Nursing Home Conditions in New Mexico:
Many Homes Fail to Meet Federal Standards for Adequate Care

Prepared for Rep. Tom Udall

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EXECUTIVE SUMMARY

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

To address these growing concerns, Rep. Tom Udall asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in New Mexico. There are 80 nursing homes in New Mexico that accept residents covered by Medicaid or Medicare. These homes serve 6,384 residents. This is the first congressional report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many of the nursing homes in New Mexico. Over 80% of the nursing homes in New Mexico violated federal health and safety standards during recent state inspections. Moreover, almost one out of every five nursing homes in New Mexico had a violation that caused actual harm to residents or placed them at risk of death or serious injury.

A. Methodology

Under federal law, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes and to investigate nursing home complaints. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents.

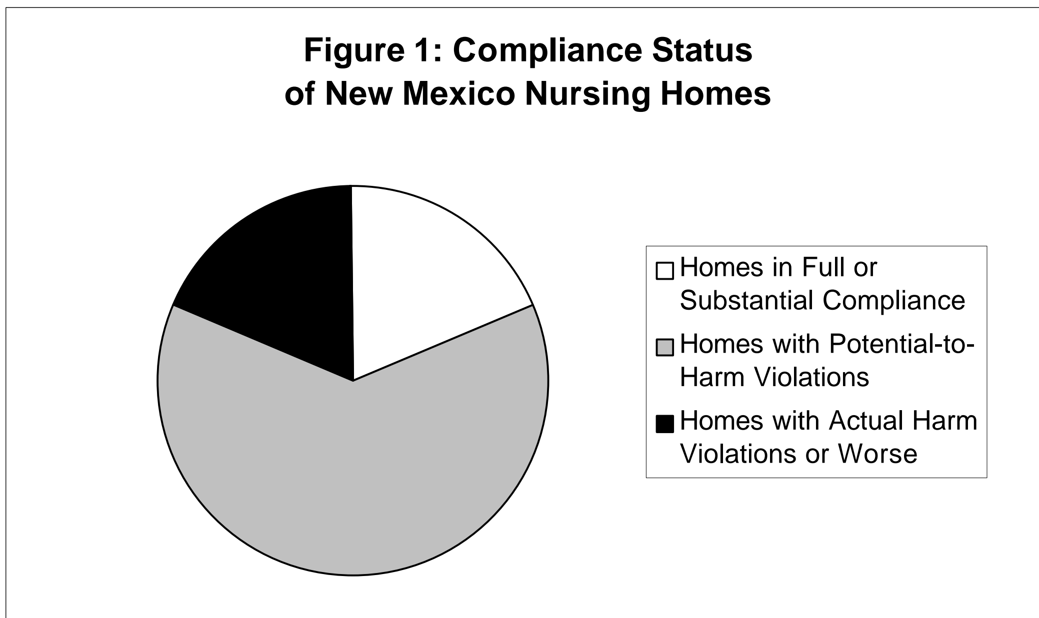
This report is based on an analysis of these state inspections. It examines the most recent annual inspections of nursing homes in New Mexico, which were conducted between August 2000 and November 2001. In addition, the report examines the results of any complaint investigations conducted during this time period.

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

B. Findings

Most nursing homes in New Mexico violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health and safety standards if no violations are detected during the annual inspection or a complaint investigation. They consider a home to be in "substantial compliance" with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 80 nursing homes in New Mexico, only 15 facilities (19%) were found to be in full or substantial compliance with the federal standards. In contrast, 65 nursing homes (81%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 65 nursing homes had 6.5 violations of federal quality of care requirements.

Many New Mexico nursing homes had violations that caused actual harm to residents. Of the 80 nursing homes in New Mexico, 15 facilities -- almost one out of every five -- had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). These deficiencies involved serious problems, such as improper medical care to residents and preventable falls and accidents. The 15 nursing homes with actual harm violations or worse serve 1,318 residents and are estimated to receive over $17 million each year in federal and state funds.



<u>An examination of the nursing homes with significant violations showed serious care problems.</u> Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations are actually trivial in nature. To assess these claims, this report examined in detail the annual inspection reports from 31 nursing homes in New Mexico cited for multiple violations. The inspection reports for these homes documented that the actual harm violations cited by state inspectors involved serious neglect and mistreatment of residents. Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that significant deficiencies can exist at nursing homes cited for potential-to-harm violations.

Examples of the violations documented by New Mexico inspectors included:

- Failure to provide proper medical care;
- Failure to provide proper nutrition and hydration;
- Failure to prevent falls and accidents;
- Failure to prevent or properly treat pressure sores;
- Failure to prevent residents from abusing other residents;
- Improper use of restraints; and
- Failure to properly clean residents.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

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

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 34.9 million Americans, 13% of the population.[2] By 2030, the number of Americans aged 65 and older will increase to 70.3 million, 20% of the population.[3]

This aging population will increase demands for long-term care. There are currently 1.5 million people living in more than 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives.[5] Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years. By 2050, the total number of nursing home residents is expected to quadruple from the current 1.5 million to 6.6 million.[6]

Most nursing homes are run by private for-profit companies. Of the 17,000 nursing homes in the United States, over 11,000 (65%) are operated by for-profit companies. During the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up smaller chains and independent homes. As of December 1999, the six largest nursing home

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

[2]U.S. Census Bureau, *Resident Population Estimates of the United States by Age and Sex: April 1, 1990 to July 1, 1999, with Short-Term Projections to November 1, 2000* (Jan. 2, 2001).

[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups and Sex with Special Age Categories: Middle Series 2025-2045* (Dec. 1999).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, 15 (2001).

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

[6]*Facts and Trends*, *supra* note 4, at vii.

chains in the United States operated 2,241 facilities with over 266,000 beds.[7]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a jointly funded, federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2001, it was estimated that federal, state, and local governments spent $61.2 billion on nursing home care, of which $46.8 billion came from Medicaid payments ($29 billion from the federal government and $17.8 billion from state governments) and $12.1 billion from federal Medicare payments. Private expenditures for nursing home care were estimated to be $38.1 billion ($31 billion from residents and their families, $5.2 billion from private insurance policies, and $1.9 billion from other private funds).[8] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

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

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises, caused by pressure or friction, that can become infected. They also establish other safety

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

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

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

[10]42 U.S.C. §1396r(b)(2).

and health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and anti-psychotic drugs, have been reduced.[11] But health and safety violations appear to be widespread. In a series of 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that "more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[12] that these incidents of actual harm "represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death";[13] and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[14]

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[15] In March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to the quality of resident care.[16] And in July 2000, HHS reported that

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[11]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998).

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

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

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

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

[16]HHS Office of Inspector General, *Nursing Home Survey and Certification: Deficiency Trends* (March 1999).

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

In light of the growing concern about nursing home conditions, Rep. Udall asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in nursing homes in New Mexico. Rep. Udall represents the 3rd congressional district of New Mexico, which is located in the northern portion of the state. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in New Mexico.

II. METHODOLOGY

To assess the conditions in New Mexico nursing homes, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) state inspection reports from 31 nursing homes cited for multiple, serious violations.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in New Mexico come from the OSCAR database and the complaint database. These databases are compiled by the Centers for Medicare and Medicaid Services (CMS), a division of HHS.[18] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to CMS, and compiled in the OSCAR and complaint databases.[19]

The OSCAR and complaint databases use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree

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

[18]Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA).

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

of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

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

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

To assess the compliance status of nursing homes in New Mexico, this report analyzed the OSCAR database to determine the results of the most recent annual inspection of each nursing home in the state. These inspections were conducted between August 2000 and November 2001. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

B. <u>Analysis of State Inspection Reports</u>

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

The Special Investigations Division selected for review the inspection reports from 31 nursing homes that were cited for multiple, serious violations. For each of these homes, the most recent state inspection report was obtained from the New Mexico Department of Health. For several of these nursing homes, the Special Investigations Division also obtained reports of other inspections and investigations conducted by the New Mexico Department of Health over the past two years. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

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

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

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

III. NURSING HOME CONDITIONS IN NEW MEXICO

There are 80 nursing homes in New Mexico that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 7,295 beds that were occupied by 6,384 residents during the most recent round of annual inspections. The majority of these residents, 4,542, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 458 residents. Sixty-one percent of the 80 nursing homes in New Mexico are private, for-profit nursing homes.

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

A. Prevalence of Violations

Less than one out of every five nursing homes in New Mexico was found to be in full or

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

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

substantial compliance with federal standards of care. Fourteen of the 80 nursing homes met all federal health and safety requirements. Another nursing home was in substantial compliance with federal standards, meaning that it was cited only for deficiencies that posed a minimal risk of harm to residents. The rest of the nursing homes in New Mexico -- 65 out of 80 -- had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Table 2 summarizes these results.

Table 2: New Mexico Nursing Homes Had Numerous Violations that Placed Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	14	18%	836
Substantial Compliance (Risk of Minimal Harm)	1	1%	80
Potential for More than Minimal Harm	50	63%	4,150
Actual Harm to Residents	13	16%	1,148
Actual or Potential Death/Serious Injury	2	3%	170

Many nursing homes had multiple violations. State inspectors found a total of 421 violations in facilities that were not in complete or substantial compliance with federal requirements, an average of 6.5 violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to the GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. These are homes with violations ranked at the G-level or above. As shown in Table 2, 15 nursing homes in New Mexico had violations that fell into this category. In total, 19% of the nursing homes in New Mexico were cited for violations that caused actual harm or worse to residents. These 15 nursing homes serve a total of 1,318 residents and are estimated to receive over $17 million in federal and state funds each year.

C. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based in large part on the data reported to CMS in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[22] One problem, according to GAO, is that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems

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

otherwise observable during normal operations."[23] A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health and safety standards.[24] Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

Representatives of the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[25] AHCA also claims that deficiencies cited by inspectors are often "technical violations posing no jeopardy to residents" and that the current inspection system "has all the trademarks of a bureaucratic government program out of control."[26] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[27]

At the national level, these assertions have proven to be erroneous. In response to AHCA's criticisms, GAO undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including "pressure sores, broken bones, severe weight loss, burns, and death."[28] GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe than

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

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

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

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

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

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

violations cited in previous or subsequent annual inspections.[29]

This report undertook a similar analysis at the state level. To assess the severity of violations at New Mexico nursing homes, the Special Investigations Division examined the annual inspection reports for 31 nursing homes with multiple violations. These inspection reports showed that the actual harm violations cited by state inspectors involved numerous examples of serious neglect and mistreatment of residents.

Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations. These violations involved improper medical care, inadequate nutrition, and untreated pressure sores.

The following discussion summarizes some examples of the violations documented in the inspection reports.

A. Failure to Provide Proper Medical Care

Several New Mexico nursing homes were cited for failing to provide appropriate medical care to residents. A resident at one facility did not receive medical care from a physician even though he was complaining of severe stomach pain and yelling, "Oh my God, it hurts." The resident was also vomiting a green substance, and his abdomen was "distended, hard, and tender." Thirty-six hours after the resident first complained of stomach pain, the facility finally sent him to an emergency room, where he was diagnosed with a possible rupture of an abdominal organ.[30]

State inspectors found that another facility failed to treat a resident for a urinary tract infection more than a month after lab reports had detected the infection. In this case, the nursing home waited two weeks before faxing the lab report to the resident's physician, and the physician did not actually review the lab report for two more weeks until after state inspectors intervened. This facility also failed to treat painful skin irritation resulting from the resident's incontinence. One nurse claimed not to have noticed the skin condition, even though the nurse's notes from the previous day stated that the treated area was "red" and "inflamed," that "bleeding occurred during cleansing," and that the resident said, "It hurts like fire." The director of nursing admitted: "This

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[29] *Id.* at 6. A subsequent GAO study in August 1999 examined several examples provided by AHCA of serious deficiencies cited by state inspectors that AHCA asserted were of questionable merit. For those deficiencies which it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against these homes were merited. The GAO report stated: "In our analysis of the cases that AHCA selected as 'symptomatic of a regulatory system run amok,' we did not find evidence of inappropriate regulatory actions." Letter from Kathryn G. Allen (GAO) to Sen. Charles E. Grassley, 2 (Aug. 13, 1999).

[30] CMS Form 2567 for Nursing Home in Alamogordo (Mar. 6, 2001) (G-level violation).

condition should have been reported. A condition like this did not occur overnight."[31]

At one nursing home, a resident suffered six fecal impactions in a little more than six months. According to state inspectors, the impactions had "the potential to lead to bowel obstruction and/or death," yet the facility failed to notify the resident's physician of the problem or properly assess the resident's condition.[32]

State inspectors cited several New Mexico nursing homes for failing to properly administer medications.[33] At one facility, state inspectors found that residents were in immediate jeopardy because staff members were improperly administering insulin to diabetic residents. In one instance, the staff administered insulin to a resident whose blood sugar was too low to be receiving insulin. The resident was subsequently observed to be slumped over in her chair and was described in the nurse's notes as "very lethargic and "difficult to arouse." A nurse later admitted to inspectors that "I shouldn't have given the insulin, I should have called the doctor."[34]

State inspectors found other examples of medication being improperly administered:

- At one facility, the staff administered the wrong medication to a resident, who unexpectedly died soon afterwards. It was not known what caused the resident's death. The facility also failed to report the incident to the proper state agencies[35]

- At a second facility, a resident was given three times the physician-prescribed dosage of Baclofen, a muscle relaxant, on 125 occasions over a three-month period. Another resident at the same nursing home did not receive a prescribed depression medication for two months.[36]

New Mexico inspectors also found that nursing homes were not providing proper therapy to residents. At one facility, nurses failed to follow physician orders that a resident be walked by

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[31]CMS Form 2567 for Nursing Home in Portales (Oct. 20, 2000) (G-level violation).

[32]CMS Form 2567 for Nursing Home in Las Cruces (Dec. 14, 2000) (K-level violation).

[33]CMS Form 2567 for Nursing Home in Clovis (Sept. 28, 2000) (D-level violation); CMS Form 2567 for Nursing Home in Hobbs (Sept. 14, 2000) (E-level violation); CMS Form 2567 for Nursing Home in Clovis (Aug. 23, 2000) (E-level violation); CMS Form 2567 for Nursing Home in Las Cruces (Aug. 1, 2000) (E-level violation).

[34]CMS Form 2567 for Nursing Home in Albuquerque (June 21, 2000) (J-level violation).

[35]CMS Form 2567 for Nursing Home in Santa Fe (Jan. 26, 2001) (D-level violation).

[36]CMS Form 2567 for Nursing Home in Gallup (July 12, 2001) (D-level violation).

staff. During the time of the inspection, the resident was only able to walk three steps, even though a physical therapy aide stated that the resident had previously been able to walk 100 feet.[37] At another facility, inspectors examined the therapy received by 15 residents and found that 14 of the residents were not receiving required therapy, including bowel and bladder training. One of the therapy aides said that the treatments did not take place because the facility was short-staffed.[38]

B. Failure to Provide Proper Nutrition and Hydration

Numerous violations cited by New Mexico inspectors involved the failure to provide proper nutrition and hydration. At one nursing home, this failure caused state inspectors to cite the facility for an immediate jeopardy violation. Inspectors found that the facility was giving a renal resident high potassium foods, even though the resident was at risk of a heart attack and was not supposed to eat foods high in potassium.[39]

At the same facility, state inspectors discovered that a resident on a feeding tube was given formula that had been left in the feeding bag for nearly three days. The formula was supposed to be changed every four hours.[40]

State inspectors found several instances in which nursing homes failed to provide appropriate amounts of fluids to residents. For example, at one facility, a resident was supposed to receive 51 oz. of fluids each day, yet was found to be receiving only 20 oz. At the same nursing home, a resident suffering from kidney failure was given almost three times the allowable amount of fluids. Instead of the prescribed 34 oz. of fluids, she was receiving almost 100 oz. This excessive intake of fluids forced the resident to undergo extensive dialysis.[41]

At other facilities, the staff did not provide adequate assistance to residents during meals. In one case, inspectors observed a resident at breakfast dropping her toast on the floor, spilling coffee on herself because the cup was too heavy, putting a sealed pack of jelly in her mouth three times in an attempt to open it, and reaching unsuccessfully for her cereal. Nurse aides in the room made no effort to assist the resident.[42] Because of understaffing at another nursing home, state

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[37]CMS Form 2567 for Nursing Home in Hobbs (July 13, 2000) (G-level violation).

[38]CMS Form 2567 for Nursing Home in Roswell (May 18, 2001) (E-level violation).

[39]CMS Form 2567 for Nursing Home in Albuquerque (June 21, 2000) (K-level violation).

[40]CMS Form 2567 for Nursing Home in Albuquerque (June 21, 2000) (D-level violation).

[41]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (D-level violation).

[42]CMS Form 2567 for Nursing Home in Santa Fe (Jan. 26, 2001) (D-level violation).

inspectors found that residents who needed help with eating were sometimes not assisted until almost two hours after the food trays were brought to the dining room.[43]

At yet another facility, inadequate staffing led to residents being improperly supervised. Three residents assessed as being at risk for aspiration were left alone in the dining room on multiple occasions, once for over 40 minutes.[44]

State inspectors found one nursing home that served its coffee at 170 to 180 degrees even though liquids over 155 degrees can instantly cause first or second degree burns. In fact, one resident was injured when coffee was spilled on his foot. However, instead of lowering the temperature of the coffee, the facility simply put ice in that resident's coffee.[45]

C. Failure to Prevent Falls and Accidents

Many violations involving preventable falls and accidents were documented in the state inspection reports. In the most serious example, New Mexico inspectors found that a facility had placed residents at risk of immediate jeopardy because of its failure to monitor residents who were at risk for falling. During an eight-month period, one resident fell 11 times, seven of which involved facial or head injuries. Another resident fell 17 times in a little more than nine months.[46]

State inspectors found violations involving preventable falls and accidents at other New Mexico nursing homes:

- At one facility, a resident suffered a right hip fracture when she fell while trying to carry a wash basin from her bathroom to her bed. The resident had tried getting a nurse aide to help her retrieve the wash basin, but a nurse aide came into the room, turned off the call light, and failed to assist the resident.[47]

- At another facility, a resident suffered head lacerations after climbing over her bedrails. The nursing home failed to explore other alternatives to the bedrails even though the resident had a history of climbing over them. Inspectors noted that the resident had tried

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[43]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (G-level violation).

[44]CMS Form 2567 for Nursing Home in Silver City (Mar. 10, 2000) (E-level violation).

[45]CMS Form 2567 for Nursing Home in Albuquerque (Apr. 20, 2000) (G-level violation).

[46]CMS Form 2567 for Nursing Home in Las Cruces (Dec. 14, 2000) (H and K-level violations).

[47]CMS Form 2567 for Nursing Home in Clovis (Aug. 16, 2001) (G-level violation).

to get out of bed six times in less than two weeks.[48]

- At a third facility, inspectors heard a resident yelling from her room and found the resident lying on the floor by the bed, with the bedrail down. The resident had a bloody skin tear on her hand. Even though the resident had been assessed as being at "high risk for falls," inspectors found that the nursing home failed to take sufficient steps to evaluate her fall patterns and try to prevent future falls.[49]

New Mexico inspectors found that staffing shortages resulted in residents not being properly supervised. At one nursing home, numerous shifts were staffed by only one nurse aide, and as a result, several residents were involved in accidents causing serious injuries, including a fractured arm, a fractured leg, and a fractured hip. According to state inspectors, these accidents could have been prevented through appropriate supervision.[50]

At the same facility, an aide attempted to transfer a 210 lb. resident with amputated legs from a wheelchair to a shower chair without seeking assistance from another aide. The aide was unable to complete the transfer, and the resident suffered contusions to the ribs and required emergency room treatment.[51]

D. Failure to Prevent or Properly Treat Pressure Sores

The inspection reports documented a wide array of violations involving pressure sores. The violations included: leaving immobile residents in the same position instead of regularly repositioning them, as required by standard medical procedures; failing to provide pressure relieving devices; failing to dress wounds in accordance with physician orders; and failing to maintain the nutritional status of at-risk residents.[52]

At one facility, a resident had three pressure sores on her buttocks. The nurse's notes indicated that the resident should not be left in the wheelchair for more than an hour at a time, yet inspectors observed her on multiple occasions in the same position for long periods of time.

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[48]CMS Form 2567 for Nursing Home in Albuquerque (Apr. 20, 2000) (G-level violation).

[49]CMS Form 2567 for Nursing Home in Clovis (Aug. 23, 2000) (G-level violation).

[50]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (G-level violation).

[51]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (G-level violation).

[52]CMS Form 2567 for Nursing Home in Roswell (Feb. 23, 2001) (G-level violation); CMS Form 2567 for Nursing Home in Las Cruces (Jan. 29, 2001) (D-level violation); CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (D-level violation); CMS Form 2567 for Nursing Home in Hobbs (July 13, 2000) (G-level violation).

Another resident in the same facility had a pressure sore on her left heel, yet contrary to the resident's care plan, the resident's heels were not kept off the mattress. A third resident with pressure sores complained that the staff would "bring [her] to the TV room and leave [her] for two hours," without regularly repositioning her.[53] The resident repeatedly pleaded with state inspectors: "Please have someone take me to bed. I'm hurting so bad."

At another facility, inspectors found that physician orders for treating a resident's pressure sores were not followed. The facility was supposed to change the dressing on the resident's sore every shift, but there was no documentation that this had been done for 29 out of 30 days.[54]

One nursing home failed to provide a physician-prescribed mattress to a bedfast resident with two sores on her ankle and one sore on her hip. The nurse's notes indicated that the wound on the hip was so severe that it would need to be "surgically opened and debrided to prevent a huge abscess from developing in that area."[55]

E. Failure to Protect Residents from Abuse and Mistreatment

The inspection reports contained several examples in which residents were the victims of abuse or mistreatment. At one nursing home, a male resident was found to have put his hand on a female resident's crotch area on more than three occasions and on her breast on one occasion. State inspectors found that the facility failed to report these incidents of abuse to the state licensing and certification agency as required.[56]

At a second facility, one resident was injured when a nurse aide did not prevent another resident from hitting her. An aide assigned to the special care unit alone initially attempted to keep the two residents apart, but when she had to deal with another resident, the male resident struck the female resident on the face, causing a bruise.[57]

F. Improper Use of Restraints

One of the major objectives of the 1987 nursing home law was to end the improper use of physical and chemical restraints. Although progress has been made in this area, the inspection reports documented that improper restraints continue to be a problem in New Mexico nursing homes. State inspectors cited several nursing homes for using physical restraints without medical

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[53]CMS Form 2567 for Nursing Home in Roswell (Feb. 23, 2001) (G-level violation).

[54]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (D-level violation).

[55]CMS Form 2567 for Nursing Home in Roswell (Jan. 17, 2001) (D-level violation).

[56]CMS Form 2567 for Nursing Home in Artesia (Nov. 16, 2000) (E-level violation).

[57]CMS Form 2567 for Nursing Home in Raton (June 2, 2000) (G-level violation).

justification:

- At one facility, residents were restrained in their wheelchairs and beds without any evidence that less restrictive alternatives had been tried or that the residents or their families had given informed consent.[58]

- At another nursing home, inspectors reviewed the records of 28 residents in restraints and found that 13 residents or their families had not given consent for the restraints. Moreover, there was no evidence that the residents or their families had been informed of the risks, benefits, and alternatives.[59]

G. Failure to Properly Clean and Care for Residents

Federal standards require that nursing homes provide residents with "the necessary services to maintain good . . . grooming and personal and oral hygiene."[60] These standards reflect the expectations of families that residents will be properly cared for and cleaned. However, state inspectors found that nursing homes in New Mexico violated even these basic standards.

In the most serious case, one facility failed to disinfect a whirlpool used by many residents, including residents with pressure sores, infections, and incontinence. State inspectors found that this violation constituted a pattern of harm that could cause serious injury or death.[61]

There were many other examples of improper care and cleaning:

- Several residents at one nursing home were given only one shower a month.[62]

- According to family members, residents at another facility were not being showered regularly. Family members also complained that the staff failed to clean residents promptly, leaving the residents sitting in feces and urine.[63]

- State inspectors observed a nurse aide helping to clean a resident soiled with urine and feces. After completing this task and without first washing her own hands, the nurse aide

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[58]CMS Form 2567 for Nursing Home in Albuquerque (July 19, 2000) (D-level violation).

[59]CMS Form 2567 for Nursing Home in Gallup (Apr. 7, 2000) (E-level violation).

[60]42 C.F.R. § 483.25(a)(3).

[61]CMS Form 2567 for Nursing Home in Roswell (Jan. 17, 2001) (K-level violation).

[62]CMS Form 2567 for Nursing Home in Santa Fe (Nov. 2, 2000) (G-level violation).

[63]CMS Form 2567 for Nursing Home in Silver City (Mar. 10, 2000) (E-level violation).

proceeded to wash the resident's face, comb the resident's hair, and touch the area around the resident's eye.[64]

New Mexico nursing homes were also cited for not maintaining the proper environment for residents. A strong urine odor was noted in some facilities.[65] Feces was observed under the mats of two shower stalls in another facility.[66]

At one facility, the temperature was maintained at an uncomfortably warm level. One resident, observed sitting in front of a fan with a wet wash cloth on her forehead, told state inspectors that "the heat affects my breathing and I don't feel well." Another resident stated that it had been so hot in the building that his "shirt was soaked, we were just limp." Another resident complained that "the heat ruins my appetite and it's hard to sleep."[67]

H. Other Violations

Other violations, while not causing immediate physical harm to residents, demonstrated the indifference of some nursing homes to the welfare of residents:

- During the entire time that the state inspectors were at one facility, residents were observed to be sitting for hours at a time in the hallways and dining room with no interaction or planned activities. Residents told inspectors that "after supper they go to bed because there is not much to do."[68]

- At another facility, one resident was able to attend only ten minutes of a church service because the staff failed to get her cleaned. Inspectors observed the resident crying and asking to be cleaned so that she could go to church. It took the staff nearly an hour to respond to her request.[69]

- One facility failed to provide residents with a telephone that would allow for private conversations. The telephone was near a noisy activity room where, as one resident explained, "I have overheard other residents' conversation." On one occasion, several

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[64]CMS Form 2567 for Nursing Home in Clovis (Aug. 16, 2001) (E-level violation).

[65]CMS Form 2567 for Nursing Home in Roswell (Feb. 23, 2001) (E-level violation); CMS Form 2567 for Nursing Home in Silver City (Mar. 10, 2000) (E-level violation).

[66]CMS Form 2567 for Nursing Home in Clovis (Dec. 7, 2000) (D-level violation).

[67]CMS Form 2567 for Nursing Home in Roswell (June 29, 2000) (E-level violation).

[68]CMS Form 2567 for Nursing Home in Roswell (Jan. 17, 2001) (E-level violation).

[69]CMS Form 2567 for Nursing Home in Clovis (Aug. 23, 2000) (D-level violation).

staff members were engaged in conversation while a resident on the phone was repeatedly saying: "Could you repeat that? I can't hear you." The staff members made no effort to stop talking or to transfer the call to a more private line.[70]

- State inspectors observed a resident wearing a gown backwards that left the resident's back and buttocks completely exposed. The resident was observed in this condition for five hours during which time the resident was taken to the dining room for both breakfast and lunch.[71]

V. CONCLUSION

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

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[70]CMS Form 2567 for Nursing Home in Las Cruces (Jan. 29, 2001) (E-level violation).

[71]CMS Form 2567 for Nursing Home in Roswell (May 18, 2001) (E-level violation).