.9	21.3
Washington	39.5	51.8	57.3	70.0	53.0
West Virginia	0.0	5.7	17.9	100.0	9.5
Wisconsin	9.5	15.2	23.2	23.2	18.5
Wyoming	12.5	21.1	45.5	100.0	28.2

Source: OSCAR

n/a: Data unavailable

Table 4.6 (b). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**15.2**	**26.9**	**33.1**	**32.8**	**27.9**
Alabama	27.3	46.2	65.7	66.7	56.0
Alaska	38.5	100.0	n/a	100.0	50.0
Arizona	9.5	11.5	12.9	10.0	11.8
Arkansas	2.9	9.1	14.9	28.6	11.7
California	16.2	28.7	34.6	37.1	27.5
Colorado	4.7	13.8	17.4	28.6	13.1
Connecticut	31.3	29.3	49.7	48.1	42.4
Delaware	0.0	25.0	44.4	0.0	33.3
District of Columbia	20.0	0.0	28.6	25.0	19.2
Florida	10.9	29.9	42.1	38.7	35.1
Georgia	0.0	14.3	30.5	36.0	23.8
Hawaii	14.3	35.7	40.0	0.0	26.2
Idaho	43.8	60.0	66.7	n/a	56.0
Illinois	14.3	27.7	29.4	39.0	28.6
Indiana	25.0	40.8	46.6	36.8	39.1
Iowa	27.8	38.4	54.6	77.8	41.4
Kansas	50.4	55.2	75.6	83.3	58.1
Kentucky	4.5	18.3	23.3	60.0	17.4
Louisiana	0.0	6.4	17.7	12.5	12.4
Maine	4.5	11.8	4.8	0.0	8.1
Maryland	6.8	16.3	27.3	38.7	23.0
Massachusetts	6.2	23.4	28.6	42.9	23.3
Michigan	36.2	35.2	46.2	62.9	43.4
Minnesota	10.6	17.4	32.6	18.5	22.0
Mississippi	8.7	21.3	35.0	50.0	24.3
Missouri	7.7	20.2	26.3	35.7	21.6
Montana	38.1	28.6	44.0	0.0	35.6
Nebraska	23.3	29.0	37.5	20.0	29.1
Nevada	22.2	57.1	73.3	50.0	47.6
New Hampshire	8.3	24.4	42.4	20.0	28.6
New Jersey	0.0	14.9	17.1	21.7	16.0
New Mexico	0.0	6.5	10.7	0.0	6.5
New York	13.6	9.2	21.7	15.2	16.7
North Carolina	2.1	26.0	43.1	66.7	32.7
North Dakota	35.0	57.6	85.7	50.0	59.2
Ohio	9.9	27.7	33.3	38.7	28.5
Oklahoma	1.3	7.3	11.8	0.0	7.7
Oregon	36.4	45.5	50.0	0.0	44.5
Pennsylvania	13.8	26.3	32.7	34.8	27.5
Rhode Island	5.0	11.8	13.5	33.3	12.4
South Carolina	20.5	31.3	41.4	0.0	31.8
South Dakota	45.5	40.0	33.3	0.0	40.0
Tennessee	0.0	11.4	9.4	21.1	9.1
Texas	7.5	21.5	27.8	31.4	22.4
Utah	7.1	11.8	21.9	0.0	13.5
Vermont	10.0	30.8	37.5	n/a	28.2
Virginia	2.8	16.0	37.6	20.0	24.0
Washington	49.0	60.2	73.7	90.0	64.7
West Virginia	10.0	8.1	14.8	66.7	12.6
Wisconsin	6.8	25.0	28.5	36.0	25.7
Wyoming	22.2	43.8	45.5	100.0	40.5

Source: OSCAR
n/a: Data unavailable

Table 4.6 (c). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**17.3**	**29.2**	**35.3**	**36.2**	**30.1**
Alabama	42.9	32.6	47.0	40.0	41.0
Alaska	10.0	50.0	n/a	100.0	31.3
Arizona	7.4	11.5	39.1	40.0	27.3
Arkansas	13.3	12.6	25.2	14.3	18.6
California	18.1	31.3	39.9	51.7	31.4
Colorado	9.1	13.2	8.3	22.2	10.7
Connecticut	26.7	55.7	58.4	63.6	56.1
Delaware	0.0	28.6	58.8	100.0	46.4
District of Columbia	0.0	0.0	40.0	20.0	17.6
Florida	19.8	32.6	43.5	50.0	38.4
Georgia	0.0	17.1	24.5	23.1	19.9
Hawaii	23.5	54.5	16.7	50.0	31.8
Idaho	35.7	65.4	73.3	n/a	58.3
Illinois	13.7	36.3	36.6	31.8	32.6
Indiana	26.8	47.3	51.4	61.8	45.6
Iowa	15.0	34.3	33.6	44.4	31.1
Kansas	41.8	54.4	65.3	50.0	52.8
Kentucky	19.5	31.1	33.3	66.7	29.4
Louisiana	3.6	12.3	16.3	16.0	13.8
Maine	6.4	7.7	11.8	50.0	9.0
Maryland	4.8	16.7	25.5	29.6	20.0
Massachusetts	8.9	32.5	33.2	47.6	28.8
Michigan	37.8	35.7	52.5	56.3	45.9
Minnesota	36.2	25.6	42.4	64.0	34.9
Mississippi	14.3	22.2	28.0	40.0	22.9
Missouri	7.1	24.3	34.2	37.0	26.4
Montana	36.8	38.7	52.2	100.0	42.6
Nebraska	37.5	32.1	40.8	75.0	35.8
Nevada	16.7	75.0	50.0	100.0	45.8
New Hampshire	11.8	23.5	40.7	20.0	26.5
New Jersey	4.4	8.2	19.1	18.5	15.2
New Mexico	28.6	14.3	24.1	50.0	21.9
New York	9.8	13.3	22.6	13.9	17.0
North Carolina	7.5	26.4	51.2	70.0	37.4
North Dakota	40.7	47.5	60.9	50.0	48.9
Ohio	18.9	29.9	36.8	44.4	32.7
Oklahoma	8.6	11.6	16.7	20.0	13.1
Oregon	42.9	49.3	56.6	100.0	50.9
Pennsylvania	16.0	22.9	39.5	43.9	31.6
Rhode Island	5.6	3.3	18.6	25.0	12.1
South Carolina	13.9	29.0	29.9	20.0	25.9
South Dakota	5.3	49.1	61.5	0.0	41.1
Tennessee	3.4	18.6	16.6	12.5	14.7
Texas	6.6	21.5	28.3	34.0	22.7
Utah	12.5	24.1	41.9	50.0	26.6
Vermont	20.0	21.4	14.3	n/a	18.4
Virginia	8.6	11.5	30.0	26.7	20.6
Washington	34.6	66.7	71.6	62.5	62.5
West Virginia	11.1	5.9	20.7	n/a	12.3
Wisconsin	5.0	18.0	21.2	41.5	20.8
Wyoming	15.4	5.9	25.0	0.0	14.0

Source: OSCAR

n/a: Data unavailable

Table 4.6 (d). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**16.7**	**29.4**	**37.2**	**40.7**	**31.4**
Alabama	12.5	33.3	55.0	50.0	43.4
Alaska	45.5	25.0	n/a	0.0	37.5
Arizona	7.7	30.0	47.9	66.7	39.1
Arkansas	29.0	33.3	33.6	0.0	32.4
California	15.7	32.9	38.0	50.0	31.3
Colorado	3.6	9.4	12.1	37.5	10.0
Connecticut	15.4	52.0	66.2	72.0	59.9
Delaware	0.0	50.0	57.1	100.0	51.4
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	10.8	25.0	34.5	35.1	29.6
Georgia	3.3	23.9	35.2	44.0	29.6
Hawaii	11.8	9.1	33.3	0.0	16.3
Idaho	37.9	69.2	69.0	n/a	58.3
Illinois	15.9	34.7	36.5	30.6	32.3
Indiana	35.1	48.0	57.0	68.6	49.5
Iowa	13.8	27.6	25.2	14.3	24.4
Kansas	26.1	45.2	62.3	71.4	43.4
Kentucky	16.5	28.0	37.1	66.7	28.7
Louisiana	2.0	14.5	25.7	44.4	21.5
Maine	21.7	19.7	16.7	100.0	20.6
Maryland	6.7	12.5	38.6	47.4	28.7
Massachusetts	11.1	29.7	39.9	55.0	32.8
Michigan	26.7	41.0	51.4	48.6	45.5
Minnesota	26.9	31.4	39.5	43.8	34.2
Mississippi	16.7	23.7	44.0	66.7	31.1
Missouri	7.4	23.3	33.6	52.0	26.6
Montana	34.9	54.5	39.3	100.0	42.9
Nebraska	31.7	27.8	33.3	0.0	29.7
Nevada	12.5	0.0	45.0	40.0	27.3
New Hampshire	23.1	28.1	52.6	40.0	34.8
New Jersey	0.0	17.0	30.5	35.8	25.9
New Mexico	15.4	30.3	31.3	50.0	28.8
New York	22.7	19.6	29.5	27.5	26.6
North Carolina	11.9	42.8	55.4	92.3	47.6
North Dakota	24.1	40.0	47.8	100.0	38.3
Ohio	14.9	25.0	34.3	52.5	30.1
Oklahoma	4.2	13.0	19.9	22.2	14.6
Oregon	35.7	62.9	61.1	100.0	57.5
Pennsylvania	17.6	24.3	38.2	45.7	32.3
Rhode Island	0.0	11.8	20.9	40.0	15.2
South Carolina	17.6	23.9	37.7	66.7	29.6
South Dakota	25.0	38.9	60.0	n/a	37.5
Tennessee	5.6	23.2	28.1	45.5	24.4
Texas	6.5	20.3	30.7	33.3	24.0
Utah	0.0	22.2	28.0	n/a	15.9
Vermont	13.3	21.4	5.6	n/a	12.8
Virginia	8.1	16.8	25.4	12.5	19.4
Washington	38.0	61.9	65.8	75.0	59.5
West Virginia	20.7	22.6	39.6	50.0	28.4
Wisconsin	5.9	14.1	20.8	32.1	18.1
Wyoming	23.1	28.6	41.7	0.0	30.0

Source: OSCAR

n/a: Data unavailable

Table 4.6 (e). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**13.9**	**22.7**	**31.1**	**30.7**	**25.5**
Alabama	0.0	21.9	37.2	33.3	28.7
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	5.3	16.7	28.6	20.0	22.0
Arkansas	39.3	22.6	41.3	0.0	33.7
California	9.5	19.5	24.3	22.6	18.8
Colorado	13.7	21.3	30.2	16.7	22.9
Connecticut	26.7	29.9	41.6	56.5	38.7
Delaware	0.0	18.2	48.1	0.0	34.1
District of Columbia	0.0	0.0	25.0	33.3	14.3
Florida	9.9	17.1	19.0	25.0	18.0
Georgia	4.2	12.5	24.7	17.4	18.8
Hawaii	11.8	11.1	46.2	0.0	22.0
Idaho	35.5	56.0	41.7	n/a	43.8
Illinois	15.4	24.9	29.0	21.0	24.6
Indiana	26.6	34.6	47.8	61.0	40.0
Iowa	6.3	12.8	15.5	0.0	12.0
Kansas	24.1	37.3	49.3	57.1	36.3
Kentucky	13.0	29.1	30.2	33.3	25.6
Louisiana	6.5	26.0	26.9	37.5	24.9
Maine	4.9	9.1	17.6	50.0	9.5
Maryland	6.7	15.4	24.8	22.9	19.5
Massachusetts	13.8	22.0	32.5	31.6	26.4
Michigan	24.5	30.8	41.0	32.5	35.5
Minnesota	14.3	20.7	29.7	34.8	23.5
Mississippi	16.1	18.4	27.6	33.3	22.0
Missouri	5.3	16.5	20.1	9.4	16.1
Montana	27.5	39.3	26.1	50.0	31.2
Nebraska	5.7	19.4	30.8	0.0	17.7
Nevada	15.4	41.7	52.6	25.0	37.5
New Hampshire	33.3	31.3	43.3	40.0	36.7
New Jersey	2.7	12.7	32.6	30.4	25.7
New Mexico	7.7	25.0	21.9	0.0	20.5
New York	25.0	29.8	39.0	35.7	35.2
North Carolina	5.8	32.9	43.2	47.1	35.3
North Dakota	37.0	22.2	13.6	0.0	24.1
Ohio	11.6	26.5	28.8	30.3	25.9
Oklahoma	15.4	12.6	28.2	42.9	19.5
Oregon	26.1	35.5	41.8	50.0	36.5
Pennsylvania	16.1	24.3	29.2	40.2	27.1
Rhode Island	0.0	6.9	16.7	0.0	9.6
South Carolina	7.0	12.5	42.9	16.7	23.4
South Dakota	11.1	20.5	35.7	n/a	19.5
Tennessee	6.3	21.5	25.4	44.4	22.6
Texas	14.4	25.2	37.7	39.6	30.8
Utah	0.0	18.8	18.2	0.0	12.4
Vermont	21.4	8.3	26.3	n/a	20.0
Virginia	2.6	10.8	23.0	20.0	16.4
Washington	26.5	40.9	42.9	14.3	38.4
West Virginia	3.0	8.8	21.4	0.0	12.0
Wisconsin	5.3	10.6	18.4	25.0	14.6
Wyoming	54.5	43.8	57.1	0.0	50.0

Source: OSCAR

n/a: Data unavailable

Table 4.6 (f).Nursing Home Surveys Resulting in Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**10.1**	**19.5**	**25.6**	**28.7**	**21.3**
Alabama	0.0	14.5	19.8	38.5	18.0
Alaska	20.0	40.0	n/a	100.0	35.3
Arizona	0.0	3.6	11.7	20.0	9.7
Arkansas	21.7	25.8	27.5	50.0	26.6
California	0.9	10.5	13.4	16.7	9.6
Colorado	10.9	22.8	37.2	20.0	25.9
Connecticut	15.4	40.8	53.7	81.0	50.2
Delaware	0.0	30.0	12.0	0.0	15.0
District of Columbia	0.0	42.9	33.3	16.7	28.6
Florida	10.7	16.5	24.8	23.7	21.6
Georgia	14.8	13.5	22.9	31.8	19.8
Hawaii	0.0	27.3	10.0	0.0	11.4
Idaho	13.8	30.4	46.2	n/a	29.5
Illinois	5.9	20.0	23.7	14.5	18.9
Indiana	14.7	24.9	31.1	33.3	25.9
Iowa	9.1	12.8	14.1	0.0	12.1
Kansas	24.3	31.3	32.1	100.0	30.4
Kentucky	18.2	31.5	28.7	60.0	27.9
Louisiana	5.6	26.2	27.7	35.0	25.4
Maine	11.9	10.0	7.7	50.0	11.1
Maryland	3.6	3.8	25.3	6.7	15.3
Massachusetts	6.0	17.9	28.4	29.4	21.9
Michigan	20.0	24.5	23.6	22.9	23.4
Minnesota	14.0	13.5	24.0	26.1	17.5
Mississippi	3.3	18.6	28.6	50.0	20.5
Missouri	2.1	10.4	13.7	22.2	11.4
Montana	21.6	26.1	26.9	0.0	23.9
Nebraska	16.7	21.4	16.2	100.0	19.9
Nevada	0.0	0.0	13.6	16.7	8.0
New Hampshire	15.4	37.9	23.3	33.3	28.0
New Jersey	10.5	8.8	27.7	36.4	23.8
New Mexico	0.0	24.1	21.4	0.0	18.1
New York	18.2	34.3	34.1	42.1	35.6
North Carolina	11.8	17.4	41.9	60.0	31.1
North Dakota	15.4	34.1	30.4	33.3	28.0
Ohio	5.8	19.7	24.6	29.7	20.7
Oklahoma	8.6	25.2	23.1	0.0	21.4
Oregon	13.0	31.1	41.3	0.0	31.1
Pennsylvania	3.2	13.4	19.1	18.7	15.1
Rhode Island	15.0	21.9	7.9	0.0	13.7
South Carolina	2.7	19.1	19.4	16.7	15.1
South Dakota	25.0	35.2	28.6	n/a	30.8
Tennessee	8.8	14.2	21.4	19.0	17.3
Texas	10.3	23.9	30.3	38.2	26.2
Utah	6.7	14.3	21.2	33.3	14.9
Vermont	0.0	33.3	22.2	n/a	19.0
Virginia	9.1	10.2	12.4	16.7	11.5
Washington	23.9	38.2	47.6	33.3	39.4
West Virginia	4.5	14.3	25.6	0.0	16.2
Wisconsin	5.7	13.0	13.5	11.1	12.4
Wyoming	8.3	23.1	30.8	n/a	21.1

Source: OSCAR

n/a: Data unavailable

Health Deficiencies
Immediate Jeopardy

Table 4.7 (a). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 1996

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**28.3**	**22.4**	**22.9**	**26.3**
Alabama	27.0	29.0	27.3	27.3
Alaska	0.0	0.0	0.0	0.0
Arizona	17.0	12.7	25.0	15.6
Arkansas	11.1	4.5	0.0	9.6
California	29.7	22.4	19.3	27.7
Colorado	16.7	3.4	23.8	13.7
Connecticut	31.5	17.0	50.0	28.7
Delaware	40.0	35.7	33.3	37.8
District of Columbia	16.7	7.7	0.0	10.0
Florida	31.9	26.4	33.3	30.8
Georgia	39.3	42.5	18.5	38.5
Hawaii	6.3	14.3	36.4	17.1
Idaho	53.1	23.1	35.0	43.9
Illinois	20.1	18.1	16.4	19.3
Indiana	45.3	27.3	33.3	40.8
Iowa	44.8	30.5	25.0	38.2
Kansas	59.5	52.6	41.7	55.1
Kentucky	12.1	6.1	9.1	10.1
Louisiana	10.9	10.3	12.0	10.9
Maine	7.1	6.3	0.0	6.6
Maryland	8.3	4.5	0.0	6.6
Massachusetts	29.7	23.3	7.1	27.7
Michigan	50.5	42.9	33.3	46.8
Minnesota	29.7	26.7	22.2	27.1
Mississippi	35.3	6.7	19.4	28.5
Missouri	29.3	15.9	12.0	24.3
Montana	44.7	28.6	38.9	36.7
Nebraska	41.7	38.6	33.9	38.8
Nevada	57.1	42.9	50.0	54.2
New Hampshire	37.5	16.7	14.3	27.2
New Jersey	20.6	16.5	23.1	19.6
New Mexico	15.4	3.7	0.0	10.3
New York	15.7	19.6	17.6	17.6
North Carolina	38.6	24.1	25.0	34.9
North Dakota	50.0	50.0	50.0	50.0
Ohio	28.1	23.4	31.7	27.2
Oklahoma	13.3	3.4	0.0	11.3
Oregon	41.4	26.5	0.0	36.9
Pennsylvania	28.4	20.5	26.5	24.2
Rhode Island	13.9	7.7	n/a	12.2
South Carolina	47.2	29.0	45.0	43.8
South Dakota	26.3	22.7	20.0	23.9
Tennessee	17.3	13.9	10.3	15.9
Texas	21.5	9.2	8.1	19.4
Utah	19.2	18.8	0.0	18.3
Vermont	18.2	12.5	50.0	18.6
Virginia	23.4	12.9	50.0	21.3
Washington	53.2	54.8	45.5	53.0
West Virginia	10.1	4.0	16.7	9.5
Wisconsin	16.9	22.5	13.6	18.5
Wyoming	31.6	16.7	28.6	28.2

Source: OSCAR

n/a: Data unavailable

Table 4.7 (b). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 1997

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**30.3**	**22.6**	**26.1**	**27.9**
Alabama	56.5	53.6	55.6	56.0
Alaska	0.0	62.5	42.9	50.0
Arizona	15.6	4.9	0.0	11.8
Arkansas	13.8	2.3	6.7	11.7
California	30.3	17.7	29.3	27.5
Colorado	17.0	6.0	8.7	13.1
Connecticut	45.1	32.8	50.0	42.4
Delaware	30.0	38.1	25.0	33.3
District of Columbia	20.0	15.4	33.3	19.2
Florida	38.1	24.3	27.3	35.1
Georgia	24.6	20.3	23.8	23.8
Hawaii	27.8	7.1	50.0	26.2
Idaho	57.7	23.1	73.7	56.0
Illinois	31.7	22.8	23.9	28.6
Indiana	42.7	27.3	37.5	39.1
Iowa	48.2	34.1	26.1	41.4
Kansas	65.2	49.7	47.3	58.1
Kentucky	21.3	10.5	10.0	17.4
Louisiana	13.3	11.3	6.9	12.4
Maine	10.1	3.1	0.0	8.1
Maryland	24.1	22.1	14.3	23.0
Massachusetts	25.8	17.1	13.3	23.3
Michigan	45.3	42.9	31.7	43.4
Minnesota	29.0	18.5	21.0	22.0
Mississippi	26.9	22.9	13.3	24.3
Missouri	27.3	11.9	4.2	21.6
Montana	34.2	34.8	40.0	35.6
Nebraska	29.4	23.8	36.4	29.1
Nevada	54.8	66.7	12.5	47.6
New Hampshire	26.5	27.6	38.5	28.6
New Jersey	18.1	11.2	17.6	16.0
New Mexico	4.7	7.4	14.3	6.5
New York	16.2	16.0	21.8	16.7
North Carolina	38.6	15.1	16.7	32.7
North Dakota	77.8	56.9	50.0	59.2
Ohio	28.9	26.9	30.0	28.5
Oklahoma	8.0	8.9	0.0	7.7
Oregon	45.8	37.5	60.0	44.5
Pennsylvania	37.5	19.0	37.8	27.5
Rhode Island	15.3	4.0	n/a	12.4
South Carolina	33.3	39.1	14.3	31.8
South Dakota	28.9	47.6	25.0	40.0
Tennessee	9.6	6.0	14.8	9.1
Texas	24.8	11.0	15.8	22.4
Utah	13.9	7.7	25.0	13.5
Vermont	31.0	20.0	n/a	28.2
Virginia	29.1	10.0	62.5	24.0
Washington	68.7	57.7	52.2	64.7
West Virginia	16.7	4.0	12.5	12.6
Wisconsin	23.5	30.6	19.4	25.7
Wyoming	35.3	33.3	50.0	40.5

Source: OSCAR

n/a: Data unavailable

Table 4.7 (c). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 1998

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**32.4**	**25.5**	**27.6**	**30.1**
Alabama	42.0	29.0	50.0	41.0
Alaska	0.0	50.0	0.0	31.3
Arizona	33.3	15.6	33.3	27.3
Arkansas	20.3	11.9	14.3	18.6
California	35.1	18.0	34.8	31.4
Colorado	13.6	3.3	13.0	10.7
Connecticut	56.3	54.0	100.0	56.1
Delaware	54.5	38.5	50.0	46.4
District of Columbia	25.0	9.1	50.0	17.6
Florida	40.1	32.2	35.7	38.4
Georgia	22.0	17.6	3.8	19.9
Hawaii	36.8	21.4	36.4	31.8
Idaho	62.7	42.9	57.9	58.3
Illinois	35.7	24.8	40.8	32.6
Indiana	48.6	39.2	20.0	45.6
Iowa	32.3	31.2	14.3	31.1
Kansas	58.7	48.6	40.9	52.8
Kentucky	30.0	25.9	55.6	29.4
Louisiana	15.6	10.5	3.8	13.8
Maine	9.2	10.0	0.0	9.0
Maryland	23.9	15.5	0.0	20.0
Massachusetts	30.7	26.1	7.7	28.8
Michigan	49.2	44.1	31.0	45.9
Minnesota	31.2	37.5	32.7	34.9
Mississippi	21.8	19.4	31.3	22.9
Missouri	30.7	20.9	13.2	26.4
Montana	50.0	38.6	37.5	42.6
Nebraska	39.3	28.4	38.9	35.8
Nevada	47.4	33.3	42.9	45.8
New Hampshire	30.4	16.7	30.8	26.5
New Jersey	17.4	11.8	11.8	15.2
New Mexico	14.9	28.6	60.0	21.9
New York	14.3	17.4	30.0	17.0
North Carolina	44.7	19.4	6.7	37.4
North Dakota	50.0	48.8	50.0	48.9
Ohio	33.8	29.6	32.1	32.7
Oklahoma	13.4	17.0	0.0	13.1
Oregon	52.5	47.2	40.0	50.9
Pennsylvania	39.8	23.3	48.9	31.6
Rhode Island	15.4	0.0	n/a	12.1
South Carolina	27.6	25.0	15.8	25.9
South Dakota	32.3	46.3	40.0	41.1
Tennessee	14.4	13.4	20.0	14.7
Texas	25.5	12.3	4.9	22.7
Utah	28.4	18.8	25.0	26.6
Vermont	20.0	16.7	0.0	18.4
Virginia	22.6	14.6	40.0	20.6
Washington	68.6	48.5	52.4	62.5
West Virginia	13.0	9.5	16.7	12.3
Wisconsin	27.0	15.5	13.1	20.8
Wyoming	10.5	16.7	16.7	14.0

Source: OSCAR

n/a: Data unavailable

Table 4.7 (d). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 1999

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**34.3**	**29.4**	**25.9**	**31.4**
Alabama	47.1	33.3	38.1	43.4
Alaska	100.0	25.0	20.0	37.5
Arizona	47.4	30.0	66.7	39.1
Arkansas	33.9	33.3	15.4	32.4
California	34.7	32.9	32.6	31.3
Colorado	11.7	9.4	4.0	10.0
Connecticut	61.3	52.0	50.0	59.9
Delaware	50.0	50.0	33.3	51.4
District of Columbia	0.0	0.0	0.0	0.0
Florida	31.7	25.0	15.4	29.6
Georgia	30.9	23.9	16.0	29.6
Hawaii	9.5	9.1	27.3	16.3
Idaho	61.5	69.2	63.2	58.3
Illinois	34.6	34.7	31.1	32.3
Indiana	55.8	48.0	17.6	49.5
Iowa	29.4	27.6	4.5	24.4
Kansas	54.3	45.2	20.0	43.4
Kentucky	32.0	28.0	40.0	28.7
Louisiana	23.3	14.5	18.5	21.5
Maine	23.9	19.7	16.7	20.6
Maryland	38.5	12.5	33.3	28.7
Massachusetts	36.9	29.7	0.0	32.8
Michigan	48.6	41.0	30.8	45.5
Minnesota	30.4	31.4	31.0	34.2
Mississippi	33.3	23.7	23.1	31.1
Missouri	31.7	23.3	12.2	26.6
Montana	56.8	54.5	47.4	42.9
Nebraska	32.1	27.8	26.5	29.7
Nevada	32.3	0.0	40.0	27.3
New Hampshire	47.2	28.1	40.0	34.8
New Jersey	27.1	17.0	38.9	25.9
New Mexico	35.4	30.3	20.0	28.8
New York	25.2	19.6	37.0	26.6
North Carolina	51.9	42.8	35.3	47.6
North Dakota	33.3	40.0	25.0	38.3
Ohio	30.7	25.0	30.0	30.1
Oklahoma	15.9	13.0	11.8	14.6
Oregon	63.0	62.9	50.0	57.5
Pennsylvania	37.9	24.3	33.3	32.3
Rhode Island	18.9	11.8	n/a	15.2
South Carolina	31.9	23.9	29.4	29.6
South Dakota	36.4	38.9	16.7	37.5
Tennessee	25.6	23.2	34.3	24.4
Texas	25.8	20.3	7.5	24.0
Utah	17.7	22.2	0.0	15.9
Vermont	10.0	21.4	50.0	12.8
Virginia	24.7	16.8	18.2	19.4
Washington	64.7	61.9	43.5	59.5
West Virginia	36.3	22.6	13.3	28.4
Wisconsin	19.3	14.1	17.5	18.1
Wyoming	33.3	28.6	29.4	30.0

Source: OSCAR

n/a: Data unavailable

Table 4.7 (e). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 2000

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**27.5**	**21.3**	**23.5**	**25.5**
Alabama	26.2	25.0	52.6	28.7
Alaska	n/a	0.0	0.0	0.0
Arizona	24.7	15.9	25.0	22.0
Arkansas	35.3	31.0	15.4	33.7
California	19.2	15.8	25.0	18.8
Colorado	26.8	20.7	4.5	22.9
Connecticut	38.5	40.7	0.0	38.7
Delaware	45.0	26.3	20.0	34.1
District of Columbia	33.3	7.7	0.0	14.3
Florida	19.7	11.7	21.4	18.0
Georgia	21.3	10.9	11.1	18.8
Hawaii	17.6	26.7	22.2	22.0
Idaho	37.0	60.0	47.4	43.8
Illinois	27.2	19.8	17.1	24.6
Indiana	46.9	21.9	21.4	40.0
Iowa	13.5	10.9	5.3	12.0
Kansas	45.3	27.9	23.1	36.3
Kentucky	28.3	21.5	12.5	25.6
Louisiana	26.6	23.7	4.5	24.9
Maine	7.4	14.3	25.0	9.5
Maryland	21.9	13.9	44.4	19.5
Massachusetts	29.6	17.7	35.7	26.4
Michigan	37.6	34.4	23.8	35.5
Minnesota	21.7	24.4	23.4	23.5
Mississippi	20.5	16.7	37.5	22.0
Missouri	17.5	11.3	20.0	16.1
Montana	25.7	34.9	33.3	31.2
Nebraska	19.0	18.3	14.0	17.7
Nevada	47.1	12.5	16.7	37.5
New Hampshire	40.0	37.0	25.0	36.7
New Jersey	31.0	15.5	26.7	25.7
New Mexico	26.5	9.1	14.3	20.5
New York	30.1	37.6	51.0	35.2
North Carolina	40.2	25.3	5.3	35.3
North Dakota	16.7	25.0	33.3	24.1
Ohio	26.0	24.6	31.3	25.9
Oklahoma	21.4	6.8	21.4	19.5
Oregon	38.5	33.3	16.7	36.5
Pennsylvania	31.5	22.8	34.1	27.1
Rhode Island	9.2	11.1	n/a	9.6
South Carolina	27.3	16.0	9.1	23.4
South Dakota	21.7	19.7	0.0	19.5
Tennessee	24.8	12.9	28.1	22.6
Texas	31.5	29.0	20.0	30.8
Utah	13.0	0.0	50.0	12.4
Vermont	17.2	26.7	0.0	20.0
Virginia	21.2	7.5	12.5	16.4
Washington	42.2	25.4	42.9	38.4
West Virginia	15.4	7.9	0.0	12.0
Wisconsin	18.2	10.2	13.8	14.6
Wyoming	50.0	66.7	42.9	50.0

Source: OSCAR

n/a: Data unavailable

Table 4.7 (f). Nursing Home Surveys Resulting in a Health Deficiency of Actual Harm or Immediate Jeopardy to Residents by Type of Ownership: United States, 2001

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**23.2**	**18.5**	**14.7**	**21.3**
Alabama	20.6	11.1	5.3	18.0
Alaska	0.0	50.0	20.0	35.3
Arizona	9.5	10.8	0.0	9.7
Arkansas	25.3	31.7	33.3	26.6
California	10.8	6.2	4.4	9.6
Colorado	30.8	15.4	19.0	25.9
Connecticut	51.4	46.4	50.0	50.2
Delaware	15.8	11.1	33.3	15.0
District of Columbia	33.3	30.8	0.0	28.6
Florida	23.9	14.2	23.1	21.6
Georgia	21.5	17.2	8.0	19.8
Hawaii	25.0	0.0	0.0	11.4
Idaho	26.7	42.9	26.3	29.5
Illinois	23.3	8.2	20.0	18.9
Indiana	29.0	19.6	12.5	25.9
Iowa	12.1	12.2	12.5	12.1
Kansas	34.6	30.1	17.0	30.4
Kentucky	31.2	21.3	25.0	27.9
Louisiana	25.3	32.8	4.8	25.4
Maine	10.8	7.1	33.3	11.1
Maryland	18.8	10.3	16.7	15.3
Massachusetts	23.7	18.5	8.3	21.9
Michigan	27.6	18.3	12.5	23.4
Minnesota	17.0	19.1	11.9	17.5
Mississippi	20.0	22.2	21.4	20.5
Missouri	12.9	10.2	0.0	11.4
Montana	25.0	26.8	15.8	23.9
Nebraska	20.6	20.0	17.9	19.9
Nevada	10.8	0.0	0.0	8.0
New Hampshire	30.0	21.7	33.3	28.0
New Jersey	25.9	19.4	26.3	23.8
New Mexico	23.4	10.0	0.0	18.1
New York	37.7	35.5	24.5	35.6
North Carolina	36.7	16.5	17.4	31.1
North Dakota	33.3	28.8	0.0	28.0
Ohio	21.0	20.9	13.3	20.7
Oklahoma	24.1	4.8	8.3	21.4
Oregon	36.3	20.0	16.7	31.1
Pennsylvania	17.2	13.8	10.3	15.1
Rhode Island	12.5	17.4	n/a	13.7
South Carolina	15.7	14.3	13.0	15.1
South Dakota	20.6	35.9	33.3	30.8
Tennessee	16.4	18.6	20.7	17.3
Texas	28.2	17.3	18.4	26.2
Utah	15.8	11.8	0.0	14.9
Vermont	21.4	15.4	0.0	19.0
Virginia	11.7	11.4	11.1	11.5
Washington	44.6	33.3	18.5	39.4
West Virginia	17.8	10.7	20.0	16.2
Wisconsin	12.8	14.3	6.5	12.4
Wyoming	35.7	20.0	10.5	21.1

Source: OSCAR

n/a: Data unavailable

Table 4.8 (a). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.3**	**0.6**	**0.6**	**0.6**	**0.6**
Alabama	5.9	0.0	0.0	0.0	0.5
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	3.0	0.0	0.0	0.0	0.3
California	0.3	1.0	1.9	1.6	1.1
Colorado	0.0	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	n/a	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	1.2	0.0	0.5	0.0	0.5
Georgia	0.0	0.0	0.5	0.0	0.2
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	0.0	0.0	0.0	0.0	0.0
Illinois	0.0	0.7	0.6	0.6	0.6
Indiana	0.0	0.0	1.4	0.0	0.5
Iowa	0.0	0.0	0.0	0.0	0.0
Kansas	0.0	1.1	2.3	0.0	1.0
Kentucky	1.2	0.0	2.0	28.6	1.6
Louisiana	0.0	0.0	0.0	0.0	0.0
Maine	0.0	0.0	0.0	0.0	0.0
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.0	0.0	0.0	0.0
Michigan	0.0	0.7	0.4	2.3	0.7
Minnesota	0.0	0.0	0.0	0.0	0.0
Mississippi	0.0	1.3	1.3	0.0	1.0
Missouri	0.0	1.7	0.9	3.6	1.2
Montana	0.0	3.0	0.0	0.0	1.0
Nebraska	1.8	0.7	2.0	0.0	1.2
Nevada	0.0	0.0	0.0	0.0	0.0
New Hampshire	0.0	7.7	0.0	0.0	3.3
New Jersey	0.0	0.0	0.0	0.0	0.0
New Mexico	0.0	0.0	0.0	0.0	0.0
New York	0.0	0.0	0.0	0.0	0.0
North Carolina	0.0	0.7	1.0	0.0	0.8
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	1.2	0.0	1.3	0.0	0.8
Oklahoma	0.0	0.0	0.0	0.0	0.0
Oregon	2.7	5.6	0.0	0.0	3.0
Pennsylvania	0.0	0.0	0.5	1.0	0.4
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	3.1	0.0	0.0	1.1
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	3.1	0.0	4.8	1.2
Texas	0.0	0.5	0.6	0.0	0.4
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	7.1	0.0	0.0	n/a	2.3
Virginia	0.0	1.2	0.0	0.0	0.4
Washington	0.0	0.0	1.6	0.0	0.7
West Virginia	0.0	0.0	0.0	0.0	0.0
Wisconsin	0.0	0.5	1.2	0.0	0.7
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.8 (b). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.5**	**1.3**	**1.2**	**0.9**	**1.1**
Alabama	0.0	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	3.2	0.0	1.7
Arkansas	0.0	0.0	0.0	0.0	0.0
California	2.3	3.3	5.0	4.8	3.5
Colorado	0.0	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	0.7	0.2	0.0	0.3
Georgia	0.0	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	3.1	4.0	0.0	n/a	2.4
Illinois	0.9	2.1	2.1	1.3	1.8
Indiana	0.0	0.0	0.5	1.8	0.3
Iowa	0.0	0.4	0.0	0.0	0.2
Kansas	1.7	3.8	8.9	0.0	4.2
Kentucky	0.0	2.9	1.1	20.0	1.9
Louisiana	0.0	1.3	0.9	0.0	0.8
Maine	0.0	1.5	0.0	0.0	0.7
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.6	0.7	0.0	0.5
Michigan	2.1	0.0	1.8	0.0	1.2
Minnesota	0.0	0.0	0.7	0.0	0.2
Mississippi	0.0	0.0	0.0	0.0	0.0
Missouri	0.0	1.8	0.0	3.6	0.8
Montana	0.0	0.0	0.0	0.0	0.0
Nebraska	1.7	0.0	0.0	0.0	0.4
Nevada	0.0	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	0.0	0.0	0.0	0.0	0.0
New Mexico	0.0	3.2	0.0	0.0	1.3
New York	0.0	0.0	0.0	0.0	0.0
North Carolina	0.0	0.0	0.0	0.0	0.0
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	0.7	3.6	3.2	1.3	2.8
Oklahoma	0.0	0.0	0.0	0.0	0.0
Oregon	3.0	4.5	3.7	0.0	3.9
Pennsylvania	0.0	0.6	0.0	0.0	0.1
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	4.7	0.0	0.0	1.7
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	1.0	0.0	0.0	0.3
Texas	0.4	1.6	2.3	2.0	1.7
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	1.2	1.8	0.0	1.2
Washington	0.0	0.8	2.5	10.0	1.7
West Virginia	0.0	0.0	0.0	0.0	0.0
Wisconsin	0.0	0.0	0.0	0.0	0.0
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.8 (c). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.8**	**2.1**	**1.7**	**2.2**	**1.7**
Alabama	0.0	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	n/a	50.0	6.3
Arizona	3.7	3.8	4.7	0.0	3.8
Arkansas	0.0	2.9	3.3	0.0	2.7
California	1.1	3.4	3.3	6.9	3.0
Colorado	0.0	1.3	0.0	0.0	0.4
Connecticut	0.0	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	1.0	0.0	1.4	2.8	1.1
Georgia	0.0	0.8	0.5	0.0	0.5
Hawaii	0.0	9.1	0.0	0.0	2.3
Idaho	0.0	0.0	0.0	n/a	0.0
Illinois	0.9	4.3	3.4	2.0	3.1
Indiana	0.8	5.9	4.8	5.5	4.3
Iowa	0.0	2.9	0.0	0.0	1.7
Kansas	3.3	4.4	4.0	0.0	4.0
Kentucky	0.0	0.8	6.7	0.0	2.5
Louisiana	0.0	0.0	0.4	0.0	0.3
Maine	2.1	0.0	0.0	0.0	0.8
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.8	1.2	0.0	0.8
Michigan	0.0	2.4	2.0	3.1	2.0
Minnesota	1.7	2.4	7.9	12.0	4.8
Mississippi	0.0	2.5	0.0	20.0	1.4
Missouri	1.2	3.8	2.6	3.7	2.9
Montana	0.0	0.0	4.3	0.0	1.1
Nebraska	0.0	0.8	0.0	0.0	0.4
Nevada	0.0	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	0.0	0.0	0.0	0.0	0.0
New Mexico	0.0	3.6	6.9	0.0	4.1
New York	0.0	1.0	0.0	0.0	0.2
North Carolina	0.0	0.7	0.5	0.0	0.5
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	3.5	3.7	2.8	8.3	3.6
Oklahoma	0.0	0.0	0.0	0.0	0.0
Oregon	8.6	4.3	5.7	0.0	5.7
Pennsylvania	0.0	0.0	0.5	1.0	0.4
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	0.0	1.5	0.0	0.6
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	3.1	2.7	4.2	2.5
Texas	0.0	1.7	0.8	2.1	1.0
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	0.0	0.0	0.0	0.0
Washington	1.9	0.9	1.8	0.0	1.4
West Virginia	0.0	0.0	0.0	n/a	0.0
Wisconsin	0.0	0.5	0.7	0.0	0.5
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.8 (d). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.8**	**1.7**	**2.0**	**2.0**	**1.7**
Alabama	0.0	0.0	5.0	8.3	3.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	4.2	0.0	2.3
Arkansas	9.7	11.9	7.4	0.0	9.1
California	1.2	1.5	3.3	0.0	1.8
Colorado	0.0	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	0.7	0.6	2.7	0.7
Georgia	0.0	0.0	1.6	0.0	0.8
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	6.9	3.8	0.0	n/a	3.6
Illinois	0.0	1.4	1.8	3.2	1.7
Indiana	2.2	2.8	2.4	2.9	2.5
Iowa	1.3	0.8	0.0	0.0	0.7
Kansas	0.0	2.3	1.3	0.0	1.4
Kentucky	0.0	3.7	5.2	0.0	3.1
Louisiana	0.0	1.3	2.3	3.7	1.9
Maine	2.2	4.5	0.0	0.0	3.1
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.0	0.4	0.0	0.2
Michigan	2.2	2.6	2.4	2.9	2.4
Minnesota	0.0	1.4	1.6	0.0	1.2
Mississippi	0.0	1.3	4.0	33.3	2.6
Missouri	0.0	4.2	2.6	0.0	2.7
Montana	0.0	0.0	0.0	0.0	0.0
Nebraska	0.0	0.0	0.0	0.0	0.0
Nevada	0.0	0.0	5.0	0.0	2.3
New Hampshire	0.0	0.0	5.3	0.0	1.4
New Jersey	0.0	1.9	0.0	0.0	0.3
New Mexico	0.0	6.1	6.3	0.0	5.0
New York	0.0	0.0	0.8	2.5	1.2
North Carolina	0.0	1.4	2.5	0.0	1.8
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	1.5	1.3	2.3	3.3	2.0
Oklahoma	0.0	0.0	2.2	0.0	0.8
Oregon	7.1	12.9	11.1	50.0	11.6
Pennsylvania	0.0	0.6	0.5	0.0	0.4
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	4.3	4.3	0.0	3.3
South Dakota	0.0	0.0	0.0	n/a	0.0
Tennessee	1.9	2.1	3.8	4.5	3.1
Texas	0.0	2.4	2.0	2.1	1.9
Utah	0.0	0.0	4.0	n/a	1.2
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	0.0	0.8	0.0	0.4
Washington	2.0	1.0	5.4	12.5	3.3
West Virginia	3.4	0.0	2.1	0.0	1.4
Wisconsin	0.0	1.1	2.0	1.9	1.4
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.8 (e). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**1.2**	**2.0**	**2.6**	**1.7**	**2.1**
Alabama	0.0	8.2	7.4	11.1	7.4
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	7.1	3.2	10.5	0.0	7.4
California	1.8	1.6	2.3	0.0	1.7
Colorado	2.0	1.3	5.8	0.0	3.2
Connecticut	0.0	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	1.2	1.4	1.1	0.0	1.1
Georgia	0.0	0.0	1.1	0.0	0.6
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	0.0	0.0	0.0	n/a	0.0
Illinois	1.9	1.8	0.6	2.5	1.5
Indiana	0.9	1.0	3.3	2.4	2.0
Iowa	0.0	1.2	1.0	0.0	0.9
Kansas	1.9	3.6	7.0	0.0	3.6
Kentucky	0.0	3.6	10.4	16.7	5.3
Louisiana	4.3	2.7	9.3	0.0	6.8
Maine	0.0	1.5	0.0	0.0	0.8
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	1.5	0.4	0.0	0.6
Michigan	2.0	0.7	2.0	0.0	1.5
Minnesota	3.2	0.9	1.4	4.3	1.6
Mississippi	3.2	5.7	7.9	0.0	6.0
Missouri	0.0	0.9	0.8	0.0	0.7
Montana	2.5	0.0	0.0	0.0	1.1
Nebraska	0.0	0.0	0.0	0.0	0.0
Nevada	7.7	16.7	0.0	0.0	6.3
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	0.0	1.8	0.0	0.0	0.3
New Mexico	0.0	3.1	6.3	0.0	3.8
New York	2.1	0.0	1.2	3.0	1.7
North Carolina	0.0	1.3	3.3	5.9	2.3
North Dakota	0.0	2.8	0.0	0.0	1.1
Ohio	0.0	0.4	1.3	0.0	0.8
Oklahoma	0.0	2.6	1.6	14.3	2.1
Oregon	4.3	2.6	7.3	0.0	4.5
Pennsylvania	0.0	0.0	0.3	0.0	0.1
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	0.0	0.0	0.0	0.0
South Dakota	0.0	0.0	0.0	n/a	0.0
Tennessee	2.1	8.6	4.1	5.6	5.2
Texas	4.1	3.8	6.0	2.1	4.9
Utah	0.0	3.1	0.0	0.0	1.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	1.2	0.0	0.0	0.4
Washington	2.0	8.2	2.9	14.3	5.2
West Virginia	0.0	0.0	3.6	0.0	1.3
Wisconsin	0.0	2.4	2.8	2.1	2.3
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.8 (f). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**1.0**	**2.4**	**2.9**	**2.6**	**2.4**
Alabama	0.0	2.6	3.8	0.0	2.9
Alaska	0.0	20.0	n/a	0.0	5.9
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	0.0	9.3	11.7	50.0	10.2
California	0.0	1.3	2.1	0.0	1.2
Colorado	0.0	1.3	1.2	0.0	0.9
Connecticut	0.0	7.0	2.9	4.8	4.1
Delaware	0.0	0.0	4.0	0.0	2.5
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	2.7	0.8	1.8	0.0	1.6
Georgia	3.7	0.0	3.9	4.5	2.7
Hawaii	0.0	9.1	0.0	0.0	2.9
Idaho	0.0	0.0	0.0	n/a	0.0
Illinois	0.0	1.3	3.4	2.4	2.2
Indiana	2.8	2.6	2.7	8.3	3.1
Iowa	1.1	1.6	0.0	0.0	1.1
Kansas	1.9	5.7	1.9	0.0	3.9
Kentucky	1.5	8.1	5.9	0.0	5.7
Louisiana	2.8	6.2	5.3	10.0	5.5
Maine	9.5	1.7	0.0	0.0	4.3
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.0	0.4	0.0	0.2
Michigan	2.0	2.0	0.0	0.0	0.9
Minnesota	1.8	2.0	2.5	4.3	2.2
Mississippi	0.0	1.2	3.9	0.0	2.1
Missouri	0.0	1.0	2.9	5.6	1.9
Montana	0.0	0.0	0.0	0.0	0.0
Nebraska	0.0	1.0	0.0	0.0	0.5
Nevada	0.0	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	2.6	0.0	1.7	3.6	1.9
New Mexico	0.0	3.4	7.1	0.0	4.2
New York	2.3	1.0	3.5	2.1	2.5
North Carolina	0.0	0.7	4.8	6.7	3.0
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	0.7	1.0	1.7	3.1	1.4
Oklahoma	2.9	6.5	7.7	0.0	6.3
Oregon	0.0	3.3	6.5	0.0	3.8
Pennsylvania	0.0	0.0	0.0	0.0	0.0
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	6.4	6.5	16.7	5.3
South Dakota	0.0	0.0	0.0	n/a	0.0
Tennessee	0.0	2.8	4.3	0.0	3.0
Texas	1.6	4.8	5.0	2.9	4.5
Utah	3.3	3.6	0.0	33.3	3.2
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	3.4	1.7	0.0	1.9
Washington	0.0	4.9	7.6	0.0	5.0
West Virginia	0.0	0.0	0.0	0.0	0.0
Wisconsin	0.0	2.7	2.6	4.4	2.6
Wyoming	0.0	0.0	0.0	n/a	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (a). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 1996

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**0.6**	**0.4**	**0.4**	**0.6**
Alabama	0.0	3.2	0.0	0.5
Alaska	0.0	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	0.4	0.0	0.0	0.3
California	1.2	0.7	1.8	1.1
Colorado	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	0.2	0.7	6.7	0.5
Georgia	0.3	0.0	0.0	0.2
Hawaii	0.0	0.0	0.0	0.0
Idaho	0.0	0.0	0.0	0.0
Illinois	0.7	0.4	0.0	0.6
Indiana	0.5	0.8	0.0	0.5
Iowa	0.0	0.0	0.0	0.0
Kansas	1.1	1.3	0.0	1.0
Kentucky	2.4	0.0	0.0	1.6
Louisiana	0.0	0.0	0.0	0.0
Maine	0.0	0.0	0.0	0.0
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.0	0.0	0.0
Michigan	0.7	0.8	0.0	0.7
Minnesota	0.0	0.0	0.0	0.0
Mississippi	1.4	0.0	0.0	1.0
Missouri	1.6	0.0	2.0	1.2
Montana	0.0	2.4	0.0	1.0
Nebraska	1.9	1.2	0.0	1.2
Nevada	0.0	0.0	0.0	0.0
New Hampshire	6.3	0.0	0.0	3.3
New Jersey	0.0	0.0	0.0	0.0
New Mexico	0.0	0.0	0.0	0.0
New York	0.0	0.0	0.0	0.0
North Carolina	1.0	0.0	0.0	0.8
North Dakota	0.0	0.0	0.0	0.0
Ohio	0.8	0.4	4.9	0.8
Oklahoma	0.0	0.0	0.0	0.0
Oregon	3.9	0.0	0.0	3.0
Pennsylvania	0.6	0.2	0.0	0.4
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	1.6	0.0	0.0	1.1
South Dakota	0.0	0.0	0.0	0.0
Tennessee	1.3	1.3	0.0	1.2
Texas	0.4	0.5	0.0	0.4
Utah	0.0	0.0	0.0	0.0
Vermont	3.0	0.0	0.0	2.3
Virginia	0.6	0.0	0.0	0.4
Washington	1.0	0.0	0.0	0.7
West Virginia	0.0	0.0	0.0	0.0
Wisconsin	0.0	1.8	0.0	0.7
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (b). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 1997

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**1.4**	**0.7**	**0.3**	**1.1**
Alabama	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	0.0	0.0
Arizona	2.6	0.0	0.0	1.7
Arkansas	0.0	0.0	0.0	0.0
California	4.0	2.1	1.7	3.5
Colorado	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	0.4	0.0	0.0	0.3
Georgia	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0
Idaho	1.9	0.0	5.3	2.4
Illinois	2.3	1.1	0.0	1.8
Indiana	0.5	0.0	0.0	0.3
Iowa	0.0	0.5	0.0	0.2
Kansas	5.4	3.1	1.8	4.2
Kentucky	2.4	1.2	0.0	1.9
Louisiana	1.0	0.0	0.0	0.8
Maine	1.0	0.0	0.0	0.7
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.5	0.7	0.0	0.5
Michigan	1.4	0.9	0.0	1.2
Minnesota	0.8	0.0	0.0	0.2
Mississippi	0.0	0.0	0.0	0.0
Missouri	1.0	0.7	0.0	0.8
Montana	0.0	0.0	0.0	0.0
Nebraska	0.0	1.3	0.0	0.4
Nevada	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	0.0	0.0	0.0	0.0
New Mexico	2.3	0.0	0.0	1.3
New York	0.0	0.0	0.0	0.0
North Carolina	0.0	0.0	0.0	0.0
North Dakota	0.0	0.0	0.0	0.0
Ohio	3.2	1.8	0.0	2.8
Oklahoma	0.0	0.0	0.0	0.0
Oregon	2.5	9.4	0.0	3.9
Pennsylvania	0.3	0.0	0.0	0.1
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	2.2	0.0	0.0	1.7
South Dakota	0.0	0.0	0.0	0.0
Tennessee	0.4	0.0	0.0	0.3
Texas	2.0	1.0	0.0	1.7
Utah	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	n/a	0.0
Virginia	1.3	1.3	0.0	1.2
Washington	2.0	1.4	0.0	1.7
West Virginia	0.0	0.0	0.0	0.0
Wisconsin	0.0	0.0	0.0	0.0
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (c). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 1998

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**1.9**	**1.3**	**1.3**	**1.7**
Alabama	0.0	0.0	0.0	0.0
Alaska	0.0	10.0	0.0	6.3
Arizona	3.6	4.4	0.0	3.8
Arkansas	2.4	2.4	7.1	2.7
California	3.6	1.1	2.2	3.0
Colorado	0.7	0.0	0.0	0.4
Connecticut	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	1.5	0.0	0.0	1.1
Georgia	0.7	0.0	0.0	0.5
Hawaii	5.3	0.0	0.0	2.3
Idaho	0.0	0.0	0.0	0.0
Illinois	4.2	0.7	4.1	3.1
Indiana	4.3	4.6	0.0	4.3
Iowa	1.2	2.1	4.8	1.7
Kansas	4.6	2.7	4.5	4.0
Kentucky	2.5	1.9	11.1	2.5
Louisiana	0.4	0.0	0.0	0.3
Maine	1.0	0.0	0.0	0.8
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.6	1.4	0.0	0.8
Michigan	1.6	3.6	0.0	2.0
Minnesota	5.1	5.2	1.8	4.8
Mississippi	2.1	0.0	0.0	1.4
Missouri	4.0	0.0	3.8	2.9
Montana	0.0	2.3	0.0	1.1
Nebraska	0.9	0.0	0.0	0.4
Nevada	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	0.0	0.0	0.0	0.0
New Mexico	4.3	4.8	0.0	4.1
New York	0.4	0.0	0.0	0.2
North Carolina	0.6	0.0	0.0	0.5
North Dakota	0.0	0.0	0.0	0.0
Ohio	3.4	4.5	0.0	3.6
Oklahoma	0.0	0.0	0.0	0.0
Oregon	7.6	0.0	0.0	5.7
Pennsylvania	0.3	0.5	0.0	0.4
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	0.8	0.0	0.0	0.6
South Dakota	0.0	0.0	0.0	0.0
Tennessee	2.8	0.0	5.7	2.5
Texas	1.1	1.0	0.0	1.0
Utah	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	0.0
Virginia	0.0	0.0	0.0	0.0
Washington	0.5	4.4	0.0	1.4
West Virginia	0.0	0.0	0.0	0.0
Wisconsin	0.9	0.0	0.0	0.5
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (d). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 1999

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**2.1**	**1.7**	**1.6**	**1.7**
Alabama	1.9	0.0	9.5	3.0
Alaska	0.0	0.0	0.0	0.0
Arizona	3.5	0.0	0.0	2.3
Arkansas	9.0	11.9	0.0	9.1
California	1.8	1.5	2.3	1.8
Colorado	0.0	0.0	0.0	0.0
Connecticut	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	0.9	0.7	0.0	0.7
Georgia	0.7	0.0	4.0	0.8
Hawaii	0.0	0.0	0.0	0.0
Idaho	1.9	3.8	10.5	3.6
Illinois	2.0	1.4	0.0	1.7
Indiana	3.2	2.8	0.0	2.5
Iowa	1.3	0.8	0.0	0.7
Kansas	2.7	2.3	0.0	1.4
Kentucky	3.3	3.7	0.0	3.1
Louisiana	1.4	1.3	7.4	1.9
Maine	3.3	4.5	0.0	3.1
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.3	0.0	0.0	0.2
Michigan	3.1	2.6	0.0	2.4
Minnesota	0.8	1.4	0.0	1.2
Mississippi	3.7	1.3	0.0	2.6
Missouri	3.0	4.2	4.1	2.7
Montana	0.0	0.0	0.0	0.0
Nebraska	0.0	0.0	0.0	0.0
Nevada	3.2	0.0	0.0	2.3
New Hampshire	2.8	0.0	0.0	1.4
New Jersey	0.0	1.9	0.0	0.3
New Mexico	8.3	6.1	0.0	5.0
New York	1.4	0.0	2.2	1.2
North Carolina	2.4	1.4	0.0	1.8
North Dakota	0.0	0.0	0.0	0.0
Ohio	2.3	1.3	3.3	2.0
Oklahoma	0.6	0.0	5.9	0.8
Oregon	15.7	12.9	0.0	11.6
Pennsylvania	0.6	0.6	0.0	0.4
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	3.4	4.3	0.0	3.3
South Dakota	0.0	0.0	0.0	0.0
Tennessee	4.1	2.1	0.0	3.1
Texas	2.2	2.4	0.0	1.9
Utah	1.6	0.0	0.0	1.2
Vermont	0.0	0.0	0.0	0.0
Virginia	0.6	0.0	0.0	0.4
Washington	3.7	1.0	4.3	3.3
West Virginia	1.1	0.0	6.7	1.4
Wisconsin	1.0	1.1	3.2	1.4
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (e). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 2000

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**2.5**	**1.2**	**1.5**	**2.1**
Alabama	7.1	3.6	15.8	7.4
Alaska	n/a	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	8.4	4.8	0.0	7.4
California	1.8	1.4	2.3	1.7
Colorado	2.9	5.2	0.0	3.2
Connecticut	0.0	0.0	0.0	0.0
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	1.3	0.6	0.0	1.1
Georgia	0.8	0.0	0.0	0.6
Hawaii	0.0	0.0	0.0	0.0
Idaho	0.0	0.0	0.0	0.0
Illinois	1.6	1.6	0.0	1.5
Indiana	2.3	1.5	0.0	2.0
Iowa	1.3	0.5	0.0	0.9
Kansas	5.7	0.7	3.8	3.6
Kentucky	7.2	2.2	0.0	5.3
Louisiana	7.6	5.1	0.0	6.8
Maine	1.1	0.0	0.0	0.8
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.9	0.0	0.0	0.6
Michigan	2.0	0.8	0.0	1.5
Minnesota	2.3	1.2	1.6	1.6
Mississippi	5.5	13.3	0.0	6.0
Missouri	0.8	0.7	0.0	0.7
Montana	2.9	0.0	0.0	1.1
Nebraska	0.0	0.0	0.0	0.0
Nevada	5.9	0.0	16.7	6.3
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	0.0	0.9	0.0	0.3
New Mexico	6.1	0.0	0.0	3.8
New York	2.1	1.1	2.0	1.7
North Carolina	2.8	1.0	0.0	2.3
North Dakota	0.0	1.4	0.0	1.1
Ohio	0.8	0.9	0.0	0.8
Oklahoma	2.5	0.0	0.0	2.1
Oregon	6.0	0.0	0.0	4.5
Pennsylvania	0.3	0.0	0.0	0.1
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	0.0	0.0	0.0	0.0
South Dakota	0.0	0.0	0.0	0.0
Tennessee	4.9	2.9	12.5	5.2
Texas	5.1	4.4	0.0	4.9
Utah	1.3	0.0	0.0	1.0
Vermont	0.0	0.0	0.0	0.0
Virginia	0.6	0.0	0.0	0.4
Washington	7.0	1.6	0.0	5.2
West Virginia	1.9	0.0	0.0	1.3
Wisconsin	0.5	3.4	5.2	2.3
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.9 (f). Nursing Home Surveys Resulting in a Health Deficiency of Immediate Jeopardy to Residents by Type of Ownership: United States, 2001

	Percent by Ownership			
	For-Profit	Non-Profit	Government	Non-Profit
Nation	**3.0**	**1.3**	**1.7**	**2.4**
Alabama	3.1	3.7	0.0	2.9
Alaska	0.0	10.0	0.0	5.9
Arizona	0.0	0.0	0.0	0.0
Arkansas	11.3	4.9	11.1	10.2
California	1.6	0.0	0.0	1.2
Colorado	1.4	0.0	0.0	0.9
Connecticut	4.9	1.8	0.0	4.1
Delaware	0.0	0.0	33.3	2.5
District of Columbia	0.0	0.0	0.0	0.0
Florida	2.0	0.6	0.0	1.6
Georgia	3.5	0.0	0.0	2.7
Hawaii	6.3	0.0	0.0	2.9
Idaho	0.0	0.0	0.0	0.0
Illinois	2.4	1.4	2.9	2.2
Indiana	3.7	1.9	0.0	3.1
Iowa	1.7	0.5	0.0	1.1
Kansas	4.9	2.4	3.8	3.9
Kentucky	7.5	2.2	0.0	5.7
Louisiana	4.9	8.2	4.8	5.5
Maine	4.8	0.0	16.7	4.3
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.3	0.0	0.0	0.2
Michigan	1.4	0.0	0.0	0.9
Minnesota	3.8	2.1	0.0	2.2
Mississippi	1.4	7.4	0.0	2.1
Missouri	2.5	0.8	0.0	1.9
Montana	0.0	0.0	0.0	0.0
Nebraska	1.0	0.0	0.0	0.5
Nevada	0.0	0.0	0.0	0.0
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	3.0	0.0	0.0	1.9
New Mexico	6.4	0.0	0.0	4.2
New York	2.6	2.4	2.0	2.5
North Carolina	3.9	1.0	0.0	3.0
North Dakota	0.0	0.0	0.0	0.0
Ohio	1.7	0.8	0.0	1.4
Oklahoma	6.8	4.8	0.0	6.3
Oregon	3.3	5.7	0.0	3.8
Pennsylvania	0.0	0.0	0.0	0.0
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	4.6	4.8	8.7	5.3
South Dakota	0.0	0.0	0.0	0.0
Tennessee	2.7	2.3	6.9	3.0
Texas	4.5	3.4	10.5	4.5
Utah	3.9	0.0	0.0	3.2
Vermont	0.0	0.0	0.0	0.0
Virginia	2.5	1.1	0.0	1.9
Washington	7.4	0.0	0.0	5.0
West Virginia	0.0	0.0	0.0	0.0
Wisconsin	3.0	2.6	1.6	2.6
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Health Deficiencies Immediate Jeopardy by Ownership

Table 4.10 (a). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2.5**	**5.8**	**7.0**	**7.1**	**5.8**
Alabama	5.9	2.4	2.8	10.0	3.2
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	2.9	0.0	0.0	0.7
Arkansas	3.0	4.9	3.5	0.0	4.0
California	2.5	9.2	11.2	15.9	8.5
Colorado	0.0	2.9	6.2	28.6	4.2
Connecticut	11.1	1.4	2.8	8.0	3.5
Delaware	0.0	0.0	8.3	n/a	5.4
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	2.4	12.9	14.1	27.3	13.0
Georgia	10.0	18.0	15.6	21.9	16.5
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	6.1	4.0	8.7	0.0	6.1
Illinois	0.9	2.8	4.0	3.2	3.1
Indiana	3.2	8.1	12.7	13.0	9.3
Iowa	4.9	1.4	1.8	0.0	2.1
Kansas	10.1	18.4	19.5	20.0	16.6
Kentucky	1.2	2.4	6.9	28.6	4.1
Louisiana	0.0	0.0	0.4	0.0	0.3
Maine	7.7	6.1	3.6	0.0	5.9
Maryland	0.0	4.1	5.6	9.7	4.8
Massachusetts	0.8	4.0	3.3	9.5	3.2
Michigan	4.4	5.9	9.7	6.8	7.8
Minnesota	1.9	1.0	2.2	0.0	1.5
Mississippi	0.0	1.3	10.7	0.0	4.5
Missouri	1.1	6.0	6.9	7.1	5.7
Montana	0.0	3.0	14.3	50.0	5.1
Nebraska	8.9	4.3	13.7	0.0	7.2
Nevada	0.0	0.0	6.3	75.0	8.3
New Hampshire	0.0	12.8	0.0	0.0	5.4
New Jersey	8.6	1.7	4.5	3.0	4.1
New Mexico	0.0	0.0	2.7	0.0	1.1
New York	4.4	0.9	1.9	2.2	2.0
North Carolina	0.0	1.4	5.6	25.0	4.0
North Dakota	0.0	0.0	4.2	0.0	1.1
Ohio	5.8	3.4	6.5	8.9	5.7
Oklahoma	0.0	1.9	4.0	14.3	2.5
Oregon	8.1	14.1	10.2	0.0	11.3
Pennsylvania	0.0	1.1	4.0	2.0	2.4
Rhode Island	0.0	0.0	4.9	0.0	2.0
South Carolina	0.0	7.7	10.4	0.0	6.7
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	6.1	3.4	19.0	4.6
Texas	0.8	7.5	10.5	2.2	7.5
Utah	3.7	2.9	3.3	0.0	3.2
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	10.5	11.2	19.0	9.9
Washington	0.0	8.2	7.3	0.0	6.3
West Virginia	0.0	3.8	10.3	100.0	6.0
Wisconsin	0.0	2.5	3.7	1.8	2.6
Wyoming	0.0	5.3	0.0	0.0	2.6

Source: OSCAR

n/a: Data unavailable

Table 4.10 (b). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.0**	**4.7**	**5.6**	**4.7**	**4.8**
Alabama	0.0	1.3	6.9	0.0	4.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	4.8	0.0	1.6	0.0	1.7
Arkansas	0.0	3.0	2.1	0.0	2.1
California	4.2	7.3	10.0	9.7	7.3
Colorado	0.0	1.3	1.2	0.0	0.8
Connecticut	0.0	1.2	5.3	0.0	3.3
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	14.3	0.0	3.8
Florida	4.3	8.0	10.8	9.7	9.3
Georgia	0.0	1.8	9.6	0.0	5.9
Hawaii	7.1	7.1	10.0	0.0	7.1
Idaho	9.4	8.0	18.5	n/a	11.9
Illinois	1.8	2.8	2.4	5.2	2.9
Indiana	3.9	5.3	5.0	5.3	4.9
Iowa	2.8	2.6	6.5	33.3	4.2
Kansas	11.3	11.9	27.8	0.0	14.5
Kentucky	1.5	4.8	4.4	20.0	4.2
Louisiana	0.0	1.3	1.3	4.2	1.3
Maine	6.8	7.4	9.5	0.0	7.4
Maryland	0.0	0.0	7.4	9.7	5.0
Massachusetts	2.7	3.2	5.9	14.3	4.9
Michigan	2.1	4.1	3.6	5.7	3.7
Minnesota	0.0	1.0	1.4	0.0	1.0
Mississippi	0.0	3.8	8.8	0.0	4.8
Missouri	2.2	2.6	4.0	10.7	3.5
Montana	2.4	2.9	8.0	0.0	3.8
Nebraska	5.0	3.8	2.1	0.0	3.7
Nevada	5.6	0.0	20.0	0.0	9.5
New Hampshire	0.0	9.8	9.1	0.0	7.7
New Jersey	0.0	2.1	3.7	5.0	3.4
New Mexico	0.0	3.2	0.0	0.0	1.3
New York	0.0	0.0	1.3	0.0	0.5
North Carolina	0.0	4.0	5.1	0.0	3.9
North Dakota	0.0	3.0	14.3	0.0	5.3
Ohio	2.6	7.9	6.7	8.0	6.5
Oklahoma	1.3	1.5	1.4	0.0	1.4
Oregon	3.0	9.1	9.3	0.0	7.7
Pennsylvania	3.9	3.6	2.3	2.2	2.9
Rhode Island	5.0	2.9	0.0	0.0	2.1
South Carolina	0.0	4.7	11.4	0.0	6.1
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	2.9	0.6	0.0	1.1
Texas	3.1	6.9	6.6	3.9	6.0
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	6.3	n/a	2.6
Virginia	0.0	6.2	9.2	15.0	7.3
Washington	8.2	11.0	7.6	10.0	9.2
West Virginia	5.0	2.7	3.7	66.7	5.7
Wisconsin	0.0	1.6	5.7	6.0	3.4
Wyoming	11.1	6.3	0.0	0.0	5.4

Source: OSCAR

n/a: Data unavailable

Table 4.10 (c). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2.3**	**5.7**	**6.4**	**6.7**	**5.5**
Alabama	0.0	0.0	0.9	10.0	0.9
Alaska	0.0	0.0	n/a	50.0	6.3
Arizona	0.0	0.0	7.8	0.0	3.8
Arkansas	6.7	6.8	8.9	0.0	7.6
California	2.8	8.8	9.2	22.4	8.2
Colorado	5.5	1.3	0.0	11.1	2.2
Connecticut	6.7	1.4	5.8	0.0	4.1
Delaware	0.0	0.0	5.9	0.0	3.6
District of Columbia	0.0	0.0	40.0	0.0	11.8
Florida	3.0	9.8	11.3	19.4	10.2
Georgia	0.0	2.4	6.4	3.8	4.4
Hawaii	5.9	9.1	8.3	25.0	9.1
Idaho	0.0	11.5	23.3	n/a	11.9
Illinois	0.9	5.4	5.8	4.0	4.7
Indiana	4.7	11.8	10.1	10.9	9.5
Iowa	0.0	5.5	2.8	0.0	3.8
Kansas	6.6	11.2	16.0	0.0	10.6
Kentucky	2.3	10.7	11.4	33.3	9.1
Louisiana	0.0	0.0	3.9	4.0	2.6
Maine	6.4	6.2	5.9	25.0	6.8
Maryland	0.0	0.0	4.3	3.7	2.4
Massachusetts	0.0	4.8	3.9	9.5	3.6
Michigan	2.2	5.6	5.9	15.6	6.2
Minnesota	5.2	3.4	13.2	16.0	7.7
Mississippi	0.0	7.4	4.0	20.0	4.8
Missouri	1.2	6.2	7.4	11.1	6.1
Montana	2.6	3.2	17.4	0.0	6.4
Nebraska	3.6	3.1	0.0	0.0	2.5
Nevada	5.6	25.0	27.8	25.0	18.8
New Hampshire	5.9	5.9	3.7	0.0	4.8
New Jersey	0.0	3.3	2.2	1.9	2.0
New Mexico	7.1	0.0	6.9	0.0	4.1
New York	0.0	1.0	0.9	0.0	0.5
North Carolina	0.0	2.7	4.3	20.0	3.6
North Dakota	0.0	0.0	17.4	0.0	4.3
Ohio	3.5	8.5	8.8	12.5	8.2
Oklahoma	3.4	3.2	2.1	0.0	2.8
Oregon	11.4	14.5	7.5	0.0	11.3
Pennsylvania	0.0	1.2	4.5	3.1	2.7
Rhode Island	0.0	6.7	2.3	0.0	3.0
South Carolina	0.0	8.1	3.0	0.0	4.1
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	1.7	5.2	5.3	4.2	4.6
Texas	0.5	5.4	6.3	4.3	5.0
Utah	3.1	6.9	6.5	0.0	5.3
Vermont	0.0	0.0	7.1	n/a	2.6
Virginia	0.0	1.3	3.6	0.0	2.1
Washington	3.8	7.0	11.9	12.5	8.5
West Virginia	0.0	0.0	3.4	n/a	1.2
Wisconsin	0.0	2.7	0.7	7.5	2.3
Wyoming	7.7	0.0	0.0	0.0	2.3

Source: OSCAR

n/a: Data unavailable

Table 4.10 (d). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**3.0**	**4.8**	**6.2**	**6.6**	**5.2**
Alabama	0.0	2.7	5.0	16.7	4.4
Alaska	18.2	0.0	n/a	0.0	12.5
Arizona	0.0	0.0	6.3	0.0	3.4
Arkansas	19.4	20.2	10.7	0.0	14.9
California	2.8	7.6	7.6	5.6	6.5
Colorado	0.0	1.2	3.3	0.0	1.7
Connecticut	0.0	1.3	4.3	4.0	3.2
Delaware	0.0	10.0	4.8	0.0	5.7
District of Columbia	0.0	0.0	0.0	25.0	6.7
Florida	2.0	3.7	9.1	10.8	7.2
Georgia	3.3	1.8	4.7	12.0	4.2
Hawaii	0.0	0.0	8.3	0.0	2.3
Idaho	6.9	7.7	10.3	n/a	8.3
Illinois	0.9	3.9	4.2	5.7	3.9
Indiana	9.0	6.8	7.2	17.1	8.1
Iowa	1.3	3.1	1.9	0.0	2.5
Kansas	0.8	5.4	14.3	14.3	5.9
Kentucky	3.8	9.3	10.3	16.7	8.3
Louisiana	3.9	6.6	2.7	7.4	4.0
Maine	10.9	9.1	0.0	0.0	8.4
Maryland	0.0	8.3	11.4	10.5	8.4
Massachusetts	1.2	1.4	4.5	10.0	3.3
Michigan	4.4	8.5	8.0	2.9	7.3
Minnesota	0.0	4.5	3.9	9.4	4.2
Mississippi	5.6	1.3	8.0	33.3	5.3
Missouri	3.7	6.5	9.5	4.0	7.2
Montana	2.3	0.0	0.0	0.0	1.0
Nebraska	1.7	0.8	6.3	0.0	2.1
Nevada	0.0	9.1	10.0	0.0	6.8
New Hampshire	0.0	3.1	15.8	20.0	7.2
New Jersey	0.0	1.9	5.7	5.7	4.4
New Mexico	7.7	6.1	9.4	0.0	7.5
New York	2.3	2.0	3.3	3.9	3.2
North Carolina	0.0	2.2	5.0	0.0	3.3
North Dakota	0.0	5.0	4.3	0.0	3.2
Ohio	4.5	5.2	7.7	14.8	7.0
Oklahoma	0.0	4.3	4.4	11.1	4.0
Oregon	3.6	17.7	20.4	100.0	17.1
Pennsylvania	0.0	2.3	2.6	1.1	1.9
Rhode Island	11.8	0.0	4.7	0.0	4.0
South Carolina	8.8	4.3	11.6	0.0	8.6
South Dakota	0.0	1.9	0.0	n/a	1.1
Tennessee	7.4	3.2	5.9	4.5	5.3
Texas	0.0	5.5	6.4	10.4	5.4
Utah	0.0	0.0	12.0	n/a	3.7
Vermont	6.7	0.0	0.0	n/a	2.1
Virginia	0.0	2.1	2.3	0.0	1.8
Washington	8.0	6.7	6.3	0.0	6.6
West Virginia	3.4	1.6	4.2	0.0	2.8
Wisconsin	0.0	1.1	2.7	5.7	2.1
Wyoming	15.4	0.0	8.3	0.0	7.5

Source: OSCAR

n/a: Data unavailable

Table 4.10 (e). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2.7**	4.6	**5.3**	**4.6**	4.6
Alabama	0.0	11.0	9.6	11.1	9.6
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	3.3	3.9	0.0	2.8
Arkansas	7.1	5.4	17.5	0.0	11.9
California	4.1	4.5	1.9	5.7	3.9
Colorado	2.0	6.7	9.3	0.0	6.4
Connecticut	6.7	1.3	1.3	4.3	1.9
Delaware	0.0	0.0	3.7	0.0	2.3
District of Columbia	0.0	0.0	25.0	0.0	4.8
Florida	1.2	2.1	3.2	0.0	2.6
Georgia	4.2	1.8	3.8	4.3	3.2
Hawaii	11.8	0.0	0.0	0.0	4.9
Idaho	0.0	4.0	0.0	n/a	1.3
Illinois	2.9	3.6	3.1	2.5	3.1
Indiana	9.2	6.3	9.6	9.8	8.4
Iowa	1.3	3.9	5.2	0.0	3.6
Kansas	2.8	10.2	14.1	14.3	9.0
Kentucky	2.9	12.7	18.8	16.7	12.5
Louisiana	4.3	11.0	7.9	4.2	7.8
Maine	4.9	3.0	11.8	0.0	4.8
Maryland	0.0	1.9	5.4	0.0	3.1
Massachusetts	1.1	3.8	3.1	5.3	3.0
Michigan	2.0	3.5	5.7	0.0	4.2
Minnesota	4.8	2.3	2.7	4.3	2.9
Mississippi	3.2	8.0	7.9	0.0	7.0
Missouri	2.6	3.5	1.3	3.1	2.4
Montana	2.5	3.6	4.3	50.0	4.3
Nebraska	0.0	1.0	5.1	0.0	1.5
Nevada	0.0	16.7	5.3	0.0	6.3
New Hampshire	8.3	0.0	3.3	0.0	2.5
New Jersey	0.0	1.8	4.3	7.1	3.9
New Mexico	0.0	3.1	9.4	0.0	5.1
New York	2.1	1.0	2.8	6.0	3.5
North Carolina	0.0	2.6	4.2	5.9	3.2
North Dakota	7.4	2.8	0.0	0.0	3.4
Ohio	1.7	5.4	5.8	7.6	5.2
Oklahoma	0.0	4.6	7.3	14.3	5.1
Oregon	4.3	3.9	9.1	0.0	5.8
Pennsylvania	0.0	1.7	1.8	3.3	1.6
Rhode Island	11.8	3.4	0.0	0.0	3.2
South Carolina	4.7	1.8	4.3	0.0	3.4
South Dakota	0.0	0.0	0.0	n/a	0.0
Tennessee	0.0	10.8	4.7	5.6	5.8
Texas	4.8	6.7	10.0	8.3	8.2
Utah	0.0	6.3	0.0	0.0	2.1
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	3.6	2.2	0.0	2.1
Washington	2.0	9.1	5.7	28.6	7.0
West Virginia	0.0	1.5	3.6	0.0	1.9
Wisconsin	0.0	2.4	2.8	2.1	2.3
Wyoming	0.0	0.0	14.3	0.0	4.8

Source: OSCAR

n/a: Data unavailable

Table 4.10 (f). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**2.2**	**4.2**	**5.1**	**4.6**	**4.3**
Alabama	0.0	2.6	7.5	0.0	4.9
Alaska	0.0	20.0	n/a	0.0	5.9
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	8.7	14.4	18.3	50.0	16.4
California	0.9	3.2	4.9	3.7	3.2
Colorado	0.0	2.5	2.3	0.0	1.9
Connecticut	0.0	4.2	2.2	0.0	2.5
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	14.3	0.0	33.3	14.3
Florida	1.3	1.6	4.3	5.3	3.5
Georgia	3.7	1.8	6.1	4.5	4.4
Hawaii	16.7	18.2	0.0	0.0	11.4
Idaho	0.0	0.0	0.0	n/a	0.0
Illinois	0.0	2.1	4.5	3.2	3.0
Indiana	4.6	3.7	5.0	13.9	5.1
Iowa	3.4	6.6	4.3	0.0	5.4
Kansas	2.8	9.9	7.5	0.0	7.3
Kentucky	9.1	13.5	8.9	0.0	10.6
Louisiana	2.8	4.6	6.3	5.0	5.5
Maine	9.5	5.0	0.0	0.0	6.0
Maryland	0.0	0.0	4.0	0.0	2.1
Massachusetts	0.0	0.0	1.5	0.0	0.8
Michigan	4.0	4.8	2.1	2.9	3.2
Minnesota	1.8	2.5	2.5	4.3	2.5
Mississippi	0.0	2.3	6.5	50.0	4.1
Missouri	0.0	1.5	3.4	5.6	2.3
Montana	5.4	4.3	3.8	0.0	4.5
Nebraska	1.9	4.1	5.4	0.0	3.7
Nevada	0.0	0.0	0.0	16.7	2.0
New Hampshire	7.7	0.0	6.7	0.0	4.0
New Jersey	5.3	0.0	6.9	7.3	5.6
New Mexico	7.1	3.4	10.7	0.0	6.9
New York	2.3	2.0	5.7	4.2	4.2
North Carolina	0.0	1.4	6.6	6.7	4.2
North Dakota	0.0	0.0	4.3	0.0	1.1
Ohio	1.4	2.2	4.8	6.3	3.6
Oklahoma	2.9	13.1	11.5	0.0	10.7
Oregon	4.3	4.9	10.9	0.0	6.8
Pennsylvania	0.0	0.6	2.2	0.0	1.2
Rhode Island	0.0	0.0	2.6	0.0	1.1
South Carolina	0.0	8.5	6.5	16.7	5.9
South Dakota	0.0	0.0	7.1	n/a	1.0
Tennessee	1.8	4.7	5.3	0.0	4.3
Texas	3.2	6.8	7.5	8.8	6.8
Utah	6.7	7.1	3.0	33.3	6.4
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	5.7	2.5	5.6	3.5
Washington	0.0	5.9	11.4	0.0	7.0
West Virginia	4.5	2.0	0.0	0.0	1.8
Wisconsin	0.0	3.8	3.2	4.4	3.3
Wyoming	0.0	0.0	7.7	n/a	2.6

Source: OSCAR

n/a: Data unavailable

Table 4.11 (a). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 1996

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**6.7**	**4.2**	**4.0**	**5.8**
Alabama	1.8	12.9	0.0	3.2
Alaska	0.0	0.0	0.0	0.0
Arizona	1.1	0.0	0.0	0.7
Arkansas	4.9	0.0	0.0	4.0
California	9.1	6.3	8.8	8.5
Colorado	6.8	0.0	0.0	4.2
Connecticut	3.9	1.9	0.0	3.5
Delaware	5.0	7.1	0.0	5.4
District of Columbia	0.0	0.0	0.0	0.0
Florida	12.9	12.9	20.0	13.0
Georgia	16.1	20.5	11.1	16.5
Hawaii	0.0	0.0	0.0	0.0
Idaho	4.1	0.0	15.0	6.1
Illinois	3.6	2.6	0.0	3.1
Indiana	10.1	6.8	6.7	9.3
Iowa	2.2	2.1	0.0	2.1
Kansas	17.9	15.6	13.3	16.6
Kentucky	4.8	3.1	0.0	4.1
Louisiana	0.4	0.0	0.0	0.3
Maine	7.1	3.1	0.0	5.9
Maryland	5.3	4.5	0.0	4.8
Massachusetts	3.0	3.1	7.1	3.2
Michigan	7.8	9.5	2.4	7.8
Minnesota	1.4	1.9	0.0	1.5
Mississippi	6.5	0.0	0.0	4.5
Missouri	7.4	1.3	6.0	5.7
Montana	13.2	0.0	0.0	5.1
Nebraska	9.3	7.2	3.4	7.2
Nevada	8.6	14.3	0.0	8.3
New Hampshire	10.4	0.0	0.0	5.4
New Jersey	3.5	6.4	0.0	4.1
New Mexico	1.9	0.0	0.0	1.1
New York	2.0	1.7	3.9	2.0
North Carolina	5.1	1.1	0.0	4.0
North Dakota	10.0	0.0	0.0	1.1
Ohio	5.8	4.7	9.8	5.7
Oklahoma	2.6	3.4	0.0	2.5
Oregon	13.3	5.9	0.0	11.3
Pennsylvania	2.7	2.1	2.0	2.4
Rhode Island	1.4	3.8	n/a	2.0
South Carolina	8.7	0.0	5.0	6.7
South Dakota	0.0	0.0	0.0	0.0
Tennessee	3.8	3.8	13.8	4.6
Texas	8.6	2.6	0.0	7.5
Utah	4.1	0.0	0.0	3.2
Vermont	0.0	0.0	0.0	0.0
Virginia	10.9	5.9	25.0	9.9
Washington	7.9	3.2	0.0	6.3
West Virginia	8.9	0.0	0.0	6.0
Wisconsin	2.7	3.6	0.0	2.6
Wyoming	0.0	0.0	7.1	2.6

Source: OSCAR

n/a: Data unavailable

Table 4.11 (b). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 1997

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**5.6**	**3.3**	**3.2**	**4.8**
Alabama	3.2	7.1	5.6	4.0
Alaska	0.0	0.0	0.0	0.0
Arizona	2.6	0.0	0.0	1.7
Arkansas	2.7	0.0	0.0	2.1
California	8.4	3.8	5.2	7.3
Colorado	0.7	1.5	0.0	0.8
Connecticut	3.3	1.6	50.0	3.3
Delaware	0.0	0.0	0.0	0.0
District of Columbia	10.0	0.0	0.0	3.8
Florida	10.3	5.9	0.0	9.3
Georgia	6.3	6.3	0.0	5.9
Hawaii	5.6	0.0	20.0	7.1
Idaho	11.5	0.0	21.1	11.9
Illinois	3.0	3.0	2.2	2.9
Indiana	5.8	0.8	12.5	4.9
Iowa	2.8	6.5	0.0	4.2
Kansas	17.6	9.8	12.7	14.5
Kentucky	5.9	1.2	0.0	4.2
Louisiana	1.4	1.4	0.0	1.3
Maine	8.1	6.3	0.0	7.4
Maryland	5.1	5.3	0.0	5.0
Massachusetts	6.0	2.1	0.0	4.9
Michigan	4.0	3.6	2.4	3.7
Minnesota	1.6	0.9	0.0	1.0
Mississippi	4.8	5.7	3.3	4.8
Missouri	4.8	1.3	0.0	3.5
Montana	5.3	2.2	5.0	3.8
Nebraska	1.8	7.5	1.8	3.7
Nevada	6.5	33.3	12.5	9.5
New Hampshire	10.2	3.4	7.7	7.7
New Jersey	4.3	2.0	0.0	3.4
New Mexico	2.3	0.0	0.0	1.3
New York	0.7	0.4	0.0	0.5
North Carolina	5.0	1.2	0.0	3.9
North Dakota	0.0	6.2	0.0	5.3
Ohio	6.5	6.4	6.7	6.5
Oklahoma	1.4	1.8	0.0	1.4
Oregon	5.9	15.6	0.0	7.7
Pennsylvania	2.7	3.1	2.2	2.9
Rhode Island	1.4	4.0	n/a	2.1
South Carolina	8.1	0.0	0.0	6.1
South Dakota	0.0	0.0	0.0	0.0
Tennessee	1.2	1.2	0.0	1.1
Texas	6.7	2.9	2.6	6.0
Utah	0.0	0.0	0.0	0.0
Vermont	3.4	0.0	n/a	2.6
Virginia	9.5	3.8	0.0	7.3
Washington	11.4	2.8	8.7	9.2
West Virginia	9.3	0.0	0.0	5.7
Wisconsin	4.9	2.4	1.6	3.4
Wyoming	5.9	0.0	7.1	5.4

Source: OSCAR

n/a: Data unavailable

Table 4.11 (c). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 1998

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**6.3**	**3.8**	**4.4**	**5.5**
Alabama	0.0	3.2	4.5	0.9
Alaska	0.0	10.0	0.0	6.3
Arizona	6.0	0.0	0.0	3.8
Arkansas	8.2	4.8	7.1	7.6
California	9.6	3.2	10.9	8.2
Colorado	1.4	1.6	8.7	2.2
Connecticut	4.7	2.0	0.0	4.1
Delaware	9.1	0.0	0.0	3.6
District of Columbia	25.0	9.1	0.0	11.8
Florida	11.8	4.8	7.1	10.2
Georgia	4.5	5.4	0.0	4.4
Hawaii	5.3	7.1	18.2	9.1
Idaho	17.6	0.0	5.3	11.9
Illinois	5.3	3.0	8.2	4.7
Indiana	9.4	10.0	6.7	9.5
Iowa	3.5	3.2	14.3	3.8
Kansas	13.1	8.8	6.1	10.6
Kentucky	9.9	5.6	33.3	9.1
Louisiana	3.3	1.3	0.0	2.6
Maine	6.1	10.0	0.0	6.8
Maryland	3.4	1.2	0.0	2.4
Massachusetts	4.0	2.8	0.0	3.6
Michigan	6.3	7.2	2.4	6.2
Minnesota	7.2	8.9	3.6	7.7
Mississippi	4.9	2.8	6.3	4.8
Missouri	8.0	1.4	7.5	6.1
Montana	8.8	6.8	0.0	6.4
Nebraska	2.7	2.7	1.9	2.5
Nevada	23.7	0.0	0.0	18.8
New Hampshire	4.3	4.2	7.7	4.8
New Jersey	2.9	0.0	5.9	2.0
New Mexico	4.3	4.8	0.0	4.1
New York	1.1	0.0	0.0	0.5
North Carolina	3.9	3.1	0.0	3.6
North Dakota	0.0	5.0	0.0	4.3
Ohio	8.1	8.5	7.1	8.2
Oklahoma	3.0	2.1	0.0	2.8
Oregon	13.6	5.6	0.0	11.3
Pennsylvania	3.5	2.3	0.0	2.7
Rhode Island	3.8	0.0	n/a	3.0
South Carolina	3.9	4.2	5.3	4.1
South Dakota	0.0	0.0	0.0	0.0
Tennessee	4.4	2.4	11.4	4.6
Texas	5.5	3.4	0.0	5.0
Utah	5.4	6.3	0.0	5.3
Vermont	0.0	8.3	0.0	2.6
Virginia	2.7	1.2	0.0	2.1
Washington	9.8	7.4	0.0	8.5
West Virginia	1.9	0.0	0.0	1.2
Wisconsin	4.7	0.0	0.0	2.3
Wyoming	0.0	0.0	5.6	2.3

Source: OSCAR

n/a: Data unavailable

Table 4.11 (d). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 1999

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**6.1**	**3.2**	**4.7**	**5.2**
Alabama	2.6	3.7	19.0	4.4
Alaska	100.0	10.0	0.0	12.5
Arizona	5.3	0.0	0.0	3.4
Arkansas	15.3	17.9	0.0	14.9
California	7.3	4.0	4.7	6.5
Colorado	1.3	3.3	0.0	1.7
Connecticut	3.7	1.7	0.0	3.2
Delaware	6.3	0.0	33.3	5.7
District of Columbia	0.0	0.0	100.0	6.7
Florida	8.1	4.8	0.0	7.2
Georgia	3.3	6.6	8.0	4.2
Hawaii	0.0	0.0	9.1	2.3
Idaho	9.6	0.0	10.5	8.3
Illinois	4.9	2.3	0.0	3.9
Indiana	9.7	4.5	0.0	8.1
Iowa	4.8	0.0	0.0	2.5
Kansas	9.9	2.1	0.0	5.9
Kentucky	8.3	8.2	10.0	8.3
Louisiana	4.3	1.4	7.4	4.0
Maine	8.7	9.1	0.0	8.4
Maryland	11.5	3.4	16.7	8.4
Massachusetts	4.0	1.7	0.0	3.3
Michigan	9.3	5.4	0.0	7.3
Minnesota	1.6	5.6	3.4	4.2
Mississippi	6.7	0.0	3.8	5.3
Missouri	8.7	4.4	4.1	7.2
Montana	0.0	2.0	0.0	1.0
Nebraska	1.9	1.2	4.1	2.1
Nevada	6.5	0.0	20.0	6.8
New Hampshire	5.6	4.3	20.0	7.2
New Jersey	4.0	3.0	16.7	4.4
New Mexico	10.4	0.0	20.0	7.5
New York	3.5	3.0	2.2	3.2
North Carolina	4.1	1.1	0.0	3.3
North Dakota	8.3	2.6	0.0	3.2
Ohio	7.9	3.6	13.3	7.0
Oklahoma	3.5	4.3	11.8	4.0
Oregon	20.4	6.3	16.7	17.1
Pennsylvania	1.5	2.2	2.2	1.9
Rhode Island	5.4	0.0	n/a	4.0
South Carolina	9.5	5.3	5.9	8.6
South Dakota	0.0	2.0	0.0	1.1
Tennessee	5.8	5.1	2.9	5.3
Texas	5.9	3.3	2.5	5.4
Utah	4.8	0.0	0.0	3.7
Vermont	3.3	0.0	0.0	2.1
Virginia	2.2	1.1	0.0	1.8
Washington	8.4	0.0	8.7	6.6
West Virginia	3.3	0.0	6.7	2.8
Wisconsin	2.4	1.3	3.2	2.1
Wyoming	5.6	0.0	11.8	7.5

Source: OSCAR

n/a: Data unavailable

Table 4.11 (e). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 2000

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All-Facilities
Nation	**5.3**	**3.3**	**3.6**	**4.6**
Alabama	9.2	7.1	15.8	9.6
Alaska	n/a	0.0	0.0	0.0
Arizona	3.2	0.0	25.0	2.8
Arkansas	13.0	9.5	0.0	11.9
California	3.5	4.5	6.8	3.9
Colorado	6.5	8.6	0.0	6.4
Connecticut	1.9	1.7	0.0	1.9
Delaware	0.0	5.3	0.0	2.3
District of Columbia	16.7	0.0	0.0	4.8
Florida	2.9	1.9	0.0	2.6
Georgia	3.4	3.6	0.0	3.2
Hawaii	0.0	6.7	11.1	4.9
Idaho	2.2	0.0	0.0	1.3
Illinois	3.2	3.1	2.4	3.1
Indiana	9.8	5.1	0.0	8.4
Iowa	3.8	3.3	5.3	3.6
Kansas	11.8	5.4	7.7	9.0
Kentucky	13.3	11.8	0.0	12.5
Louisiana	9.3	3.4	0.0	7.8
Maine	3.2	7.1	25.0	4.8
Maryland	3.3	2.0	11.1	3.1
Massachusetts	4.1	0.7	0.0	3.0
Michigan	5.9	1.5	0.0	4.2
Minnesota	6.2	1.6	1.6	2.9
Mississippi	6.2	13.3	4.2	7.0
Missouri	2.4	0.7	7.3	2.4
Montana	5.7	2.3	6.7	4.3
Nebraska	0.0	1.4	4.7	1.5
Nevada	8.8	0.0	0.0	6.3
New Hampshire	2.5	3.7	0.0	2.5
New Jersey	4.3	2.7	6.7	3.9
New Mexico	8.2	0.0	0.0	5.1
New York	3.1	4.2	2.0	3.5
North Carolina	3.8	2.0	0.0	3.2
North Dakota	0.0	2.8	33.3	3.4
Ohio	5.5	4.7	3.1	5.2
Oklahoma	5.8	2.3	0.0	5.1
Oregon	6.0	6.1	0.0	5.8
Pennsylvania	2.4	1.2	0.0	1.6
Rhode Island	1.3	11.1	n/a	3.2
South Carolina	3.9	4.0	0.0	3.4
South Dakota	0.0	0.0	0.0	0.0
Tennessee	5.3	2.9	15.6	5.8
Texas	8.7	7.1	0.0	8.2
Utah	2.6	0.0	0.0	2.1
Vermont	0.0	0.0	0.0	0.0
Virginia	3.4	0.0	0.0	2.1
Washington	9.6	1.6	0.0	7.0
West Virginia	2.9	0.0	0.0	1.9
Wisconsin	0.5	3.4	5.2	2.3
Wyoming	9.1	0.0	0.0	4.8

Source: OSCAR

n/a: Data unavailable

Table 4.11 (f). Nursing Home Surveys Resulting in a Citation for Substandard Quality of Care by Type of Ownership: United States, 2001

	Percentile by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**5.1**	**2.9**	**2.3**	**4.3**
Alabama	5.0	7.4	0.0	4.9
Alaska	0.0	10.0	0.0	5.9
Arizona	0.0	0.0	0.0	0.0
Arkansas	16.5	14.6	22.2	16.4
California	3.8	0.9	2.2	3.2
Colorado	2.8	0.0	0.0	1.9
Connecticut	3.3	0.0	0.0	2.5
Delaware	0.0	0.0	0.0	0.0
District of Columbia	33.3	7.7	0.0	14.3
Florida	4.3	1.3	0.0	3.5
Georgia	5.1	3.4	0.0	4.4
Hawaii	12.5	15.4	0.0	11.4
Idaho	0.0	0.0	0.0	0.0
Illinois	3.6	1.4	2.9	3.0
Indiana	5.5	4.4	0.0	5.1
Iowa	6.9	4.2	0.0	5.4
Kansas	10.4	3.3	5.7	7.3
Kentucky	12.9	6.7	0.0	10.6
Louisiana	4.5	9.8	4.8	5.5
Maine	4.8	7.1	16.7	6.0
Maryland	3.8	0.0	0.0	2.1
Massachusetts	0.9	0.7	0.0	0.8
Michigan	4.5	0.8	2.1	3.2
Minnesota	5.7	1.7	0.0	2.5
Mississippi	3.6	7.4	3.6	4.1
Missouri	3.2	0.8	0.0	2.3
Montana	3.6	7.3	0.0	4.5
Nebraska	4.1	3.6	2.6	3.7
Nevada	2.7	0.0	0.0	2.0
New Hampshire	7.5	0.0	0.0	4.0
New Jersey	7.0	3.9	0.0	5.6
New Mexico	10.6	0.0	0.0	6.9
New York	4.9	4.0	2.0	4.2
North Carolina	4.8	2.1	4.3	4.2
North Dakota	0.0	1.3	0.0	1.1
Ohio	4.5	1.6	0.0	3.6
Oklahoma	12.0	4.8	0.0	10.7
Oregon	7.7	5.7	0.0	6.8
Pennsylvania	1.5	1.1	0.0	1.2
Rhode Island	1.4	0.0	n/a	1.1
South Carolina	5.6	9.5	4.3	5.9
South Dakota	0.0	1.6	0.0	1.0
Tennessee	3.5	4.7	10.3	4.3
Texas	6.7	6.7	10.5	6.8
Utah	6.6	5.9	0.0	6.4
Vermont	0.0	0.0	0.0	0.0
Virginia	4.9	1.1	0.0	3.5
Washington	9.7	1.8	0.0	7.0
West Virginia	1.4	3.6	0.0	1.8
Wisconsin	3.4	3.9	1.6	3.3
Wyoming	7.1	0.0	0.0	2.6

Source: OSCAR

n/a: Data unavailable

Table 4.12 (a). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.9**	**1.4**	**1.8**	**2.4**	**1.6**
Alabama	0.0	1.2	0.0	0.0	0.5
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	3.0	1.6	0.7	0.0	1.3
California	1.9	5.1	4.4	11.1	4.5
Colorado	1.8	0.0	0.0	0.0	0.5
Connecticut	0.0	0.0	1.4	4.0	1.2
Delaware	0.0	0.0	0.0	n/a	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	0.8	2.5	6.1	2.0
Georgia	0.0	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	3.0	0.0	13.0	0.0	4.9
Illinois	0.0	0.7	1.2	5.1	1.5
Indiana	3.9	1.7	4.1	1.9	3.1
Iowa	0.0	0.0	0.9	0.0	0.2
Kansas	1.7	0.4	1.1	0.0	0.8
Kentucky	0.0	0.0	1.0	0.0	0.3
Louisiana	0.0	0.0	0.9	0.0	0.5
Maine	2.6	0.0	0.0	0.0	0.7
Maryland	0.0	4.1	0.9	6.5	2.2
Massachusetts	0.8	0.0	1.1	0.0	0.7
Michigan	6.7	2.9	8.0	6.8	6.2
Minnesota	0.0	0.5	0.7	0.0	0.5
Mississippi	2.4	1.3	2.7	0.0	2.0
Missouri	0.0	0.9	1.7	3.6	1.2
Montana	2.4	3.0	4.8	0.0	3.1
Nebraska	0.0	0.0	0.0	0.0	0.0
Nevada	0.0	0.0	18.8	0.0	6.3
New Hampshire	0.0	5.1	0.0	0.0	2.2
New Jersey	0.0	0.0	1.0	1.5	0.8
New Mexico	0.0	0.0	2.7	0.0	1.1
New York	0.0	0.0	0.4	0.4	0.3
North Carolina	0.0	0.7	0.0	0.0	0.3
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	1.2	0.3	1.3	0.0	0.9
Oklahoma	0.0	0.5	0.0	0.0	0.2
Oregon	2.7	7.0	0.0	0.0	3.6
Pennsylvania	0.0	2.3	2.4	2.0	1.9
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	4.6	6.0	0.0	3.9
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	0.0	1.0	0.6	0.0	0.6
Texas	0.0	1.4	2.2	0.0	1.5
Utah	0.0	2.9	0.0	0.0	1.1
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	1.2	0.0	4.8	0.7
Washington	0.0	1.8	4.0	0.0	2.4
West Virginia	0.0	0.0	7.7	0.0	2.6
Wisconsin	2.4	1.5	0.0	1.8	1.1
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.12 (b). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.7**	**1.6**	**1.8**	**2.1**	**1.6**
Alabama	0.0	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	0.0	0.0	1.4	0.0	0.7
California	1.3	4.5	7.0	6.5	4.4
Colorado	0.0	0.0	0.0	0.0	0.0
Connecticut	0.0	4.9	2.6	7.4	3.6
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	1.5	4.4	6.5	3.3
Georgia	0.0	0.0	0.5	0.0	0.3
Hawaii	7.1	0.0	0.0	0.0	2.4
Idaho	3.1	8.0	7.4	n/a	6.0
Illinois	0.9	0.7	0.9	3.2	1.2
Indiana	1.6	4.1	5.5	5.3	4.2
Iowa	0.0	0.7	0.0	0.0	0.4
Kansas	0.9	2.1	2.2	0.0	1.8
Kentucky	0.0	1.9	0.0	0.0	0.8
Louisiana	0.0	0.0	0.4	0.0	0.3
Maine	0.0	0.0	0.0	0.0	0.0
Maryland	0.0	0.0	0.0	0.0	0.0
Massachusetts	0.0	0.6	1.0	4.8	0.9
Michigan	0.0	1.6	5.8	8.6	4.2
Minnesota	0.0	0.0	0.0	0.0	0.0
Mississippi	0.0	1.3	0.0	0.0	0.5
Missouri	0.0	0.4	0.0	0.0	0.2
Montana	2.4	5.7	8.0	0.0	4.8
Nebraska	0.0	0.8	0.0	0.0	0.4
Nevada	0.0	0.0	13.3	0.0	4.8
New Hampshire	0.0	4.9	0.0	0.0	2.2
New Jersey	0.0	2.1	0.5	0.0	0.6
New Mexico	0.0	0.0	0.0	0.0	0.0
New York	0.0	0.0	0.0	0.0	0.0
North Carolina	0.0	0.7	1.5	0.0	1.0
North Dakota	0.0	3.0	0.0	0.0	1.3
Ohio	0.7	1.2	0.4	0.0	0.6
Oklahoma	0.0	0.5	0.0	14.3	0.5
Oregon	9.1	0.0	3.7	0.0	3.2
Pennsylvania	0.6	0.6	1.5	3.3	1.3
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	2.6	6.3	10.0	16.7	7.3
South Dakota	0.0	1.4	0.0	0.0	1.0
Tennessee	0.0	0.0	0.6	0.0	0.3
Texas	1.3	0.9	1.7	0.0	1.3
Utah	0.0	2.9	0.0	0.0	1.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	2.5	2.8	0.0	2.0
Washington	2.0	2.5	2.5	10.0	2.7
West Virginia	0.0	0.0	0.0	0.0	0.0
Wisconsin	0.0	0.5	1.3	0.0	0.7
Wyoming	0.0	18.8	0.0	0.0	8.1

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.12 (c). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.9**	**1.8**	**2.0**	**2.6**	**1.8**
Alabama	0.0	1.2	0.0	0.0	0.4
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	0.0	1.0	1.6	0.0	1.1
California	1.8	4.8	6.5	13.8	5.0
Colorado	3.6	1.3	0.0	11.1	1.8
Connecticut	6.7	5.7	6.6	4.5	6.1
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	1.0	2.3	3.9	13.9	3.7
Georgia	0.0	2.4	0.0	0.0	0.8
Hawaii	0.0	0.0	0.0	25.0	2.3
Idaho	3.6	3.8	16.7	n/a	8.3
Illinois	1.7	1.8	1.8	0.0	1.5
Indiana	0.8	2.4	7.7	5.5	4.3
Iowa	1.3	0.4	0.9	0.0	0.6
Kansas	2.5	2.0	5.3	0.0	2.7
Kentucky	0.0	0.8	0.0	0.0	0.3
Louisiana	0.0	0.0	0.0	0.0	0.0
Maine	0.0	0.0	5.9	0.0	0.8
Maryland	0.0	0.0	3.2	0.0	1.5
Massachusetts	0.0	0.0	0.8	4.8	0.6
Michigan	2.2	3.2	5.0	3.1	4.0
Minnesota	0.0	0.5	0.7	0.0	0.5
Mississippi	0.0	0.0	0.0	0.0	0.0
Missouri	0.0	0.0	0.0	0.0	0.0
Montana	2.6	0.0	0.0	0.0	1.1
Nebraska	0.0	0.8	0.0	0.0	0.4
Nevada	0.0	0.0	5.6	25.0	4.2
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	0.0	1.6	1.6	1.9	1.5
New Mexico	0.0	3.6	0.0	0.0	1.4
New York	0.0	1.0	0.0	0.5	0.4
North Carolina	0.0	0.0	2.4	0.0	1.2
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	0.0	0.4	0.9	1.4	0.6
Oklahoma	0.0	2.1	0.7	0.0	1.3
Oregon	5.7	2.9	3.8	0.0	3.8
Pennsylvania	0.0	1.2	1.1	3.1	1.1
Rhode Island	0.0	0.0	0.0	12.5	1.0
South Carolina	0.0	6.5	7.5	20.0	5.9
South Dakota	0.0	0.0	0.0	0.0	0.0
Tennessee	1.7	1.0	0.5	4.2	1.1
Texas	0.0	1.5	1.0	0.0	0.9
Utah	0.0	3.4	0.0	0.0	1.1
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	2.9	0.0	3.6	0.0	2.1
Washington	1.9	7.9	3.7	12.5	5.3
West Virginia	0.0	2.9	3.4	n/a	2.5
Wisconsin	2.5	0.5	0.0	0.0	0.5
Wyoming	0.0	5.9	0.0	0.0	2.3

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.12 (d). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.7**	**1.8**	**2.6**	**4.3**	**2.1**
Alabama	0.0	1.3	1.0	0.0	1.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	5.0	8.3	0.0	5.7
Arkansas	0.0	3.6	1.6	0.0	2.1
California	2.4	4.8	9.4	14.8	5.8
Colorado	0.0	0.0	0.0	0.0	0.0
Connecticut	0.0	9.3	11.5	12.0	10.3
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	25.0	6.7
Florida	1.0	2.9	3.6	2.7	3.1
Georgia	0.0	0.0	0.0	4.0	0.3
Hawaii	0.0	0.0	8.3	0.0	2.3
Idaho	0.0	0.0	3.4	n/a	1.2
Illinois	0.0	0.4	1.2	2.5	1.0
Indiana	3.0	4.0	5.3	11.4	4.7
Iowa	0.0	0.4	0.0	0.0	0.2
Kansas	0.0	1.4	3.9	0.0	1.4
Kentucky	0.0	0.0	3.1	0.0	1.0
Louisiana	0.0	1.3	1.4	11.1	1.9
Maine	2.2	1.5	0.0	0.0	1.5
Maryland	0.0	0.0	1.4	5.3	1.4
Massachusetts	0.0	0.0	0.4	0.0	0.2
Michigan	0.0	2.6	2.4	8.6	2.7
Minnesota	0.0	0.5	0.0	0.0	0.2
Mississippi	0.0	0.0	0.0	0.0	0.0
Missouri	0.0	0.0	2.6	0.0	1.1
Montana	0.0	0.0	3.6	0.0	1.0
Nebraska	0.0	0.0	0.0	0.0	0.0
Nevada	0.0	0.0	10.0	20.0	6.8
New Hampshire	0.0	0.0	0.0	0.0	0.0
New Jersey	0.0	1.9	4.5	0.0	2.8
New Mexico	0.0	3.0	0.0	0.0	1.3
New York	2.3	1.0	1.2	2.9	1.9
North Carolina	0.0	0.0	1.0	7.7	0.8
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	0.7	0.0	1.4	6.6	1.3
Oklahoma	0.0	1.6	1.5	0.0	1.3
Oregon	7.1	12.9	13.0	0.0	11.6
Pennsylvania	0.0	0.6	1.0	3.2	1.0
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	2.2	10.1	0.0	5.3
South Dakota	0.0	1.9	0.0	n/a	1.1
Tennessee	0.0	2.1	2.7	9.1	2.5
Texas	0.0	2.9	2.0	2.1	2.0
Utah	0.0	0.0	0.0	n/a	0.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	2.1	5.4	0.0	3.2
Washington	0.0	0.0	2.7	12.5	1.5
West Virginia	0.0	3.2	2.1	0.0	2.1
Wisconsin	0.0	0.5	0.0	3.8	0.7
Wyoming	15.4	0.0	8.3	0.0	7.5

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.12 (e). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.5**	**1.9**	**2.0**	**2.7**	**1.8**
Alabama	0.0	0.0	1.1	0.0	0.5
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	1.3	0.0	0.7
Arkansas	0.0	1.1	5.6	0.0	3.3
California	2.7	6.8	4.6	11.3	5.7
Colorado	0.0	0.0	3.5	0.0	1.4
Connecticut	0.0	3.9	3.2	8.7	3.7
Delaware	0.0	0.0	3.7	0.0	2.3
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	2.7	2.8	0.0	2.3
Georgia	0.0	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0	0.0
Idaho	0.0	4.0	4.2	n/a	2.5
Illinois	0.0	0.7	1.5	0.0	0.8
Indiana	0.9	2.1	2.4	4.9	2.2
Iowa	0.0	0.0	0.0	0.0	0.0
Kansas	0.9	4.9	1.4	0.0	3.2
Kentucky	0.0	0.0	0.0	16.7	0.4
Louisiana	2.2	0.0	2.2	4.2	1.9
Maine	0.0	3.0	0.0	0.0	1.6
Maryland	0.0	0.0	0.8	2.9	0.8
Massachusetts	1.1	1.5	0.8	0.0	1.0
Michigan	0.0	1.4	2.9	2.5	2.1
Minnesota	0.0	0.5	0.0	0.0	0.2
Mississippi	0.0	0.0	0.0	16.7	0.5
Missouri	1.3	0.4	0.4	0.0	0.5
Montana	2.5	0.0	0.0	0.0	1.1
Nebraska	0.0	1.0	2.6	0.0	1.0
Nevada	0.0	16.7	0.0	25.0	6.3
New Hampshire	0.0	0.0	0.0	20.0	1.3
New Jersey	0.0	0.0	1.6	7.1	2.1
New Mexico	0.0	0.0	0.0	0.0	0.0
New York	0.0	1.0	2.4	3.5	2.3
North Carolina	0.0	0.7	1.9	0.0	1.2
North Dakota	0.0	0.0	0.0	0.0	0.0
Ohio	0.0	0.8	0.9	0.0	0.7
Oklahoma	0.0	1.3	1.6	0.0	1.2
Oregon	4.3	9.2	1.8	0.0	5.8
Pennsylvania	0.0	0.6	1.6	1.1	1.0
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	0.0	5.4	11.4	0.0	6.3
South Dakota	0.0	0.0	0.0	n/a	0.0
Tennessee	0.0	1.1	4.7	5.6	3.0
Texas	0.0	1.9	2.7	4.2	2.2
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	2.4	2.2	0.0	1.8
Washington	0.0	0.9	2.9	0.0	1.5
West Virginia	3.0	0.0	1.8	0.0	1.3
Wisconsin	0.0	0.0	0.0	0.0	0.0
Wyoming	0.0	6.3	7.1	0.0	4.8

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.12 (f). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**0.6**	**1.3**	**1.9**	**2.2**	**1.5**
Alabama	0.0	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	0.0	0.0	0.0
Arkansas	0.0	2.1	1.7	0.0	1.6
California	1.8	2.7	4.2	3.7	2.9
Colorado	0.0	2.5	5.8	0.0	3.2
Connecticut	0.0	4.2	7.4	14.3	6.6
Delaware	0.0	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	0.0	0.8	1.1	0.0	0.9
Georgia	0.0	0.0	1.7	4.5	1.2
Hawaii	8.3	0.0	0.0	0.0	2.9
Idaho	0.0	4.3	0.0	n/a	1.3
Illinois	0.0	2.5	1.0	0.0	1.2
Indiana	0.9	1.1	0.5	5.6	1.1
Iowa	0.0	0.0	0.0	0.0	0.0
Kansas	0.0	1.6	3.8	0.0	1.4
Kentucky	0.0	0.0	1.0	0.0	0.4
Louisiana	0.0	0.0	2.4	5.0	1.8
Maine	0.0	1.7	0.0	0.0	0.9
Maryland	0.0	0.0	2.7	0.0	1.4
Massachusetts	0.0	0.0	0.4	0.0	0.2
Michigan	2.0	3.4	2.1	2.9	2.6
Minnesota	0.0	0.0	0.0	0.0	0.0
Mississippi	0.0	0.0	0.0	0.0	0.0
Missouri	0.0	0.0	0.5	0.0	0.2
Montana	0.0	8.7	3.8	0.0	3.4
Nebraska	0.0	1.0	0.0	0.0	0.5
Nevada	0.0	0.0	4.5	16.7	4.0
New Hampshire	0.0	3.4	0.0	0.0	1.3
New Jersey	2.6	1.8	2.3	3.6	2.5
New Mexico	0.0	0.0	0.0	0.0	0.0
New York	2.3	1.0	6.1	3.2	3.9
North Carolina	0.0	0.0	0.0	0.0	0.0
North Dakota	3.8	0.0	0.0	0.0	1.1
Ohio	0.0	1.9	3.0	3.1	2.2
Oklahoma	5.7	2.8	1.3	0.0	2.7
Oregon	4.3	1.6	10.9	0.0	5.3
Pennsylvania	0.0	0.0	0.3	1.1	0.3
Rhode Island	0.0	0.0	0.0	0.0	0.0
South Carolina	2.7	0.0	1.6	0.0	1.3
South Dakota	0.0	1.9	7.1	n/a	1.9
Tennessee	0.0	1.9	0.5	0.0	0.8
Texas	0.0	0.8	1.5	0.0	1.0
Utah	0.0	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	n/a	0.0
Virginia	0.0	3.4	2.5	5.6	2.7
Washington	2.2	0.0	5.7	16.7	3.1
West Virginia	0.0	4.1	2.6	0.0	2.7
Wisconsin	0.0	0.0	0.0	0.0	0.0
Wyoming	0.0	7.7	7.7	n/a	5.3

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (a). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 1996

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**1.9**	**0.8**	**1.7**	**1.6**
Alabama	0.6	0.0	0.0	0.5
Alaska	0.0	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	1.6	0.0	0.0	1.3
California	4.6	3.0	10.5	4.5
Colorado	0.0	1.7	0.0	0.5
Connecticut	1.5	0.0	0.0	1.2
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	1.8	2.1	6.7	2.0
Georgia	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0
Idaho	6.1	0.0	5.0	4.9
Illinois	1.7	0.7	3.6	1.5
Indiana	4.2	0.0	0.0	3.1
Iowa	0.4	0.0	0.0	0.2
Kansas	1.5	0.0	0.0	0.8
Kentucky	0.5	0.0	0.0	0.3
Louisiana	0.7	0.0	0.0	0.5
Maine	1.0	0.0	0.0	0.7
Maryland	1.5	1.1	28.6	2.2
Massachusetts	0.9	0.0	0.0	0.7
Michigan	6.7	5.6	4.8	6.2
Minnesota	1.4	0.0	0.0	0.5
Mississippi	2.2	3.3	0.0	2.0
Missouri	1.3	0.0	4.0	1.2
Montana	5.3	0.0	5.6	3.1
Nebraska	0.0	0.0	0.0	0.0
Nevada	8.6	0.0	0.0	6.3
New Hampshire	4.2	0.0	0.0	2.2
New Jersey	0.4	1.8	0.0	0.8
New Mexico	0.0	3.7	0.0	1.1
New York	0.3	0.3	0.0	0.3
North Carolina	0.3	0.0	0.0	0.3
North Dakota	0.0	0.0	0.0	0.0
Ohio	1.3	0.0	0.0	0.9
Oklahoma	0.3	0.0	0.0	0.2
Oregon	4.7	0.0	0.0	3.6
Pennsylvania	2.7	1.4	0.0	1.9
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	3.9	3.2	5.0	3.9
South Dakota	0.0	0.0	0.0	0.0
Tennessee	0.4	1.3	0.0	0.6
Texas	1.8	0.0	0.0	1.5
Utah	1.4	0.0	0.0	1.1
Vermont	0.0	0.0	0.0	0.0
Virginia	0.6	1.2	0.0	0.7
Washington	3.0	1.6	0.0	2.4
West Virginia	3.8	0.0	0.0	2.6
Wisconsin	0.9	1.2	1.5	1.1
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (b). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 1997

	Percent by Ownership			
	For-Profit	Non-Profit	Governemt	All Facilities
Nation	**2.0**	**0.5**	**1.7**	**1.6**
Alabama	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	0.4	0.0	6.7	0.7
California	5.0	2.4	3.4	4.4
Colorado	0.0	0.0	0.0	0.0
Connecticut	4.2	1.6	0.0	3.6
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	4.0	0.7	0.0	3.3
Georgia	0.0	1.6	0.0	0.3
Hawaii	0.0	0.0	10.0	2.4
Idaho	7.7	0.0	5.3	6.0
Illinois	1.7	0.4	0.0	1.2
Indiana	4.9	2.3	0.0	4.2
Iowa	0.8	0.0	0.0	0.4
Kansas	3.2	0.0	0.0	1.8
Kentucky	1.2	0.0	0.0	0.8
Louisiana	0.4	0.0	0.0	0.3
Maine	0.0	0.0	0.0	0.0
Maryland	0.0	0.0	0.0	0.0
Massachusetts	0.7	1.4	0.0	0.9
Michigan	5.1	0.9	7.3	4.2
Minnesota	0.0	0.0	0.0	0.0
Mississippi	0.7	0.0	0.0	0.5
Missouri	0.3	0.0	0.0	0.2
Montana	7.9	2.2	5.0	4.8
Nebraska	0.9	0.0	0.0	0.4
Nevada	6.5	0.0	0.0	4.8
New Hampshire	4.1	0.0	0.0	2.2
New Jersey	1.0	0.0	0.0	0.6
New Mexico	0.0	0.0	0.0	0.0
New York	0.0	0.0	0.0	0.0
North Carolina	1.3	0.0	0.0	1.0
North Dakota	11.1	0.0	0.0	1.3
Ohio	0.9	0.0	0.0	0.6
Oklahoma	0.6	0.0	0.0	0.5
Oregon	2.5	6.3	0.0	3.2
Pennsylvania	2.7	0.0	4.4	1.3
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	7.4	0.0	14.3	7.3
South Dakota	2.6	0.0	0.0	1.0
Tennessee	0.0	1.2	0.0	0.3
Texas	1.4	0.5	2.6	1.3
Utah	1.3	0.0	0.0	1.0
Vermont	0.0	0.0	n/a	0.0
Virginia	2.5	1.3	0.0	2.0
Washington	2.5	1.4	8.7	2.7
West Virginia	0.0	0.0	0.0	0.0
Wisconsin	1.5	0.0	0.0	0.7
Wyoming	5.9	0.0	14.3	8.1

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (c). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 1998

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**2.2**	**0.8**	**1.5**	**1.8**
Alabama	0.6	0.0	0.0	0.4
Alaska	0.0	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	1.0	0.0	7.1	1.1
California	6.0	1.4	4.3	5.0
Colorado	1.4	0.0	8.7	1.8
Connecticut	5.7	8.0	0.0	6.1
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	4.2	0.7	14.3	3.7
Georgia	1.0	0.0	0.0	0.8
Hawaii	0.0	7.1	0.0	2.3
Idaho	11.8	7.1	0.0	8.3
Illinois	2.2	0.4	0.0	1.5
Indiana	5.8	0.0	0.0	4.3
Iowa	0.8	0.5	0.0	0.6
Kansas	2.1	3.4	3.0	2.7
Kentucky	0.5	0.0	0.0	0.3
Louisiana	0.0	0.0	0.0	0.0
Maine	1.0	0.0	0.0	0.8
Maryland	1.7	1.2	0.0	1.5
Massachusetts	0.6	0.7	0.0	0.6
Michigan	4.0	3.6	4.8	4.0
Minnesota	0.7	0.4	0.0	0.5
Mississippi	0.0	0.0	0.0	0.0
Missouri	0.0	0.0	0.0	0.0
Montana	0.0	2.3	0.0	1.1
Nebraska	0.9	0.0	0.0	0.4
Nevada	5.3	0.0	0.0	4.2
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	1.9	0.8	0.0	1.5
New Mexico	2.1	0.0	0.0	1.4
New York	0.7	0.0	0.0	0.4
North Carolina	1.6	0.0	0.0	1.2
North Dakota	0.0	0.0	0.0	0.0
Ohio	0.7	0.4	0.0	0.6
Oklahoma	1.2	2.1	0.0	1.3
Oregon	5.1	0.0	0.0	3.8
Pennsylvania	1.2	0.7	4.3	1.1
Rhode Island	1.3	0.0	n/a	1.0
South Carolina	5.5	8.3	5.3	5.9
South Dakota	0.0	0.0	0.0	0.0
Tennessee	1.2	1.2	0.0	1.1
Texas	1.2	0.0	0.0	0.9
Utah	1.4	0.0	0.0	1.1
Vermont	0.0	0.0	0.0	0.0
Virginia	1.4	2.4	10.0	2.1
Washington	6.7	1.5	4.8	5.3
West Virginia	3.7	0.0	0.0	2.5
Wisconsin	0.5	0.6	0.0	0.5
Wyoming	5.3	0.0	0.0	2.3

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (d). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 1999

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**2.5**	**1.8**	**2.2**	**2.1**
Alabama	0.6	1.3	0.0	1.0
Alaska	0.0	0.0	0.0	0.0
Arizona	7.0	5.0	0.0	5.7
Arkansas	2.1	3.6	0.0	2.1
California	6.7	4.8	2.3	5.8
Colorado	0.0	0.0	0.0	0.0
Connecticut	11.5	9.3	0.0	10.3
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	100.0	6.7
Florida	3.0	2.9	0.0	3.1
Georgia	0.4	0.0	0.0	0.3
Hawaii	0.0	0.0	9.1	2.3
Idaho	1.9	0.0	0.0	1.2
Illinois	1.0	0.4	2.2	1.0
Indiana	5.7	4.0	5.9	4.7
Iowa	0.0	0.4	0.0	0.2
Kansas	1.8	1.4	0.0	1.4
Kentucky	0.6	0.0	0.0	1.0
Louisiana	1.8	1.3	3.7	1.9
Maine	2.2	1.5	0.0	1.5
Maryland	2.6	0.0	0.0	1.4
Massachusetts	0.3	0.0	0.0	0.2
Michigan	2.7	2.6	2.6	2.7
Minnesota	0.0	0.5	1.7	0.2
Mississippi	0.0	0.0	0.0	0.0
Missouri	1.4	0.0	2.0	1.1
Montana	2.7	0.0	0.0	1.0
Nebraska	0.0	0.0	0.0	0.0
Nevada	6.5	0.0	20.0	6.8
New Hampshire	0.0	0.0	0.0	0.0
New Jersey	2.5	1.9	11.1	2.8
New Mexico	2.1	3.0	0.0	1.3
New York	2.1	1.0	4.3	1.9
North Carolina	1.0	0.0	0.0	0.8
North Dakota	0.0	0.0	0.0	0.0
Ohio	1.2	0.0	0.0	1.3
Oklahoma	1.3	1.6	0.0	1.3
Oregon	11.1	12.9	33.3	11.6
Pennsylvania	1.5	0.6	0.0	1.0
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	5.2	2.2	5.9	5.3
South Dakota	0.0	1.9	0.0	1.1
Tennessee	2.1	2.1	2.9	2.5
Texas	1.9	2.9	5.0	2.0
Utah	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	0.0
Virginia	5.1	2.1	0.0	3.2
Washington	1.6	0.0	0.0	1.5
West Virginia	2.2	3.2	0.0	2.1
Wisconsin	0.5	0.5	1.6	0.7
Wyoming	5.6	0.0	11.8	7.5

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (e). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 2000

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**2.2**	**1.0**	**0.7**	**1.8**
Alabama	0.7	0.0	0.0	0.5
Alaska	n/a	0.0	0.0	0.0
Arizona	1.1	0.0	0.0	0.7
Arkansas	2.8	7.1	0.0	3.3
California	6.4	3.2	4.5	5.7
Colorado	2.2	0.0	0.0	1.4
Connecticut	4.3	1.7	0.0	3.7
Delaware	5.0	0.0	0.0	2.3
District of Columbia	0.0	0.0	0.0	0.0
Florida	2.5	1.9	0.0	2.3
Georgia	0.0	0.0	0.0	0.0
Hawaii	0.0	0.0	0.0	0.0
Idaho	4.3	0.0	0.0	2.5
Illinois	0.7	1.2	0.0	0.8
Indiana	2.3	2.2	0.0	2.2
Iowa	0.0	0.0	0.0	0.0
Kansas	3.8	2.0	3.8	3.2
Kentucky	0.6	0.0	0.0	0.4
Louisiana	2.1	1.7	0.0	1.9
Maine	1.1	3.6	0.0	1.6
Maryland	0.7	1.0	0.0	0.8
Massachusetts	1.5	0.0	0.0	1.0
Michigan	3.0	0.8	0.0	2.1
Minnesota	0.0	0.4	0.0	0.2
Mississippi	0.7	0.0	0.0	0.5
Missouri	0.5	0.7	0.0	0.5
Montana	2.9	0.0	0.0	1.1
Nebraska	2.4	0.0	0.0	1.0
Nevada	8.8	0.0	0.0	6.3
New Hampshire	0.0	0.0	8.3	1.3
New Jersey	2.9	0.9	0.0	2.1
New Mexico	0.0	0.0	0.0	0.0
New York	2.8	1.9	2.0	2.3
North Carolina	1.6	0.0	0.0	1.2
North Dakota	0.0	0.0	0.0	0.0
Ohio	0.5	1.4	0.0	0.7
Oklahoma	1.4	0.0	0.0	1.2
Oregon	7.7	0.0	0.0	5.8
Pennsylvania	1.8	0.5	0.0	1.0
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	8.6	0.0	0.0	6.3
South Dakota	0.0	0.0	0.0	0.0
Tennessee	3.5	2.9	0.0	3.0
Texas	2.4	1.1	2.9	2.2
Utah	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	0.0
Virginia	2.2	1.1	0.0	1.8
Washington	2.1	0.0	0.0	1.5
West Virginia	1.0	2.6	0.0	1.3
Wisconsin	0.0	0.0	0.0	0.0
Wyoming	9.1	0.0	0.0	4.8

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.13 (f). Nursing Home Surveys Resulting in a Citation for Abuse of Residents by Type of Ownership: United States, 2001

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**1.8**	**0.8**	**1.9**	**1.5**
Alabama	0.0	0.0	0.0	0.0
Alaska	0.0	0.0	0.0	0.0
Arizona	0.0	0.0	0.0	0.0
Arkansas	1.0	4.9	0.0	1.6
California	3.4	1.3	2.2	2.9
Colorado	4.2	0.0	4.8	3.2
Connecticut	7.1	5.4	0.0	6.6
Delaware	0.0	0.0	0.0	0.0
District of Columbia	0.0	0.0	0.0	0.0
Florida	1.0	0.6	0.0	0.9
Georgia	1.6	0.0	0.0	1.2
Hawaii	0.0	0.0	16.7	2.9
Idaho	0.0	0.0	5.3	1.3
Illinois	1.8	0.0	0.0	1.2
Indiana	1.1	1.3	0.0	1.1
Iowa	0.0	0.0	0.0	0.0
Kansas	2.2	0.0	1.9	1.4
Kentucky	0.5	0.0	0.0	0.4
Louisiana	1.6	1.6	4.8	1.8
Maine	1.2	0.0	0.0	0.9
Maryland	2.5	0.0	0.0	1.4
Massachusetts	0.0	0.7	0.0	0.2
Michigan	4.2	0.0	0.0	2.6
Minnesota	0.0	0.0	0.0	0.0
Mississippi	0.0	0.0	0.0	0.0
Missouri	0.0	0.8	0.0	0.2
Montana	7.1	0.0	5.3	3.4
Nebraska	1.0	0.0	0.0	0.5
Nevada	5.4	0.0	0.0	4.0
New Hampshire	0.0	0.0	8.3	1.3
New Jersey	3.0	1.9	0.0	2.5
New Mexico	0.0	0.0	0.0	0.0
New York	4.9	2.0	8.2	3.9
North Carolina	0.0	0.0	0.0	0.0
North Dakota	0.0	1.3	0.0	1.1
Ohio	2.0	2.8	3.3	2.2
Oklahoma	2.6	0.0	8.3	2.7
Oregon	6.6	2.9	0.0	5.3
Pennsylvania	0.0	0.5	0.0	0.3
Rhode Island	0.0	0.0	n/a	0.0
South Carolina	0.9	0.0	4.3	1.3
South Dakota	0.0	1.6	16.7	1.9
Tennessee	0.4	2.3	0.0	0.8
Texas	1.3	0.0	0.0	1.0
Utah	0.0	0.0	0.0	0.0
Vermont	0.0	0.0	0.0	0.0
Virginia	4.3	0.0	0.0	2.7
Washington	3.4	0.0	7.4	3.1
West Virginia	2.7	0.0	10.0	2.7
Wisconsin	0.0	0.0	0.0	0.0
Wyoming	14.3	0.0	0.0	5.3

Source: OSCAR

n/a: Data unavailable

Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines in the "State Operations Manual for Provider Certification"

Table 4.14 (a). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**11.3**	**14.1**	**15.7**	**15.6**	**14.4**
Alabama	17.6	13.4	27.1	50.0	22.2
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	13.3	17.6	18.6	23.1	17.7
Arkansas	27.3	11.5	9.9	0.0	12.3
California	20.6	27.7	31.5	28.6	27.0
Colorado	3.6	5.9	9.9	0.0	6.6
Connecticut	5.6	2.8	1.4	0.0	1.9
Delaware	20.0	25.0	20.8	n/a	21.6
District of Columbia	0.0	0.0	0.0	0.0	0.0
Florida	6.0	12.9	21.5	12.1	17.3
Georgia	3.3	2.7	2.4	9.4	3.1
Hawaii	6.7	0.0	9.1	50.0	9.8
Idaho	12.1	20.0	13.0	0.0	14.6
Illinois	12.4	16.9	15.3	14.7	15.3
Indiana	6.3	11.0	13.6	16.7	11.5
Iowa	9.9	6.8	8.3	27.3	8.1
Kansas	11.8	15.5	16.1	40.0	15.0
Kentucky	8.2	14.6	8.9	14.3	11.1
Louisiana	0.0	2.8	7.1	4.8	5.0
Maine	7.7	12.1	3.6	0.0	8.8
Maryland	2.6	6.1	8.3	6.5	6.6
Massachusetts	12.9	22.1	26.4	33.3	22.6
Michigan	20.0	17.6	27.4	31.8	24.2
Minnesota	7.7	11.3	19.0	11.5	13.4
Mississippi	7.1	7.7	13.3	20.0	10.0
Missouri	17.2	9.9	9.5	17.9	11.2
Montana	11.9	24.2	19.0	50.0	18.4
Nebraska	10.7	9.4	5.9	20.0	9.2
Nevada	35.0	75.0	62.5	100.0	56.3
New Hampshire	6.7	10.3	3.2	0.0	6.5
New Jersey	0.0	6.7	6.0	6.0	5.5
New Mexico	5.3	6.9	18.9	0.0	11.5
New York	11.1	9.4	13.4	8.0	10.6
North Carolina	6.5	10.3	10.8	8.3	10.1
North Dakota	13.0	20.5	29.2	100.0	22.7
Ohio	14.6	12.1	19.9	17.8	16.8
Oklahoma	11.8	21.4	17.2	0.0	18.1
Oregon	8.1	16.9	11.9	0.0	13.1
Pennsylvania	14.6	15.3	20.8	16.3	17.8
Rhode Island	10.5	6.3	9.8	0.0	8.2
South Carolina	15.0	23.1	31.3	33.3	24.7
South Dakota	18.5	16.7	46.7	100.0	22.0
Tennessee	9.6	14.3	17.8	28.6	16.2
Texas	4.1	7.8	8.3	10.9	7.5
Utah	3.7	8.8	6.7	0.0	6.5
Vermont	28.6	9.1	22.2	n/a	20.9
Virginia	5.0	11.6	20.8	23.8	15.8
Washington	20.9	19.1	19.4	0.0	18.8
West Virginia	4.3	15.1	10.3	100.0	12.1
Wisconsin	4.8	12.1	14.6	26.8	14.1
Wyoming	0.0	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.14 (b). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**10.4**	**13.8**	**14.9**	**16.6**	**13.9**
Alabama	9.1	11.5	20.6	22.2	16.5
Alaska	23.1	0.0	n/a	100.0	25.0
Arizona	9.5	23.1	19.4	40.0	20.2
Arkansas	22.9	13.1	12.8	14.3	14.2
California	21.0	24.7	32.2	37.1	26.1
Colorado	4.7	5.0	18.6	28.6	10.5
Connecticut	6.3	3.7	3.3	7.4	4.0
Delaware	0.0	25.0	7.4	0.0	11.1
District of Columbia	0.0	0.0	14.3	0.0	3.8
Florida	8.7	10.2	15.9	9.7	13.5
Georgia	4.3	5.4	3.0	0.0	3.6
Hawaii	7.1	7.1	20.0	25.0	11.9
Idaho	18.8	28.0	37.0	n/a	27.4
Illinois	15.2	15.2	17.9	18.8	16.9
Indiana	18.0	30.2	26.9	31.6	26.4
Iowa	6.9	4.9	21.3	0.0	9.0
Kansas	11.3	18.5	27.8	0.0	18.3
Kentucky	9.1	11.5	14.4	60.0	12.8
Louisiana	0.0	5.1	3.5	4.2	3.4
Maine	9.1	4.4	9.5	0.0	6.6
Maryland	6.8	0.0	2.5	3.2	2.9
Massachusetts	11.5	13.0	16.4	19.0	14.6
Michigan	14.9	18.0	20.4	14.3	18.6
Minnesota	19.1	15.9	33.3	55.6	24.9
Mississippi	4.3	7.5	2.5	0.0	4.8
Missouri	3.3	6.6	8.4	10.7	7.0
Montana	7.1	5.7	4.0	0.0	5.8
Nebraska	6.7	6.1	6.3	20.0	6.6
Nevada	27.8	71.4	73.3	50.0	52.4
New Hampshire	8.3	9.8	3.0	0.0	6.6
New Jersey	0.0	4.3	8.0	10.0	7.1
New Mexico	12.5	16.1	17.9	0.0	15.6
New York	6.8	13.3	8.7	7.9	9.1
North Carolina	2.1	6.0	9.1	0.0	6.9
North Dakota	5.0	18.2	33.3	0.0	18.4
Ohio	9.9	11.9	14.5	17.3	13.3
Oklahoma	10.7	22.4	20.8	42.9	20.2
Oregon	0.0	15.2	16.7	0.0	12.3
Pennsylvania	9.4	15.0	17.8	15.2	15.1
Rhode Island	0.0	11.8	18.9	50.0	14.4
South Carolina	17.9	18.8	18.6	0.0	17.9
South Dakota	22.7	15.7	41.7	0.0	20.0
Tennessee	3.6	5.7	4.4	10.5	5.0
Texas	3.5	10.9	10.7	13.7	9.7
Utah	3.6	0.0	0.0	0.0	1.0
Vermont	30.0	0.0	31.3	n/a	20.5
Virginia	2.8	2.5	9.2	5.0	5.7
Washington	10.2	13.6	18.6	20.0	15.3
West Virginia	15.0	18.9	25.9	33.3	20.7
Wisconsin	9.1	16.8	15.2	32.0	17.2
Wyoming	0.0	37.5	9.1	0.0	18.9

Source: OSCAR
n/a: Data unavailable

Table 4.14 (c). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**9.4**	**13.8**	**13.7**	**16.6**	**13.2**
Alabama	7.1	9.3	13.7	20.0	11.9
Alaska	30.0	50.0	n/a	100.0	43.8
Arizona	3.7	15.4	14.1	40.0	15.2
Arkansas	33.3	18.4	13.8	28.6	18.3
California	17.4	22.0	29.1	31.0	23.1
Colorado	9.1	9.2	6.0	0.0	7.6
Connecticut	0.0	4.3	4.4	0.0	3.7
Delaware	0.0	28.6	29.4	100.0	28.6
District of Columbia	0.0	0.0	20.0	0.0	5.9
Florida	7.9	18.9	16.6	25.0	16.2
Georgia	0.0	4.9	2.0	3.8	2.9
Hawaii	17.6	9.1	8.3	25.0	13.6
Idaho	10.7	11.5	16.7	n/a	13.1
Illinois	13.7	13.3	13.2	11.3	13.0
Indiana	22.0	22.5	35.1	50.9	29.9
Iowa	2.5	8.4	12.2	0.0	8.1
Kansas	9.8	16.0	18.7	0.0	14.6
Kentucky	17.2	13.9	15.2	50.0	15.9
Louisiana	0.0	3.1	5.2	0.0	3.7
Maine	12.8	13.8	29.4	25.0	15.8
Maryland	0.0	2.4	0.0	3.7	1.0
Massachusetts	4.0	11.1	14.5	28.6	12.1
Michigan	20.0	25.4	26.2	31.3	25.7
Minnesota	19.0	16.4	23.2	28.0	19.7
Mississippi	2.0	7.4	5.3	20.0	5.7
Missouri	5.9	7.1	5.6	7.4	6.3
Montana	21.1	22.6	30.4	0.0	23.4
Nebraska	3.6	7.6	8.2	0.0	6.7
Nevada	16.7	25.0	55.6	25.0	33.3
New Hampshire	5.9	2.9	3.7	0.0	3.6
New Jersey	2.2	3.3	3.3	13.0	4.7
New Mexico	7.1	3.6	13.8	0.0	8.2
New York	4.9	7.1	9.1	8.0	8.1
North Carolina	3.8	14.2	9.0	0.0	10.0
North Dakota	18.5	17.5	13.0	0.0	16.3
Ohio	7.7	10.0	11.6	20.8	11.2
Oklahoma	8.6	25.8	24.3	20.0	22.7
Oregon	2.9	15.9	20.8	0.0	14.5
Pennsylvania	6.3	13.5	14.9	19.4	13.3
Rhode Island	5.6	6.7	18.6	12.5	12.1
South Carolina	8.3	12.9	9.0	20.0	10.6
South Dakota	5.3	24.6	38.5	0.0	22.2
Tennessee	1.7	7.2	4.3	4.2	4.6
Texas	2.8	10.4	8.7	12.8	8.4
Utah	3.1	3.4	3.2	0.0	3.2
Vermont	10.0	14.3	7.1	n/a	10.5
Virginia	0.0	14.1	15.5	20.0	13.0
Washington	15.4	20.2	20.2	25.0	19.4
West Virginia	0.0	14.7	17.2	n/a	12.3
Wisconsin	2.5	9.3	18.5	18.9	13.1
Wyoming	38.5	11.8	16.7	0.0	20.9

Source: OSCAR

n/a: Data unavailable

Table 4.14 (d). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**8.2**	**11.8**	**12.8**	**14.2**	**11.8**
Alabama	18.8	5.3	15.0	25.0	12.3
Alaska	36.4	50.0	n/a	100.0	43.8
Arizona	23.1	10.0	22.9	33.3	20.7
Arkansas	25.8	26.2	25.4	0.0	25.3
California	11.7	20.6	31.2	37.0	21.9
Colorado	7.3	7.1	11.0	12.5	8.8
Connecticut	0.0	5.3	8.6	12.0	7.5
Delaware	0.0	10.0	28.6	0.0	20.0
District of Columbia	0.0	0.0	0.0	25.0	6.7
Florida	5.9	8.1	11.2	10.8	9.9
Georgia	0.0	8.9	8.3	4.0	7.5
Hawaii	17.6	27.3	33.3	33.3	25.6
Idaho	6.9	15.4	13.8	n/a	11.9
Illinois	14.2	10.9	14.2	12.1	12.8
Indiana	16.4	16.4	15.5	40.0	17.5
Iowa	0.0	1.6	1.9	0.0	1.3
Kansas	11.8	13.6	24.7	42.9	15.6
Kentucky	5.1	13.1	19.6	16.7	13.1
Louisiana	0.0	2.6	3.6	0.0	2.7
Maine	13.0	3.0	5.6	0.0	6.9
Maryland	0.0	20.8	4.3	21.1	8.4
Massachusetts	3.7	13.8	12.3	25.0	11.8
Michigan	13.3	21.4	18.9	17.1	18.8
Minnesota	0.0	2.7	3.1	3.1	2.5
Mississippi	0.0	9.2	17.3	0.0	10.5
Missouri	3.7	6.0	6.0	12.0	6.0
Montana	11.6	30.3	17.9	100.0	20.0
Nebraska	5.0	8.7	6.3	0.0	7.2
Nevada	0.0	9.1	40.0	20.0	22.7
New Hampshire	15.4	3.1	0.0	0.0	4.3
New Jersey	0.0	3.8	6.2	7.5	5.4
New Mexico	15.4	18.2	9.4	0.0	13.8
New York	9.1	18.6	10.0	8.3	10.8
North Carolina	0.0	8.7	7.9	15.4	7.6
North Dakota	0.0	5.0	0.0	50.0	3.2
Ohio	6.7	9.9	9.7	13.1	9.6
Oklahoma	14.6	25.4	25.7	22.2	24.1
Oregon	7.1	11.3	22.2	50.0	15.1
Pennsylvania	4.7	9.8	12.1	18.1	11.0
Rhode Island	29.4	17.6	7.0	0.0	14.1
South Carolina	8.8	15.2	18.8	0.0	15.1
South Dakota	37.5	14.8	50.0	n/a	25.0
Tennessee	3.7	3.2	3.2	4.5	3.4
Texas	3.3	9.1	9.9	16.7	8.9
Utah	0.0	3.7	4.0	n/a	2.4
Vermont	0.0	7.1	5.6	n/a	4.3
Virginia	10.8	9.5	16.2	12.5	13.0
Washington	18.0	17.1	23.4	0.0	19.3
West Virginia	6.9	11.3	25.0	0.0	14.9
Wisconsin	5.9	8.2	15.4	15.1	11.4
Wyoming	7.7	42.9	25.0	0.0	25.0

Source: OSCAR

n/a: Data unavailable

Table 4.14 (e). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**8.1**	**11.1**	**12.0**	**13.0**	**11.2**
Alabama	0.0	12.3	5.3	11.1	8.0
Alaska	0.0	40.0	n/a	0.0	14.3
Arizona	5.3	26.7	19.5	13.3	18.4
Arkansas	25.0	22.6	28.0	33.3	25.9
California	10.9	19.1	25.5	28.3	19.4
Colorado	7.8	10.7	11.6	0.0	10.1
Connecticut	20.0	9.1	11.7	13.0	11.5
Delaware	0.0	9.1	25.9	0.0	18.2
District of Columbia	0.0	12.5	0.0	0.0	4.8
Florida	0.0	4.8	9.8	7.5	7.6
Georgia	4.2	4.5	9.7	8.7	7.5
Hawaii	0.0	22.2	15.4	0.0	9.8
Idaho	29.0	36.0	33.3	n/a	32.5
Illinois	5.8	9.4	13.9	14.8	11.6
Indiana	11.9	8.4	14.4	17.1	12.0
Iowa	1.3	1.9	1.0	0.0	1.6
Kansas	9.3	13.8	15.5	0.0	12.7
Kentucky	8.7	13.6	17.7	50.0	14.6
Louisiana	2.2	5.5	11.0	20.8	9.5
Maine	4.9	6.1	0.0	0.0	4.8
Maryland	0.0	3.8	3.1	2.9	2.7
Massachusetts	10.3	12.1	14.9	26.3	13.8
Michigan	12.2	15.4	19.3	15.0	17.0
Minnesota	1.6	3.7	2.0	0.0	2.7
Mississippi	3.2	11.5	14.5	0.0	11.0
Missouri	9.2	4.3	2.5	3.1	4.2
Montana	22.5	28.6	13.0	0.0	21.5
Nebraska	3.8	2.9	12.8	0.0	5.1
Nevada	7.7	50.0	10.5	0.0	18.8
New Hampshire	8.3	3.1	3.3	0.0	3.8
New Jersey	2.7	3.6	8.0	8.9	6.9
New Mexico	15.4	3.1	21.9	0.0	12.8
New York	8.3	9.6	12.5	11.1	11.2
North Carolina	1.9	4.6	6.6	17.6	5.8
North Dakota	14.8	5.6	4.5	0.0	8.0
Ohio	5.0	7.8	9.1	15.2	8.6
Oklahoma	26.9	35.8	29.0	57.1	32.3
Oregon	4.3	10.5	7.3	0.0	8.3
Pennsylvania	2.9	7.5	8.8	9.8	7.6
Rhode Island	0.0	6.9	11.9	16.7	8.5
South Carolina	14.0	16.1	15.7	0.0	14.9
South Dakota	8.3	12.3	21.4	n/a	12.2
Tennessee	12.5	6.5	9.5	5.6	8.8
Texas	4.1	13.1	11.1	12.5	11.0
Utah	6.7	0.0	0.0	0.0	2.1
Vermont	14.3	0.0	5.3	n/a	6.7
Virginia	2.6	8.4	7.2	15.0	7.5
Washington	22.4	19.1	16.2	28.6	18.8
West Virginia	9.1	13.2	16.1	0.0	13.3
Wisconsin	5.3	11.8	17.0	20.8	14.1
Wyoming	18.2	0.0	7.1	0.0	7.1

Source: OSCAR

n/a: Data unavailable

Table 4.14 (f). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**7.8**	**10.9**	**12.6**	**15.2**	**11.3**
Alabama	0.0	7.9	9.4	15.4	8.7
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	5.6	0.0	11.7	13.3	8.2
Arkansas	25.0	22.7	17.5	50.0	18.9
California	11.1	17.6	26.1	29.6	18.7
Colorado	8.2	5.1	18.6	20.0	10.6
Connecticut	20.0	19.7	26.5	38.1	25.3
Delaware	0.0	10.0	8.0	0.0	7.5
District of Columbia	0.0	14.3	0.0	0.0	4.8
Florida	0.0	7.1	6.6	21.1	7.4
Georgia	4.2	8.1	7.8	9.1	8.0
Hawaii	0.0	27.3	60.0	50.0	37.1
Idaho	31.3	17.4	19.2	n/a	12.8
Illinois	6.0	8.8	10.7	11.3	9.5
Indiana	12.4	7.4	10.5	30.6	10.7
Iowa	1.8	2.3	6.5	0.0	3.4
Kansas	6.8	16.7	26.4	0.0	17.9
Kentucky	9.0	19.8	13.9	20.0	14.5
Louisiana	2.2	27.7	22.3	30.0	22.9
Maine	5.0	11.7	7.7	0.0	9.4
Maryland	0.0	0.0	2.7	6.7	2.8
Massachusetts	9.3	10.6	17.6	29.4	13.2
Michigan	12.8	8.8	12.0	14.3	10.5
Minnesota	1.6	5.5	1.7	4.3	4.0
Mississippi	3.3	14.0	23.4	0.0	15.9
Missouri	9.7	7.9	4.9	5.6	6.1
Montana	21.1	4.3	7.7	0.0	10.2
Nebraska	4.0	3.1	13.5	0.0	4.7
Nevada	0.0	10.0	27.3	33.3	28.0
New Hampshire	0.0	10.3	6.7	0.0	6.7
New Jersey	2.9	7.0	14.5	7.3	10.8
New Mexico	15.4	13.8	21.4	0.0	13.9
New York	8.7	13.7	14.4	14.2	13.3
North Carolina	1.9	10.9	8.4	13.3	8.6
North Dakota	12.0	7.3	17.4	33.3	9.7
Ohio	5.7	7.0	7.6	17.2	7.7
Oklahoma	23.8	26.2	33.3	25.0	27.7
Oregon	4.3	9.8	15.2	0.0	11.4
Pennsylvania	3.4	2.4	10.5	9.9	7.3
Rhode Island	0.0	18.8	5.3	40.0	10.5
South Carolina	11.9	6.4	3.2	0.0	3.9
South Dakota	8.8	14.8	14.3	n/a	13.5
Tennessee	13.0	15.1	23.5	19.0	19.1
Texas	2.4	5.3	8.9	11.8	7.2
Utah	6.9	0.0	9.1	0.0	6.4
Vermont	7.7	25.0	11.1	n/a	11.9
Virginia	2.8	14.8	11.6	11.1	11.5
Washington	20.9	14.7	14.3	16.7	15.1
West Virginia	6.9	14.3	12.8	0.0	10.8
Wisconsin	3.1	12.5	9.7	13.3	10.7
Wyoming	22.2	23.1	7.7	n/a	13.2

Source: OSCAR

n/a: Data unavailable

Table 4.15 (a). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 1996

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**14.4**	**14.1**	**15.5**	**14.4**
Alabama	20.2	29.0	27.3	22.2
Alaska	0.0	0.0	0.0	0.0
Arizona	14.8	20.0	50.0	17.7
Arkansas	9.8	27.3	7.1	12.3
California	27.1	26.4	28.1	27.0
Colorado	7.6	5.1	4.8	6.6
Connecticut	2.5	0.0	0.0	1.9
Delaware	20.0	14.3	66.7	21.6
District of Columbia	0.0	0.0	0.0	0.0
Florida	16.7	19.3	20.0	17.3
Georgia	2.2	8.2	0.0	3.1
Hawaii	0.0	14.3	18.2	9.8
Idaho	12.2	15.4	20.0	14.6
Illinois	14.3	16.7	20.0	15.3
Indiana	11.5	11.4	13.3	11.5
Iowa	7.1	9.5	8.3	8.1
Kansas	14.6	16.2	13.3	15.0
Kentucky	12.6	8.2	9.1	11.1
Louisiana	6.0	1.5	4.0	5.0
Maine	8.2	9.4	16.7	8.8
Maryland	4.5	10.2	0.0	6.6
Massachusetts	25.8	12.4	21.4	22.6
Michigan	23.7	27.8	16.7	24.2
Minnesota	13.8	13.8	11.1	13.4
Mississippi	10.8	13.3	3.2	10.0
Missouri	9.8	13.2	16.0	11.2
Montana	13.2	21.4	22.2	18.4
Nebraska	7.4	10.8	10.2	9.2
Nevada	62.9	28.6	50.0	56.3
New Hampshire	10.4	3.3	0.0	6.5
New Jersey	6.6	4.6	0.0	5.5
New Mexico	17.3	3.7	0.0	11.5
New York	8.5	11.3	19.6	10.6
North Carolina	10.5	10.3	0.0	10.1
North Dakota	20.0	23.7	0.0	22.7
Ohio	16.1	17.2	26.8	16.8
Oklahoma	19.0	8.5	30.0	18.1
Oregon	14.1	11.8	0.0	13.1
Pennsylvania	21.6	14.9	18.4	17.8
Rhode Island	5.6	15.4	n/a	8.2
South Carolina	29.1	16.1	10.0	24.7
South Dakota	23.7	22.7	0.0	22.0
Tennessee	15.2	17.7	20.7	16.2
Texas	7.9	4.6	8.1	7.5
Utah	6.8	0.0	25.0	6.5
Vermont	18.2	12.5	100.0	20.9
Virginia	16.0	11.8	41.7	15.8
Washington	17.7	19.4	27.3	18.8
West Virginia	12.7	8.0	16.7	12.1
Wisconsin	16.0	10.1	18.2	14.1
Wyoming	0.0	0.0	0.0	0.0

Source: OSCAR

n/a: Data unavailable

Table 4.15 (b). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 1997

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**14.0**	**13.0**	**16.1**	**13.9**
Alabama	16.9	10.7	22.2	16.5
Alaska	0.0	12.5	42.9	25.0
Arizona	18.2	22.0	100.0	20.2
Arkansas	12.9	23.3	6.7	14.2
California	26.1	25.0	32.8	26.1
Colorado	12.9	3.0	17.4	10.5
Connecticut	4.2	3.3	0.0	4.0
Delaware	0.0	14.3	50.0	11.1
District of Columbia	10.0	0.0	0.0	3.8
Florida	14.9	8.1	9.1	13.5
Georgia	4.0	1.6	4.8	3.6
Hawaii	11.1	7.1	20.0	11.9
Idaho	25.0	15.4	42.1	27.4
Illinois	16.9	17.6	13.0	16.9
Indiana	25.6	27.3	37.5	26.4
Iowa	9.6	9.2	0.0	9.0
Kansas	20.4	15.3	16.4	18.3
Kentucky	10.1	16.3	30.0	12.8
Louisiana	3.5	4.2	0.0	3.4
Maine	6.1	9.4	0.0	6.6
Maryland	2.2	4.2	0.0	2.9
Massachusetts	16.2	11.0	6.7	14.6
Michigan	17.8	18.8	24.4	18.6
Minnesota	22.6	27.3	21.0	24.9
Mississippi	6.2	0.0	3.3	4.8
Missouri	7.0	6.6	8.3	7.0
Montana	2.6	6.5	10.0	5.8
Nebraska	2.8	12.5	5.5	6.6
Nevada	51.6	66.7	50.0	52.4
New Hampshire	10.2	3.4	0.0	6.6
New Jersey	7.1	8.2	0.0	7.1
New Mexico	14.0	18.5	14.3	15.6
New York	8.9	6.8	20.0	9.1
North Carolina	7.3	5.8	5.6	6.9
North Dakota	11.1	20.0	0.0	18.4
Ohio	14.1	10.0	16.7	13.3
Oklahoma	20.4	19.6	18.5	20.2
Oregon	11.0	15.6	20.0	12.3
Pennsylvania	22.0	9.2	22.2	15.1
Rhode Island	18.1	4.0	n/a	14.4
South Carolina	17.0	17.4	23.8	17.9
South Dakota	10.5	23.8	50.0	20.0
Tennessee	4.0	4.8	14.8	5.0
Texas	9.9	9.1	5.3	9.7
Utah	1.3	0.0	0.0	1.0
Vermont	24.1	10.0	n/a	20.5
Virginia	6.3	2.5	25.0	5.7
Washington	15.9	14.1	13.0	15.3
West Virginia	18.5	20.0	37.5	20.7
Wisconsin	16.2	20.0	12.9	17.2
Wyoming	5.9	16.7	35.7	18.9

Source: OSCAR

n/a: Data unavailable

Table 4.15 (c). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 1998

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**13.7**	**11.9**	**13.7**	**13.2**
Alabama	12.6	9.7	9.1	11.9
Alaska	0.0	60.0	20.0	43.8
Arizona	15.5	13.3	33.3	15.2
Arkansas	16.9	23.8	21.4	18.3
California	23.0	23.0	26.1	23.1
Colorado	6.4	8.2	13.0	7.6
Connecticut	3.6	4.0	0.0	3.7
Delaware	36.4	15.4	50.0	28.6
District of Columbia	0.0	9.1	0.0	5.9
Florida	18.4	9.6	0.0	16.2
Georgia	3.1	1.4	3.8	2.9
Hawaii	10.5	14.3	18.2	13.6
Idaho	15.7	0.0	15.8	13.1
Illinois	11.4	15.2	18.4	13.0
Indiana	29.2	33.1	20.0	29.9
Iowa	9.2	6.9	4.8	8.1
Kansas	16.5	10.8	16.7	14.6
Kentucky	16.3	13.9	33.3	15.9
Louisiana	4.3	2.6	0.0	3.7
Maine	14.3	20.0	20.0	15.8
Maryland	1.7	0.0	0.0	1.0
Massachusetts	14.3	7.7	0.0	12.1
Michigan	26.6	18.0	40.5	25.7
Minnesota	14.5	20.2	30.9	19.7
Mississippi	7.0	5.6	0.0	5.7
Missouri	6.5	6.1	5.7	6.3
Montana	11.8	29.5	31.3	23.4
Nebraska	7.1	2.7	11.1	6.7
Nevada	36.8	0.0	28.6	33.3
New Hampshire	6.5	0.0	0.0	3.6
New Jersey	5.3	4.2	0.0	4.7
New Mexico	6.4	14.3	0.0	8.2
New York	7.3	8.5	10.0	8.1
North Carolina	10.7	8.2	6.7	10.0
North Dakota	0.0	17.5	50.0	16.3
Ohio	10.7	14.4	0.0	11.2
Oklahoma	24.7	17.0	4.5	22.7
Oregon	16.9	8.3	0.0	14.5
Pennsylvania	18.3	8.8	19.1	13.3
Rhode Island	12.8	9.5	n/a	12.1
South Carolina	13.4	0.0	5.3	10.6
South Dakota	19.4	22.2	40.0	22.2
Tennessee	4.8	4.9	2.9	4.6
Texas	9.1	5.9	2.4	8.4
Utah	4.1	0.0	0.0	3.2
Vermont	12.0	8.3	0.0	10.5
Virginia	15.8	8.5	10.0	13.0
Washington	19.6	17.6	23.8	19.4
West Virginia	13.0	9.5	16.7	12.3
Wisconsin	17.1	9.7	8.2	13.1
Wyoming	10.5	16.7	33.3	20.9

Source: OSCAR

n/a: Data unavailable

Table 4.15 (d). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 1999

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**12.7**	**11.8**	**10.7**	**11.8**
Alabama	10.3	5.3	23.8	12.3
Alaska	100.0	50.0	40.0	43.8
Arizona	17.5	10.0	33.3	20.7
Arkansas	24.9	26.2	0.0	25.3
California	24.4	20.6	14.0	21.9
Colorado	11.0	7.1	4.0	8.8
Connecticut	7.9	5.3	0.0	7.5
Delaware	18.8	10.0	33.3	20.0
District of Columbia	0.0	0.0	100.0	6.7
Florida	10.4	8.1	15.4	9.9
Georgia	7.6	8.9	0.0	7.5
Hawaii	28.6	27.3	27.3	25.6
Idaho	13.5	15.4	5.3	11.9
Illinois	12.5	10.9	11.1	12.8
Indiana	18.1	16.4	5.9	17.5
Iowa	0.9	1.6	0.0	1.3
Kansas	17.5	13.6	9.1	15.6
Kentucky	13.8	13.1	20.0	13.1
Louisiana	1.8	2.6	0.0	2.7
Maine	6.5	3.0	0.0	6.9
Maryland	11.5	20.8	16.7	8.4
Massachusetts	13.4	13.8	0.0	11.8
Michigan	19.7	21.4	17.9	18.8
Minnesota	4.8	2.7	3.4	2.5
Mississippi	12.6	9.2	3.8	10.5
Missouri	5.1	6.0	8.2	6.0
Montana	13.5	30.3	26.3	20.0
Nebraska	4.7	8.7	14.3	7.2
Nevada	29.0	9.1	20.0	22.7
New Hampshire	5.6	3.1	0.0	4.3
New Jersey	5.5	3.8	5.6	5.4
New Mexico	14.6	18.2	20.0	13.8
New York	8.9	18.6	19.6	10.8
North Carolina	7.9	8.7	5.9	7.6
North Dakota	0.0	5.0	0.0	3.2
Ohio	11.2	9.9	6.7	9.6
Oklahoma	23.9	25.4	23.5	24.1
Oregon	17.6	11.3	0.0	15.1
Pennsylvania	11.2	9.8	15.6	11.0
Rhode Island	17.6	17.6	n/a	14.1
South Carolina	18.1	15.2	11.8	15.1
South Dakota	21.2	14.8	0.0	25.0
Tennessee	2.1	3.2	11.4	3.4
Texas	9.5	9.1	7.5	8.9
Utah	3.2	3.7	0.0	2.4
Vermont	3.3	7.1	0.0	4.3
Virginia	15.2	9.5	0.0	13.0
Washington	20.0	17.1	21.7	19.3
West Virginia	18.7	11.3	6.7	14.9
Wisconsin	15.0	8.2	7.9	11.4
Wyoming	27.8	42.9	29.4	25.0

Source: OSCAR

n/a: Data unavailable

Table 4.15 (e). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 2000

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**12.1**	**8.9**	**11.4**	**11.2**
Alabama	7.1	7.1	15.8	8.0
Alaska	n/a	22.2	0.0	14.3
Arizona	20.4	15.9	0.0	18.4
Arkansas	25.1	28.6	30.8	25.9
California	20.3	17.6	12.5	19.4
Colorado	11.6	6.9	9.1	10.1
Connecticut	10.6	15.3	0.0	11.5
Delaware	15.0	21.1	20.0	18.2
District of Columbia	0.0	7.7	0.0	4.8
Florida	8.2	6.2	0.0	7.6
Georgia	7.2	7.3	12.0	7.5
Hawaii	17.6	6.7	0.0	9.8
Idaho	32.6	26.7	36.8	32.5
Illinois	13.0	7.8	17.9	11.6
Indiana	13.0	9.5	7.1	12.0
Iowa	0.8	2.7	0.0	1.6
Kansas	15.6	7.5	10.4	12.7
Kentucky	15.6	10.8	37.5	14.6
Louisiana	11.4	3.4	0.0	9.5
Maine	6.4	0.0	0.0	4.8
Maryland	2.6	3.0	0.0	2.7
Massachusetts	16.9	7.8	0.0	13.8
Michigan	16.8	16.8	19.0	17.0
Minnesota	2.3	3.5	0.0	2.7
Mississippi	8.9	16.7	17.4	11.0
Missouri	3.2	5.3	7.7	4.2
Montana	11.4	34.9	6.7	21.5
Nebraska	6.0	5.6	2.4	5.1
Nevada	20.6	12.5	0.0	18.8
New Hampshire	2.5	3.7	8.3	3.8
New Jersey	8.6	2.7	7.7	6.9
New Mexico	18.4	4.5	0.0	12.8
New York	6.3	13.7	26.5	11.2
North Carolina	7.0	2.0	5.6	5.8
North Dakota	16.7	5.6	33.3	8.0
Ohio	10.0	5.2	3.4	8.6
Oklahoma	32.2	31.8	33.3	32.3
Oregon	10.3	3.0	0.0	8.3
Pennsylvania	8.6	6.6	10.3	7.6
Rhode Island	9.2	5.6	n/a	8.5
South Carolina	15.6	16.0	9.1	14.9
South Dakota	8.7	15.5	0.0	12.2
Tennessee	9.7	5.7	10.3	8.8
Texas	11.6	9.8	0.0	11.0
Utah	1.3	6.3	0.0	2.1
Vermont	0.0	20.0	0.0	6.7
Virginia	10.1	3.2	0.0	7.5
Washington	19.3	14.3	30.0	18.8
West Virginia	14.4	7.9	23.1	13.3
Wisconsin	15.1	11.6	19.3	14.1
Wyoming	4.5	0.0	14.3	7.1

Source: OSCAR

n/a: Data unavailable

Table 4.15 (f). Nursing Home Surveys Resulting in a Citation for Use of Physical Restraints by Type of Ownership: United States, 2001

	Percent by Ownership			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**12.6**	**8.4**	**10.5**	**11.3**
Alabama	9.4	7.4	5.3	8.7
Alaska	0.0	0.0	0.0	0.0
Arizona	9.5	5.4	0.0	8.2
Arkansas	20.6	12.2	11.1	18.9
California	20.3	12.8	17.8	18.7
Colorado	13.3	3.8	9.5	10.6
Connecticut	27.3	19.6	0.0	25.3
Delaware	5.3	5.6	33.3	7.5
District of Columbia	0.0	7.7	0.0	4.8
Florida	7.4	6.5	15.4	7.4
Georgia	7.4	8.6	12.0	8.0
Hawaii	37.5	23.1	66.7	37.1
Idaho	11.1	14.3	15.8	12.8
Illinois	10.0	7.7	11.4	9.5
Indiana	11.3	9.5	6.3	10.7
Iowa	3.4	3.2	4.2	3.4
Kansas	25.3	8.9	13.2	17.9
Kentucky	17.2	10.1	0.0	14.5
Louisiana	20.4	32.8	23.8	22.9
Maine	8.4	10.7	16.7	9.4
Maryland	2.5	1.7	16.7	2.8
Massachusetts	14.2	10.4	16.7	13.2
Michigan	10.5	11.5	8.3	10.5
Minnesota	3.8	3.8	5.1	4.0
Mississippi	17.9	11.1	10.7	15.9
Missouri	6.9	3.2	10.3	6.1
Montana	7.1	7.3	21.1	10.2
Nebraska	4.1	5.5	5.1	4.7
Nevada	24.3	37.5	40.0	28.0
New Hampshire	2.5	13.0	8.3	6.7
New Jersey	12.4	7.8	10.5	10.8
New Mexico	14.9	15.0	0.0	13.9
New York	13.8	12.5	14.3	13.3
North Carolina	9.3	8.2	0.0	8.6
North Dakota	11.1	10.0	0.0	9.7
Ohio	9.5	2.8	6.7	7.7
Oklahoma	30.9	9.5	8.3	27.7
Oregon	12.1	8.6	16.7	11.4
Pennsylvania	10.0	4.6	10.3	7.3
Rhode Island	12.5	4.3	n/a	10.5
South Carolina	3.7	9.5	0.0	3.9
South Dakota	5.9	18.8	0.0	13.5
Tennessee	21.1	14.0	17.2	19.1
Texas	8.5	2.2	0.0	7.2
Utah	7.9	0.0	0.0	6.4
Vermont	14.3	7.7	0.0	11.9
Virginia	12.3	11.4	0.0	11.5
Washington	14.3	17.5	14.8	15.1
West Virginia	11.0	3.6	30.0	10.8
Wisconsin	11.3	11.0	8.1	10.7
Wyoming	21.4	0.0	10.5	13.2

Source: OSCAR
n/a: Data unavailable

Table 4.16 (a). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 1996

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**7.9**	**15.1**	**17.8**	**19.0**	**15.3**
Alabama	5.9	19.5	26.2	50.0	23.1
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	3.3	8.8	4.3	0.0	4.8
Arkansas	15.2	27.9	33.3	50.0	29.5
California	12.4	20.4	26.5	27.0	20.3
Colorado	14.3	13.2	24.7	14.3	17.9
Connecticut	5.6	9.7	13.3	24.0	12.8
Delaware	0.0	12.5	16.7	n/a	13.5
District of Columbia	0.0	12.5	66.7	20.0	20.0
Florida	1.2	14.4	17.5	21.2	15.0
Georgia	0.0	12.7	9.5	12.5	10.2
Hawaii	6.7	0.0	18.2	0.0	7.3
Idaho	3.0	8.0	4.3	0.0	4.9
Illinois	8.9	13.8	17.9	12.2	14.5
Indiana	15.0	16.3	20.9	24.1	18.5
Iowa	6.2	21.4	27.5	27.3	20.3
Kansas	21.0	32.1	47.1	60.0	32.4
Kentucky	1.2	2.4	6.9	14.3	3.8
Louisiana	3.4	9.7	7.1	14.3	7.4
Maine	2.6	6.1	3.6	33.3	5.1
Maryland	0.0	4.1	11.1	16.1	8.4
Massachusetts	1.6	8.1	7.6	19.0	6.8
Michigan	8.9	24.3	48.2	38.6	36.1
Minnesota	5.8	10.3	14.6	15.4	11.5
Mississippi	2.4	9.0	26.7	0.0	14.0
Missouri	4.6	16.7	15.1	14.3	14.1
Montana	11.9	15.2	28.6	100.0	18.4
Nebraska	12.5	14.5	33.3	40.0	18.4
Nevada	0.0	37.5	31.3	0.0	16.7
New Hampshire	0.0	28.2	9.7	28.6	17.4
New Jersey	2.9	3.3	4.0	10.4	5.0
New Mexico	5.3	3.4	8.1	0.0	5.7
New York	8.9	11.1	14.5	14.7	13.6
North Carolina	4.3	9.0	11.8	16.7	10.1
North Dakota	17.4	20.5	33.3	100.0	25.0
Ohio	14.6	11.1	20.9	27.8	17.8
Oklahoma	4.4	9.2	16.6	42.9	11.6
Oregon	10.8	28.2	18.6	0.0	20.8
Pennsylvania	3.2	7.4	15.7	15.3	11.4
Rhode Island	0.0	6.3	9.8	16.7	7.1
South Carolina	20.0	21.5	29.9	33.3	24.7
South Dakota	11.1	25.8	13.3	0.0	20.2
Tennessee	11.5	12.2	13.2	28.6	13.6
Texas	4.9	11.6	13.0	17.4	11.3
Utah	0.0	5.9	16.7	0.0	7.5
Vermont	7.1	9.1	16.7	n/a	11.6
Virginia	2.5	12.8	14.4	23.8	12.9
Washington	11.6	31.8	34.7	20.0	29.6
West Virginia	0.0	1.9	7.7	100.0	4.3
Wisconsin	9.5	7.6	13.4	16.1	10.9
Wyoming	0.0	5.3	18.2	0.0	7.7

Source: OSCAR

n/a: Data unavailable

Table 4.16 (b). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 1997

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**7.8**	**15.6**	**19.5**	**21.4**	**16.3**
Alabama	18.2	42.3	62.7	55.6	52.0
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	4.8	7.7	1.6	0.0	3.4
Arkansas	5.7	30.3	32.6	42.9	28.7
California	12.6	22.5	30.6	40.3	22.8
Colorado	3.1	8.8	19.8	14.3	11.4
Connecticut	18.8	12.2	21.9	14.8	18.1
Delaware	40.0	8.3	55.6	100.0	42.2
District of Columbia	0.0	0.0	0.0	50.0	15.4
Florida	8.7	10.9	19.8	22.6	16.6
Georgia	0.0	6.3	9.6	16.0	8.4
Hawaii	21.4	28.6	0.0	0.0	16.7
Idaho	6.3	16.0	29.6	n/a	16.7
Illinois	15.2	25.5	18.5	23.4	21.2
Indiana	7.0	11.8	17.8	12.3	13.1
Iowa	11.1	15.7	23.1	22.2	16.8
Kansas	16.5	29.4	43.3	33.3	29.0
Kentucky	6.1	5.8	11.1	20.0	7.9
Louisiana	1.7	7.7	10.2	4.2	8.0
Maine	2.3	7.4	4.8	0.0	5.1
Maryland	2.3	16.3	11.6	12.9	10.9
Massachusetts	3.5	5.2	9.1	9.5	7.0
Michigan	25.5	28.7	39.1	48.6	35.4
Minnesota	0.0	6.2	13.9	7.4	8.2
Mississippi	10.9	18.8	22.5	0.0	18.1
Missouri	3.3	11.8	14.7	35.7	12.9
Montana	19.0	8.6	28.0	0.0	17.3
Nebraska	5.0	12.2	14.6	0.0	10.7
Nevada	5.6	14.3	53.3	0.0	23.8
New Hampshire	8.3	19.5	30.3	20.0	22.0
New Jersey	6.5	4.3	4.3	11.7	5.8
New Mexico	0.0	6.5	3.6	0.0	3.9
New York	6.8	10.2	15.2	12.6	12.8
North Carolina	0.0	4.0	9.6	0.0	6.1
North Dakota	15.0	24.2	52.4	0.0	28.9
Ohio	7.2	19.8	27.3	30.7	22.3
Oklahoma	2.7	10.2	17.4	0.0	11.1
Oregon	9.1	24.2	18.5	0.0	18.7
Pennsylvania	5.0	8.4	13.9	14.1	10.9
Rhode Island	5.0	5.9	13.5	16.7	9.3
South Carolina	15.4	18.8	31.4	33.3	23.5
South Dakota	4.5	8.6	0.0	100.0	7.6
Tennessee	5.4	16.2	12.7	31.6	13.6
Texas	5.3	12.5	15.5	25.5	13.2
Utah	3.6	11.8	9.4	0.0	8.3
Vermont	0.0	15.4	25.0	n/a	15.4
Virginia	0.0	9.9	23.9	40.0	17.1
Washington	18.4	31.4	39.8	60.0	33.6
West Virginia	0.0	8.1	11.1	33.3	8.0
Wisconsin	0.0	6.5	12.0	34.0	11.0
Wyoming	11.1	6.3	18.2	100.0	13.5

Source: OSCAR
n/a: Data unavailable

Table 4.16 (c). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 1998

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**9.9**	**16.3**	**20.6**	**21.2**	**17.3**
Alabama	35.7	17.4	28.2	10.0	23.8
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	3.7	3.8	20.3	13.3	12.9
Arkansas	6.7	19.4	32.5	0.0	23.6
California	13.1	23.3	34.3	50.0	24.9
Colorado	5.5	9.2	11.9	33.3	10.3
Connecticut	6.7	20.0	25.5	31.8	23.4
Delaware	0.0	0.0	35.3	100.0	25.0
District of Columbia	0.0	0.0	20.0	20.0	11.8
Florida	7.9	18.2	24.0	25.0	20.6
Georgia	3.0	7.3	12.7	11.5	10.1
Hawaii	11.8	63.6	8.3	25.0	25.0
Idaho	14.3	26.9	40.0	n/a	27.4
Illinois	14.5	26.6	27.1	27.2	25.3
Indiana	12.6	17.8	20.7	27.3	18.6
Iowa	5.0	15.7	21.5	11.1	15.1
Kansas	17.2	33.6	42.7	25.0	30.6
Kentucky	9.2	16.4	13.3	16.7	13.4
Louisiana	5.5	9.2	12.9	12.0	11.1
Maine	0.0	3.1	11.8	25.0	3.8
Maryland	2.4	4.8	16.0	11.1	10.2
Massachusetts	5.0	15.1	9.4	19.0	10.3
Michigan	20.0	22.2	37.1	46.9	31.4
Minnesota	12.1	7.2	22.5	36.0	14.7
Mississippi	16.3	13.6	16.0	60.0	16.2
Missouri	9.4	12.9	19.9	25.9	15.9
Montana	13.2	19.4	17.4	50.0	17.0
Nebraska	12.5	13.0	30.6	75.0	17.5
Nevada	5.6	50.0	38.9	25.0	27.1
New Hampshire	11.8	11.8	22.2	0.0	14.5
New Jersey	0.0	4.9	9.3	9.3	7.3
New Mexico	21.4	7.1	6.9	0.0	9.6
New York	9.8	11.2	14.8	10.0	12.1
North Carolina	1.9	7.4	17.5	10.0	11.8
North Dakota	22.2	25.0	17.4	0.0	21.7
Ohio	12.6	20.7	23.8	20.8	21.0
Oklahoma	8.6	10.0	17.4	20.0	12.6
Oregon	14.3	14.5	17.0	0.0	15.1
Pennsylvania	10.9	11.8	20.4	15.3	16.0
Rhode Island	0.0	0.0	18.6	12.5	9.1
South Carolina	22.2	33.9	31.3	20.0	30.0
South Dakota	0.0	15.8	38.5	0.0	15.6
Tennessee	1.7	15.5	13.9	4.2	11.7
Texas	5.2	11.6	14.9	19.1	12.4
Utah	9.4	13.8	12.9	0.0	11.7
Vermont	10.0	0.0	21.4	n/a	10.5
Virginia	5.7	11.5	19.1	13.3	14.3
Washington	19.2	28.1	35.8	62.5	30.4
West Virginia	0.0	0.0	10.3	n/a	3.7
Wisconsin	5.0	6.0	9.3	28.3	9.8
Wyoming	15.4	0.0	16.7	0.0	9.3

Source: OSCAR

n/a: Data unavailable

Table 4.16 (d). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 1999

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**10.8**	**17.4**	**21.6**	**25.4**	**18.6**
Alabama	12.5	21.3	34.0	33.3	27.6
Alaska	9.1	25.0	n/a	0.0	12.5
Arizona	0.0	15.0	22.9	50.0	19.5
Arkansas	12.9	29.8	23.8	0.0	24.1
California	20.6	28.1	31.9	38.9	27.9
Colorado	5.5	9.4	12.1	25.0	10.0
Connecticut	7.7	12.0	19.4	36.0	18.3
Delaware	0.0	20.0	23.8	0.0	20.0
District of Columbia	0.0	16.7	0.0	0.0	6.7
Florida	2.0	11.0	16.5	16.2	13.5
Georgia	0.0	8.0	17.1	24.0	13.3
Hawaii	17.6	9.1	33.3	0.0	18.6
Idaho	10.3	26.9	37.9	n/a	25.0
Illinois	14.2	31.9	30.0	26.1	27.9
Indiana	13.4	10.2	23.2	31.4	17.2
Iowa	10.0	12.8	19.4	28.6	14.1
Kansas	16.8	31.7	41.6	42.9	29.5
Kentucky	10.1	15.9	27.8	33.3	18.7
Louisiana	0.0	13.2	12.6	18.5	11.4
Maine	10.9	10.6	16.7	0.0	11.5
Maryland	3.3	12.5	28.6	21.1	19.6
Massachusetts	1.2	8.0	14.0	10.0	10.0
Michigan	13.3	30.8	34.4	42.9	31.8
Minnesota	5.8	9.1	20.2	31.3	13.6
Mississippi	11.1	17.1	22.7	66.7	18.9
Missouri	11.1	17.2	29.3	40.0	22.4
Montana	25.6	48.5	32.1	0.0	34.3
Nebraska	10.0	13.5	18.8	0.0	13.6
Nevada	0.0	18.2	35.0	40.0	25.0
New Hampshire	15.4	15.6	36.8	40.0	23.2
New Jersey	0.0	11.3	14.1	22.6	13.6
New Mexico	0.0	3.0	6.3	0.0	3.8
New York	31.8	18.6	24.1	17.2	21.3
North Carolina	2.4	13.0	17.8	30.8	14.9
North Dakota	13.8	22.5	47.8	50.0	26.6
Ohio	16.4	19.8	24.8	37.7	23.1
Oklahoma	8.3	7.0	19.1	33.3	12.2
Oregon	25.0	32.3	35.2	100.0	32.9
Pennsylvania	8.1	15.0	18.3	21.3	16.1
Rhode Island	0.0	11.8	18.6	0.0	12.1
South Carolina	23.5	15.2	26.1	0.0	21.7
South Dakota	4.2	13.0	50.0	n/a	14.8
Tennessee	7.4	12.6	17.8	31.8	15.7
Texas	5.4	10.5	13.5	12.5	11.3
Utah	0.0	18.5	16.0	n/a	11.0
Vermont	13.3	0.0	11.1	n/a	8.5
Virginia	5.4	11.6	18.5	18.8	14.4
Washington	12.0	26.7	36.0	62.5	28.8
West Virginia	3.4	3.2	14.6	0.0	7.1
Wisconsin	5.9	11.4	10.1	24.5	12.1
Wyoming	15.4	0.0	16.7	0.0	10.0

Source: OSCAR

n/a: Data unavailable

Table 4.16 (e). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 2000

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**10.3**	**16.1**	**21.6**	**24.7**	**18.2**
Alabama	8.3	16.4	19.1	22.2	17.6
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	10.0	18.2	13.3	13.5
Arkansas	7.1	21.5	30.1	16.7	24.4
California	15.8	26.4	32.3	35.8	26.2
Colorado	7.8	17.3	24.4	66.7	19.3
Connecticut	6.7	18.2	31.2	30.4	26.0
Delaware	0.0	9.1	22.2	0.0	15.9
District of Columbia	0.0	12.5	0.0	16.7	9.5
Florida	4.9	8.9	11.5	15.0	10.5
Georgia	8.3	11.6	16.1	4.3	13.3
Hawaii	11.8	33.3	53.8	0.0	29.3
Idaho	12.9	24.0	25.0	n/a	20.0
Illinois	15.4	25.6	29.3	22.2	25.1
Indiana	16.5	12.0	19.6	19.5	16.4
Iowa	1.3	10.9	15.5	0.0	10.0
Kansas	18.5	29.8	42.3	28.6	29.0
Kentucky	7.2	10.9	24.0	33.3	14.9
Louisiana	2.2	20.5	10.1	25.0	12.2
Maine	0.0	3.0	11.8	0.0	3.2
Maryland	2.2	5.8	12.4	2.9	8.0
Massachusetts	3.4	7.6	16.5	15.8	11.8
Michigan	12.2	25.2	29.1	32.5	26.5
Minnesota	9.5	10.6	17.6	34.8	14.0
Mississippi	9.7	14.9	22.4	66.7	18.5
Missouri	19.7	16.5	33.5	37.5	25.1
Montana	30.0	25.0	30.4	50.0	29.0
Nebraska	7.5	15.5	17.9	0.0	13.6
Nevada	7.7	25.0	36.8	25.0	25.0
New Hampshire	16.7	9.4	20.0	0.0	13.9
New Jersey	0.0	9.1	25.1	21.4	19.1
New Mexico	0.0	9.4	3.1	0.0	5.1
New York	25.0	28.8	31.3	26.6	28.8
North Carolina	0.0	9.9	17.4	23.5	12.9
North Dakota	22.2	8.3	13.6	0.0	13.8
Ohio	9.1	18.7	25.9	33.3	22.1
Oklahoma	11.5	6.0	18.5	28.6	12.0
Oregon	26.1	19.7	27.3	50.0	23.7
Pennsylvania	8.0	13.9	21.7	27.2	18.3
Rhode Island	5.9	0.0	19.0	0.0	9.6
South Carolina	4.7	17.9	20.0	16.7	15.4
South Dakota	5.6	6.8	14.3	n/a	7.3
Tennessee	6.3	8.6	14.8	33.3	12.8
Texas	6.8	12.9	18.8	22.9	15.5
Utah	0.0	15.6	24.2	0.0	13.4
Vermont	21.4	0.0	21.1	n/a	15.6
Virginia	2.6	7.2	19.4	30.0	14.3
Washington	20.4	31.8	29.5	28.6	28.8
West Virginia	6.1	1.5	8.9	0.0	5.1
Wisconsin	7.9	6.5	7.1	25.0	9.1
Wyoming	54.5	18.8	21.4	0.0	28.6

Source: OSCAR

n/a: Data unavailable

Table 4.16 (f). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Bed Size Category: United States, 2001

	Percent by Number of Beds				
	<50	50-99	100-199	>199	All Facilities
Nation	**9.0**	**15.9**	**20.3**	**22.6**	**17.2**
Alabama	9.1	10.5	14.2	23.1	13.1
Alaska	0.0	0.0	n/a	0.0	0.0
Arizona	0.0	0.0	15.6	13.3	10.4
Arkansas	0.0	26.8	20.8	25.0	21.3
California	12.7	23.2	30.0	33.3	23.3
Colorado	19.6	22.8	32.6	0.0	25.5
Connecticut	7.7	26.8	38.2	28.6	32.4
Delaware	0.0	20.0	24.0	0.0	20.0
District of Columbia	50.0	28.6	16.7	50.0	33.3
Florida	2.7	7.9	11.2	10.5	9.6
Georgia	3.7	9.0	14.0	13.6	11.5
Hawaii	8.3	27.3	10.0	0.0	14.3
Idaho	3.4	8.7	19.2	n/a	10.3
Illinois	9.4	28.8	28.2	16.9	24.3
Indiana	9.2	14.8	14.2	22.2	13.9
Iowa	5.7	6.2	10.9	12.5	7.2
Kansas	18.7	28.6	24.5	50.0	25.4
Kentucky	9.1	21.6	25.7	20.0	20.1
Louisiana	5.6	23.1	18.4	20.0	18.0
Maine	4.8	3.3	7.7	0.0	4.3
Maryland	3.6	7.7	10.7	6.7	8.3
Massachusetts	1.2	13.0	15.7	29.4	13.0
Michigan	8.0	23.1	28.3	28.6	24.5
Minnesota	5.3	7.0	11.6	13.0	8.5
Mississippi	10.0	9.3	20.8	50.0	14.4
Missouri	8.3	9.4	22.0	44.4	16.1
Montana	16.2	30.4	23.1	0.0	21.6
Nebraska	20.4	10.2	21.6	100.0	16.2
Nevada	0.0	0.0	22.7	33.3	14.0
New Hampshire	15.4	6.9	20.0	0.0	13.3
New Jersey	7.9	8.8	28.3	27.3	22.3
New Mexico	0.0	10.3	14.3	0.0	9.7
New York	31.8	32.4	30.1	28.4	30.1
North Carolina	7.8	12.3	17.2	13.3	14.4
North Dakota	7.7	19.5	13.0	0.0	14.0
Ohio	6.5	14.0	20.3	32.8	17.2
Oklahoma	5.7	21.5	25.6	0.0	20.1
Oregon	21.7	19.7	39.1	50.0	27.3
Pennsylvania	8.1	11.0	17.7	17.6	14.6
Rhode Island	5.0	12.5	15.8	0.0	11.6
South Carolina	8.1	10.6	25.8	33.3	17.1
South Dakota	8.3	14.8	14.3	n/a	12.5
Tennessee	10.5	12.3	13.4	9.5	12.4
Texas	4.8	11.6	18.2	14.7	14.4
Utah	3.3	10.7	12.1	33.3	9.6
Vermont	0.0	25.0	16.7	n/a	14.3
Virginia	6.1	9.1	13.2	22.2	11.5
Washington	15.2	28.4	28.6	16.7	25.9
West Virginia	4.5	14.3	20.5	100.0	15.3
Wisconsin	8.6	6.0	17.4	15.6	11.5
Wyoming	0.0	30.8	61.5	n/a	31.6

Source: OSCAR

n/a: Data unavailable

Table 4.17 (a). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 1996

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**16.9**	**12.1**	**12.1**	**15.3**
Alabama	22.7	22.6	27.3	23.1
Alaska	0.0	0.0	0.0	0.0
Arizona	5.7	1.8	25.0	4.8
Arkansas	32.0	20.5	14.3	29.5
California	21.6	17.5	10.5	20.3
Colorado	21.2	8.5	23.8	17.9
Connecticut	14.8	5.7	0.0	12.8
Delaware	10.0	21.4	0.0	13.5
District of Columbia	50.0	7.7	0.0	20.0
Florida	15.7	12.1	20.0	15.0
Georgia	10.2	13.7	0.0	10.2
Hawaii	12.5	0.0	9.1	7.3
Idaho	8.2	0.0	0.0	4.9
Illinois	15.7	13.0	9.1	14.5
Indiana	20.9	11.4	13.3	18.5
Iowa	23.9	17.4	4.2	20.3
Kansas	36.5	30.5	18.3	32.4
Kentucky	5.3	0.0	9.1	3.8
Louisiana	8.5	2.9	8.0	7.4
Maine	6.1	3.1	0.0	5.1
Maryland	9.8	6.8	0.0	8.4
Massachusetts	7.5	4.7	7.1	6.8
Michigan	39.6	31.0	28.6	36.1
Minnesota	13.1	10.5	11.1	11.5
Mississippi	17.3	3.3	9.7	14.0
Missouri	16.6	8.6	12.0	14.1
Montana	31.6	9.5	11.1	18.4
Nebraska	18.5	22.9	11.9	18.4
Nevada	20.0	14.3	0.0	16.7
New Hampshire	22.9	10.0	14.3	17.4
New Jersey	5.7	3.7	3.8	5.0
New Mexico	7.7	3.7	0.0	5.7
New York	13.1	13.1	19.6	13.6
North Carolina	12.9	1.1	6.3	10.1
North Dakota	20.0	25.0	50.0	25.0
Ohio	17.9	16.0	26.8	17.8
Oklahoma	13.3	1.7	10.0	11.6
Oregon	25.8	5.9	0.0	20.8
Pennsylvania	14.7	8.3	16.3	11.4
Rhode Island	9.7	0.0	n/a	7.1
South Carolina	26.0	16.1	30.0	24.7
South Dakota	34.2	13.6	0.0	20.2
Tennessee	11.8	16.5	20.7	13.6
Texas	12.3	6.7	2.7	11.3
Utah	9.6	0.0	0.0	7.5
Vermont	15.2	0.0	0.0	11.6
Virginia	16.0	7.1	8.3	12.9
Washington	34.5	19.4	13.6	29.6
West Virginia	5.1	4.0	0.0	4.3
Wisconsin	12.4	11.8	3.0	10.9
Wyoming	5.3	33.3	0.0	7.7

Source: OSCAR

n/a: Data unavailable

Table 4.17 (b). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 1997

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**17.9**	**12.8**	**14.3**	**16.3**
Alabama	52.6	50.0	50.0	52.0
Alaska	0.0	0.0	0.0	0.0
Arizona	2.6	4.9	0.0	3.4
Arkansas	33.5	11.6	6.7	28.7
California	25.2	15.3	20.7	22.8
Colorado	10.9	10.4	17.4	11.4
Connecticut	19.7	11.5	50.0	18.1
Delaware	50.0	33.3	50.0	42.2
District of Columbia	10.0	7.7	66.7	15.4
Florida	18.0	11.8	9.1	16.6
Georgia	7.4	12.5	9.5	8.4
Hawaii	16.7	7.1	30.0	16.7
Idaho	19.2	7.7	15.8	16.7
Illinois	23.0	16.9	23.9	21.2
Indiana	15.4	5.5	12.5	13.1
Iowa	17.7	16.8	8.7	16.8
Kansas	32.6	25.8	20.0	29.0
Kentucky	8.3	8.1	0.0	7.9
Louisiana	9.1	5.6	3.4	8.0
Maine	6.1	3.1	0.0	5.1
Maryland	12.4	9.5	0.0	10.9
Massachusetts	7.5	6.2	0.0	7.0
Michigan	35.9	36.6	29.3	35.4
Minnesota	12.9	6.2	6.5	8.2
Mississippi	19.3	22.9	6.7	18.1
Missouri	15.5	8.6	4.2	12.9
Montana	15.8	13.0	30.0	17.3
Nebraska	9.2	8.8	16.4	10.7
Nevada	32.3	0.0	0.0	23.8
New Hampshire	18.4	20.7	38.5	22.0
New Jersey	6.7	3.1	11.8	5.8
New Mexico	2.3	7.4	0.0	3.9
New York	13.3	13.1	9.1	12.8
North Carolina	7.6	1.2	5.6	6.1
North Dakota	33.3	27.7	50.0	28.9
Ohio	22.7	20.5	26.7	22.3
Oklahoma	12.9	5.4	0.0	11.1
Oregon	17.8	18.8	40.0	18.7
Pennsylvania	15.8	6.9	13.3	10.9
Rhode Island	11.1	4.0	n/a	9.3
South Carolina	25.2	26.1	9.5	23.5
South Dakota	7.9	7.9	0.0	7.6
Tennessee	14.0	10.7	18.5	13.6
Texas	14.2	9.1	5.3	13.2
Utah	7.6	7.7	25.0	8.3
Vermont	10.3	30.0	n/a	15.4
Virginia	19.0	10.0	50.0	17.1
Washington	34.8	35.2	17.4	33.6
West Virginia	9.3	0.0	25.0	8.0
Wisconsin	12.3	11.8	4.8	11.0
Wyoming	17.6	16.7	7.1	13.5

Source: OSCAR

n/a: Data unavailable

Table 4.17 (c). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 1998

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**19.2**	**13.8**	**14.6**	**17.3**
Alabama	24.1	19.4	27.3	23.8
Alaska	0.0	0.0	0.0	0.0
Arizona	15.5	8.9	0.0	12.9
Arkansas	28.0	7.1	7.1	23.6
California	27.9	14.5	26.1	24.9
Colorado	13.6	4.9	4.3	10.3
Connecticut	26.6	10.0	50.0	23.4
Delaware	36.4	7.7	50.0	25.0
District of Columbia	25.0	0.0	50.0	11.8
Florida	21.9	17.1	7.1	20.6
Georgia	10.8	9.5	3.8	10.1
Hawaii	42.1	7.1	18.2	25.0
Idaho	29.4	21.4	26.3	27.4
Illinois	27.4	20.0	30.6	25.3
Indiana	19.6	16.9	6.7	18.6
Iowa	16.9	13.8	4.8	15.1
Kansas	38.4	22.3	21.2	30.6
Kentucky	13.3	12.0	33.3	13.4
Louisiana	12.3	9.2	3.8	11.1
Maine	3.1	6.7	0.0	3.8
Maryland	10.3	10.7	0.0	10.2
Massachusetts	12.6	5.6	0.0	10.3
Michigan	35.7	27.0	16.7	31.4
Minnesota	14.5	15.3	12.7	14.7
Mississippi	14.1	13.9	28.1	16.2
Missouri	19.6	8.8	11.3	15.9
Montana	23.5	11.4	18.8	17.0
Nebraska	18.8	16.2	16.7	17.5
Nevada	28.9	0.0	28.6	27.1
New Hampshire	17.4	8.3	15.4	14.5
New Jersey	9.7	3.4	5.9	7.3
New Mexico	8.5	14.3	0.0	9.6
New York	11.0	13.0	14.0	12.1
North Carolina	14.2	6.1	0.0	11.8
North Dakota	20.0	22.5	0.0	21.7
Ohio	21.5	19.7	17.9	21.0
Oklahoma	13.7	10.6	0.0	12.6
Oregon	16.1	13.9	0.0	15.1
Pennsylvania	20.4	12.4	17.0	16.0
Rhode Island	11.5	0.0	n/a	9.1
South Carolina	29.9	33.3	26.3	30.0
South Dakota	16.1	16.7	0.0	15.6
Tennessee	9.2	15.9	20.0	11.7
Texas	13.0	10.8	4.9	12.4
Utah	9.5	18.8	25.0	11.7
Vermont	8.0	16.7	0.0	10.5
Virginia	15.1	12.2	20.0	14.3
Washington	32.0	29.4	19.0	30.4
West Virginia	5.6	0.0	0.0	3.7
Wisconsin	13.7	7.7	1.6	9.8
Wyoming	10.5	0.0	11.1	9.3

Source: OSCAR

n/a: Data unavailable

Table 4.17 (d). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 1999

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**20.7**	**17.4**	**15.2**	**18.6**
Alabama	29.0	21.3	28.6	27.6
Alaska	0.0	25.0	0.0	12.5
Arizona	24.6	15.0	33.3	19.5
Arkansas	27.5	29.8	15.4	24.1
California	31.2	28.1	18.6	27.9
Colorado	11.7	9.4	8.0	10.0
Connecticut	19.9	12.0	50.0	18.3
Delaware	18.8	20.0	0.0	20.0
District of Columbia	0.0	16.7	0.0	6.7
Florida	15.3	11.0	7.7	13.5
Georgia	13.8	8.0	4.0	13.3
Hawaii	19.0	9.1	9.1	18.6
Idaho	32.7	26.9	15.8	25.0
Illinois	33.1	31.9	26.7	27.9
Indiana	20.1	10.2	0.0	17.2
Iowa	16.5	12.8	0.0	14.1
Kansas	34.5	31.7	23.6	29.5
Kentucky	21.0	15.9	30.0	18.7
Louisiana	12.5	13.2	7.4	11.4
Maine	9.8	10.6	16.7	11.5
Maryland	26.9	12.5	33.3	19.6
Massachusetts	12.6	8.0	0.0	10.0
Michigan	35.1	30.8	28.2	31.8
Minnesota	9.6	9.1	12.1	13.6
Mississippi	20.7	17.1	15.4	18.9
Missouri	24.9	17.2	12.2	22.4
Montana	43.2	48.5	36.8	34.3
Nebraska	16.0	13.5	6.1	13.6
Nevada	32.3	18.2	20.0	25.0
New Hampshire	30.6	15.6	40.0	23.2
New Jersey	17.6	11.3	11.1	13.6
New Mexico	6.3	3.0	0.0	3.8
New York	20.6	18.6	23.9	21.3
North Carolina	17.2	13.0	17.6	14.9
North Dakota	25.0	22.5	25.0	26.6
Ohio	24.8	19.8	20.0	23.1
Oklahoma	11.8	7.0	23.5	12.2
Oregon	35.2	32.3	0.0	32.9
Pennsylvania	17.6	15.0	15.6	16.1
Rhode Island	16.2	11.8	n/a	12.1
South Carolina	25.0	15.2	11.8	21.7
South Dakota	12.1	13.0	0.0	14.8
Tennessee	17.8	12.6	20.0	15.7
Texas	12.1	10.5	5.0	11.3
Utah	12.9	18.5	0.0	11.0
Vermont	10.0	0.0	50.0	8.5
Virginia	16.9	11.6	9.1	14.4
Washington	26.8	26.7	26.1	28.8
West Virginia	9.9	3.2	6.7	7.1
Wisconsin	15.5	11.4	4.8	12.1
Wyoming	11.1	0.0	11.8	10.0

Source: OSCAR

n/a: Data unavailable

Table 4.17 (e). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 2000

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**19.8**	**15.2**	**14.5**	**18.2**
Alabama	16.3	21.4	21.1	17.6
Alaska	n/a	0.0	0.0	0.0
Arizona	16.1	6.8	25.0	13.5
Arkansas	26.0	21.4	7.7	24.4
California	28.1	21.3	13.6	26.2
Colorado	21.7	20.7	0.0	19.3
Connecticut	27.4	22.0	0.0	26.0
Delaware	20.0	15.8	0.0	15.9
District of Columbia	33.3	0.0	0.0	9.5
Florida	10.9	9.9	0.0	10.5
Georgia	13.3	14.5	11.1	13.3
Hawaii	23.5	40.0	22.2	29.3
Idaho	23.9	13.3	15.8	20.0
Illinois	29.5	15.6	24.4	25.1
Indiana	19.3	8.8	7.1	16.4
Iowa	11.0	9.2	5.3	10.0
Kansas	35.4	25.9	11.5	29.0
Kentucky	16.1	14.0	0.0	14.9
Louisiana	14.5	5.1	0.0	12.2
Maine	2.1	7.1	0.0	3.2
Maryland	10.6	5.0	0.0	8.0
Massachusetts	12.4	9.2	21.4	11.8
Michigan	31.4	19.8	11.9	26.5
Minnesota	14.7	14.0	12.5	14.0
Mississippi	19.9	13.3	16.7	18.5
Missouri	27.2	21.2	21.8	25.1
Montana	25.7	27.9	40.0	29.0
Nebraska	17.9	11.3	9.3	13.6
Nevada	32.4	12.5	0.0	25.0
New Hampshire	25.0	3.7	0.0	13.9
New Jersey	23.8	10.0	20.0	19.1
New Mexico	4.1	9.1	0.0	5.1
New York	25.9	31.6	31.4	28.8
North Carolina	14.9	9.1	0.0	12.9
North Dakota	8.3	13.9	33.3	13.8
Ohio	22.5	19.4	31.3	22.1
Oklahoma	13.4	4.5	7.1	12.0
Oregon	26.5	12.1	33.3	23.7
Pennsylvania	20.8	15.0	29.5	18.3
Rhode Island	11.8	0.0	n/a	9.6
South Carolina	14.8	20.0	13.6	15.4
South Dakota	6.5	8.5	0.0	7.3
Tennessee	12.4	15.7	9.4	12.8
Texas	15.7	13.7	20.0	15.5
Utah	14.3	6.3	25.0	13.4
Vermont	13.8	20.0	0.0	15.6
Virginia	16.8	9.7	12.5	14.3
Washington	31.0	23.8	23.8	28.8
West Virginia	3.8	10.5	0.0	5.1
Wisconsin	13.5	5.4	3.4	9.1
Wyoming	27.3	66.7	14.3	28.6

Source: OSCAR

n/a: Data unavailable

Table 4.17 (f). Nursing Home Surveys Resulting in a Citation for Failure to Treat or Prevent Pressure Ulcers by Type of Ownership: United States, 2001

	Percent by Ownership Type			
	For-Profit	Non-Profit	Government	All Facilities
Nation	**19.0**	**14.2**	**12.3**	**17.2**
Alabama	14.4	11.1	5.3	13.1
Alaska	0.0	0.0	0.0	0.0
Arizona	12.6	5.4	0.0	10.4
Arkansas	19.6	24.4	44.4	21.3
California	25.2	16.4	20.0	23.3
Colorado	28.7	23.1	9.5	25.5
Connecticut	35.5	23.2	0.0	32.4
Delaware	31.6	11.1	0.0	20.0
District of Columbia	33.3	38.5	0.0	33.3
Florida	11.2	4.5	7.7	9.6
Georgia	11.7	15.5	0.0	11.5
Hawaii	31.3	0.0	0.0	14.3
Idaho	13.3	14.3	0.0	10.3
Illinois	27.5	15.9	28.6	24.3
Indiana	14.8	13.3	0.0	13.9
Iowa	5.6	10.1	0.0	7.2
Kansas	34.6	17.1	13.2	25.4
Kentucky	24.7	12.4	0.0	20.1
Louisiana	18.4	21.3	4.8	18.0
Maine	3.6	3.6	16.7	4.3
Maryland	11.3	5.2	0.0	8.3
Massachusetts	15.4	8.1	0.0	13.0
Michigan	27.3	22.1	14.6	24.5
Minnesota	7.5	8.9	8.5	8.5
Mississippi	13.6	11.1	21.4	14.4
Missouri	18.9	10.2	10.3	16.1
Montana	17.9	29.3	10.5	21.6
Nebraska	16.5	10.9	23.1	16.2
Nevada	16.2	12.5	0.0	14.0
New Hampshire	7.5	13.0	33.3	13.3
New Jersey	24.9	17.5	21.1	22.3
New Mexico	14.9	0.0	0.0	9.7
New York	28.7	31.5	30.6	30.1
North Carolina	16.1	10.3	8.7	14.4
North Dakota	22.2	13.8	0.0	14.0
Ohio	17.0	18.6	10.0	17.2
Oklahoma	20.4	19.0	16.7	20.1
Oregon	33.0	17.1	0.0	27.3
Pennsylvania	19.0	11.4	7.7	14.6
Rhode Island	13.9	4.3	n/a	11.6
South Carolina	16.7	9.5	26.1	17.1
South Dakota	5.9	17.2	0.0	12.5
Tennessee	11.3	16.3	10.3	12.4
Texas	15.6	8.9	10.5	14.4
Utah	9.2	11.8	0.0	9.6
Vermont	17.9	7.7	0.0	14.3
Virginia	12.3	11.4	0.0	11.5
Washington	31.4	17.5	7.4	25.9
West Virginia	19.2	7.1	10.0	15.3
Wisconsin	17.2	7.1	3.2	11.5
Wyoming	50.0	20.0	21.1	31.6

Source: OSCAR

n/a: Data unavailable

Table 4.18 (a). Prevalence of Tube Feeding in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**3.7**	**4.4**	**4.2**	**4.2**
Alabama	11.3	20.2	20.2	20.2
Alaska	6.7	4.8	8.5	6.7
Arizona	2.2	2.8	2.9	2.2
Arkansas	4.2	5.3	5.0	5.2
California	5.2	6.6	6.7	6.3
Colorado	1.8	2.1	1.8	1.9
Connecticut	2.5	3.0	3.1	3.2
Delaware	5.3	6.6	5.5	4.8
District of Columbia	10.0	10.1	12.6	10.7
Florida	5.6	6.5	6.5	5.9
Georgia	6.8	7.0	7.3	7.3
Hawaii	6.5	9.4	8.7	9.6
Idaho	1.1	1.2	1.9	2.3
Illinois	2.6	3.2	3.1	3.3
Indiana	3.9	4.5	4.3	4.2
Iowa	0.0	1.1	1.0	0.7
Kansas	0.8	1.6	1.6	1.4
Kentucky	7.0	7.8	7.8	7.3
Louisiana	6.5	8.0	8.3	8.1
Maine	1.6	1.9	1.9	1.7
Maryland	5.8	6.7	6.0	5.7
Massachusetts	2.2	2.6	2.5	2.3
Michigan	3.0	4.1	4.0	3.7
Minnesota	1.3	1.5	1.5	1.4
Mississippi	7.5	8.8	8.7	9.1
Missouri	3.0	3.4	3.3	3.4
Montana	1.6	1.9	1.7	1.9
Nebraska	1.0	1.4	1.6	1.7
Nevada	5.2	3.5	5.6	5.7
New Hampshire	1.1	1.1	1.3	1.1
New Jersey	5.4	5.6	5.6	5.5
New Mexico	2.7	2.1	3.1	2.4
New York	6.3	6.2	6.2	6.0
North Carolina	6.9	7.7	7.6	7.1
North Dakota	1.8	2.2	2.0	2.0
Ohio	5.7	6.3	5.8	5.3
Oklahoma	4.2	4.8	5.4	5.4
Oregon	1.6	2.5	2.3	2.2
Pennsylvania	4.1	4.8	4.8	4.4
Rhode Island	2.3	2.8	2.8	2.9
South Carolina	5.7	7.4	7.9	7.4
South Dakota	1.5	1.7	1.6	1.7
Tennessee	5.1	6.1	6.1	6.1
Texas	4.8	5.7	5.9	5.6
Utah	0.7	1.5	1.8	2.0
Vermont	1.9	2.4	2.0	2.2
Virginia	5.1	6.3	6.3	6.0
Washington	2.9	3.4	2.9	3.0
West Virginia	4.8	5.1	4.9	4.7
Wisconsin	1.5	1.8	1.8	1.7
Wyoming	0.0	0.8	0.9	0.9

Source: MDS

Table 4.18 (b). Prevalence of Weight Loss in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**10.1**	**10.2**	**9.5**	**9.5**
Alabama	11.4	11.4	11.3	10.8
Alaska	13.6	11.9	10.5	11.3
Arizona	10.9	9.4	10.0	8.3
Arkansas	10.5	11.3	9.5	9.7
California	10.2	9.9	9.0	9.3
Colorado	10.7	10.2	10.4	9.5
Connecticut	9.3	9.8	8.8	9.3
Delaware	12.1	10.6	10.3	11.5
District of Columbia	9.9	10.2	8.4	10.1
Florida	11.6	11.2	11.1	10.3
Georgia	10.6	10.8	10.6	10.4
Hawaii	9.4	10.8	9.9	9.8
Idaho	12.2	13.5	12.4	12.5
Illinois	9.1	9.0	8.2	8.3
Indiana	9.9	9.9	9.4	9.1
Iowa	8.0	7.5	6.8	7.6
Kansas	8.4	8.0	7.5	7.9
Kentucky	12.1	11.7	10.9	10.9
Louisiana	9.6	9.2	8.9	9.6
Maine	9.4	8.3	8.9	9.3
Maryland	11.6	11.2	10.2	9.9
Massachusetts	10.8	11.8	10.4	9.8
Michigan	11.1	11.5	10.0	11.2
Minnesota	8.2	8.7	8.6	9.0
Mississippi	10.3	9.6	8.9	9.2
Missouri	9.7	10.3	9.1	8.7
Montana	9.5	11.1	11.2	9.4
Nebraska	8.6	8.6	8.3	8.3
Nevada	11.6	11.5	11.1	8.8
New Hampshire	10.5	10.8	10.4	11.5
New Jersey	11.1	11.7	11.5	11.8
New Mexico	9.4	10.3	9.3	10.9
New York	8.8	9.2	8.7	8.9
North Carolina	11.5	11.1	10.8	10.5
North Dakota	8.4	8.1	7.0	8.4
Ohio	9.8	10.3	9.4	9.4
Oklahoma	8.5	8.2	8.3	7.5
Oregon	11.4	11.1	10.5	10.6
Pennsylvania	11.1	11.3	10.6	10.4
Rhode Island	11.7	12.8	11.5	11.1
South Carolina	10.8	11.1	10.6	11.5
South Dakota	6.8	7.5	8.1	8.5
Tennessee	11.1	11.9	11.6	10.8
Texas	9.6	9.1	8.0	7.9
Utah	11.5	10.5	10.5	9.9
Vermont	10.3	10.8	10.2	12.0
Virginia	10.4	11.2	10.1	10.8
Washington	12.8	13.4	11.8	12.9
West Virginia	10.7	11.1	10.5	10.6
Wisconsin	10.7	11.6	10.2	10.4
Wyoming	9.7	12.3	10.4	10.9

Source: MDS

Table 4.18 (c). Prevalence of Physical Restraints in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**7.5**	**6.7**	**6.4**	**6.4**
Alabama	4.4	3.0	3.4	3.7
Alaska	7.1	6.8	5.3	5.0
Arizona	9.0	9.2	7.6	7.7
Arkansas	20.3	22.1	21.3	22.0
California	18.3	16.3	15.7	15.2
Colorado	8.6	7.7	6.3	6.9
Connecticut	11.0	9.7	9.1	8.9
Delaware	1.9	1.7	1.2	0.6
District of Columbia	5.4	3.5	3.4	3.1
Florida	5.3	4.9	4.9	5.6
Georgia	10.7	10.2	10.8	12.4
Hawaii	5.3	7.0	4.8	5.8
Idaho	6.5	5.2	5.5	5.7
Illinois	5.1	4.0	3.3	2.9
Indiana	7.4	5.9	5.4	5.6
Iowa	1.2	0.9	1.0	1.3
Kansas	4.1	3.6	3.6	3.6
Kentucky	7.8	6.8	7.1	8.2
Louisiana	20.6	20.3	20.4	18.2
Maine	5.0	4.1	3.7	3.3
Maryland	7.9	7.5	5.6	5.2
Massachusetts	4.5	4.4	4.1	4.6
Michigan	8.7	6.2	5.0	4.5
Minnesota	4.6	3.2	3.2	3.1
Mississippi	11.9	13.1	15.0	15.0
Missouri	5.7	5.6	5.9	6.1
Montana	5.3	3.8	2.6	1.9
Nebraska	0.5	0.0	0.0	0.6
Nevada	9.1	7.4	7.9	8.9
New Hampshire	1.9	2.2	2.3	2.8
New Jersey	2.8	2.4	2.8	2.9
New Mexico	5.4	7.8	6.8	6.7
New York	6.4	5.9	5.9	5.4
North Carolina	7.4	6.5	6.7	6.6
North Dakota	6.2	4.5	4.4	5.2
Ohio	6.9	6.8	7.2	7.4
Oklahoma	9.7	8.7	9.5	8.3
Oregon	9.8	10.3	9.2	10.4
Pennsylvania	5.6	5.1	4.2	4.0
Rhode Island	4.8	4.9	4.2	3.6
South Carolina	5.7	6.9	6.4	8.9
South Dakota	10.9	8.3	7.4	7.2
Tennessee	13.4	12.1	12.0	11.9
Texas	15.2	16.3	16.7	16.6
Utah	7.2	5.7	5.8	5.3
Vermont	4.3	3.9	3.5	3.6
Virginia	6.3	5.2	4.9	5.8
Washington	8.0	5.9	6.4	6.3
West Virginia	6.4	5.1	4.9	5.7
Wisconsin	7.0	4.8	3.9	2.9
Wyoming	4.7	5.8	6.3	7.0

Source: MDS

Table 4.18 (d). Prevalence of Pressure Ulcers in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**7.1**	**7.4**	**7.7**	**7.9**
Alabama	7.0	7.2	7.8	7.7
Alaska	6.3	5.3	6.4	4.3
Arizona	8.6	8.8	7.7	8.8
Arkansas	7.4	7.5	7.1	7.4
California	9.6	9.8	10.0	10.2
Colorado	4.9	5.6	6.1	6.5
Connecticut	5.3	5.5	5.9	6.8
Delaware	7.8	7.1	8.4	8.3
District of Columbia	10.4	10.9	10.3	11.4
Florida	9.2	9.3	9.8	9.9
Georgia	7.6	8.2	9.0	8.6
Hawaii	7.7	6.3	7.2	7.2
Idaho	5.3	4.7	5.6	5.8
Illinois	7.0	7.4	7.2	7.3
Indiana	7.5	7.4	7.5	7.9
Iowa	3.4	3.1	3.6	3.8
Kansas	5.0	4.8	5.6	5.1
Kentucky	7.1	7.8	8.2	9.1
Louisiana	6.9	7.5	8.2	9.1
Maine	6.5	7.0	6.8	7.1
Maryland	8.7	9.9	9.0	10.4
Massachusetts	6.7	7.1	7.7	8.0
Michigan	7.5	7.5	7.9	8.3
Minnesota	3.6	4.1	3.9	4.4
Mississippi	7.4	8.1	7.6	6.8
Missouri	5.9	6.3	6.7	6.6
Montana	3.2	4.0	4.0	5.0
Nebraska	4.1	3.7	4.2	4.2
Nevada	9.6	8.8	11.1	10.5
New Hampshire	4.9	5.4	4.9	5.9
New Jersey	8.7	9.9	10.9	11.2
New Mexico	7.0	7.4	7.4	8.1
New York	8.2	8.5	8.9	9.3
North Carolina	8.2	8.6	8.9	9.2
North Dakota	3.5	3.0	3.7	3.5
Ohio	6.4	7.3	7.5	7.5
Oklahoma	6.3	6.8	7.5	7.3
Oregon	6.7	6.7	7.1	8.0
Pennsylvania	8.5	9.5	9.8	10.1
Rhode Island	6.6	7.7	7.4	7.9
South Carolina	8.3	7.7	9.1	9.6
South Dakota	4.3	4.2	5.3	5.0
Tennessee	7.7	8.5	8.5	8.0
Texas	7.4	7.9	8.1	7.7
Utah	5.1	5.0	5.7	6.9
Vermont	6.7	4.8	7.1	6.8
Virginia	7.9	8.9	9.3	10.2
Washington	7.6	7.6	8.3	8.6
West Virginia	7.8	9.5	8.7	9.4
Wisconsin	5.7	5.9	5.7	5.7
Wyoming	4.7	4.2	5.6	6.5

Source: MDS

Table 4.18 (e). Prevalence of Dehydration in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**2.7**	**2.4**	**1.7**	**1.5**
Alabama	3.0	2.0	1.4	1.2
Alaska	5.9	6.7	12.0	4.3
Arizona	3.8	3.6	2.2	1.4
Arkansas	3.0	2.5	1.7	1.4
California	3.0	2.9	1.7	1.5
Colorado	4.0	3.5	1.9	1.6
Connecticut	2.2	2.0	1.4	1.4
Delaware	2.2	1.5	1.3	1.3
District of Columbia	2.8	1.7	3.2	1.0
Florida	2.4	2.3	1.1	1.0
Georgia	1.8	1.8	1.3	1.4
Hawaii	4.5	1.6	1.0	1.9
Idaho	5.7	3.9	2.4	2.9
Illinois	1.9	1.4	0.9	0.8
Indiana	2.7	2.3	1.5	1.0
Iowa	1.7	1.7	1.3	0.7
Kansas	2.6	2.4	1.9	1.6
Kentucky	3.2	2.4	1.5	1.4
Louisiana	3.1	3.3	2.0	2.0
Maine	2.9	2.7	2.4	2.2
Maryland	2.7	2.2	1.6	1.4
Massachusetts	2.8	3.2	1.9	1.9
Michigan	2.9	2.4	1.5	1.3
Minnesota	1.7	1.8	1.4	1.2
Mississippi	3.0	1.6	1.6	0.8
Missouri	3.8	3.1	2.2	1.9
Montana	6.3	4.6	3.2	3.0
Nebraska	2.6	2.1	1.8	1.5
Nevada	3.8	2.8	2.0	1.0
New Hampshire	1.3	2.9	1.7	1.5
New Jersey	1.7	1.7	1.3	1.4
New Mexico	3.2	3.1	1.5	1.1
New York	1.5	1.6	1.2	1.1
North Carolina	2.5	2.4	1.9	1.6
North Dakota	2.4	2.3	1.3	2.0
Ohio	2.4	2.2	1.4	1.1
Oklahoma	3.7	2.8	2.5	1.9
Oregon	4.0	3.6	2.6	2.1
Pennsylvania	2.8	2.4	1.4	1.2
Rhode Island	2.5	2.2	1.6	1.7
South Carolina	2.0	2.1	2.3	2.0
South Dakota	1.9	2.3	2.3	1.9
Tennessee	3.1	2.9	1.5	1.6
Texas	2.4	2.3	1.4	1.2
Utah	4.5	3.0	2.8	2.8
Vermont	2.0	3.0	2.4	3.2
Virginia	1.8	1.9	2.2	1.5
Washington	8.2	6.6	4.4	4.9
West Virginia	4.3	3.2	3.2	2.0
Wisconsin	2.2	2.0	1.8	1.5
Wyoming	4.5	2.5	3.4	2.0

Source: MDS

Table 4.18 (f). Prevalence of Severe Bowel or Bladder Incontinence in Nursing Homes at the Median Percentile: United States, Third Quarter 1998-2001

	Percent of Nursing Homes			
Percentile	1998 Quarter 3 Median	1999 Quarter 3 Median	2000 Quarter 3 Median	2001 Quarter 3 Median
Nation	**35.7**	**36.0**	**35.7**	**35.7**
Alabama	42.8	43.3	42.1	42.1
Alaska	23.5	23.5	18.0	18.0
Arizona	36.3	36.8	35.7	35.7
Arkansas	37.3	37.8	38.6	38.6
California	47.7	47.6	47.2	47.2
Colorado	26.1	27.1	27.1	27.1
Connecticut	31.2	30.5	30.6	30.6
Delaware	39.7	40.4	40.2	40.2
District of Columbia	50.0	52.1	49.5	49.5
Florida	38.5	38.6	38.8	38.8
Georgia	44.5	44.2	45.0	45.0
Hawaii	53.4	49.5	50.8	50.8
Idaho	29.8	27.0	28.7	28.7
Illinois	25.0	24.5	24.1	24.1
Indiana	31.4	32.9	31.9	31.9
Iowa	19.0	18.2	18.2	18.2
Kansas	23.3	23.2	23.4	23.4
Kentucky	46.9	46.6	46.0	46.0
Louisiana	37.1	37.9	38.1	38.1
Maine	36.0	36.6	34.5	34.5
Maryland	45.6	47.4	45.9	45.9
Massachusetts	41.6	41.7	41.3	41.3
Michigan	33.3	32.7	31.1	31.1
Minnesota	28.6	27.2	26.5	26.5
Mississippi	42.1	44.2	45.2	45.2
Missouri	29.2	29.6	27.3	27.3
Montana	27.0	26.2	23.3	23.3
Nebraska	19.6	19.4	20.0	20.0
Nevada	39.3	37.8	40.2	40.2
New Hampshire	24.3	25.4	24.0	24.0
New Jersey	37.3	37.0	36.9	36.9
New Mexico	35.1	36.2	36.2	36.2
New York	43.8	41.9	42.2	42.2
North Carolina	46.6	47.3	47.9	47.9
North Dakota	24.2	24.1	23.0	23.0
Ohio	30.2	29.5	28.6	28.6
Oklahoma	33.3	33.3	31.6	31.6
Oregon	36.7	35.2	35.5	35.5
Pennsylvania	41.4	43.2	43.4	43.4
Rhode Island	27.8	27.6	28.0	28.0
South Carolina	52.5	54.4	52.3	52.3
South Dakota	22.1	21.8	22.6	22.6
Tennessee	43.1	44.0	43.9	43.9
Texas	43.4	45.2	45.8	45.8
Utah	25.6	29.1	29.7	29.7
Vermont	31.8	30.4	28.9	28.9
Virginia	51.9	50.0	48.8	48.8
Washington	32.2	31.0	32.5	32.5
West Virginia	38.3	38.3	38.7	38.7
Wisconsin	23.8	23.5	23.5	23.5
Wyoming	15.7	14.7	17.3	17.3

Source: MDS

Appendix A

Methods Used

Data Sources

There are three principal sources of data used in this data compendium: (1) CMS's survey and certification administrative dataset, Online Survey Certification and Reporting System known as OSCAR, (2) a set of clinical data collected on every resident of every Medicare- and Medicaid-certified nursing home in the country, the Minimum Data Set (MDS), and (3) United States population data from the United States Bureau of the Census.

Notes on Data Quality

It is important to note that the Minimum Data Set (MDS) data, from which measures of nursing home resident characteristics are derived, are self-reported by each nursing home. In self-reported databases such as the MDS, there are likely to be significant variations in the quality of record keeping and reporting at the facility level (for example, errors in coding date of birth, race, sex and facility). Studies of the accuracy of the MDS have suggested that measurement error is largely random (Chomiak, et. al., 2001). We cannot, however, rule out systematic differences in the way in which nursing homes record the MDS assessment data. These systematic differences may include biases in the way in which nursing homes observe or record data, and systematic changes in the way in which data are observed or recorded over time.

Notes on Measures of Resident Clinical Characteristics

It is important to note that the measures used throughout this report were derived using standard epidemiological and demographic methods. Although many of the measures use descriptions similar to those used in quality indicators or quality measures (for example, the prevalence of pressure ulcers) they were often calculated in different ways. We describe the calculations in more detail below.

Calculation of Resident-Specific Measures

Annual Measures

Gender, age, race, Cognitive Performance Scale (CPS) Score, and number of ADL impairments were calculated for each resident from the MDS assessment closest to July 1 of the year of interest. All of these measures are reported by the nursing home.

CPS

The Cognitive Performance Scale (Morris, 1994) is one method for estimating the cognitive ability of nursing home residents based on items reported in the MDS assessment. Based on the scoring algorithm a resident is classified as having very severe, severe, moderately severe, moderate, mild, very mild, or no impairment.

Activities of Daily Living

There are many ways of estimating the amount of impairment in ADLs. For this analysis the ADLs evaluated were: bed mobility, dressing, eating, transferring, and toileting. In addition, dependency was considered to exist only when a resident required extensive assistance with one or more of these activities. The data presented are summary counts of the number of ADLs with which a resident requires extensive assistance.

Incidence and Prevalence Measures: A General Note

All prevalence and incidence data presented in this compendium were derived from MDS assessment data. It is important to examine both incidence and prevalence rates in assessing many aspects of quality of care provided to nursing home residents. The two measures give different information. Prevalence quantifies the proportion of individuals in a population who have a given condition at a specific point in time. Incidence quantifies the number of new events or occurrences of a condition that develop in a population of individuals at risk during a time interval. For example, prevalence of pressure ulcers in a nursing home would give the proportion of the residents who had a pressure ulcer during a time interval. These could be newly occurring ulcers or ulcers that had been present for some period of time. Incidence of pressure ulcers in a nursing home would be the proportion of residents who have newly occurring ulcers during a time interval. If we exclude pressure ulcers noted on admission or readmission MDS assessments, we can infer that incident ulcers occurred while the residents were under the care of the nursing home.

Since MDS assessments are collected on a schedule that differs for every resident, there are methodological challenges in the calculation of incidence and prevalence measures. For these figures and tables, prevalence was assessed using the midpoint of each calendar quarter as a starting point (baseline). Cases of interest occurred 60 days before or after the midpoint and were unique. That is, if a resident had two assessments collected during the observation period, only the one closest in time to the starting point was retained. Prevalence was calculated as the number of identified cases divided by the number of eligible residents at baseline (the midpoint estimate of the nursing home population). Prevalence calculations include admission and readmission assessments.

Incidence calculations were slightly more complicated. To illustrate, incidence of pressure ulcers was calculated by identifying all pressure ulcer cases that are not noted on admission or readmission assessments during a quarter of interest (for example, January 1 to March 31). Each assessment indicating presence of a pressure ulcer (index assessment) is then compared with the resident's immediately preceding assessment. If the preceding comparison assessment indicates that no pressure ulcer is present, then the index assessment is considered an incident pressure ulcer. Incident pressure ulcers constitute the numerator of the quarter. The denominator consists of all eligible assessments closest to the midpoint of the quarter (but not more than 60 days from the midpoint) that indicate presence of no pressure ulcers.

Use of Descriptive Statistics: A General Note

A number of the conditions and characteristics assessed for this report are not normally distributed in the nursing home population; sometimes the distribution is quite skewed. For example, in 2001 the prevalence of dehydration is zero percent for more than half the nursing homes in the nation. For conditions like dehydration, the use of a mean (or average) value will not characterize how the data are distributed (or spread out). Therefore, in the tables for those conditions and characteristics we have presented the median (or middle value) as well as the 90th and 10th percentile values. The 90th percentile is the value below which 90% of the values in the distribution fall, and the 10th percentile is the value below which 10% of the values fall. These two pieces of information help one understand how values are clustered at the ends of the distribution.

Prevalence of Dehydration

To estimate the prevalence of dehydration, we identified all individuals for whom the nursing home indicated that fluid output exceeded fluid input. It is important to note that we excluded assessments of individuals who were reported by the nursing home to be in end-stage disease or who were receiving hospice care.

Pressure Ulcer Incidence and Prevalence

To estimate the incidence and prevalence of pressure ulcers, we identified individuals with a pressure ulcer of stage 2 or greater. We then calculated incidence and prevalence rates as detailed in "Incidence and Prevalence Measures: A General Note" above.

Restraints Incidence and Prevalence
To estimate the incidence and prevalence of physical restraint use, we adopted a conservative approach, considering only individuals whom the nursing home reported were in a trunk restraint, limb restraint, or some sort of restraining chair at least once during the 7 days prior to the assessment. It is important to note that we did not report the use of bed rails for this measure, because of our concern about biases in the measurement of this item.

Prevalence of Weight Loss
To estimate the prevalence of weight loss, we identified all individuals whom the nursing home indicated had experienced weight loss of more than 5% in the 30 days prior to the assessment or more than 10% in the 180 days prior to the assessment. It is important to note that we excluded individuals who were reported by the nursing home to be in end-stage disease or who were receiving hospice care.

Prevalence of Tube Feeding
To estimate the prevalence of feeding tube use in nursing homes we identified all individuals whom the nursing home reported had a feeding tube, defined as "any tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system." We excluded assessments of individuals admitted to the nursing home with feeding tubes because we wanted to separate the use of feeding tubes by nursing homes from the use of feeding tubes by hospitals.

Prevalence of Incontinence
For this measure, we identified persons who were incontinent of bladder or of bowel on almost all occasions. This is a measure of severe incontinence. It is important to note that this differs from the Quality Indicator on incontinence that is used in the survey process.

OSCAR Measures

Number of Nursing Homes
We have derived counts of the number of nursing homes from an Online Survey Certification and Reporting System (OSCAR) file created in March of each year. It was derived from OSCAR's table of survey records. The counts may differ slightly from other published estimates of the number of nursing homes. Such difference may occur because the counts were made at different points in the year, because different assumptions were made about eliminating potential duplicate records, or because the number of nursing homes was derived from the master provider table in OSCAR, rather than from survey records.

Average Number of Deficiencies
The figures and tables report the mean number of health deficiencies cited during an on-site survey by state and for the nation by calendar year. Health deficiency citations are based on the Interpretive Guidelines from the "State Operations Manual for Provider Certification." Note that for all of the calendar year tables the weighting scheme is unique. Any facility that was not surveyed during the particular calendar year is not counted and any facility that was surveyed twice during the year is doubly counted, giving it a weight of 2. Facilities are surveyed once a year on average.

Percentage of Surveys Resulting in No Deficiencies
This measure is defined as the number of surveys that resulted in zero citations for health deficiencies during a calendar year, divided by the number of surveys conducted that year.

Percentage of Surveys Resulting in Citation for Substandard Quality of Care
The table reports the percentage of surveys resulting in citations for substandard quality of care (SSQC) nationally and by state by calendar year. SSQC is defined as any deficiency in meeting Federal regulations as outlined in the Code of Federal Regulations (42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42CFR 483.25 Quality of Care), at a scope and severity level of 'F', 'H', 'I', 'J', 'K', or 'L'. A grid that details the scope and severity levels is included as the last page of this Methods Section.

Percentage of Surveys Resulting in Citation for Abuse
The table reports the percentage of on-site nursing home surveys resulting in citations for abuse of residents. Abuse citations are those deficiencies cited under tag F223 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification".

Percentage of Surveys Resulting in Citation for Improper Restraint Use
The table reports the percentage of nursing home surveys resulting in a citation for improper restraint use (tags F221-F222 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification").

Percentage of Surveys Resulting in Citation for Pressure Ulcers
This table reports the percentage of nursing home surveys resulting in a citation for pressure ulcers (tag F314 of the Interpretive Guidelines from the "State Operations Manual for Provider Certification").

Percentage of Surveys Resulting in Citation for Actual Harm or Worse
This table reports the percentage of surveys resulting in a citation for actual harm, defined as a deficiency citation that is rated at scope and severity 'G' or more severe. (See grid at the end of the Methods Section.)

Percentage of Surveys Resulting in Citation for Immediate Jeopardy
This table reports the percentage of surveys resulting in a citation for immediate jeopardy to resident health and safety. Immediate jeopardy is a deficiency that constitutes an immediate threat to the health or life of one or more nursing home residents. It is recorded by the state survey agency at scope and severity of 'J' or higher. (See the *Scope and Severity Grid* at the end of the Methods Section).

Scope and Severity Distribution by Year
CMS describes the magnitude and breadth of a nursing home's failure to meet Federal regulations in terms of "scope and severity." (See *Scope and Severity Grid* at the end of the Methods Section.). To describe the portion of all scope and severity scores that one score represents, we divide the number of deficiency citations receiving that score by the total number of citations.

Additional Notes

Change in Methodology: Nursing Home Occupancy Rates
For the Data Compendium 2000, we calculated a nursing home's occupancy rate by dividing the total number of residents by the total number of beds, as recorded in OSCAR fields described as *total residents/clients* and *beds-total* respectively. We concluded that this method leads to an underestimation of occupancy rates: The *beds-total* field captures the count of beds in a nursing home when that nursing home is freestanding; however, when the nursing home exists as the distinct part of another institution (such as a hospital), it captures a count of all beds in the institution. This dilutes the occupancy rate, since beds that are not certified for use by nursing home residents are counted in the denominator.

We calculate occupancy rates differently, and we believe more accurately, in the 2001 edition of the Data Compendium. Instead of using *beds-total* to obtain the bed count, we use the *beds-total certified* field. When the

nursing home is the distinct part of another institution, this field captures the number of beds that are certified for nursing home use only.

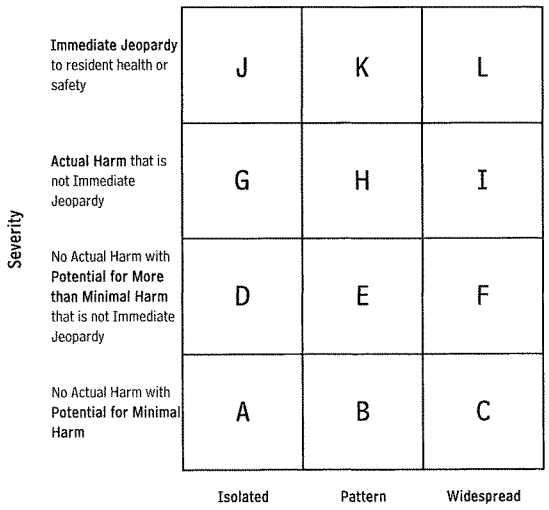
Changes in Historical Data

OSCAR is an administrative database that allows users to add, change, and delete data from the OSCAR database almost continually. In addition, OSCAR stores no more than four standard surveys per provider. The system automatically deletes older surveys as new ones are entered. For these reasons, analysis of the same data elements or fields may yield slightly different results if they use OSCAR data that were retrieved from the database at different points in time. Such variation may become apparent when comparing OSCAR measures in this document to the same measures in the Nursing Home Data Compendium 2000.

Data from Multiple Sources

For analyses dependent on resident-specific (MDS) data only, we include every qualifying assessment regardless of whether the facility from which it originates has an identifiable record in OSCAR. However, where resident-specific data are summarized by OSCAR facility-level data (ownership, certification, bed size category, or chain affiliation), we exclude every MDS assessment from a nursing home 1) that does not have an identifiable record in OSCAR, or 2) for which the facility-level data are missing or invalid in the OSCAR record for that nursing home.

Scope and Severity Grid for Rating Nursing Home Deficiencies



References

Chomiak A, Eccord M, Frederickson E, Glass R, et. Al. Development and Testing of a Minimum Data Set Accuracy Verification Protocol. Final Report, HCFA Contract No. 500-96-0003/TO#6, February 2001.

Morris JN, Fries BE, Mehr DR, Hawes C, Phillips C, Mor V, Lipsitz LA. MDS Cognitive Performance Scale. *J Gerontol.* 1994 Jul; 49(4): M174-82.

COMMUNICATIONS

AAHSA

American Association of Homes and Services for the Aging

2519 Connecticut Avenue, NW
Washington, DC 20008-1520
(202) 783-2242 • FAX (202) 783-2255
www.aahsa.org

Statement for the Record

American Association of Homes and Services For the Aging

Senate Finance Committee

"Nursing Home Quality Revisited: The Good, the Bad, and the Ugly"

July 17, 2003

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit this statement for the record of the Committee's hearing on the quality of care in our nation's nursing homes. AAHSA represents more than 5,600 mission-driven, not-for-profit members providing affordable senior housing, assisted living, nursing home care, continuing care retirement communities, and community services. Every day, our members serve more than one million older persons across the country. AAHSA is committed to advancing the vision of healthy, affordable, and ethical aging services for America.

For the past forty-two years, AAHSA has been an advocate for elderly nursing home residents and has striven in the public policy arena to create a long-term care delivery system that assures the provision of quality care to every individual our members serve in a manner and environment that enhances his or her quality of life. Although we have been closely involved in the development of federal nursing home quality standards, we recognize that quality problems persist and continued efforts are needed to eliminate poor care. Long-term care providers themselves must do much of the work, but we believe that there are also opportunities for public policy changes to encourage continued improvement in the quality of care in our nation's nursing homes.

Quality First

AAHSA, partnering with the American Health Care Association and the Alliance for Quality Nursing Home Care, has embarked on a multi-year plan to ensure true excellence in aging services, going beyond simple compliance with government quality initiatives and taking the responsibility for raising the bar in our field. So far, approximately 800 AAHSA members have signed a covenant that we view as a pact between providers, consumers, and government, and the number of AAHSA members who have signed is growing steadily. All of AAHSA's thirty-seven state affiliates have endorsed the covenant as well. Covenant signors commit themselves to a process that is based on seven core principles: continuous quality improvement, public disclosure and accountability, consumer and family rights, workforce excellence, community involvement, ethical practices, and financial integrity. The goals for Quality First are continued improvements in compliance scores under federal regulations, progress in promoting fiscal integrity, demonstrable improvements in clinical outcomes, better measurement of quality, high scores on consumer satisfaction surveys, and higher employee retention rates and reduction in turnover.

To accomplish these goals, AAHSA is making a number of tools available to members that give them the information they need on best practices in our field, how to evaluate their current strengths and weaknesses, and how to orient all of their operations toward quality care. We are emphasizing research into best practices, education and shared knowledge among our members, leading-edge care and services, codes of ethics, and fiscal and social accountability. We are committing ourselves to providing full and accessible information to consumers on facilities' services, policies, amenities, and rates. To address staffing issues, covenant signers promise to invest in staff

training, competitive wages and benefits, and a supportive work environment for both paid caregivers and volunteers. Quality First emphasizes ongoing assessments of facilities' policies and practices to ensure a continuous process of quality improvement.

To measure and report on the success of this initiative, AAHSA and its partners have called for the appointment of a national commission made up of academic experts and leaders from the private sector who have no financial interest in or direct ties to our field. These impartial community representatives will keep nursing homes accountable for living up to the commitments we have made under the Quality First Covenant and will provide a credible resource for consumers, government, and other stakeholders.

Institute for the Future of Aging Services

Key to any improvement in the quality of nursing home care will be staff recruitment, training and retention. A number of well-documented challenges face health care and aging services providers across the spectrum of care, including the shrinkage of the working-age population in relation to the aging population, broader career opportunities for women who traditionally worked as caregivers, less attractive wages and benefits in the caregiving field, and so on.

The Institute for the Future of Aging Services (IFAS), housed within AAHSA and under the leadership of Dr. Robyn Stone, is implementing several initiatives directed at finding creative solutions to these staffing challenges, including the following:

- **Better Jobs/Better Care** (BJBC), a four-year research and demonstration program to change long-term care policies and practices that contribute to high staff vacancies and turnover rates. Working in partnership with the Paraprofessional Healthcare Institute and with funding from the Robert Wood Johnson Foundation and Atlantic Philanthropies, BJBC is making grants for both demonstration projects and applied research and evaluation. Funding will go to teams of long-term care providers, workers, and consumers to work with state and local officials in developing and implementing changes in policy and provider practices to support recruitment and retention of a quality workforce. Other grants will be awarded to study federal and state policy changes, workplace management and culture, job preparation and training for long-term care workers, and innovative approaches to recruiting qualified workers.

  The response to BJBC's initial call for grant proposals has been strong, and the first grants will soon be announced. We are confident that these research and demonstration projects will provide a solid foundation for changes in both nursing home practices and public policies to attract and retain workers who are well qualified to care for nursing home residents.

- **Practice Profile Database**

  The Institute for the Future of Aging Services and the Paraprofessional Healthcare Institute also have teamed up in putting on-line a database of successful direct-care worker recruitment, training and retention programs that aging services organizations can use to improve staffing. The database, at www.futureofaging.org, provides information on a variety of topics, including recruitment, career advancement, and training for both entry-level workers and management. Projects selected for the database were required to provide quantitative or qualitative evidence of results in the areas of staff satisfaction, successful completion of training programs, and employee-resident relations. Listings in the database include complete information on how the project was implemented and contact information for further discussion. This database provides proven, real-life solutions to staffing issues that confront all long-term care providers.

- **Wellspring Model Refinement, Replication, and Sustainability**

  Almost ten years ago, a group of eleven AAHSA members in Wisconsin decided to pool their resources to accomplish two objectives: to improve clinical care for residents and to create a better working environment by giving employees needed skills, a voice in how their work should be accomplished, and the ability to work as a

team toward common goals. The Wellspring alliance included clinical education by a geriatric nurse practitioner, shared staff training and data on resident outcomes, and culture change that empowered front-line workers to develop and implement care practices that they determined would be beneficial for residents.

A fifteen-month study and evaluation by IFAS and a team of leading academicians in the field of long-term care concluded that the Wellspring alliance had achieved its goals and had pioneered changes that could have broad implications for improving the quality of nursing home care. Positive outcomes noted in the evaluation included greatly reduced staff turnover, improved performance on federal surveys, increased staff initiative to assess and act on care problems, better quality of life for residents, and improved relationships between staff and residents.

IFAS now is working with Wellspring Innovative Solutions, Inc., a not-for-profit organization established in 1997, to develop a strategic plan for disseminating, replicating, and sustaining the Wellspring model among other long-term care providers.

Policy Recommendations

Survey Improvement

Through the nursing home survey and enforcement process mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA), the federal government has sought to ensure that nursing homes meet minimal standards of quality. As noted previously, AAHSA was closely involved in the development of the OBRA standards, and we believe that the quality of care in nursing homes today generally is far above the level that prevailed prior to OBRA.

However, there continue to be serious issues with inconsistency in survey results and the imposition of remedies, as is shown both in the most recent General Accounting Office report and in other testimony offered at this hearing. We believe that improvements to the present system need to be considered objectively and with an unbiased view toward better ensuring quality care. OBRA was enacted sixteen years ago, and the system that it implemented was based on research that now is over twenty years old. Best practices in our field have advanced enormously since that time, and yet those in our field who want to provide innovative, high-quality care are sometimes hamstrung by a highly prescriptive federal regulatory system that in many respects is out-of-date.

A numbe of states, including Minnesota, Washington and Wisconsin, have worked hard and thoughtfully to develop alternative approaches for measuring and ensuring quality nursing home care. They have sought waivers from CMS to use these alternatives in place of the OBRA-mandated system. Realistically, given the resources that states must now commit to the current survey system, they cannot carry out parallel survey processes. CMS has not granted any waiver requests from states, and may be precluded from doing so by the OBRA statute. We would recommend that Congress authorize a limited number of waivers under close supervision by CMS to give states greater flexibility to develop and explore innovative approaches to ensuring quality care. Ultimately, these state experiments could well lead to improvements in the present federal survey system that would better ensure quality care nationwide.

Payment and Quality

AAHSA firmly believes that a two-way commitment is essential to foster improvement in the quality of care and services provided in nursing homes. As the dominant payers for nursing home care, the federal and state governments have an obligation to ensure that payments for nursing home care are adequate to allow for the provision of high quality clinical care in an atmosphere that also ensures quality of life for residents.

Nursing home providers, in turn, have an obligation to serve as responsible stewards of public funds by ensuring that they are delivering the high quality of care and services that federal and state governments purchase for their residents through the Medicare and Medicaid programs. This is possible only by dedicating sufficient resources to the costs of direct care services. AAHSA agrees with Senator Grassley's comments in his July 7 letter to HHS Secretary Thompson stating that additional federal dollars CMS has proposed incorporating into the SNF Medicare

payment system should be used for direct care services, to improve the quality of care provided to nursing home residents.

AAHSA welcomes the growing focus of this Administration, Congress, and other interested parties on the question of how payment policies can be re-designed to foster and support the provision of the highest possible quality in health care. We were pleased with the June 2003 Medicare Payment Advisory Commission (MedPAC) Report to Congress recommending the initiation of demonstrations of "provider payment differentials and revised payment structures to improve quality." As MedPAC points out, "In the Medicare program, the payment system is largely neutral or negative towards quality. All providers meeting basic requirements are paid the same regardless of the quality of service provided. At times, providers are paid even more when quality is worse, such as when complications occur as the result of error." This is equally true of some state Medicaid payment systems, though a number have successfully implemented strategies to foster greater accountability and quality.

AAHSA is eager to work closely with the Administration and Congress to design and test alternative approaches to payment for long-term care services that will not be blind to quality.

Building on State Experience; Implementing a Demonstration

We offer two approaches to re-orient payment for nursing home services to promote high quality care:

One way of linking payment and quality involves applying lessons learned in successful state Medicaid programs. Payment systems need to balance a set of competing objectives: quality, reasonable cost containment, and administrative feasibility. A number of states -- including Iowa, Indiana, Ohio, and Pennsylvania – have "modified pricing" systems that create this balance and provide accountability for public payments by splitting payments into at least two components. Prospective payments for direct care (e.g., nurse staffing) are directly tied to spending on direct care (up to appropriate limits); profit potential on this direct care component is minimized. This linkage ensures that dollars added to the system achieve the desired objective – sufficient staffing to deliver high quality services and meet residents' needs. Incentives to reduce spending are focused on other aspects of nursing home costs such as administration. By contrast, the Medicare system and some state Medicaid systems create strong incentives for homes to reduce spending on both direct and indirect care by providing profit opportunities on the total payment amount. AAHSA suggests that Medicare consider adapting some successful strategies such as modified pricing systems used in state Medicaid payment systems to better link payment and quality.

Second, AAHSA recommends that the federal government implement a demonstration program, with a strong evaluation component, to explore ways to successfully link the quality of care and services provided with payments for nursing home care, beyond ensuring that sufficient resources are allocated to direct care services. The demonstration should develop and test a method for paying bonuses to facilities that achieve excellent ratings in performance of a set of appropriate quality markers—similar to the demonstration recently announced for hospital payments under Medicare.

A critical first step in implementing such a demonstration for nursing facilities would be the development of a set of quality markers that capture desired *processes* of care that should be fostered, e.g., implementation of standardized pressure ulcer risk assessment protocols to identify high risk residents, use of pressure-reducing devices and strategies for residents at high risk of developing pressure ulcers, consistent screening and monitoring of all residents for pain, etc.

Current measures used in long-term care focus on resident-level outcomes, e.g., prevalence of pressure ulcers, prevalence of pain, decline in ability to perform Activities of Daily Living, etc. The outcomes measured are often the result of a vast set of complex interactions between intrinsic resident-specific factors (e.g., major medical conditions, co-morbidities, resident preferences and choices, etc.) and the care provided by the nursing home and other providers. The difficulties inherent in teasing apart the relative influence on outcomes of intrinsic versus extrinsic factors have led to a greater focus on process measures in other health care settings such as hospitals and managed care plans.

Definition of valid process markers, based on research to identify clinically appropriate, evidence-based care for specific types of residents, will allow public and private payers to create incentives that encourage the adoption and consistent use of evidence-based care processes. This can be expected, in turn, to lead to improved outcomes. Focusing on measurement of appropriate processes, however, rather than outcomes, eliminates the need for complex, controversial risk-adjustment formulas to attempt to account for the various intrinsic factors that play a significant part in influencing resident outcomes. Process measurement also allows for capturing the implementation of appropriate preventive health services that should be offered to nursing home residents, such as immunizations to prevent influenza and pneumonia.

In addition to incorporating markers of quality care processes, it is equally important for such a demonstration to expand the definition of nursing home quality beyond the clinical domain addressed in currently available measure sets. It is critical that a system designed to link payment with quality also includes valid, reliable markers of resident quality of life, as well as resident and staff satisfaction. Nursing homes are far more than settings where clinical care is provided – for long-term residents, these facilities are in fact, their homes. To accurately capture key elements of quality that are important to nursing home residents, our systems for measuring quality must evolve to be more holistic.

Finally, AASHA believes that this demonstration should also involve implementing and testing innovative technologies for information management that improve accuracy while reducing the paper work burden on staff. Better information systems and technology will be an important part of tracking the type of quality markers we envision without new and excessive paperwork. In addition, advances in technology, including information technology, are critical to enhancing the quality of aging services for the future.

AAHSA strongly encourages the Administration and Congress to embark upon this path of greater accountability for public funds directed to the provision of services for America's frail elderly and looks forward to participating in the process of designing a system that will benefit nursing home residents across the nation.

Conclusion

AAHSA commends Chairman Grassley for his longstanding dedication to ensuring that nursing home residents receive the highest quality of care. Achieving this vision will require all of us – members of Congress, long-term care providers, consumers, workers, families, and other stakeholders – to work together on innovative solutions to the challenges we all face in making sure that our residents receive the care and services they need.

[For information about AAHSA, see www.aahsa.org}

Statement for the Record
U.S. Senate Finance Committee Hearing
Nursing Home Quality Revisited: The Good, the Bad and the Ugly, July 17, 2003

Submitted by

AARP
601 E Street, NW, Washington, DC 20049

AARP appreciates the opportunity to clarify the hearing record regarding our position with respect to the use of reverse mortgages to purchase long-term care insurance. AARP has long supported the availability of reverse mortgages that enable older persons who are "house rich but cash poor" to meet their basic needs. However, **AARP does not support the targeted use of the proceeds from reverse mortgages.** For this reason we do not support the incentive to use reverse mortgages solely for the purchase of long-term care insurance.

In 1987, AARP supported enactment of the Home Equity Conversion Mortgage (HECM) insurance program. Since then, AARP has trained the loan counselors required under the HECM program, advocated for the most complete consumer disclosure standards in the mortgage industry, and promoted other program enhancements that have made HECM loans the standard for reverse mortgages.

Just as private long-term care insurance is not for everyone, so too reverse mortgages are not for everyone. These are two very different financial instruments that meet the needs of different populations. AARP's support for reverse mortgages and the suitable purchase of long-term care insurance is contingent upon requirements for consumer protections and counseling to enable older consumers to make the best decisions for themselves.

Reverse Mortgages and Long-Term Care Insurance

In 2000, Congress included a provision in the American Homeownership and Economic Opportunity Act that would forgive the up front mortgage insurance premium (generally two percent of the value of the home) for HECM loans in which all of the proceeds are used to purchase long-term care insurance. The Department of Housing and Urban Development (HUD) recently released an independent actuarial study that evaluates the likely consequences of this legislation on three groups: 1) traditional reverse mortgage borrowers who might use the proceeds to purchase long-term care insurance; 2) potential long-term care insurance purchasers who might want to use a reverse mortgage to fund such purchases; and 3) HUD and the Federal Housing Administration (FHA) insurance pool it administers.

1) **Traditional Reverse Mortgage Borrowers:** The typical HECM borrower is a 75-year-old woman, who is living alone in a home worth about $110,000. In 1995, more than 90 percent of HECM borrowers had incomes less than $20,000. Since they generally have no spouse and few assets to protect, purchasing private long-term care insurance is not generally advisable for traditional HECM

borrowers. Furthermore, these borrowers are likely to outlive any long-term care insurance product they could afford. (See Table 1)

2) **Potential Long-Term Care Insurance Purchasers:** The high costs and use restrictions associated with this program would likely make it very unattractive to traditional long-term care insurance purchasers. Even with the forgiveness of the up front mortgage insurance premium, the costs of using a reverse mortgage to purchase long-term care insurance are very high. Moreover, the 2000 legislation requires that all of the proceeds from loans under which the up front mortgage insurance has been forgiven must be used for the purchase of long-term care insurance. For a few thousand dollars of savings, the borrower would forever give up the right to access his or her own equity for other uses, such as home modifications and long-term care services not covered under an insurance policy.

3) **HUD and the FHA Insurance Pool:** While the HUD actuarial study assumes that the unattractive features of the program would result in very low usage, it estimates that the FHA insurance pool would lose over $1 million for every 1000 participants. If consumers could be induced to use the program, the losses would be transferred to the traditional low-income HECM borrowers or require an appropriation from Congress. Moreover, the unique blend of reverse mortgages and long-term care insurance would likely result in difficult and costly administrative problems for HUD.

The HUD actuarial study and our own analysis indicate major problems that would likely occur with implementation of the program enacted in 2000. AARP is concerned that implementing the program could have the perverse effect of inducing older consumers to purchase inadequate long-term care insurance policies that would jeopardize their access to needed public benefits while denying access to their own equity to pay for their own individual needs. The effective endorsement implied by HUD insurance could induce older consumers to enter into agreements that are not in their best interest and would not have been considered in the absence of federal involvement.

AARP agrees with the HUD actuarial study conclusion **"that the longer-term consequences of the LTCi (long-term care insurance) HECM offering warrant additional thought."** More time and discussions are needed to produce programs and products that will adequately serve older people with disabilities. To that end, AARP is participating in a program sponsored by the National Council on Aging and funded by the Robert Wood Johnson Foundation to research ways to tap home equity to meet long-term care needs. We encourage HUD, CMS, and interested members of Congress to engage in these discussions so that the programs and policies that are implemented truly serve older consumers with disabilities.

Table 1

Age at Which a 62-Year-Old Couple Would Run Out of Reverse Mortgage Loan Funds to Pay Annual Long Term Care Insurance Premiums

Assumptions:
Loan = Monthly-adjustable HECM*
Cost of annual premium = $5,000**
Increase in annual premium = none
Upfront MIP on HECM = none

	Interest Rate Used To Calculate Loan Amounts***					
	Rate on 1/16/03		Rate on 1/16/03 + 1%		Rate on 1/16/03 + 2%	
	Loan Amount	Age at which loan funds <$5000	Loan Amount	Age at which loan funds <$5000	Loan Amount	Age at which loan funds <$5000
Home Value at Closing						
$100,000	$50,700	**Age 73**	$39,500	**Age 70**	$28,600	**Age 67**
$150,000	$79,900	**Age 83**	$63,200	**Age 78**	$49,700	**Age 74**
$200,000	$109,000	**Age 99**	$87,000	**Age 89**	$68,700	**Age 81**

* HECM is the federally-insured Home Equity Conversion Mortgage; loan amounts for annually-adjustable rate HECMs are less than the amounts in the table, which are for monthly-adjustable rate HECMs.

**The $5000 premium for a 62-year-old couple is a rounded approximation based on a current AARP premium (($243 x 2 x 12) x 90% = $5,248) and premiums for two prepackaged plans from the Federal Long Term Care Insurance Program (at www.opm.gov): $4,499 for "150 Comprehensive" and $6,099 for "150 Comprehensive +".

***The rate being used to calculate HECM loan amounts on 1/16/03 (5.6%) is near an all-time low (5.2%). To show a range of outcomes based on higher rates, the table adds 1% and 2% to the current rate. For example, the +1% rate (6.6%) was last used to calculate HECM loan amounts in August of 2001; the +2% rate (7.6%) was last used in July of 2000.

THE AMERICAN COLLEGE OF NURSE PRACTITIONERS
1111 19th Street, NW
Suite 404
Washington, D.C. 20036

Written Testimony for the July 17th Senate Finance Hearing , "Nursing Home Quality Revisited: The Good, the Bad and the Ugly"

Chairman Grassley, the American College of Nurse Practitioners (ACNP) focuses on legislative, regulatory and clinical practice issues that affect the utilization of nurse practitioners (NPs) in the rapidly changing health care arena. ACNP is committed to ensuring an appropriate, prevention-based health care system to better meet the health care needs of individuals, families and communities. Based upon these goals, our organization wanted to provide comments in regard to the July 17th hearing hosted by the Senate Finance Committee reviewing nursing home quality.

NPs are registered nurses who are prepared through advanced education and clinical training to provide a wide range of preventive and acute health care services to individuals of all ages. NPs practice in a variety of specialty areas, such as geriatrics, HMOs, independent practices, home health care agencies, hospitals, and long-term care facilities including nursing homes. Nursing home patients deserve the very best care available, and increased utilization of nurse practitioners in our nation's federal health care programs would play a valuable role in strengthening the quality of care received by our country's most vulnerable population.

The Balanced Budget Act of 1997 states that a State may opt to include an NP in the definition of a primary care case manager under Medicaid Managed Care programs. NPs, historically, have been a critical source of primary health care for Medicaid beneficiaries in rural and urban America. Statistics show that oftentimes, NPs are the main or only access to the health care system for the most poor in our society. These NPs become a trusted resource to families and a source of continuity in their health care. However, as it is left up to State option to place NPs within the definition of a primary care case manager, some States do not ensure that families have the ability to continue to choose an NP as their primary care provider. This leaves many Medicaid patients in nursing homes unable to access a nurse practitioner as a primary care provider.

ACNP fully supports legislation introduced by Congressman John Olver (D-MA), H.R. 2295, the Medicaid Nursing Incentive Act, which seeks to establish advanced practice registered nurses, such as NPs, as primary care case managers rather than leaving it to the option of each State. We are convinced that passage of this legislation would assure Medicaid beneficiaries access to the high-quality, cost-effective care offered by the advanced practice nursing community.

ACNP is also concerned about other limitations in federal law that limit seniors access to NPs. Seniors sometimes transition from home based, home health care services to a nursing home, and back home again when their condition improves. One of the most common frustrations that we hear from our members is the inability of NPs to certify and recertify for home health care services. Under the Social Security Act, in order for a home health agency to receive payment for services by Medicare, a physician must certify or initiate those services on behalf of a beneficiary. In some cases, the certifying physician, who does not have a relationship with the patient, relies

upon the input of the patient's nurse practitioner in certifying a Medicare beneficiary for home health. The Balanced Budget Act of 1997 authorized NPs to develop a plan of care for home health patients, but overlooked initiation of the care. ACNP finds this inconsistent, and encourages legislative action to correct this problem.

Our members also express frustration about their inability to provide the initial assessment for Medicare patients in skilled nursing facilities (SNFs). By statute, SNFs are required as a Condition of Participation in Medicare to ensure that every resident is provided health care under the supervision of a physician. The physician may delegate some of the requisite patient care to a NP who is not an employee of the SNF facility, but may not delegate the initial assessment. This is true even though the patient's primary care provider may be an NP. By barring NPs from performing this role, the laws impede NPs from serving a role in an area where Medicare beneficiaries are in desperate need of quality, consistent services. Again, ACNP views this distinction as arbitrary and a remnant of outdated laws and regulations.

In 2000, Mundinger et al reported in the Journal of the American Medical Association that nurse practitioners have improved outcomes, have maintained quality and have decreased costs in patients with heart failure, geriatric patients, and infants in neonatal intensive care units. In 1993 alone, it was estimated that annual lost cost savings to the health care system from the failure to use NPs to their full potential was between $6.4 billion and $8.75 billion.

As you know, the federal government's health programs serve as a model for the private sector, creating high standards for providers and for patient care. Although the United States has the strongest health care system in the world, ACNP believes that our nation and its patients can only benefit by establishing a federal government model that gives NPs the ability to fulfill the full range of their scope of practice authorities as established through State practice acts and licensure.

ACNP appreciates your commitment to our nation's seniors and to ensuring that they are adequately provided for and protected in institutional settings, and encourages the Finance Committee, under your leadership, to better serve seniors by ensuring access to all qualified providers.

Thank you.

Contacts:
Carolyn Hutcherson
Executive Director
ACNP
202-659-2190

Stacy Harbison
Washington Representative
Arent Fox
202-828-3461

A strong public enforcement system is necessary to assure that skilled nursing facilities and nursing facilities provide their residents with the care and services that are promised by federal law. But too often, enforcement of federal standards of care has been lax and federal and state agencies have been overly tolerant of poor care practices that harm residents.

Five years ago this month, two significant events occurred that began to change the pattern. In July 1998, Senator Charles E. Grassley, as chairman of the Senate Special Committee on Aging, began a lengthy series of hearings on nursing home survey and enforcement issues and President William J. Clinton announced a multi-pronged Nursing Home Initiative to strengthen the tools of public oversight. From 1998 until the end of the Clinton Administration, Senator Grassley and the Clinton Administration worked together to begin to make significant changes in public oversight of nursing homes. They sought to improve care for the 1.6 million people who live in nursing homes.

We see no evidence that the Bush Administration has continued this work. The initiatives begun in the Clinton Administration with the support and encouragement of Senator Grassley and supported by numerous reports by the General Accounting Office and the Office of the Inspector General, particularly between 1998 and 2000, appear to have been all but abandoned. In their place, we see a Nursing Home Quality Initiative that combines public information about resident outcomes with technical assistance to nursing homes provided by Quality Improvement Organizations. Neither approach * neither the marketplace nor a collaborative approach to oversight * has ever been demonstrated to improve quality of care for nursing home residents.

We also see no evidence that the Administration has responded to nursing home reports issued during its own tenure. The CMS-commissioned Complaint Improvement Project confirmed "a generally bleak picture of the state of nursing home complaint investigation across the country." Zimmerman, et al., Complaint Improvement Project, pages 8-9, CMS #A-99-034?LC (Jun. 3, 2002). The June 2002 report identified "shortcomings and deficiencies of the entire system of the complaint investigation function and organizational structure" and called for "fundamental and comprehensive reform" in states' complaint investigation systems and federal oversight. We are unaware of any activities to implement any of the recommendations of this report, which was issued more than thirteen months ago.

Nor has the Administration taken steps to implement the CMS report, issued more than two years ago, about nurse staffing ratios, despite the report's research-based finding that more than 92% of facilities fail to have sufficient staff to prevent avoidable harm to residents. CMS, Appropriateness of Minimum Staffing Ratios in Nursing Homes (2001). The Administration's primary response to staffing has been a proposal to create a new category of staff * "feeding assistants" * who will not be required to have the 75 hours of training that certified nurse assistants must have in order to provide nursing-related services to residents.

Advocates for residents believe and recognize that care for some residents has improved. There is general agreement that the reform law has been instrumental in reducing the use of physical restraints in nursing homes nationwide. Nursing facilities such as the Pioneers and the Wellspring facilities recognize that they can be innovative and provide good care while complying with the requirements of the federal nursing home reform law. We believe that the nursing home reform law is a good law that sets out a high standard of care that all residents are entitled to receive. Making sure that all of the standards of care are actually met for each resident is the laudable goal of the public enforcement system. Unfortunately, we are far from reaching that goal.

Today's hearing is the first to look at the Bush Administration's nursing home record. We thank Senator Grassley for his continuing leadership on nursing home issues and his unwavering commitment to improving the life of nursing home residents.

Toby S. Edelman

The Center for Medicare Advocacy, Inc. is a national, non-partisan education and advocacy organization that identifies and promotes policy and advocacy solutions to ensure that elders and people with disabilities have access to Medicare and quality health care. The Center for Medicare Advocacy's national office is in Connecticut, with offices throughout the country, including Washington, DC.

Statement of the

National Citizens' Coalition for Nursing Home Reform

Senate Committee on Finance

The Honorable Charles E. Grassley, Chair
The Honorable Max Baucus, Ranking Democratic Member

Nursing Home Quality Revisited: The Good, the Bad, and the Ugly

July 17, 2003

The National Citizens' Coalition for Nursing Home Reform has been working for almost 30 years to improve the quality of care in nursing homes. During these years we have been privileged to work with a number of true Congressional champions of nursing home residents, including Senator Grassley, who held his first hearing on nursing home regulation in 1998 and has steadfastly asserted the federal government's responsibility for nursing home quality ever since. If enforcement of the 1987 Nursing Home Reform Act has often disappointed us, we should pause to think how much worse the condition of nursing homes would be today without his intervention. NCCNHR would like to express its gratitude to Senator Grassley for his advocacy on behalf of more than one-and-a-half million Americans who live in nursing homes.

We would also like to thank Senator Baucus for his support for better nursing home care and strong concern about one of the most intransigent problems in long term care, understaffing; Senator Bond for requesting (with Senator Grassley) the GAO report on nursing home regulation that is being released today; Senator Breaux for his own extraordinary leadership as chairman and ranking member of the Special Committee on Aging and as the sponsor of the Elder Justice Act; Senator Rockefeller for his co-sponsorship last year with Senator Grassley and Senator Breaux of the Staffing Accountability Act; and the other members of the Finance Committee who have demonstrated their concern for some of America's most vulnerable citizens.

NCCNHR was instrumental in the passage of the Nursing Home Reform Act, and we have consistently maintained that it is a *good* law that has not always had good enforcement. Much of the testimony at the hearing focuses on the failure of many if not most nursing homes to provide good or even decent care, and on the failure of the state survey agencies and the Centers for Medicare and Medicaid Services to remedy the problems. *These are not failures of the law – they are failures to enforce the law.*

While the GAO has found that the proportion of nursing homes with serious problems has declined, what is truly shocking about this report – and others before it – is how much abuse and neglect is *tolerated.* The GAO has documented 38 cases from a sample of 76 surveys in which residents suffered from infections; multiple bedsores and skin tears; severe weight loss; avoidable falls and lacerations; fecal impaction; untreated pain; delayed treatment of fractures; contractures; multiple bruises; and untreated acute respiratory distress in which the resident stopped breathing – all without state survey agencies finding that the residents had been harmed. In a series of reports for his colleagues in the House of Representatives, Representative Henry Waxman has found similar undercoding of serious deficiencies. Surely, if there is anything we can do as a society for our elders and the disabled, it is at least to give such treatment the right name so that we can assign it an appropriate remedy.

This spring, NCCNHR joined with its Texas member group, Texas Advocates for Nursing Home Residents, in publishing 83 case histories of men and women who suffered serious abuse and neglect in Texas nursing homes. The photographs in this book, *Faces of Neglect: Behind the Closed Doors of Texas Nursing Homes*, show graphically

and painfully what far too many suffer in nursing homes. In many of the cases, the state had taken little or no action to penalize the provider who did not prevent or adequately treat the painful condition that – in many cases – killed these residents. Two of these residents, for example, Alice R. and Vera M., were admitted to hospitals from their nursing homes with life-threatening Stage IV pressure sores. The three open wounds on Alice R's hips and back had extended through every layer of her skin to underlying muscle, tendons, and bones, and the bedsores' dying tissue was poisoning her bloodstream. Vera M's crater-like pressure sore had fatal results: She died from complications associated with the infection from the sore. In both cases, surveyors cited the facilities merely for "level D" deficiencies ("potential for more than minimal harm"), and no fines or penalties were assessed in connection with their cases.

CMS must give priority to state surveyors' understatement of actual harm deficiencies, including initiating immediate efforts to address the underlying causes of the problem cited by GAO.

One of the most disturbing things about bad nursing home care is that so many providers defend it. Most of the victims in *Faces of Neglect* (or their distraught families) ended up in court, where outraged judges and juries awarded appropriate monetary penalties that often were the only justice the residents got. Yet the nursing home industry maintains that most private lawsuits are frivolous and calls for caps on damages for the pain and suffering that its clients endure. At the same time, nursing homes clog the administrative law system with appeals of violations every bit as serious as those cited in the GAO's case examples. According to the American Health Care Association in 2001, administrative law judges found against providers in 90 percent of their appeals – and yet the industry blames, not the negligent nursing homes, but the judges. It supports legislation that would encourage more meritless administrative appeals, slow the system, and delay the imposition of penalties.

Although the GAO study shows that the serious problems in nursing homes are abetted by *too little* enforcement, industry leaders have a wish list of changes to weaken the Nursing Home Reform Act that they would like to see implemented – by regulation, if the Administration is willing, or by legislation, if necessary. We believe that assaults on critical aspects of the law and regulations that require reasonable standards of care and clear penalties for violations affect morale and enforcement decisions in the regulatory agencies. Moreover, they keep the industry from moving forward and from resolving, finally, to meet public expectations and their fiscal and moral obligations to the residents with whose care they are charged.

Industry leaders, for example, are actively supporting a survey system that would rely substantially on collaboration with those whose negligence allows residents to become malnourished, dehydrated, contracted, and covered with bedsores. In this scheme, surveyors would consult with nursing homes to help them provide better care, even though the industry frequently rails that these same surveyors are incompetent – and even though preventing and treating pressure sores, for example, like most of the pervasive problems in nursing homes, is basic nursing science. Accountability for neglect and abuse

would be dismissed in a consultative system, along with penalties. We should not forget that we had a collaborative survey system before the reform law was enacted, and it did not work.

Industry representatives have also successfully campaigned for a reduction in the qualifications of those who provide nursing-related services, namely transportation and feeding, in spite of rampant evidence that nursing staff in nursing homes are already poorly prepared for their responsibilities and need more training. CMS says that in September it will publish a final regulation creating a new category of worker, a feeding assistant, who will receive minimal training but who may work unobserved by a registered nurse in one of the most hazardous jobs in the nursing home. CMS has already, without notice and comment, told nursing homes they can use untrained workers to transport residents, thus allowing facilities to place residents with fragile health in the care of individuals whose only skill is driving a van or pushing a wheelchair. Since the addition of this new classification of workers is to be cost-neutral, in CMS's view – meaning that there will be no additional reimbursement for their services – we can expect that nursing homes will use them to replace certified nursing assistants who have met the minimum training and competency evaluation requirements intended by Congress.

In 2002, the U.S. District Court for the District of Columbia ruled against Beverly Health and Rehabilitation Services in a suit that the American Health Care Association had supported and predicted would overturn the existing survey system. Florida surveyors had terminated a Beverly facility in 1998 for causing "immediate jeopardy" to residents and imposed civil monetary penalties of $10,000 a day. Beverly appealed the case to an administrative law judge, the Departmental Appeals Board, and finally the federal court. In her decision, Judge Helen Segal Huvelle said the plaintiff's requested remedies (including invalidating the survey process) would "eviscerate" Congress's efforts to improve the quality of care of nursing home residents and to bring substandard facilities into compliance.

Judge Huvelle's decision included a statement that NCCNHR urges the executive and legislative branches of government to take to heart: "The solution to fixing problems . . . is not, as plaintiffs suggest, to dismantle an imperfect enforcement system; rather, it is to continue to make improvements."

The GAO's report provides a prescription for the Centers for Medicare and Medicaid Services to make these improvements. For the past several years, CMS has focused heavily on an endeavor we have cautiously supported – the development of quality measures to help consumers identify quality nursing homes. But as we have said repeatedly, this effort cannot be a substitute for tough and effective enforcement. Most Americans who enter nursing homes will spend some time (perhaps the rest of their lives) in nursing homes that perform poorly on quality measures. We must protect the majority who have little or no choice.

As an organization that represents nursing home residents; their families, friends, and other advocates; and state and local long term care ombudsmen, we would particularly

like to point out the GAO's findings about states' continuing failure to implement an effective complaint process. NCCNHR logs hundreds of calls a year from frustrated and often frightened and tearful family members who are extremely worried about the quality of care a resident is receiving but who do not know how to get help. Too many times they have filed a complaint with a state survey agency that responded with a cursory investigation that found no violation. This encourages nursing homes to disregard consumers and to continue to give poor care with impunity, and it sends a message to residents and families that there is no way to resolve problems, no matter how serious. Providers have multiple levels of appeal when they want to challenge deficiencies, but consumers do not have any forum in which to protest a survey that has overlooked serious problems.

The GAO report clearly demonstrates that to ensure quality care in our nation's nursing homes, CMS oversight and state surveys and enforcement must be strengthened. Congress must also play a role in improving care. NCCNHR makes the following recommendations:

- CMS should act immediately to begin implementing the GAO's recommendations, including developing a more rigorous survey methodology and an effective complaint system; assessing state survey reports for the appropriateness of their citations of scope and severity; and refining state performance reviews.
- CMS must address the factors that contribute to the understatement of deficiencies, including poor investigation and documentation practices and turnover of survey personnel.
- CMS and state survey agencies should work with Administration budget officials and Congressional budget and appropriations committees to ensure that states receive adequate funding to implement the changes called for in the report. No increases in survey and certification funding are called for in FY 2004 appropriations.
- CMS should implement a system that allows residents and their representatives to obtain a review if they believe surveyors have erroneously failed to cite deficiencies or if they believe that deficiencies were cited at a lower level than was warranted.
- Congress and HHS should send clear signals to nursing facilities and their representatives that they will not entertain recommendations to weaken the standards or enforcement provisions of the Nursing Home Reform Act or its implementing regulations and guidelines.
- Congress must act to ensure that nursing homes are adequately staffed, and that any increases in reimbursement are strictly tied to increases in nursing staff. For almost 30 years, the most intractable problem in nursing homes has been understaffing. This is the source of most critical quality of care problems, and it is not solely or even primarily the result of underpayment, as the industry claims. Increases in reimbursement do not result in better care, as numerous studies have shown.

- Congress should reintroduce and pass the Staffing Accountability Act, which would require CMS to develop a new system for collecting and auditing nurse staffing data and a quality measure for staffing. Changes will not occur until the public has access to this most critical piece of information.
- Congress should pass the Elder Justice Act, which will significantly increase federal protections against neglect and abuse in long term care facilities.

Finally, we wish to thank Senator Grassley, Senator Baucus, and members of the Finance Committee again for holding this hearing, and to urge you to continue your oversight of this issue so critical to your constituents and millions of other Americans.

The Coalition of Geriatric Nursing Organizations

Representing Geriatric Nurses

American Academy of Nursing (AAN) Expert Panel on Aging

•

•

The John A. Hartford Foundation Institute for Geriatric Nursing, New York University

•

•

National Conference of Gerontological Nurse Practitioners (NCGNP)

•

August 7, 2003

Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Grassley:

The American Academy of Nursing: Expert Panel on Aging, The John A. Hartford Institute for Geriatric Nursing, and the National Conference of Gerontological Nurse Practitioners, participants in the Coalition of Geriatric Nursing Organizations (CGNO) whose purpose is to improve the quality of care for seniors across the continuum, request that you include this letter and the attachment in the record of the hearing on July 17, 2003, "Nursing Home Quality Revisited: The Good, the Bad, and the Ugly."

Thank you for your leadership and tireless efforts to improve care for the 17,000 residents in America's nursing homes through public hearings and resulting improvements in public policy. This letter is in support of your strong recommendation, made more than once during the hearing, to the Centers for Medicare and Medicaid Services (CMS) that the 3.26% Medicare increase, proposed as a result of the forecasting error adjustment, be tied specifically and measurably to improvements in nurse staffing.

The attached background paper is a summary of the research supporting the importance of total nurse staffing, Registered Nurse staffing including nurse practitioners, and Certified Nursing Assistants on resident outcomes in nursing homes. Poor outcomes for residents, described in the testimonies of the daughters of nursing home residents, Sheila Albores and Jeanne Hodgson, are a result of inadequate numbers and supervision of staff and include, but are not limited to:

Increased incontinence,
Higher use of restraints,
Increased pressure ulcers-especially more serious stages, and
Increased functional dependency,
Increased hospitalizations,

Coordinated by: Sarah Burger • The Hartford Institute for Geriatric Nursing
Division of Nursing, The Steinhardt School of Education, New York University
246 Greene Street, New York, NY 10003
Contact: Tel: 212.998.5355 • Fax: 212.995.4561 • Hartford.ign@nyu.edu

Increased hospitalizations,
Poor Nutrition and subsequent weight loss,
Choking, aspiration, and fear of eating,
Depression,
Higher use of psychotropic and hypnotic medications,
Falls and injuries.

Testimony also revealed that many nursing homes are providing good, improving, or outstanding quality of care and life for residents. This upward trend depends upon greater support for professional nursing, including the use of nurse practitioners, to supervise certified nursing assistants and provide on site clinical support of residents. The attached background paper strongly supports the importance of professional nursing in quality nursing home care for residents.

Thank you for the opportunity to provide additional testimony for the record in support of efficient and effective care for the vulnerable elders in our nation's nursing homes.

Sincerely,

Sarah Greene Burger, RN, MPH
Coordinator, Coalition of Geriatric Nursing Organizations

Attachment: Background Paper

SIGNIFCANCE OF TOTAL NURSE STAFFING, REGISTERED NURSE, NURSE PRACTITIONERS AND CERTIFIED NURSING ASSISTANTS: IMPROVING AND SUSTAINING QUALITY CARE AND LIFE IN NURSING HOMES

A BACKGROUND PAPER
From
THE COALITION OF GERIATRIC NURSING ORGANIZATIONS

SIGNIFICANCE OF TOTAL NURSE STAFFING

Considerable research has been conducted and reported on the relationship between various nurse staffing levels and outcomes for nursing home residents. Research, directed by CMS, and reported to the U.S. Congress in 2001, established a clear relationship between nurse staffing levels and resident care quality. While there is no assurance that high quality care will be provided at any given staffing level there appears to be a level at which the likelihood of poor care and poor outcomes increases substantially. This is defined by CMS as the "minimum preferred" staffing level for licensed staff. Although a similar minimum total staffing level was not established by CMS, available research and industry averages provide some guidance to providers. Further, the likelihood of specific untoward resident outcomes has been linked to both specific staffing levels and to the increase or decrease of nursing staff. Several studies have documented relationships between levels and ratios or specific nursing staff types (Registered Nurse, [RN], Licensed Vocational Nurse, [LVN], Certified Nursing Assistants, [CNAs]) and particular resident outcomes. Overall this research reveals that residents do better in many important ways, as staffing levels rise. This relationship is especially significant for each incremental drop below the preferred minimum levels. Thus facilities that staff well below the preferred minimum can expect negative resident outcomes. Resident outcomes that have been found to be associated with low levels of Total Nurse Staffing include :

(1) increased incontinence levels
(2) higher use of restraints
(3) increased pressure ulcers -- especially more serious stages
(4) increased functional dependency.

Qualitative studies have documented relationships between inadequate staffing and each of the following resident outcomes :

(1) poor nutrition with subsequent weight loss
(2) choking, aspiration and fear of eating
(3) depression
(4) urinary incontinence that is reversible
(5) generally poor quality of life
(6) hospitalizations due to failure to identify a serious change in resident condition
(7) greater use of PRN medications
(8) higher use of psychotropic and hypnotic medication

(9) falls and injuries
(10) decreased resident ambulation

Inadequate nurse staffing causes long wait times for residents for all types of care. In addition, long waits often lead to "functional incontinence" which simply means that the resident cannot get to a bathroom. For this reason, high levels of incontinence often reflect a poor response to the residents rather than a resident incapacity. Individualized toileting plans have been shown to result in facility-wide reductions in levels of incontinence.

Functional incontinence is preventable, and in fact, can also be substantially reduced with a resident toileting plan. Such plans can only be carried out with adequate staffing and minimal staff turnover. Based on research with CNAs across many facilities, toileting plans are likely to be abandoned as staffing levels drop, increasing resident incontinence. This type of incontinence should not be confused with irreversible, or physiological causes of incontinence.

Inadequate staffing at mealtimes is directly related to resident weight loss, choking, aspiration and pneumonia. Inadequate time to assist residents with meals often causes residents to reject food -- to avoid being rushed through meals. This "rejection" of food is sometimes related to swallowing difficulties common in this population. Being rushed leads to choking and / or fear of choking. Under these circumstances, many residents claim they are not hungry simply out of fear. Rushed feeding also encourages staff to mix foods together in a way that is efficient but unpalatable. Food that sits for long periods of time, as is often the case with short staffing, changes temperature and texture leading to unappealing meals as well. Taken together, short staffing is a serious threat to resident nutrition.

In many facilities with inadequate nurse staffing, there is insufficient time to ambulate residents. Along with toileting and feeding, ambulating residents is a frequently dependent on adequate total nurse staffing, especially CNA staffing. An inability to ambulate leads to artificially high overall resident dependency levels, compounding the short staffing problems and undermining resident recovery.

Failing to ambulate residents on a regular basis quickly causes physical decline (as soon as 48 hours,) compromising a residents ability to perform simple activities such as walking to a bathroom or attending social activities and decreases the chances that residents will be discharged to home.

Importantly, failing to respond to residents in a timely manner, as occurs with inadequate staffing, leads to a lowering of resident expectations. Residents whose needs are not attended to, quite simply lower their expectations and ask for less. This further contributes to the likelihood of residents receiving inadequate care and experiencing poor outcomes.

In addition, research has demonstrated a relationship between low staffing and high staff turnover, which in turn, undermines the quality of care and leads to further compromising of resident outcomes. High front-line staff turnover is one of the most

important determinants of resident quality of life and quality of care. Residents have identified high turnover as a serious impediment to quality of care and quality of life.

SIGNIFICANCE OF REGISTERED NURSE STAFFING

The relationship between RN staffing levels and resident outcomes in nursing homes has been well documented. Research has shown a clear relationship between ratios of RNs to residents and both the overall quality of care and specific resident outcomes. In particular, inadequate RN presence has been correlated with higher mortality rates among residents, a decrease in functional status of residents, a likelihood that fewer residents will be discharged back to their homes, and an increased number of deficiencies on the annual survey.

The importance of RN staffing is clearly reflected by the results of one study demonstrating a 53% drop in survey deficiencies with each 25% increase in the RN to LVN staff ratio. As RN staffing drops, serious consequences for residents occur. Accurate assessment, adequate monitoring of medical conditions and follow through on treatment plans are all undermined by low RN staffing.

The importance of the RN is not confined to the ability to provide the skilled care required by residents of long term care facilities. Several studies have documented the importance of the unit charge nurse in setting the tone for the unit, having a direct impact on both quality of work life for CNAs and improved quality of life for residents.

SIGNFICANCE OF NURSE PRACTITIONERS

Nurse practitioners are becoming necessary members of the nursing team caring for older institutionalized adults. Documented positive outcomes are associated with the increased presence of nurse practitioners in the nursing facility.

Geriatric nurse practitioners were first introduced to nursing facilities in the 1970's in order to improve access to medical services and augment the role of the attending physician. In reality, they did much more than provide medical services. When employed by the nursing facility, nurse practitioners provided primary care to residents and enhanced nursing services by participating in quality improvement, infection control, staff education, and research. Clinical nurse specialists are also associated with positive benefits including reduction of pressure ulcers, improvement in toileting programs, and decreased staff turnover.

Nurse practitioners have been associated with improved quality of care and quality of life for residents under their care. Consistent outcomes across various practice models include reduction in hospitalizations and use of emergency room services. Hospitalization and emergency room services are associated with increased negative

outcomes such as delirium, use of urinary catheters, medication side effects, and physical restraints.

In addition, nurse practitioners have been associated with increased use of rehabilitation and restorative nursing services. Both of these programs enhance physical functioning leading to greater independence in ambulation, continence, and eating. Independence in physical functioning is associated with an overall improvement in quality of life.

Nurse practitioners have superior observations skills for detecting a change in condition. Inexperienced or untrained staff members have difficulty recognizing a subtle change in condition in a frail, older adult. The result is a delay in treatment and increases the need for hospitalization. On site nurse practitioners would enhance earlier detection and treatment. In addition, with the addition of an advance practice nurse, the facility may be able to manage a higher level of acuity overall, saving federal dollars by avoiding hospitalizations.

Resident, family, and staff satisfaction is high for services provided by nurse practitioners and clinical nurse specialists. Retention of nurse practitioners who are employed by facilities is high, offering stability for clinical leadership and continuity of care for the residents.

In summary, nurse practitioners and clinical nurse specialists are valuable members of the interdisciplinary team. Their practices are associated with improvements in quality of care, quality of life and reduced costs to the health care system

SIGNIFICANCE OF CNA STAFFING

Research that has examined the relationship between nurse aide staffing levels and resident quality of care and quality of life has demonstrates that CNA staffing levels are related to weight loss, malnutrition, bladder and bowel incontinence, functional decline, and overall poor quality of life. The incidence of skin breakdown and pressure ulcers also rises dramatically with poor nutrition and is compounded still further by incontinence and impaired functional status. Malnutrition also leads to an increased incidence of drug reactions in the elderly which, in turn, lead to a host of often serious negative outcomes.

In addition to the published research by others, my own research (both published and unpublished,) and my personal experience in many long term care settings, it is clear to me that CNA staffing levels are fundamental to both quality of care and quality of life for residents. When asked about what are the most important quality parameters, residents consistently point to their relationships with CNAs. Being able to have enough time with CNAs and having consistency in the CNAs who provide their care (undermined by high turnover rates,) are basic to quality of care and quality of life for nursing home residents.

The psychological impact of inadequate CNAs is also important. Residents look to CNAs for much of their social interaction. CNAs often become surrogate family for

lonely residents. Having enough time to sit and talk with residents or read to them are basic to a decent quality of life and impossible to do unless staffing is sufficient.

Bliesmer, M. M., Smayling, M., Kane, R. L., & Shannon, I. (1998). The relationship between nursing staffing levels and nursing home outcomes. *Journal of Aging and Health, 10*(3), 351-371.

Bowers, B. (Unpublished report). *The work of nurses and nurse aides in long term care facilities*. Washington DC: Institute of Medicine.

Bowers, B. J., Esmond, S., & Jacobson, N. (2000). The relationship between staffing and quality in long-term care facilities: Exploring the views of nurse aides. *Journal of Nursing Care Quality, 14*(4), 55-64.

Bowers, B. J., Esmond, S., & Jacobson, N. (2003). Turnover reinterpreted: CNAs talk about why they leave. *Journal of Gerontological Nursing, 29*(3), 36-43.

Brody SJ, Cole, L., Storey, P.B., & Wink, N. The geriatric nurse practitioner: A new medical resource in the skilled nursing home. *Journal of Chronic Disease.* 1976:29:537-543.

Buchanan JL, Bell RM, Arnold SB, Witsberger C, Kane RL & Garrard J. Assessing cost effects of nursing home based geriatric nurse practitioners. *Health Care Financ Rev.* 1990;11(3):67-68.

Burl JB, Bonner A, Rao M, Khan AM. Geriatric nurse practitioners in long-term care: demonstration of effectiveness in managed care. *J Am Geriatr Soc.* 1998;46(4):506-510.

Cadogan MP, Franzi C, Osterweil D. Utilization of standardized procedures in skilled nursing facilities: The California experience. *Nursing Home Medicine.* April, 1998. Retrieved May 31, 2003 from http://www.mmhc.com/engine.pl?station=mmhc&template=altcfull.html&id=56

Eisch JS, Brozovic, B., Colling, K., & Wold, K. Nurse practitioner geropsychiatric consultation service to nursing homes. *Geriatric Nursing.* 2000;21(3):150 -155.

Evans LK, Strumpf NE, Allen-Taylor SL, Capezuti E, Maislin G, Jacobsen B. A clinical trial to reduce restraints in nursing homes. *J Am Geriatr Soc.* 1997;45(6):675-681.

Farley DO, Zellman, G., Ouslander, J., & Reuben, D.B. Use of primary care teams by HMOS for care on long-stay nursing home residents. *Journal of American Geriatrics Society.* 1999;47(138-144.):139-144.

Garrard J, Kane RL, Radosevich DM, et al. Impact of geriatric nurse practitioners on nursing-home residents' functional status, satisfaction, and discharge outcomes. *Med Care.* 1990;28(3):271-283.

Harrington, C., Zimmerman, D., Karon, S. L., Robinson, J., & Beutel, P. (2000). Nursing home staffing and its relationship to deficiencies. *Journal of Gerontology, 55B*(5), 278-8287.

Hawes, C., Zimmerman, D., & Bowers, B. (2001). *State complaint investigation systems: A report of findings from a survey of state survey agencies and CMS regional offices.* Madison, WI: Center for Health Systems Research and Analysis.

Health Care Financing Administration. (2000). *Report to Congress: Appropriateness of minimum nursing staffing ratios in nursing homes, executive summary.* Baltimore: HCFA.

Health Care Financing Administration. (2001). *Report to Congress: Appropriateness of minimum nurse staffing ratios in nursing homes, phase II final report.* Baltimore: HCFA.

Irvine D, Sidani, S, & McGillis-Hall, L. Linking outcomes to nurses roles in health care. *Nursing Economics.* 1998;16(2):58-64.

Jackson MM, Fierer, J., Barrett-Connor, E., Fraser, D., Kaluber, M.R., Hatch, R., Burkhart, B., & Jones, M. Intensive surveillance for infections in a three year study of nursing home patients. *American Journal of Epidemiology.* 1992;135(6):685-696.

Johnson-Pawlson, J., & Infeld, D. L. (1996). Nurse staffing and quality of care in nursing facilities. *Journal of Gerontological Nursing, 22*(8), 36-45.

Joseph A, & Boult C. (Brummel-Smith, K. series editor). Managed primary care of nursing home residents. *Journal of American Geriatrics Society.* 1998;46:1152-1156.

Kane RA, Kane RL, Arnold S., Garrard J, McDermott S & Kepferle L. Geriatric nurse practitioners as nursing home employees: Implementing the role. *The Gerontologist.* 1988;28(4):469-477.

Kane RL, Flood, S., Keckhafer, G., Rockwood, T. How EverCare nurse practitioners spend their time. *Journal of American Geriatrics Society.* 2001;49(11):1530-1534.

Kane RL, Garrard J., Buchanan JL, Rosenfeld, A, Skay, C, & McDermott, S. Improving primary care in the nursing home. *Journal of American Geriatrics Society.* 1991: 39:359-367.

Kane RL, Garrard J, Ska, CL, Radosevich DM, Buchanan JL, McDermott SM, Arnold SB, & Kepferle L. Effects of a geriatric nurse practitioner on process and outcome of nursing home care. *American Journal of Public Health.* 1989: 79(9), 1271-1277

Kane RL, Huck S. The implementation of the EverCare demonstration project. *Journal of American Geriatrics Society.* 2000;48:218-223.

Karlin N, Schneider, K & Pepper, S. Issues of attraction, retention, and affective states for geriatric nurse practitioners in long-term care. *Geriatric Nursing.* 2002;23(6):324-329.

Kayser-Jones, J., & Schell, E. (1997). The effect of staffing on the quality of care at mealtime. *Nursing Outlook, 45*(2), 64-72.

Lowenthal G, & Breitenbucher R. The geriatric nurse practitioner's value in a nursing home. *Geriatrics.* 1975;November:87-91.

Mezey M, Fulmer, T., Burl, J., Bonner, A., Rao, M., & Khan, A. Geriatric nurse practitioners in long-term care: Demonstration of effectiveness in managed care. *Journal of the American Geriatrics Society.* 1998;46(4):506-510.

Munroe, D. J. (1990). The influence of registered nurse staffing on the quality of nursing home care. *Research in Nursing and Health, 13*(4), 263-270.

Omnibus Budget Reconciliation Act. H.R. 3545; Pub. L. No. 100-203, 1987, Retrieved September 22, 2002 from http://www.senate.gov/~budget/republican/reference/cliff_notes/cliffaph.htm

Ouslander JG, Morley, J., & Osterweil, D. *Medical Care in the Nursing Home.* 2nd ed. New York: McGraw-Hill; 1996.

Panicucci C, Ingman, S., & Alyea, B. The nurse practitioner-physician team in nursing home practice. *Gerontology and Geriatrics in Education.* 1984/85;5(2):55-65.

Radosevich DM, Kane RL, Garrard J, et al. Career paths of geriatric nurse practitioners employed in nursing homes. *Public Health Rep.* 1990;105(1):65-71.

Rantz MJ, Popejoy L, Petroski GF, Madsen RW, Mehr DR, Zwygart,-Stauffer, M, Hicks LL, Grando V, Wipke-Tevis DD, Bostick J, Porter R, Conn VS, & Maas M. Randomized clinical trial of a quality improvement intervention in nursing homes. *The Gerontologist 41.* 2001;4:525-538.

Reuben DB, Schnelle JF, Buchanan JL, et al. Primary care of long-stay nursing home residents: approaches of three health maintenance organizations. *J Am Geriatr Soc.* 1999;47(2):131-138.

Ryden MB, Snyder, M., Grosss, C.R., Savik, K., Pearson, V., Krichbaum, K., & Mueller, C. Value-added outcomes: The use of advanced practice nurses in long-term care facilities. *The Gerontologist.* 2000;40(6):654-662.

Sayhoun NR, Pratt, LA, Lentzner, Dey, A., & Robinson, KN. *The changing profile of nursing home residents: 1985-1997.* Hyattsville, MD: National Center for Health Statistics.; 2001. No. 4.

Schaefer, J. A., & Moos, R. H. (1996). Effects of work stressors and work climate on long-term care staff's job morale and functioning. *Research in Nursing and Health, 19*(1), 63-73.

Schultz PR, & McGlone, F.B. Primary health care provided to the elderly by a nurse practitioner/physician team: Analysis of cost effectiveness. *Journal of American Geriatrics Society.* 1977;25(10):443-446.

Sheridan, J. E., White, J., & Fairchild, T. J. (1992). Ineffective staff, ineffective supervision, or ineffective administration? Why some nursing homes fail to provide adequate care. *Gerontologist, 32*(3), 334-341.

Sidani S, Irvine D. A conceptual framework for evaluating the nurse practitioner role in acute care settings. *J Adv Nurs.* 1999;30(1):58-66.

Stefanacci RG. Will nurse practitioners replace physicians as attendings in long-term care? *Journal of the American Medical Directors Association.* 2001;September/October:222-224.

Stone, R., Reinhard, S., Fielding, J., Zimmerman, D., Bowers, B. J., Jacobson, N., et al. (2002). *Evaluating the Wellspring Program as a Model for Promoting Quality of Care in Nursing Homes.* Washington, DC: Commonwealth Fund.

Stryker, R. (1982). The effect of managerial interventions on high personnel turnover in nursing homes. *Journal of Long Term Care Administration, 10*(2), 21-33.

von Sternberg T, Hepburn, K., Cibuzar, P., Convery, L., Dokken, B., Haefemeyer, J., Rettke, S., Ripley, J., Vosenau, V., Rothe, Pl, Schurle, D., & Won-Savage, R. Post-hospital sub-acute care: An example of a managed care model. *Journal of American Geriatrics Society.* 1997;45:87-91.

Wieland D, Rubenstein LZ, Ouslander JG, & Martin SE. Organizing an academic nursing home. *Journal of the American Medical Association.* 1986;255(16):2622-2627.

Yeatts, D. E., & Seward, R. R. (2000). Reducing turnover and improving health care in nursing homes: the potential effects of self-managed work teams. *Gerontologist, 40*(3), 358-363.

Department of Veterans Affairs
Statement for the Record
Hearing on Quality of Care in Nursing Homes
before the
Committee on Finance
United States Senate

July 17, 2003

The Department of Veterans Affairs (VA) is pleased to submit this statement for the record to discuss VA's enhanced oversight program to ensure that nursing homes the Department contracts with provide the highest quality of care possible.

VA began operating a contract Community Nursing Home Program (CNH) in 1965. The purpose of the program is to provide veterans with the option of receiving care at VA expense in a nursing home close to their families and communities. Today, VA contracts for the care of veterans in approximately 2,000 nursing homes across America.

Ensuring that nursing homes provide veterans with a high quality of care and quality of life is critical to the success of VA's program. VA has always maintained oversight responsibility for veterans in CNHs. Prior to the Department's latest initiatives, a team of VA staff would inspect each CNH annually. Inspection protocols were developed locally within a broad national framework. Please note that this VA oversight is above and beyond the oversight traditionally provided by the Centers for Medicare and Medicaid Services.

In response to concerns raised by the General Accounting Office (GAO) and VA's Inspector General, VA developed a comprehensive new policy to govern oversight of the Community Nursing Home Program. Issued in June 2002, the new policy effectively implemented recommendations that had been made by the GAO and the Inspector General. The policy established a national

standard for annual reviews of CNHs and monthly visits by VA staff to patients in those homes. The new oversight system integrates the best information available from the Centers for Medicare and Medicaid Services (CMS), State Survey Agencies, and VA's staff observations. At the national level, VA has also implemented a certification process to ensure that annual reviews are conducted on time and has established a monitor to determine timeliness of monthly visits. In response to an OIG follow-up report on CNH (December 2002), VA conducted an internal review of the program and outlined a 25-point plan to further refine its oversight efforts, and to enhance related program areas. VA is scheduled to complete its implementation of the plan by the end of FY 2003.

Staff education is a critical element in VA's enhanced oversight process. In August 2002, VA introduced the new policy on CNH oversight with a 2-hour satellite broadcast. Currently, the Department is developing web-based training modules on the oversight policies, to be reinforced with a series of small group web casts. VA continues to provide weekly teleconference training to its medical centers on the interpretation of CMS reports.

In the area of patient neglect and abuse, VA is adding five additional CMS monitors to its exclusionary criteria. Nursing homes with significant deficiencies in these areas will be prohibited from participation in the CNH Program.

VA will use the newly upgraded CMS COMPARE database to monitor findings in abuse and neglect cases. COMPARE will also be used to monitor CNHs' deficiencies and quality indicators.

VA is improving its coordination with State Ombudsmen and the Administration on Aging, focusing on enhanced information sharing.

VA will continue to use the latest information systems available to assess quality in nursing homes, while maintaining its commitment to on-site monthly monitoring of CNH patients. The Department will continue to enhance its relationships with other Federal and state agencies.

We wish to assure the Committee that the Department is fully committed to ensuring that veterans who are patients in our CNH Program are not forgotten,

abused or neglected but will always receive care of high quality. Thank you for affording the Department an opportunity to submit this statement for the record.

Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of the Veterans Health Administration's Contract Community Nursing Home Program

Report No. 02-00972-44

December 31, 2002

VA Office of Inspector General
Washington, DC 20420

CONTENTS

EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an evaluation of the Veterans Health Administration's (VHA's) Community Nursing Home (CNH) Program. The purpose of the evaluation was to follow up on VHA's efforts to strengthen its monitoring of CNH activities, and ensure that veterans receive good care in safe environments.

The OIG received a request from Senator Christopher S. Bond to review VHA efforts to implement OIG and United States (U.S.) General Accounting Office (GAO) recommendations to strengthen oversight of the CNH program. The OIG identified the need to strengthen CNH oversight and control practices as far back as January 1994. The OIG reported that similar conditions and vulnerabilities continued to exist in a Combined Assessment Program (CAP) Summary Report dated October 30, 2001. GAO reported on CNH oversight and control concerns as far back as November 1987, and discussed similar oversight and control vulnerabilities in a 2001 report entitled, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening.* In this latter report, GAO found that VHA's adherence to oversight policies has been mixed. Senator Bond asked that we follow up on the progress of VHA's efforts to strengthen oversight and control procedures, and to determine whether veterans residing in these nursing homes were vulnerable to abuse, neglect, or financial exploitation.

During fiscal year (FY) 2001, there was a daily average census of 3,990 veterans residing in VHA-contracted CNHs. VHA program officials informed us that FY 2001 expenditures for the CNH Program totaled $325.6 million. We reviewed past OIG and GAO reports on CNH activities and the status of recommendations that resulted from these reports. We visited 8 VA medical facilities nationwide that contracted with 302 CNHs in their areas of jurisdiction. VHA CNH review teams monitored the care provided to 737 veterans in these nursing homes. We visited 25 of these CNHs, assessed the adequacy of VHA CNH oversight and control activities, and contract administration. We also reviewed a sample of 111 veterans' medical records at VA medical facilities and CNHs. At each VA medical facility, we interviewed the VHA CNH review team and reviewed local policies. We interviewed the nursing home administrators and the directors of nursing, toured the physical plants, and interviewed veterans and their family members. We also reviewed data from the Department of Health and Human Services (HHS) Center for Medicaid and Medicare Services (CMS) On-Line Survey Certification and Reporting (OSCAR) data, contract files, and we interviewed State Ombudsman officials.

We found that VHA has taken years to implement standardized inspection procedures for monitoring CNH activities and for approving homes for participation in the program. VHA policy for the CNH program has been under review since 1995. We believe this slow pace of revising policy has led to variances over time in the way local managers and clinicians administer and monitor CNH activities. In response to GAO's 2001 report, the Secretary agreed that VA's oversight of the CNH program needed

strengthening, and he committed VHA to publishing new directives before the end of FY 2001. VHA issued a draft policy proposal to field CNH clinicians in March 2002, and we provided more than 20 suggestions to strengthen proposed procedural changes. Further hindering the ability of VHA to provide the necessary leadership in implementing new CNH policy was the fact that the Chief Consultant of the Geriatrics and Extended Care position has been vacant since August 2001. The task of revising and clarifying CNH policy was given to this position and the Geriatrics and Extended Care Strategic Health Group several years ago.

VHA published a new CNH policy on June 24, 2002, at the conclusion of this follow-up review. We concluded this new CNH policy should clarify and strengthen certain oversight controls, but was silent on, or liberalized other procedures that had originally been designed to better monitor the care and safety of veterans. Overall, the new VHA policy still needs clarification to address these procedures.

The veterans we visited were generally well cared for, and mostly satisfied with CNH services and accommodations. However, the majority of VHA CNH review teams we interviewed were aware of reports that veterans were abused or neglected in CNHs under their jurisdiction. These teams generally reacted after the fact to these incidents. Actions have ranged from giving the affected families and veterans choices to transfer to other nursing homes, to removing veterans from nursing homes and canceling contracts. We found 9 reported cases of abuse, neglect, or financial exploitation during our review of the records of 111 veterans residing in 25 CNHs. There were three reported cases of neglect, three reported cases of abuse, and three reported cases of financial exploitation. This represents an average 8.1 percent incidence rate in the sample population. We also found veterans not in our sample and non-veterans residing with our veterans in VHA contracted CNHs who were subjected to serious adverse incidents. These conditions emphasize the need for VHA to strengthen, not liberalize, oversight practices.

Rather than reacting to such adverse events, we believe VHA could reduce the risk of incidents occurring by strengthening oversight of CNH activities. We found that similar program vulnerabilities as were discussed in prior OIG and GAO reports, continue to exist. Not all VHA CNH review teams analyzed CMS data before initiating contracts and prior to annual contract renewals. This was evidenced by the fact that 27 percent of the veterans at the 8 VA medical facilities visited were placed in CMS "watch listed" homes. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data includes health care deficiencies found during the nursing homes' most recent state nursing home surveys and from recent complaint investigations. Nursing homes confirmed as placing residents in harms-way or in immediate jeopardy are placed on a CMS watch list that identifies the nursing homes and the related issues or violations.

The 8 VA medical facilities we visited had active contracts with 41 (14 percent) nursing homes listed on the CMS watch list. Of the 41 CNHs on the watch list, 7 (17 percent) were managed at VHA headquarters under regional contracts. The 41 CNHs were cited 273 times for administrative and quality of care violations.

We found that CNH contract procedures and inspection practices continued to vary among VA medical facilities. The standardization of contracting requirements and expectations placed on CNHs would reduce vulnerabilities and ensure veterans receive the same standard of care. Not all medical facility managers accepted the requirement that VHA employees visit and routinely monitor the adequacy of care provided to veterans. Medical record documentation needed improvement. In addition, VAMC clinicians needed to routinely obtain CNH performance monitors (e.g. resident falls, incident reports, and medication errors) to better monitor occurrences at these CNH facilities and to coordinate performance improvement initiatives.

We found that VHA CNH review teams do not meet annually with Veterans Benefits Administration (VBA) Fiduciary and Field Examination (F&FE) examiners to discuss veterans of mutual concern as required by VBA policies. VHA does not have a corollary policy to discuss CNH patient issues with VBA representatives. We also found that VHA CNH review teams do not always contact VBA examiners when the cognitive competencies of veteran residents change. The absence of effective communication between VBA and VHA employees reduces the VA's ability to adequately protect veterans from financial exploitation and protect VA-derived payments.

We made recommendations to further clarify and strengthen the CNH oversight process and to reduce the risk that veterans in CNHs will be subject to adverse incidents.

Under Secretary for Health Comments:

The Under Secretary for Health concurred in all recommendations except one effecting contract nursing home residents residing more than 50 miles away from parent facilities. In addition, the Under Secretary announced that a new Chief Consultant for Geriatrics and Extended Care had been selected. VHA's action plans are in Appendix A.

Under Secretary for Benefits Comments:

In general, the Under Secretary for Benefits concurred with the recommendation to coordinate improved lines of communication between appropriate VHA personnel, including CNH managers, and F&FE supervisors. The current F&FE program mandate, as outlined in M21-1, Part VIII, 6.08a, requires a meeting at least once yearly between these parties to discuss services to incompetent veterans. It should be noted that these meetings are not limited to CNH personnel but would also include VHA personnel involved with both the residential care program and VHA inpatients to the extent they involve incompetent veterans.

The Central Office F&FE Program staff reminded all Fiduciary Program managers nationwide of this requirement in an e-mail message on June 20, 2002. Additionally, this was an agenda item on the Veterans Service Center Managers' call on June 19, 2002, and extensively discussed in the quarterly F&FE Program Teleconference on July 18, 2002. Compliance with this requirement will be monitored during routine VBA site visits beginning in October 2002.

While the Under Secretary for Benefits agreed with the necessity of these annual meetings, he had reservations about some of the information to be shared as outlined in the second part of the recommendation, and who should be the recipient of the information. He therefore proposed that a meeting between Central Office VHA and VBA Fiduciary staff be held to determine what information would be of value to share and the proper procedures for this exchange of information. VBA's action plans are in Appendix B.

Inspector General Comments:

The Under Secretary for Health concurred with our findings and all but one of our recommendations (1i). Upon further review and consideration of the Under Secretary's response to recommendation 1i, we agree that no immediate action is required but we encourage VHA managers to closely monitor this important issue. The Under Secretary provided acceptable detailed implementation plans on the remaining recommendations. The Under Secretary for Benefits concurred with our findings and recommendation and proposed a meeting between VHA and VBA Central Office managers to determine what and how information should be shared. We will follow-up on the planned actions until they are completed.

ALANSON J. SCHWEITZER
Assistant Inspector General for
Healthcare Inspections

INTRODUCTION

Purpose

We conducted an evaluation of the VHA CNH Program. The purpose of the evaluation was to follow up on VHA's efforts to strengthen its monitoring of CNH activities, and ensuring that veterans receive good care in safe environments.

Background

The OIG received a request from Senator Christopher S. Bond to review the adequacy of oversight of VHA's CNH program. In Senator Bond's letter, he referenced CNH issues raised in an OIG report entitled, *OIG Combined Assessment Program (CAP) Summary Report at Veterans Health Administration Medical Facilities,* [1] and a U.S. GAO report entitled, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening.*[2] These reports discussed vulnerabilities in VHA CNH oversight practices. The reports discussed the need to standardize inspection procedures and criteria and noted that inspection procedures varied among VHA facilities, inspection team composition and processes needed improvement, and VHA clinicians did not always monitor the adequacy of care provided to veterans as required by policies.

Senator Bond's letter noted that OIG and GAO issued earlier reports on the same issues dating back many years and that similar problems continue to be identified. Senator Bond asked that we follow up on VHA's efforts to strengthen oversight and control procedures given that these same vulnerabilities have been identified over a number of years. Senator Bond also referenced two OHI reported incidents, which concerned the deaths of two veterans residing in CNHs.[3] [4] The Senator was hopeful that these were isolated incidents, and that other veterans were not vulnerable to adverse incidents. Senator Bond therefore asked that we broaden our review to determine whether other CNH veterans are vulnerable to adverse incidents.

History of Prior Reports and Issues

The GAO and OIG reported on CNH oversight and control vulnerabilities dating back to November 1987,[5] and January 1994,[6] respectively. In 1987, the GAO reported that VHA

---

[1] OIG *CAP Summary Report at Veterans Health Administration Medical Facilities*, Report Number 01-00504-9, October 10, 2001

[2] GAO, *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening* (GAO-01-768, Washington, D.C. 2001)

[3] OIG OHI, *Allegations of Wrongful Death in a VA Community Contract Nursing Home*, Report Number 01-00787-81, June 1, 2001

[4] OIG OHI, *Contract Nursing Home Issues, North Florida/South Georgia Veterans Health System,* Report Number 01-2889-60, February 26, 2002

[5] GAO Report *VA Health Care: Assuring Quality Care for Veterans in Community and State Nursing Homes,* Report Number GAO/HRD-88-18, November 1987

needed to improve CNH oversight practices. GAO recommended that VHA employees perform annual CNH reviews, routinely use quality-of-care information from state agencies in evaluations, and conduct inspections and patient visitations every 30 days to ensure veterans receive good care.

In 1994, the OIG reported that VHA needed to improve controls over the CNH program and implement GAO's 1987 recommendations. The OIG recommended that VHA revise its oversight policies and develop standardized CNH inspection procedures and criteria for approving homes for participation in the program. The OIG also recommended using external data to better assess the quality of care provided at CNHs before and after contracting with them, and standardizing initial and annual inspection and contracting processes. Additionally, the OIG report recommended strengthening procedures for conducting routine staff visits to the CNHs, and establishing interdisciplinary quality management (QM) monitors to oversee the quality of care provided to CNH veterans.

In July 2001, the GAO issued a report that discussed similar issues to those discussed in the 1994 OIG report.[7] In October 2001, the OIG reported in its CAP Summary Report that VHA still needed to strengthen oversight of the CNH program. The CAP reviews found that VHA still needed to standardize evaluations, use external information to better assess the quality of care, and conduct inspections and routine patient visitations at prescribed intervals. Action was also needed to ensure VHA CNH review teams participated in the approval of CNH contracts prior to initiation and renewal, and to include CNH data in the collection and analysis of performance improvement reviews.

In April 2002, we reported in the OIG Semi-Annual Report (SAR) to Congress,[8] our concerns that VHA had still not implemented our recommendations to strengthen controls over the CNH Program. Additionally, there have been other Government reports on the nursing home industry over the past several years that highlighted concerns about CNH care and reported incidents of abuse and neglect.[9] [10] [11] [12] [13]

---

[6] *Audit of Veterans Health Administration Activities for Assuring Quality Care for Veterans in Community Nursing Homes,* Report Number 4R3-A28-016, January 11, 1994

[7] GAO Report *VA Long Term Care: Oversight of Community Nursing Homes Needs Strengthening* (GAO-01-768) (Washington, D.C. July 2001)

[8] OIG Semiannual Report to Congress, October 1, 2001 to March 31, 2002, Unimplemented Recommendations and Status, Page 53

[9] GAO, *Nursing Home Care-Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* GAO/HEHS-00-6 (Washington, D.C.: 1999)

[10] *Abuse Complaints of Nursing Home Patients,* Department of Health and Human Services Office of Inspector General, Office of Evaluations and Inspections, May 1999 OEI-06-98-00340

[11] U.S. House of Representatives, *Abuse of Residents Is a Major Problem in U. S. Nursing Homes,* July 30, 2001 Minority Staff Special Investigations Division, Committee on Government Reform

[12] GAO, *Nursing Homes, Sustained Efforts are Essential to Realize Potential of the Quality Initiatives,* GAO/HEHS-00-197, (Washington, D.C.: 2000)

[13] GAO, *Nursing Homes: More Can Be Done To Protect Residents from Abuse*, (GAO-02-312, Washington, D.C. 2002)

The Under Secretary for Health issued new VHA CNH policies at the conclusion of this review.[14]

VHA CNH Program

The VHA CNH Program places veterans requiring nursing home care in community nursing facilities at VA expense. VA contracts with community nursing homes should require that the CNHs meet Medicare and Medicaid standards, and the most recent Life-Safety Code (LSC) standards, and provide good nursing care.

Veterans, who require care because of activities-of-daily-living (ADL) dependencies, medical or psychiatric illnesses, or the inability of informal and formal care systems to provide care in their homes or in their communities, comprise the population for CNHs.[15] The CNH population includes veterans in need of rehabilitation, special clinical care, and behavioral management. Statutory authority for the VA CNH program was established in Public Law 88-450. The applicable regulations are codified in 38 United States Code, 1720.

VHA policy, issued in 1995, required multi-disciplinary teams and coordinators to oversee and provide CNH program policy and supervision.[16] VHA medical facility contracting officers were instructed to negotiate local contracts in coordination with the facilities' CNH review teams. The review teams were expected to conduct initial inspections and perform annual evaluations of the CNHs. VHA CNH review teams were expected to provide monthly follow-up supervisory visits to monitor care, assure continuity of care, and assist in the veterans' transitions back to their communities.[17]

VHA also issued regional contracts (previously referred to as multi-state contracts) to provide CNH services. These contracts, administered by VHA headquarters program managers, were developed to reduce administrative and direct costs while improving access to nursing home care for veterans. VHA encourages its medical facilities to use regional contracts whenever feasible to place eligible veterans in CNHs. However, VA medical facilities may continue to use locally-negotiated nursing home contracts whenever it better serves the veterans' needs.

Unlike local contracts, which are required to have initial VHA inspections and annual renewal inspections by the local VHA CNH review teams, CNH facilities under regional contracts are not subject to initial or annual inspections. Rather, VHA headquarters program managers receive assurances from nationally recognized nursing home companies about the quality and safety of care provided, and conduct paper reviews as part of the regional contracting process. The new VHA policy, issued in June 2002, liberalized the process of conducting initial and annual inspections of locally-contracted CNHs. VHA CNH review teams now have the option of conducting paper reviews when

[14] VHA Policy CNH Handbook 1143.1, dated June 24, 2002
[15] Administration on Aging, U.S. Department of Health and Human Services (Washington, D.C.)
[16] VHA Policy M-5, Part II, Chapter 3, CNH, March 28, 1995
[17] VHA Policy M-5 Part II, Chapter 3, CNH, paragraph 3.10c, March 28, 1995

applicable. The new VHA policy also liberalized the requirement for VHA CNH review teams periodically visiting veterans placed in CNHs under local or regional contracts. The 1995 VHA policy required VHA CNH review team members to visit CNH veterans every 30 days. The new policy liberalizes visiting requirements to every 90 days for selected cases and removes the requirement for yearly comprehensive physical examinations for veterans on long-term placements.

Reporting of Incidents

Literature on incident reporting shows that each year thousands of older persons are reportedly abused, neglected, and exploited. Many victims are frail and vulnerable. They depend on others to meet their most basic ADL needs. According to a July 30, 2001 congressional report prepared by a Special Investigation Division of the House Government Reform Committee, reports of serious physical, sexual, and verbal abuse are "numerous" despite the increased awareness of abuse of the elderly in nursing home settings. The review showed that more than 40 percent of the 3,800 abuse violations recorded in a 2-year period had been discovered only after the filing of formal complaints.[18]

VA employees are required to identify and report suspected abuse and neglect.[19] [20] Nursing homes that are approved to receive Medicaid funds, and are subject to the review of the HHS CMS, must have policies and procedures for identifying, assessing, evaluating, managing, and reporting suspected patient abuse, neglect, and exploitation.

The Code of Federal Regulations (CFR)[21] defines abuse as "...willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." The CFR definition of neglect is "...failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

The CMS defines exploitation as the "...conscious deception or intimidation of a disabled adult or elderly person by a person who stands in a position of trust and confidence to obtain or use, or endeavor to obtain or use, the disabled adult's or elderly person's funds, assets, or property with the intent to temporarily or permanently deprive the person of the use, benefit, or possession of the funds, assets, or property for the benefit of someone other than the exploited person." Examples include cashing an elderly person's checks without permission, forging an elderly person's signature, misusing or stealing an elderly person's money or possessions, coercing or deceiving an elderly person into signing any document, and the improper use of conservatorship, guardianship, or power of attorney.

---

[18] Minority Staff Report, House Committee on Government Reform, *Abuse of Patients is a Major Problem in U.S. Nursing Homes* (July 2001)
[19] VHA Policy M-2, Part I, Chapter 35, paragraph 35.05c
[20] VHA CNH Handbook 1143.1, dated June 24, 2002
[21] 42 CFR § 488.300 (Subpart E), Section 301

Eligibility and Coordination

Eligibility for placement in a CNH is determined by reviewing each veteran's medical and administrative records. Service-connected veterans with spouses retain rights to monthly benefits during the durations of their CNH stays. Social workers working with service-connected veterans rated as incompetent for financial purposes should work with VBA F&FE employees to ensure fiduciaries or guardians are assigned to manage the veterans' funds. F&FE employees are responsible for assuring that fiduciaries assert and protect the rights of VA beneficiaries and their dependents to VA benefits, other assets, and income.

F&FE employees and VHA CNH review teams are frequently involved in cases of mutual concern. VBA policy requires the fiduciary activity supervisor to meet at least annually with appropriate personnel from each VA medical facility his or her jurisdiction to discuss services provided to incompetent veterans, including VA-sponsored veterans in CNHs.[22]

Scope and Methodology

We reviewed VHA's efforts to strengthen CNH oversight controls and procedures, and assessed veterans' levels of vulnerability to incurring adverse incidents such as abuse, neglect, or financial exploitation. In preparation for this review, we met with VA Central Office CNH Program officials, and at their suggestion, visited one medical center CNH activity, and three of that medical center's CNHs to learn more about current oversight and control processes and procedures and to test our examination tools.

We reviewed prior OIG and GAO reports and VHA actions taken to respond to recommendations. We reviewed new VHA CNH procedures issued in June 2002. In order to obtain background data on the nursing homes under contract with VHA, we utilized CMS websites and obtained and analyzed complaint violation investigations and OSCAR data. The OSCAR data include information on the results of State Medicaid inspections.

We selected eight VA medical facilities for review based on their high average daily CNH census. At each of these eight medical facilities, we visited and physically inspected three CNHs. At one site we inspected one additional nursing home because of local nursing home placement patterns. Therefore, we visited 25 CNHs out of the total 302 CNHs under contract by the 8 VA medical facilities during the review.

There were 737 veterans residing at the 302 CNHs. We reviewed the medical records of 111 of these veterans during our visits. In FY 2001, the average daily census nationwide was 3,990 and CNH expenditures totaled $325.6 million.

We reviewed local CNH contract files. We reviewed the contract specifications for requirements for state licensing and CNH employee background check requirements,

[22] VBA Policy M21, Part VIII, 6.08

VHA access to incident reports, CNH performance improvement data flow, and CMS minimum staffing requirements.[23] We also reviewed relevant local VHA contract nursing home policies. We reviewed the medical records of selected veterans in CNHs.

We interviewed the members of the CNH review teams at each of the eight VA medical facilities. At the CNHs, we interviewed veterans, and the administrators and directors of nursing. We also reviewed veterans' CNH medical records and conducted environmental inspections of the nursing homes in the presence of CNH managers. Finally, we explored interactions between the VHA CNH review teams, local CNH ombudsmen representatives, and state nursing home ombudsmen officials.

The information contained in this report reflects the data collected on our patient sample and associated CNH inspections. It also includes data we elicited through interactions with VHA and CNH employees that related to reports of episodes of abuse and neglect at nursing homes that had contracts to care for veterans. We also reviewed procedures for sharing information between VHA and VBA officials with respect to safeguarding incompetent veterans' financial affairs.

We conducted the evaluation in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[23] http// www.hcfa.gov/Medicaid/reports/rp700hmp.htm *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* page E.S. - 6

RESULTS AND CONCLUSIONS

Issue 1: VHA Policy on CNH Activities

Findings

VHA took years to implement OIG recommendations to standardize CNH inspection procedures and criteria for approving nursing homes for participation in the program. We believe this lengthy process contributed to variances over time in the way local managers and clinicians administered and monitored CNH activities, and consequently caused many of the repeated findings in OIG and GAO reports.

In response to the 1994 OIG report on CNH oversight activities, VHA managers acted on March 28, 1995, to revise M-5, Part II, Chapter 3. The revised policy included provisions for the establishment of CNH oversight committees at VA medical facilities and integration of the CNH Program into QM Programs. The 1995 policy required VHA-sponsored veterans in CNHs to be visited by VHA employees at least every 30 days, and as a minimum, by a nurse every 60 days. The 1995 policy also required VA medical facilities to review CNH clinical indicators to include pressure ulcers, falls, and medication errors.

In April 1996, VHA informed the OIG that the Veterans Integrated Service Networks (VISN) would incorporate CNH QM data into a new VHA performance management system. On March 14, 1997, VHA responded to our 1994 recommendation to provide CNH teams access to the data in CMS online systems. VHA assured OIG that VHA CNH review teams were being provided access to OSCAR data and would use it to evaluate and monitor CNH activities. At that time, the 1994 OIG recommendation to develop standardized CNH inspection procedures and criteria for approving CNHs for participation in the program remained unresolved.

The GAO, in its July 2001 report, again asserted that VHA's adherence to oversight policies had been mixed. The GAO found that VHA lacked a department-wide approach to monitoring medical center CNH activities. The GAO findings essentially paralleled the findings of the OIG's 1994 report. On June 27, 2001, the VA Secretary responded to the GAO report, and agreed that VHA's oversight of the CNH program needed strengthening. The VA Secretary informed the GAO that VHA would publish new policy before the end of the 2001 fiscal year.

In September 2001, and again in February 2002, VHA placed into its concurrence process a draft policy on CNH evaluation and follow-up services that would address both the OIG 1994 and GAO 2001 reports. On March 1, 2002, CNH headquarters program managers sent a VHA-proposed draft policy entitled, *VHA Community Nursing Home Procedures* to field activities for comments. The OIG also commented on the draft document on March 12, 2002, and made more than 20 suggestions to strengthen

controls discussed in the draft policy. OIG expressed concern that the draft policy sought to liberalize and not strengthen oversight processes.

In April 2002, we reported in the OIG SAR to Congress, our concerns that VHA had still not responded to our recommendation to strengthen oversight of its CNH Program. Further hindering the ability of VHA to provide the necessary leadership in implementing new CNH policy was the fact that the Chief Consultant of the Geriatrics and Extended Care position has been vacant since August 2001. The task of revising and clarifying CNH policy was given to this position and the Geriatrics and Extended Care Strategic Health Group several years ago.

The Under Secretary for Health signed a new VHA CNH policy on June 24, 2002, at the conclusion of this review. The June 2002 CNH policy addressed some of our earlier recommendations and some of the conditions identified during this review. The new VHA policy emphasizes the need for CNH review teams to critically review and score CMS information, which was a weakness identified during this review. It also establishes CNH exclusion and termination criteria and actions to be taken against local homes, thereby addressing recommendations made in our 1994 report. The new CNH policy requires reporting of all sentinel events or adverse patient occurrences to senior managers in the field and headquarters. The policy also requires CNH review teams transferring patients to CNHs outside their jurisdiction to coordinate the transfers with the responsible receiving CNH review teams overseeing the CNHs. This requirement was consistent with an OIG recommendation resulting from a recently issued Healthcare Inspection of a CNH.[24] Additionally, the new policy enforces the need to integrate CNH activities into the VA medical facilities' QM programs, which was a weakness identified during this review.

The new CNH policy, however, also differed in important details from the 1995 VHA policy. The 1995 policy required medical facilities to establish CNH oversight committees, but the June 2002 policy is silent on this requirement. The new policy does not clarify if it was the intent of policy makers to have VHA CNH review teams assume the responsibilities of the CNH oversight committees. This would include such functions as the oversight of placements, expenditures, and budgets. The new policy is not clear as to whether these functions would be the responsibility of the CNH review teams or other oversight committees.

The June 2002 VHA policy liberalizes standards for conducting initial reviews of prospective CNHs and deletes the requirement that new local contracts have inspections performed by VA employees. The initial reviews of locally-facilitated contracts differ from reviews of regional contracts. By not consistently applying criteria and inspection standards for both types of contracts VHA creates a risk of providing differing standards of care. By removing the requirement for initial inspections of CNHs under local contracts, VHA oversight of CNHs is weakened not strengthened.

---

[24] OIG OHI, *Allegations of Wrongful Death in a VA Community Contract Nursing Home*, Report Number 01-00787-81, June 1, 2001

For example, the recently issued VHA policy permits a VA representative from the CNH review team to visit the CNH in lieu of conducting a multi-disciplinary initial inspection if the paper review does not reveal deficiencies. The policy does not clarify what is to be done if the visit raises additional concerns. The policy does not clarify whether the visits preclude Safety Officers from conducting LSC inspections, or whether a VA representative or Safety Officer would visit, or whether a Safety Officer alone could be the VA representative in these cases.

The recently issued VHA policy is also not consistent with instructions issued by the Deputy Under Secretary for Health for Operations and Management, who required that LSC inspections be conducted annually, or in some cases every 3 years.[25] As written, the new VHA policy requires locally-contracted CNHs to have initial LSC inspections, but there is no provision for mandatory subsequent reviews. This further liberalizes CNH oversight activities.

There are no provisions in the June 2002 VHA policy for requiring CNHs to provide VA assurances that their employees' clinical qualifications are current, or that CNH employees do not have criminal histories, and are free from substance abuse. These are standards required of VHA clinicians entering employment at parent VA medical facilities.

Additionally, the recently issued CNH policy liberalizes the requirement for CNH review teams to routinely visit veterans who are long-term placements, or are residing in CNHs more than 50 miles away from the parent VA medical facility, under certain circumstances. These CNH veterans could be seen every 90 days, or in some cases over longer periods.

Conclusions

VHA acted to implement new CNH policy on authorizing, overseeing veterans' care, and monitoring compliance, at the conclusion of this review. However, the new VHA CNH policy liberalizes or is silent on several important oversight controls that were established in 1995.

As written, the policy needs some modification to make it more likely that veterans will receive good care. Also, it does not remove discrepancies in the evaluation requirements between locally-contracted and regionally-contracted nursing homes. Rather, it appears the policy was liberalized to reduce operating costs and employee resources that would need to be devoted to CNH oversight functions. We concluded that the VHA policy continues to need clarification in prescribing the responsibilities of CNH review teams, inspection procedures, monitoring requirements, and contracting provisions.

[25] VHA Information Letter (IL 10N-2000-002)

Issue 2: Risk of Adverse Incidents

Findings

We concluded that veterans in CNHs are vulnerable to incurring abuse, neglect, and financial exploitation. The veterans and families we visited were generally well cared for, and mostly satisfied with CNH services and accommodations. However, our review found reports of veterans in CNHs subjected to abuse, neglect, and financial exploitation, and veterans residing in CNHs in which non-veterans have been subjected to such adverse incidents. Sixty-three percent of the CNH review teams we interviewed knew of veterans who reported abuse or neglect while residing in CNHs. These CNH review teams had taken actions that ranged from the removal of a veteran from a CNH to canceling the CNH contract and reporting the incident to appropriate Government agencies. Rather than reacting to such incidents, we believe VHA could reduce the risk of such occurrences by strengthening oversight controls.

Currently, VA policies prescribe that VHA health care employees are responsible for immediately reporting suspected abuse.[26] If criminal abuse or exploitation is suspected, the information should be forwarded to the VA facility police and regional counsel.[27] A copy of the incident should be forwarded to the OIG for information. VHA clinicians and managers also need to determine whether the suspected infractions, if confirmed, warrant further actions against the CNHs. Such actions might include reporting the information to State Licensing Boards and pertinent Federal agencies, and transferring veterans to other facilities. The June 2002 VHA policy, Part 11 (f) 1, instructs VHA CNH review teams visiting CNHs to observe and gain impressions about the overall care provided to CNH residents and document them. The new VHA policy requires CNH review teams to review CNHs for patient abuse or neglect, and the quality of sensory and environmental aesthetics. The new VHA policy requires potential abuse or neglect and other adverse conditions to be reported to the VHA CNH review team and to the VISN office.

CMS-approved nursing homes are required to have policies and procedures for identifying, assessing, evaluating, managing, and reporting suspected abuse, neglect, and exploitation. The CMS requires that states designate a specific telephone number for reporting complaints and that all nursing homes publicize these numbers. Residents, families, friends, physicians, and nursing home employees can submit complaints.

We visited 25 CNHs and sampled 111 patient records. We found incidents in which veterans were reportedly subjected to abuse, neglect, or financial exploitation, and other incidents in which non-veterans in the homes were reportedly subjected to abuse or neglect. The study sample of 111 veterans residing in CNHs had an average age of 72.5 years (range 46-93 years). Sixty-five percent of the veterans had diagnoses of significant psychiatric disorders. Thirty-one percent of the veterans had diagnoses of

[26] VHA Policy M-2, Part I, Chapter 35, paragraph 35.05c
[27] 38 C.F.R. 14.560

dementia. Twenty-nine percent of the veterans suffered from serious heart problems and 13 percent were epileptic.

We found that 36 percent of the CNH administrators in our sample held their positions for a year or less. Similarly, about the same ratio of directors of nursing at these CNHs were in their positions less than a year.

We were able to interview 72 of the 111 veterans in our sample. The remaining veterans were not able to carry on rational conversations, or were not able to speak with us because they were at clinics or were otherwise unavailable. Of the 72 veterans interviewed, 49 (68 percent) told us they relied on someone to help them make medical decisions on their behalf and handle their finances.

We found 9 (8 percent) of the 111 veterans whose records we reviewed had been subjects of reported abuse, neglect, or financial exploitation.[28] The reported incidents identified consisted of three cases of neglect, three cases of verbal or physical abuse, and three cases of financial exploitation. Examples of CNH-reported adverse incidents follow:

> A 59-year-old veteran sustained a burn at a CNH when hot coffee spilled in his lap. His spouse alleged that nursing home employees failed to adequately care for his burns. Because the CNH did not conscientiously address the injury when it occurred, the veteran's condition worsened, and he eventually had to be admitted to a VHA medical facility where he received surgical debridement of his wounds and skin grafting. Upon completion of this surgery, the patient's spouse and VHA physician were reluctant to return the veteran to the nursing home for continued care. The incident prompted CNH managers to revise procedures for serving coffee and promptly responding to such incidents. The veteran returned to the CNH.
>
> In another case, a Certified Nursing Assistant (CNA) taunted an 81-year-old veteran resulting in a violent reaction that led the patient to strike, punch, and curse at other members of the nursing home staff. In this case the CNA was fired.

While not in our sample, we found other examples of veterans at the VHA CNHs who experienced adverse incidents. For example:

> A veteran at a contracted CNH we visited fell from his chair in February 2001, and was taken to a local emergency room where he received 12 stitches to repair a head laceration. Despite the stitches, his head wound continued to bleed (he was taking two medications that impaired blood clotting) thus requiring the veteran to return to an emergency room to have his stitches replaced. He sustained a second fall 2 days later at the

[28] The confidence level was 95 percent with a sample size of 111 and a population of 737, which yielded an average 8.1 percent [+- 4.7 percent] or a 3.4 to 12.8 percent range of incidents in the population

nursing home. The CNH did not timely contact the family after the veteran fell. The veteran's daughter arrived at the nursing home and he did not recognize her. The daughter insisted that the veteran be taken to the VA medical facility for further evaluation and treatment. The veteran was admitted to the Intensive Care Unit at the VA medical facility and died 16 days later. The veteran's daughter reported the incident, which is currently under review by the state Ombudsman.

A 100-percent service-connected veteran CNH resident with multiple sclerosis was found by a court to have suffered a loss of at least $13,974 from his personal checking accounts. This was done through the deliberate and wrongful actions of a CNA who was employed first by the nursing home and then by the patient. The court found the CNA guilty of misappropriating the veteran's property under the provisions of the Federal Nursing Home Reform Act.[29] [30]

During the course of our CNH visits we also found examples of abuse and neglect of non-VA residents. For example:

In October 2001, a non-VA female resident with Alzheimer's disease wandered from her room into the CNH's fenced-in courtyard on a night when the temperature was reportedly around 40 degrees. The patient wandered outside unnoticed because nursing home employees deactivated the door alarm to allow for smoking breaks. She was found dead around 4:30 a.m., outside the facility. Nursing home employees did not immediately notify the resident's family of this tragic situation but instead returned the dead patient to her room. An autopsy determined that the patient had died of heart disease aggravated by exposure to the cold. An investigation is currently underway to determine the circumstances surrounding this death.

At the time of our inspection, two CNAs were arrested for an assault on an 89-year-old non-VA resident that left him with 3 broken ribs.[31] The two CNAs were arrested for physically assaulting the resident. Two VA-sponsored veterans were residents in the CNH and another veteran was pending discharge and scheduled to be placed at the CNH. At our suggestion, the CNH review team notified the veteran residents and their families of the incident and gave them the option of staying or transferring to another CNH. We also encouraged the CNH review team to place a hold on placements pending the outcome of the investigation, and suggested they conduct an immediate inspection of the facility as opposed

[29] Department of Public Health, Petitioner V. Julia T. Tebeau respondent docket number 97-0195 Common Wealth of Massachusetts

[30] 42 U.S.C. §1396r and §1395i - 3

[31] http://ap.tbo.com Tampa Bay on line quote police; 89-Year-Old Man Assaulted by Largo Nursing Home Staff" Associated Press, March 28, 2002

to waiting until the CNH's annual contract renewal date, which was about 5 months away.

The examples highlighted above illustrate the importance of VHA implementing safeguards to protect residents from potentially significant adverse incidents.

Conclusions

Veterans in CNHs constitute an elderly, frail population who are reliant upon others when making significant medical and financial decisions. The apparent instability of CNH leadership in our sample punctuates the importance of VA oversight of veterans in CNHs to ensure that our veteran residents' continuity of care is adequately followed.

VHA has been slow in providing new policy for the CNH program in response to OIG and GAO program findings and recommendations. VHA CNH review teams confirmed to us during interviews that veterans are at risk for abuse and neglect in CNHs. Our review identified reports of abuse and neglect with an average incidence of 8 percent. The risk for abuse and neglect is faced not only by veterans, but by all residents who reside in CNHs, as this report demonstrates. VHA needs strong oversight policy that will safeguard veterans from adverse incidents and ensure they receive good care while in non-VA CNH facilities.

Issue 3: Follow-up on the Unresolved Recommendations and Implementation of CNH Oversight Controls

Findings

VHA responded to the OIG's 1994 recommendation to strengthen its oversight policies by developing and publishing standardized CNH inspection procedures and criteria for approving homes for participation in the program, at the conclusion of this review. However, during this review, the implementation of OIG and GAO prior recommendations by local VHA CNH review teams still varied among medical facilities.

We found that CNH coordinators and review teams still were not using available CMS information to assess whether CNHs under review had been the subjects of reported violations and investigations. VHA CNH review teams did not consistently conduct initial reviews or annual inspections of the CNHs in their jurisdictions. Also, we found contracting processes needed strengthening, and CNH review teams still were not visiting veteran residents monthly to ensure that the provisions of the contracts were upheld, and that veterans were receiving good, safe care. In addition, we found that CNH activities were still not integrated into each medical facility's QM programs, and that interdisciplinary QM program monitors to address the quality of care for CNH veterans were not implemented.

Use of CMS External Information During Initial and Follow-up Inspections

Our review showed that VHA managers were not always using CMS external information to assess the quality of care provided at CNHs. We reviewed CMS investigations and OSCAR annual state inspection reports available from Government websites. CMS provides detailed information about the performance of every Medicare and Medicaid-certified nursing home in the country. The data include health deficiencies found during the nursing homes' most recent state nursing home surveys and recent complaint investigations. Substantiated violations of nursing homes cited for placing residents in harms-way or in immediate jeopardy result in the nursing homes being placed on a CMS "watch list" that identifies the nursing homes and the offending issues or violations.

We reviewed the watch list for all nursing homes that had active contracts with VA medical facilities at the eight sites we visited. Seven of the 8 VA medical facilities had active contracts with 41 nursing homes listed on the CMS watch list. Of the 41 nursing homes on the watch list, 7 (17 percent) were managed at VA headquarters under regional contracts.

It is significant to note that veterans were disproportionately placed in CNHs that were on the CMS watch list.[32] This condition suggests that managers have not adequately monitored CMS information, which adds risk to CNH placements. There were 198 (27 percent) of the 737 CNH veterans in our population residing in these 41 nursing homes. Nineteen (10 percent) of the 198 veterans residing in watch-listed nursing homes were in CNHs under regional contracts. The watch list cited the 41 nursing homes 273 times for administrative and quality of care violations. Of the 273 violations, 140 (51 percent) were quality of care violations.

We found that VHA CNH review teams did not always analyze OSCAR data and other relevant data before initiating the contracts or conducting annual follow-up inspections. Our results showed that 75 percent of the CNH review teams (6/8) reported conducting annual inspections and reviewing the deficiency reports prior to the annual inspections. Only 13 percent of the CNH review teams (1/8) reported that they reviewed the Quality Improvement profiles of the nursing homes participating in the program, annually. Moreover, only 25 percent of the CNH review teams (2/8) told us that they reviewed the OSCAR report annually. CNH coordinators also told us they did not routinely communicate with ombudsman officials in each state to determine whether any quality of care issues existed.

VHA CNH review teams told us these conditions existed because they considered other factors when placing veterans in nursing homes and because of resource constraints. In some cases, CNH coordinators kept veterans in these nursing homes at the families' requests because of the close proximity to their homes. In other cases, the veterans were difficult to place elsewhere because of psychosocial problems.

[32] Veterans in watch list homes = 198/737 or 27 percent; watch list homes = 41/302 or 14 percent

Many of the CNH review team members told us that overseeing CNH activities was a collateral duty, and they did not always have the time to research and monitor external program data. Not using CMS data to research the histories of CNHs prior to entering into contracts and selecting homes for veterans to reside in increases the risk of placing veterans in CNHs that have histories of providing questionable care.

Standardized Inspection Procedures

Initial and Follow-up Inspections of CNHs

We found that multi-disciplinary teams were not always used for initial and follow-up inspections of CNHs, a condition described in prior OIG and GAO reports. VHA requires that Medical Center Directors designate CNH review teams which consist at a minimum of a registered nurse, a social worker, a physician, a dietician, a pharmacist, a fire safety officer, a contracting officer, an environmental management specialist, and a medical administration specialist.[33] The functions of the CNH review team include: reviewing all annual and interim inspection findings of other agencies and following up on these findings; reviewing appropriate available findings of the state Ombudsman or local complaint office; and evaluating the use of quality assessments and performance improvement activities to improve care and correct problems.

CNH review teams are supposed to use these tools to determine whether to contract with the CNHs to care for veterans, to continue services, or to discontinue the use of the CNHs' services. New VHA policy provides local managers discretion in the disciplines that constitute these CNH review teams for overseeing CNH activities. This change in policy adds further variation to the mix of disciplines that will review the adequacy of CNHs for potential veteran residents.

In regard to inspections of nursing homes prior to initial contract awards, we found that 15 (88 percent) of the 17 local contract files that we reviewed contained inspection reports by social workers and nurses.[34] Dietitian inspections were completed only 41 percent of the time (7/17). Safety officer inspections were only documented 59 percent of the time (10/17). Pharmacist input to inspections was only documented 29 percent of the time (5/17).

We visited eight nursing homes with multi-state CNH contracts. These contracts were not available at the VA medical facilities. Through interviews with the CNH coordinators and review teams, we learned that these nursing homes were not physically inspected at the initiation of the contracts or annually thereafter. The variation in inspection requirements between local and regional contracts adds another potential vulnerability to the overall CNH oversight process.

---

[33] VA Policy M-5, Part II, Chapter 3, CNH Program

[34] We reviewed 17 locally issued contracts that required initial and annual inspections by CNH review teams. The remaining eight CNHs were operating under regional contracts, and did not require initial or annual inspections. These contracts were retained in VHA headquarters.

VHA CNH review teams told us that forming complete teams was not always possible because of the utilization of part-time employees who had other principal duties and could not devote sufficient time to overseeing CNH activities as a collateral duty. This factor, and other resource constraints, caused managers not to fully staff CNH review teams with all the required disciplines as outlined in the 1995 VHA CNH policy. It also appears this led to the June 2002 CNH policy giving managers more flexibility in whether to conduct initial or annual inspections.

Standardizing CNH Contracting Criteria

We identified several contracting features that, if standardized, could reduce the risk of patient abuse, neglect, and exploitation. At the 8 VHA sites, we evaluated 17 locally-developed contracts.[35] We found that only 59 percent of the local contracts (10/17) required CNHs to have state licenses, and only 35 percent of the local contracts (6/17) required CMS certification. One of the 25 CNHs we visited did not have a current state license on file. Upon further inspection, we found that the CNH had applied for license renewal but the state was slow to respond. At another site, the contracting officer was not aware the CNH had been sold and was under new ownership. Therefore, an assurance that the new owner had a license was not obtained. Ensuring that CNH facilities are licensed reduces the risk that they are not following prescribed state requirements. Also, using CMS-approved CNHs to the fullest extent possible strengthens the oversight of the nursing homes by other Government agencies.

Contracts did not require CNHs to provide VHA CNH Program coordinators routine performance data on issues such as the incidence and treatment progress for residents' skin breakdowns, medication errors, or patient falls. None of the contracts required the nursing homes to assure that their employees did not have criminal backgrounds or substance abuse histories. This differed from practices at our pilot VHA medical facility and three of its CNH sites in that all of the nursing homes submitted routine performance improvement data, conducted state background investigations, and required employees to agree to state drug testing.

We found that only 12 percent of the contracts reviewed (2/17) set standards equal to the CMS minimum-acceptable staffing required for VA residents. Of the CNHs visited, 40 percent of them provided less than the CMS minimum standard of 2 hours of CNA time per patient day. We also found that 32 percent of the CNHs did not provide the CMS minimum standard of 0.45 hours per resident per day of Registered Nurse (RN) time.[36]

---

[35] We reviewed 17 local contracts and 8 regional contracts at VHA Headquarters

[36] http//: www.hcfa.gov/Medicaid/reports/rp700hmp.htm *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* Page E.S.- 6

Additionally, contracting officers generally did not routinely discuss negotiations and contract issues with VHA CNH review teams before awarding contracts. Designating the CNH coordinator or other applicable clinician as the contracting officer's technical representative would enhance the contract administration process.

We noted that CNH contracts did not prescribe transportation requirements for veterans who would require frequent visits back to the VA medical facilities for rehabilitation or other medical needs. In fact, we found the issue of transporting CNH veterans between facilities a cumbersome process that needed improvement. CNH veterans often require transportation to their supervising VA medical facilities for routine and complex medical care, such as physical therapy, even when the care is offered at the CNHs. This is necessary because contracts have been limited to only providing for the placement of the veterans into CNHs with the expectation that VHA facilities would provide ancillary services.

Transports, which were paid under different contracts, often delivered the veterans to their VA medical facilities prior to their appointments. Following the appointments, there were often delays in obtaining transport back to the CNHs. During these periods of waiting, veterans were often unsupervised and had difficulty obtaining regularly scheduled medications, appropriate meals, and bathroom access. This was clearly a significant issue for most of the CNH veterans whom we interviewed, but there was little evidence in the medical records that VHA managers and clinicians were monitoring this issue to ensure these transportation problems were minimized.

New VHA CNH policy allows veterans to receive rehabilitation therapies at VA expense at CNHs. This should reduce the risk and inconvenience associated with veterans having to be transported to and from VA medical facilities 3-4 days per week and left unsupervised for sometimes lengthy periods of time. However, the new CNH policy is not clear as to whether this provision could apply to other treatment needs such as speech therapy or psychiatric consultations when veterans have acute episodes warranting immediate attention and a psychiatrist is on the CNH staff.

VHA Monthly Visits to CNHs

Not all VHA medical facility managers accepted the requirement that CNH review team members visit veterans in CNHs every 30 days. Some VHA managers asserted that this process duplicated state inspections, and was inefficient because the VA clinical staff assigned to these duties could better be utilized elsewhere in the VA medical facility. Half of the 111 VA medical records we reviewed did not contain evidence of nursing progress notes every 60 days and only 56 percent of the VA charts contained social worker or nurse progress notes every 30 days. Only 50 percent of the nurse progress notes that we reviewed contained evidence that nurses physically examined the veterans while 73 percent of the social work notes contained relevant information about the veterans' psychosocial issues.

We accompanied nurses and social workers, assigned to oversee CNH activities, to the nursing homes. We observed some CNH review team members, who had been assigned to teams for some time, introducing themselves to the nursing home personnel as if they were strangers. The records at the VA medical facilities and CNHs visited, contained inadequate documentation by the CNH review teams, and visiting nurses and social workers, to demonstrate that CNH residents were receiving good nursing home care. CNH policy encourages maximizing first-hand knowledge of the care provided in nursing homes and encouraging the VA medical facilities to utilize those CNHs that will provide the best care to veterans. In a substantial number of cases, we believe the personal monitoring of veterans by VHA clinicians was not always being effectively accomplished.

In contrast, during our inspection at one of the CNHs, we learned that veterans complained directly to a CNH review team nurse of poor care. In reaction to these complaints, VHA managers further investigated the complaints and determined that veterans' skin care at the CNH was not adequate. CNH review team members promptly removed all veterans from the nursing home due to their findings of inadequate care. This example of CNH review team intervention was possible because the medical facility demonstrated a proactive approach to ensuring the safety and well being of our veterans in non-VA institutional settings.

The June 2002 VHA policy reduces the need for CNH review teams to routinely visit long-term veteran placements, or residents residing more than 50 miles away under certain circumstances. These CNH veterans could be seen every 90 days instead of every 30 days, which was the standard prescribed by VHA's 1995 CNH policy. The new CNH policy does not clarify exceptions to this new rule (e.g. long-term placements and residents residing more than 50 miles away who need to be seen more frequently because of their medical conditions and veterans who do not have family support systems). The risk of adverse incidents occurring and not being addressed increases once VHA CNH review teams extend periodic visits to veterans in nursing homes from 30 days to 90 days.

CNH Performance Data and QM Oversight

Because contracts did not require performance data, none of the VHA CNH review teams interviewed reported receiving and critically analyzing performance improvement data from nursing homes (e.g. monitors of bedsores, falls, medication errors, complaints, and other indicators). In one veteran's medical record, we found that a VHA medical facility admission history and assessment form (Part 7) "...suspected abuse/neglect screening" was not properly utilized on several admissions to a VHA medical facility. In the last months of this veteran's life he was transferred between the VHA medical facility and the nursing home several times. As he medically deteriorated he progressively developed multiple areas of skin breakdowns. In this case, the failure of quality improvement processes to monitor and trend data routinely available on veterans' VHA admission records resulted in a missed opportunity for VHA clinicians to

intercede in the care of this veteran who was slowly medically deteriorating as he was transferred between facilities.

We also found that VA medical facility QM programs had not integrated CNH performance into their plans. Of the eight sites visited, none incorporated CNH activities into their QM Programs. Consequently, CNH performance data was not reviewed or analyzed to permit VA clinicians to work with CNH employees to improve clinical issues that would benefit from performance improvement initiatives.

Conclusions

We concluded that VHA's efforts to strengthen CNH oversight controls as recommended by prior OIG and GAO reports continued to need improvement. VHA CNH initial and annual inspections were inconsistently performed and when performed they were done without the data available online through CMS websites. CNH review teams were not ensuring that veteran residents were visited monthly as required. The fact that CNH review teams placed 27 percent of the veterans in our sample in CMS watch listed homes is an indication that this information is not reviewed or used when considering veteran placements.

Current VHA local contracts do not set appropriate standards for the procurement of health care in that they frequently do not require that CNHs meet basic standards of state licensure, CMS certification, and minimum CMS-recommended staff-to-patient ratios. Local contracting officers did not have, and were not familiar with, the provisions of regional contracts. Local and regional contract provisions must sufficiently align to ensure one standard of care is provided to veteran residents regardless of whether they are placed under the provisions of local contracts or regional contracts. None of the eight sites we visited incorporated data from the CNH Program into their ongoing QM programs.

VHA program managers issued new CNH policy at the conclusion of this review. VHA needs to strengthen and clarify this policy, and discuss the need to strengthen CNH oversight in VISN and VHA facility manager meetings, and educate VHA facility coordinators, teams, contracting personnel, and other applicable employees of the need to consistently apply these requirements to all CNHs in their programs. VHA CNH review teams need to more critically analyze reported incidents of abuse, neglect, and exploitation, and increase efforts to work closer with state ombudsmen officials to ensure CNHs are not contracted if they are not CMS-approved.

VHA CNH expectations and requirements must be clearly documented and communicated to CNH administrators, and VHA managers need to strengthen controls to ensure VHA clinicians and managers effectively and routinely monitor veterans' care at CNHs, and while they are in transport to and from these facilities. VA medical facilities' QM programs need to include reviews of the quality of the care provided to veterans residing in CNHs.

Issue 4: Coordination between VHA and VBA

Findings

Strengthening efforts to share information on CNH veterans' health statuses could enhance VHA and VBA oversight of veterans' care and financial welfare. We found several examples of veterans who were incompetent to handle their own financial affairs that needed to be referred to VBA for action. Conversely, we found VBA field examiners could benefit from exchanging information with VHA CNH coordinators on veterans of mutual concern.

F&FE units, located in VA Regional Offices (VAROs), are responsible for assuring that fiduciaries assert and protect the rights of VA beneficiaries and their dependents to VA benefits, other assets, income, and other benefits, regardless of the source. To fulfill these responsibilities, F&FE personnel perform initial and subsequent field examinations and analyze and audit accountings prepared by the fiduciary.

F&FE employees, and social workers or other case managers at VA medical facilities are frequently involved in cases of mutual concern. VHA has primary responsibility for the coordination of all services to veterans enrolled in the CNH program. F&FE employees are responsible for protecting the VA-derived income of incompetent veterans. To provide the best possible services to veterans and their dependents and to prevent duplication of efforts, there must be an understanding by employees in each program of the others' goals and priorities, and the recognition of the need for joint cooperation and consultation in areas of mutual concern. Currently, VBA policy requires the fiduciary activity supervisor to meet with appropriate personnel from each VA medical facility in his or her jurisdiction at least once each year for this purpose.[37]

The importance of protecting the VA-derived income of incompetent veterans has recently been enhanced by legislation that repealed the ($1,500) limitation of veterans' benefits. Public Law 107-103, the Veterans Education and Benefits Expansion Act of 2001, Section 204, repeals the limitation of benefits for incompetent institutionalized veterans and amends 38 U.S.C. Section 5503.

F&FE employees have a duty to assist all VA beneficiaries. This responsibility applies when oral or written information is received on veterans not within the fiduciary program, from VHA or other sources, and when the veterans can be assisted within the scope of VA responsibility. When information is received that a veteran may not be capable of handling his or her funds, or is being deprived of his or her rights, further inquiry should be made to determine the facts, by field examination if necessary.[38]

Fiduciary activity supervisors should meet with appropriate VA medical facility personnel at least annually to discuss areas of mutual concern, because VBA policies do not require examiners to closely follow incompetent veterans under VHA supervision in

[37] VBA Manual M21-1, Part VIII, Section 6.08
[38] VBA Manual M21-1, Part VIII, Section 2.05

CNHs. F&FE employees are required to contact VA medical facilities, domiciliaries, or CNHs by telephone every 3 years to confirm that incompetent veterans, supervised by court-appointed fiduciaries or guardians, have remained at the facilities. The examiners are required to ensure there are no anticipated release dates, and determine the sizes of the estates during these telephone conversations.[39]

We found the VHA CNH review teams and coordinators do not meet annually with F&FE activity supervisors to discuss veterans of mutual concern. We also found that CNH clinicians and managers do not always contact F&FE employees or other appropriate VBA personnel when CNH veterans' cognitive capacities change (e.g. competent to incompetent). VHA CNH clinicians and managers confirmed with us their belief that veterans under their care are not the responsibility of VBA, and therefore, communication has been limited, even to 3-year intervals. VBA officials also confirmed with us that their F&FE employees generally defer to VHA when veterans are residing in contracted CNHs. Better communication between these groups could reduce the risk of financial exploitation and protect VA-derived payments.

We believe this is important because one-third of the reported abuse and neglect that we identified in our study sample represented financial exploitation. VHA is charged with determining the medical status of veterans under its care, to include their cognitive capabilities. VBA has the responsibility of ensuring that money provided to veterans through the VA is utilized to benefit the veteran. When a veteran is determined to be incompetent, VBA will take administrative actions to provide proper fiduciary control of the veteran's assets.

Our review of the veterans' VHA medical facility discharge summaries found that statements regarding the veterans' competence to handle their financial affairs were most often absent. There appeared to be no consistent or timely method of alerting VBA to changes in the competency levels of veterans or changes in marital status that might affect benefits. VHA CNH review teams and F&FE employees also rarely share information such as OSCAR data, and F&FE Reports of Adverse Conditions in the Distribution of Operational Resources (DOOR) system. However, F&FE officials acknowledged that the data in these DOOR system reports are not always complete.

Increasing communication and coordination between VHA and VBA officials could achieve positive results. For example, we discussed the conditions of 12 veterans residing in 3 CNHs with F&FE employees at a VARO. The following 3 cases describe the importance of VHA communicating changes in CNH veterans' conditions to VBA.

> One veteran, receiving 100-percent service-connected compensation of $2,287 monthly, had been admitted to a CNH in November 2000. During our interview with the veteran, review of the medical record, discussions with the VHA social worker, and interview with his daughter, we became concerned that the veteran was not competent to handle his own affairs. We also learned from the daughter that the veteran's spouse had died.

[39] VBA Manual M21-1, Part VIII, Section I (6-13)

We discussed this case with the F&FE employee, and he obtained a copy of the spouse's death certificate from the daughter, and a physician's statement from the VHA medical facility documenting that the veteran was incompetent. After a 60-day due process period, the final rating of incompetence will be initiated, and a field examiner will visit the CNH to appoint a fiduciary for the veteran's benefits and begin accounting for the VA-derived funds. VBA will adjust the veteran's award, and begin following up on the account to ensure his funds are safeguarded.

Another veteran, receiving 100-percent service-connected compensation of $2,546 monthly, had been admitted to a CNH in December 2001. During our interview with the veteran, and review of the medical record, we became concerned that the veteran was not competent to handle his own affairs. VBA records showed the veteran was married. However, the checks were forwarded to his sister via direct deposit. We discussed this case with the VHA social worker, and F&FE employee and they obtained the necessary documentation confirming that the veteran was incompetent. After a 60-day due process period, the rating of incompetence will be resolved. A field examiner has been assigned to visit the family and the veteran to determine the status of the spouse and funds. Action will be taken to appoint an appropriate payee at that time to ensure the veteran's VA-derived funds are protected.

Another service-connected veteran rated 40 percent for hypertension and stroke was admitted to a CNH on April 9, 2001. After reviewing the medical record and discussing the case with the VHA social worker, we became concerned about the competency status of the veteran, and the spouse's ability to financially manage the veteran's funds. We discussed the case with a VBA F&FE employee, who conducted a field examination. As suspected, VBA was required to replace the spouse as the payee, and appoint a professional guardian as legal custodian to safeguard the veteran's benefits.

F&FE employees told us that these conditions existed because reductions in VBA field resources and increasing workloads have made it difficult for F&FE employees to routinely meet with VHA CNH review teams. They also told us that annual visits with VHA personnel were discontinued several years ago.[40] VBA program officials were aware that their reporting of adverse incidents in the DOOR system needed improvement and they were in the process of addressing this issue. VBA program officials also acknowledged that communication efforts have declined over the past several years because of resource constraints and increasing workloads, and informed us they have begun addressing this issue. They also pointed out to us that VHA does not have a similar policy to meet with VBA annually, which made compliance with their VBA policy problematic. VHA CNH coordinators and review teams were unaware of the VBA policy, or informed us that VHA does not have a similar policy to meet at least

[40] VBA Senior Managers indicate that annual meetings are still required by M21-1, VIII, 6.08.

annually with VARO F&FE employees. Because there was no VHA requirement to meet with F&FE employees routinely, this was not done.

Conclusions

We believe it is important for effective communication to exist between VHA and VBA because it maximizes the likelihood that a fiduciary is appointed when needed given the vulnerability of the elderly CNH population. Veterans could be better served, and actions could be taken to reduce risks of adverse events, if VHA CNH clinicians and managers and VBA F&FE employees would meet annually, increase the sharing of information pertaining to changes in veterans' competency statuses, share inspection and evaluation data, and routinely communicate telephonically.

RECOMMENDATIONS AND COMMENTS

Recommendation 1:

The Under Secretary for Health needs to ensure that:

a. VHA medical facility managers devote the necessary resources to adequately administer the CNH program.

b. Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable QM Program employees using education and training mediums.

c. VHA medical facility managers emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials.

d. Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee.

e. Consistently apply local and regional contracting requirements to preclude the potential for them to provide differing standards of care.

f. Survey requirements for LSC compliance are clarified between the recently issued CNH policy and instructions issued by VHA in April 2000.

g. Contracting officers strengthen the contracting process by requiring CNHs to produce current state licenses, CMS certifications, assurances of the clinical competency and backgrounds of CNH clinical employees, CMS or State minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data.

h. CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities.

i. Clarify exceptions to visiting long-term placements and residents residing more than 50 miles away from the parent medical facilities at least quarterly, particularly in the cases of veterans who need to be seen more frequently because of their medical conditions or absence of family support systems.

j. Managers integrate CNH activities into medical facility QM programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention.

Recommendation 2:

The Under Secretary for Health needs to coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits.

Under Secretary for Health Comments

The Under Secretary concurred with all the recommendations except 1i. See Appendix A for the Under Secretary's comments and corrective action plans.

Under Secretary for Benefits Comments

The Under Secretary agreed with the findings and the recommendation. The Under Secretary proposed that Central Office VHA senior managers and VBA Fiduciary staff meet to determine what information would be of value to share and the proper procedures for this exchange of information. See Appendix B for the Under Secretary's comments and corrective action plan.

Inspector General Comments

The Undersecretary for Health concurred with our findings and all but one of our recommendations (1i). Upon further review and consideration of the Under Secretary's response to recommendation 1i, we agree that no immediate action is required but we encourage VHA managers to closely monitor this important issue. The Undersecretary provided acceptable detailed implementation plans on the remaining recommendations. The Under Secretary for Benefits concurred with our findings and recommendation and proposed a meeting between VHA and VBA Central Office managers to determine what and how information should be shared. We will follow-up on the planned actions until they are completed.

Appendix A

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs **Memorandum**

Date:

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report: ***Healthcare Inspection-Review of VHA Community Nursing Home (CNH) Program*** (Project No. 2002-00972-HI-0129) (EDMS 193404)

To: Assistant Inspector General for Healthcare Inspections (54)

1. In VHA's August 28, 2002 initial response to the referenced report, I noted my charge to the Health Systems Committee of the National Leadership Board to convene a work group to fully explore your findings and recommendations and develop a viable plan of corrective action to address identified deficiencies. I am very pleased to report that the group did an outstanding job in both systematically defining the expected elements of a first rate CNH oversight process, as well as in delineating specific steps that will be taken within VHA to assure implementation of corrective actions in response to report recommendations. Attached is the work group's proposal, which serves as VHA's official response to this report.

2. As detailed in the proposal, VHA concurs in all recommendations but 1i: that the newly-developed CNH Handbook clarify expectations on visiting (at least quarterly) long-term placements and residents residing more than 50 miles away from the parent facilities. We believe that the current Handbook approach is specific and practical in addressing this issue, and our comments detail our reasoning in this regard. If you have some specific points in mind regarding the visit expectations, we welcome your comments.

3. I am also pleased to announce that a new Chief Consultant for Geriatrics and Extended Care has recently been selected. Dr. James F. Burris, previously VA's Deputy Chief Research and Development Officer, brings extensive experience in geriatric medicine to this position. Dr. Burris has been briefed about the CNH work group proposal, and will oversee implementation of the approved action plan.

Appendix A

4. Thank you for your assistance in helping us to prioritize improvement opportunities in our CNH oversight processes. Under the supervision of Dr. Burris and other members of the Geriatrics and Extended Care staff, I am confident that the proposed actions will be fully implemented. We look forward to sharing our progress to you through upcoming status updates. If additional information is required, please contact Margaret M. Seleski, Director, Management Review and Administration Service (105E), Office of Policy and Planning (105), at 273-8360.

Robert H. Roswell, M.D.

Attachment

Appendix A

OIG Recommendation 1a:
"VHA medical facility managers must devote the necessary resources to adequately administer the CNH program"

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the Chief Consultant, Patient Care Services (or designee) collaborate with the CC-GEC and with the Chief Consultant, Office of Quality and Performance to identify one or more Network Director indicators (e.g., self-report), initially, and annually thereafter, that reflect process and outcomes associated with CNH oversight. This will require presentation of the concept to OQP, as well as requesting to be on the agenda of that office's Performance Measures Workgroup. The 2003 measures have already been determined. The action plan target date must therefore be for 2004 and all activities contributing to accomplishment must be completed by March 2003 at the latest. The proximity of this date means that the 2004 indicators will likely be procedural, inasmuch as identification of actual outcome indicators—dependent on the recommendations of other workgroups described further below in this work plan—will be proposed for 2005 or beyond. These ongoing actions will be facilitated by collaboration between the GEC SHG's OPQ Liaison and the OPQ's GEC Liaison.
2) the CC-GEC negotiate with the Senior Advisor to the Undersecretary of Health to identify suitable VACO- and field-based representatives of GEC, OIT, and DSS to collaboratively agree upon appropriate, standardized stop codes for reporting CNH visits. The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.
3) the CC-GEC, develops and provides education (as described in greater detail under "OIG Recommendation 1b", following) to VAHCF managers on the revised procedures for CNH Oversight (as described in greater detail throughout the remainder of these recommendations) and workload reporting (as articulated in the preceding section).

OIG Recommendation 1b:
"Critical aspects of the new VHA policy are discussed with senior managers, CNH review teams, and other applicable QM program employees using education and training mediums"

Workgroup response: Concur

Appendix A

Action Plan:
It is recommended that:

1) the CC-GEC add an element to the GEC strategic plan, and specify an outcome measure or measures, that will drive timely development of educational information and materials to support effective implementation of new procedures concerning CNHs. The CC-GEC will identify field- and VACO-based GEC representatives and EES representatives who will be able to provide ongoing input on content, format, and target audiences. Education and training needs will have to constantly incorporate new knowledge about quality measures and sources from CMS, for example the new facility-specific quality measures for each Medicare and Medicaid-certified nursing home. Further information is available at http://www.medicare.gov/NHCompare/home. The elements of strategic plans for 2003 have already been formalized. A strategic plan element for 2004 is to be added by August 1, 2003 and the educational outcome measure identified no later than that date, with reporting no less frequent than twice annually, beginning March, 2004.
2) the CC-GEC to present in a timely manner (by self or designee) to NLB at one or more of their monthly meetings; to VHA Senior Management at the January meeting; and to facility directors at one or more of their monthly calls, on topics selected by the process described in the preceding paragraph that will include but will not necessarily be limited to the developmental status or definitive version of these aspects of CNH oversight: renewal of the Oversight Committee requirement, access to and use of CMS databases, integration of CNH and facility QM programs, reporting of CNH sentinel events, and new Network Director Performance Measure(s). These educational activities are to begin as soon as the procedural elements called for in these recommendations begin to adopt their final forms. The activities will continue until formal training on the amended Handbook has been completed in December 2003.
3) the CC-GEC develop in a timely manner one or a series of educational interactive teleconferences for field-based, front-line personnel, providing operational specifics on workload reporting and accessing MDS-based performance data on CNHs, as advised in (1) above. Timing is as described in preceding paragraph.

OIG Recommendation 1c:
"VHA medical facility managers must emphasize the need for CNH review teams to access and critically analyze external reports of incidents of patient abuse, neglect, and exploitation, and to increase their efforts to collaborate with state ombudsman officials."

Workgroup response: Concur

OIG Recommendation 1d:
"Clarify whether the new VHA policy intended the responsibilities of CNH oversight committees to be extended to CNH review teams or some other committee."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the CC-GEC identify and oversee suitable field- and VACO-based expertise in GEC and OIT to develop a mechanism for web-based, timely reporting by VAHCFs, of review status of CNHs and annual CNH summary data. The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.
2) the CC-GEC identify and task suitable field- and VACO-based expertise to draft amendments to the CNH Handbook to specify the need for and different scope of responsibilities of CNH Oversight and CNH Review teams, as described on pp. 8-10 of this report; and employing the mechanism developed in (1) preceding.
3) recommended wording of Handbook amendments will be provided to the HSC by CC-GEC by July 1, 2003.
4) the proposed revisions to the Handbook, when they have assumed their final form, will be communicated by the CC-GEC to the GEC/EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1e:
"Consistently apply local and regional contracting requirements to preclude the potential for them to provide differing standards of care"

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC propose to amend the CNH Handbook to require of all local and regional contracts CNH SOW elements identified as described under "OIG Recommendation 1c" and "OIG Recommendation 1g" above. Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
2) the proposed revision to the Handbook, when it has assumed its final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1f:
"Survey requirements for LSC compliance must be clarified between the recently issued CNH policy and instructions issued by VHA in April 2000."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC propose to amend the CNH Handbook with language clarifying the recission of the conflicting section of IL 10N-2000-002 by July 1, 2003.
2) in light of the multiple Handbook revisions that will be recommended by CC-GEC and the time necessary to effect adoption of a new Handbook, CC-GEC issue an Information Letter on this topic, to be issued no later than January 31, 2003.
3) this Information Letter and the revision to the Handbook be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1g:
"Contracting officers must strengthen the contracting process by requiring CNHs to produce current state licenses, CMS certifications, assurances of the clinical competency and backgrounds of CNH clinical employees, CMS or State minimum standards for staffing levels to provide direct nursing care to veterans on a daily basis, and submissions of routine performance improvement data."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) CC-GEC specify to the group identified in "OIG Recommendation 1c" above that the elements listed in "OIG Recommendation 1g" be included in the SOW.
2) CC-GEC request the Deputy Under Secretary for Health Policy Coordination to make necessary and appropriate arrangements with representatives of the Department of Health and Human Services to: 1) actualize the development and drive the implementation of workable processes, particularly electronic forms of access, to make available to VAHCFs on an on-demand basis the quality reports generated by RAI/MDS; and 2) develop and implement a mechanism for immediate notification to the VACO GEC SHG by CMS regional offices of any home that receives a rating of "immediate jeopardy". The CC-GEC will provide a preliminary report on this activity to the HSC by April 15, 2003. A final report will be due to the HSC by June 1, 2003.

3) CC-GEC propose to amend the CNH Handbook with language: to require of all local and regional CNH contracts the SOW elements identified as described under "OIG Recommendation 1c" above; to specify means developed through (2) preceding for accessing quality reports generated by the RAI/MDS; and to articulate the procedure to follow in the event a VAHCF is alerted by GEC SHG that a CNH with which it has a contract has received a rating of "immediate jeopardy".
4) Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
5) the proposed revision to the Handbook, when it has assumed its final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1h:
"CNH review teams are reminded to critically evaluate and mitigate the risks associated with routinely transporting veterans between CNHs and VA medical facilities."

Workgroup response: Concur

Action Plan:
It is recommended that:
1) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to draft amendments to specify that routine medical services are already covered under contract provisions and that travel to VHA to obtain these services should be discouraged unless it is in the patient's best interest. Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
1) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to amend the CNH Handbook to emphasize to VHA CNH program staff that fee basis authority exists to pay for medically necessary specialty services on-site in the CNH when VAHCF CNH program staff deem that transportation to the parent VHA facility would be costly, onerous or deleterious to patient health. Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.
2) the CC-GEC identify and task suitable field- and VACO-based expertise, as necessary, to amend the CNH Handbook to clarify the principles and procedures VAHCFs are to follow when a CNH in which reside veterans on CNH contract is found to have one or more of the characteristics listed in section 13 of the Handbook; local alternative resources are not available; and quality of care is not so much the issue as is an administrative situation (e.g., loss of liability insurance). Recommended wording of Handbook amendment will be provided to the HSC by CC-GEC by July 1, 2003.

4) the proposed revisions to the Handbook, when they have assumed their final form, will be communicated by the CC-GEC to the GEC-EES group that provides education content and format recommendations as described in "OIG Recommendation 1b" above.

OIG Recommendation 1i:
"Clarify expectations on visiting long-term placements and residents residing more than 50 miles away from the parent medical facilities at least quarterly, particularly in the cases of veterans who need to be seen more frequently because of their medical conditions or absence of family support systems."

Workgroup response: Do Not Concur

Comment:
The workgroup is of the opinion that the approach advocated in the Handbook for addressing the need for ongoing oversight of veterans residing in CNHs at considerable distance from the VAHCF is specific, practical, reasonable, and appropriately patient-centered in its present iteration. The Handbook stresses that every plan for post-discharge care is to "delineate, on an individual patient basis, the particular needs and services to be provided to the patient;" and that it unambiguously directs that the patient's needs are to dictate the particulars of the post-placement plan. Residents placed at distance from the VAHCF who (in the words of the OIG draft report) "need to be seen more frequently because of their medical conditions or absence of family support systems" will, per the Handbook, be seen more frequently, as their needs dictate. In much the same way, a veteran residing in a CNH closer than 50 miles to the VAHCF may not require monthly visits and paragraph 12c addresses this contingency as well. Essential to the successful implementation of the Handbook's direction in this matter is a thorough and rigorous program of quality oversight, directed both to the performance of the facility (through the OSCAR 3 and 4, the QIs, and all other reports indicated for the particular situation), and to the patient's own status (through monitoring the patient's MDSs, discussions with CNH staff, and family).

OIG Recommendation 1j:
"Managers integrate CNH activities into medical facility QM programs and review performance data to monitor bedsores, medication errors, falls, and other treatment quality indicators that may warrant their attention."

Action Plan:
is addressed under "OIG Recommendation 1c" and "OIG Recommendation 1d" above

Appendix A

OIG Recommendation 2a:

"The Under Secretary for Health needs to coordinate efforts with the Under Secretary for Benefits to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions, to protect the financial interests of veterans receiving health care and VA-derived benefits."

Workgroup response: Concur

Action Plan:
It is recommended that:

1) the Senior Advisor to the Under Secretary for Health request that the Secretary of Veterans Affairs direct that a standing committee of representatives from VHA and VBA be convened to determine how VHA CNH managers and F&FE employees can most effectively complement each other and share information such as medical record competency notes, OSCAR data, and F&FE Reports of Adverse Conditions.
2) This committee will report to the Secretary at 6-month intervals. The initial report, due June 30, 2003, will provide concrete recommendations and action plans for all of the elements specified in the preceding paragraph. Succeeding reports will address processes, initially articulated in the first report, that have needed to be changed in the interim as the two agencies' internal processes evolve.

Appendix B

UNDER SECRETARY FOR BENEFITS COMMENTS

In general, we concur with the recommendation to coordinate improved lines of communication between appropriate VHA personnel, including CNH managers, and Fiduciary activity supervisors. The current Fiduciary program mandate, as outlined in M21-1, Part VIII, 6.08a, requires a meeting at least once yearly between these parties to discuss services to incompetent veterans. It should be noted that these meetings are not limited to CNH personnel but would also include VHA personnel involved with both the residential care program and VHA inpatients to the extent they involve incompetent veterans.

The Central Office Fiduciary Program staff reminded all Fiduciary Program managers nationwide of this requirement in an e-mail message on June 20, 2002 (copy attached). Additionally, this was an agenda item on the Veterans Service Center Managers' call on June 19, 2002, and extensively discussed in the quarterly Fiduciary Program Teleconference on July 18, 2002 (copies attached). Compliance with this requirement will be monitored during routine site visits beginning in October 2002.

While we agree with the necessity of these annual meetings, we have reservations about some of the information to be shared as outlined in the second part of the recommendation, and who should be the recipient of the information. We recommend that a meeting between Central Office VHA and VBA Fiduciary staff be held to determine what information would be of value to share and the proper procedures for this exchange of information.

Appendix C

DISTRIBUTION

VA Distribution
Secretary (00)
Deputy Secretary (001)
Executive Secretariat (001B)
Chief of Staff, Office of the Secretary (00A)
Under Secretary for Health (105E)
Under Secretary for Benefits (20A11)
Chief of Staff, Under Secretary for Health (10B)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Assistant Secretary for Human Resources and Administration (006)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Public Affairs (80)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
Medical Inspector (10MI)
Deputy Under Secretary for Health for Operations and Management (10N)
VHA Chief Information Officer (19)
VBA Chief Information Officer (20S)
Director, Center for Patient Safety (10X)
Directors, Veterans Integrated Service Networks (1 through 22)
Chief Consultant for Geriatrics and Extended Care (114)

Non-VA Distribution
Office of Management and Budget
U.S. General Accounting Office
The Honorable Christopher S. Bond, U.S. Senate
Congressional Committees: (Chairmen and Ranking Members):
- Committee on Veterans' Affairs, U.S. Senate
- Committee on Appropriations, U.S. Senate
- Committee on Governmental Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Committee on Appropriations, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives

Subcommittee on National Security, Veterans' Affairs, and International Relations, Committee on Government Reform, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Benefits, Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives

Congressional Staff Directors:
Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
Committee on Veterans' Affairs, U.S. House of Representatives
Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives