Nursing Home Conditions in the San Francisco Bay Area: Many Homes Fail to Meet Federal Standards for Adequate Care

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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, Reps. Fortney Pete Stark, Anna G. Eshoo, Tom Lantos, Barbara Lee, Zoe Lofgren, George Miller, Nancy Pelosi, Ellen O. Tauscher, and Lynn C. Woolsey asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the San Francisco Bay Area, which comprises the San Francisco, Oakland, San Jose, Vallejo, and Santa Rosa metropolitan areas. There are 288 nursing homes in the Bay Area that accept residents covered by Medicaid or Medicare. These homes serve approximately 22,000 residents. This is the first report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many Bay Area nursing homes. Only 18 nursing homes in the Bay Area were in full or substantial compliance with federal standards during their most recent annual inspection. In contrast, 119 nursing homes in the Bay Area -- more than one out of every three -- had violations 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. 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. State inspectors are instructed to rate the scope and severity of each violation. There are four general categories of violations: (1) violations that have the potential for only minimal harm; (2) violations that have the potential for more than minimal harm; (3) violations that cause actual harm; and (4) violations that cause actual death or have the potential to cause death or serious injury.

This report is based on an analysis of the most recent annual inspections of Bay Area nursing homes. These inspections were conducted from September 1997 to January 2000. When a nursing home was reported to have serious violations, the report examined the results from the prior round of inspections to assess the home's compliance history. The report also examined summaries of recent state citations of Bay Area nursing homes.

Because this report is based on recent annual inspections, the results are representative of current conditions in Bay Area nursing homes as a whole. Conditions in individual homes can change, however. 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

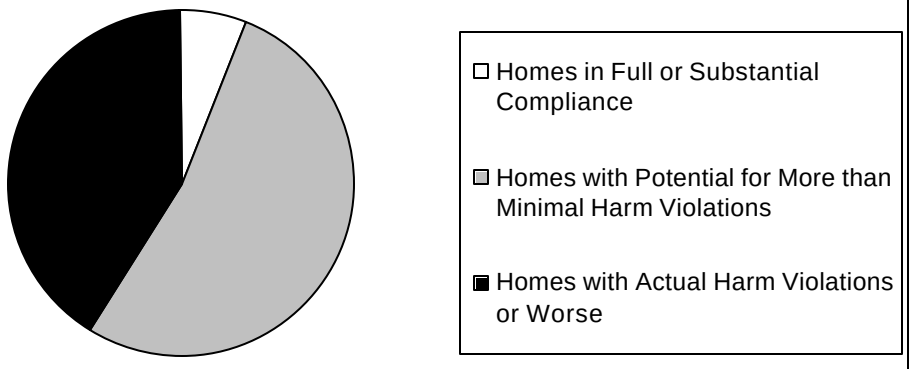
"snapshot" of overall conditions in Bay Area nursing homes, not an analysis of current conditions in any specific home. Conditions could be better -- or worse -- at any individual nursing home today than when the most recent annual inspection was conducted.

B. Findings

Nursing homes in the Bay Area routinely violate federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal standards if no violations are detected during the annual inspection. They will consider a home to be in "substantial compliance" with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 288 nursing homes in the Bay Area, only 18 homes (6.3%) were found to be in full or substantial compliance with the federal standards. The other 270 nursing homes (94%) had at least one violation with the potential to cause more than minimal harm to residents. On average, each of these 270 nursing homes had 13.2 violations of federal quality of care requirements.

Many nursing homes in the Bay Area have violations that cause actual harm to residents. Of the nursing homes in the Bay Area, 119 homes -- more than one out of every three -- 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 the failure to prevent or properly treat pressure sores, preventable accidents, inadequate medical treatment, and the failure to provide proper nutrition or hydration. The most frequently cited violations causing actual harm were the failure to prevent or treat pressure sores and the failure to prevent accidents to residents. These 119 homes with actual harm violations serve 13,419 residents and are estimated to receive $141 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in the San Francisco Bay Area



Many nursing homes in the Bay Area have multiple or repeat violations that cause actual harm. Seventy-six nursing homes in the Bay Area were cited for more than one violation that caused actual harm to residents or had the potential to cause death or serious injury. Moreover, 59 nursing homes had an actual harm violation in the previous year's annual inspection.

An examination of state citations showed serious care problems. Representatives of nursing homes argue that the "overwhelming majority" of nursing homes meet government standards and that many violations causing actual harm are actually trivial in nature. To assess these claims, this report examined summaries of citations issued by the California Department of Health Services to Bay Area nursing homes in 1999. The state citations documented many instances of serious neglect and mistreatment of residents, including untreated pressure sores, preventable accidents, inadequate medical care, and physical and sexual abuse of 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 34.6 million Americans, or 13% of the population.[2] In 25 years, the number of Americans aged 65 and older will increase to 62 million, nearly 20% of the population.[3]

This aging population will increase demands for long-term care. There are currently 1.6 million people living in almost 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives.[5] Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years. The total number of nursing home residents is expected to quadruple from the current 1.6 million to 6.6 million by 2050.[6]

Most nursing homes are run by private for-profit companies. Of the 17,000 nursing homes in

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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 August 1, 1999* (Oct. 1, 1999).

[3]U.S. Census Bureau, *Resident Population of the United States: Middle Series Projections, 2015 - 2030, by Age and Sex* (March 1996).

[4]Testimony of Rachel Block, Deputy Director of HCFA's Center for Medicaid, before the Senate Special Committee on Aging (June 30, 1999).

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

[6]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, 5 (1999).

the United States, over 11,000 (65%) are operated by for-profit companies. In the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up smaller chains and independent homes. The five largest nursing home chains in the United States operated over 2,000 facilities and had revenues of nearly $14 billion in 1998.[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 2000, it is projected that federal, state, and local governments will spend $58.1 billion on nursing home care, of which $44.9 billion will come from Medicaid payments ($27.7 billion from the federal government and $17.2 billion from state governments) and $11.2 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $36 billion ($29.2 billion from residents and their families, $5 billion from insurance policies, and $1.8 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 required nursing homes to "provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[10]

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[7]Thomas J. Cole, *Awash in Red Ink*, Albuquerque Journal, A1 (Aug. 3, 1999).

[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).

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

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

Other researchers have reached similar conclusions. In July 1998, Professor Charlene Harrington of the University of California-San Francisco, a leading nursing home expert, found that the current level of nursing home staffing is "completely inadequate to provide care and supervision."[15] In

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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). Despite this progress, the improper use of physical and chemical restraints continues to be a problem at some nursing homes, as documented in part IV of this report.

[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).

March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to quality of resident care.[16] And in September 1999, the Coalition to Protect America's Elders concluded: "Every day, thousands of frail elderly Americans are endangered by nursing home abuse and neglect that have reached epidemic proportions."[17]

In light of the growing concern about nursing home conditions, Reps. Fortney Pete Stark, Anna G. Eshoo, Tom Lantos, Barbara Lee, Zoe Lofgren, George Miller, Nancy Pelosi, Ellen O. Tauscher, and Lynn C. Woolsey asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in Bay Area nursing homes.[18] This report presents the results of this investigation. It is the first report to comprehensively investigate nursing home conditions in the San Francisco, Oakland, San Jose, Vallejo, and Santa Rosa metropolitan areas.

II. METHODOLOGY

To assess the conditions in Bay Area nursing homes, this report analyzed two sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; and (2) summaries of citations issued by the California Department of Public Health to nursing homes in the San Francisco Bay area.

A. Analysis of the OSCAR Database

To assess the conditions in Bay Area nursing homes, this report analyzed the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of

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[16]HHS Office of Inspector General, *Nursing Home Survey and Certification* (Mar. 1999).

[17]Coalition to Protect America's Elders, *America's Secret Crisis: The Tragedy of Nursing Home Care*, 6 (Sept. 14, 1999).

[18]Rep. Stark represents California's 13th congressional district, which comprises the southwestern portion of Alameda County. Rep. Eshoo represents California's 14th congressional district, which comprises southern San Mateo and northern Santa Clara Counties. Rep. Lantos represents California's 12th congressional district, which comprises part of San Francisco and most of San Mateo County. Rep. Lee represents California's 9th congressional district, which comprises Oakland and Berkeley. Rep. Lofgren represents California's 16th congressional district, which comprises San Jose and the eastern portion of Santa Clara County. Rep. Miller represents California's 7th congressional district, which comprises Vallejo and parts of Solano and Contra Costa Counties. Rep. Pelosi represents California's 8th congressional district, which comprises San Francisco. Rep. Tauscher represents California's 10th congressional district, which comprises the eastern portions of Contra Costa and Alameda Counties. Rep. Woolsey represents California's 6th congressional district which comprises Marin County and the southern portion of Sonoma County.

nursing home inspections.

Operating through the Health Care Financing Administration (HCFA), which administers the federal Medicaid and Medicare programs, HHS contracts with states to conduct annual inspections of nursing homes. During these inspections, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to HCFA, and compiled in the OSCAR database.[19]

HCFA has established a ranking system in order to identify the violations that pose the greatest risk to patients. This ranking system is used by state inspectors, and the rankings are included in the OSCAR database. The rankings are based on the severity (degree of actual harm to patients) and the scope (the number of patients 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 patients) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause "more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And, homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

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

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

This report analyzed the results, as reported in the OSCAR database, of the most recent state inspections of each nursing home in the San Francisco, Oakland, San Jose, Vallejo, and Santa Rosa

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

metropolitan areas. These inspections were conducted between September 1997 and January 2000. 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.

In cases where nursing homes were reported to have violations causing actual harm to residents in the most recent inspection, the report also analyzed the results of the previous inspection of the nursing home. This analysis was undertaken to assess whether there was a pattern of noncompliance at Bay Area nursing homes.

B. Analysis of State Citations

In addition to analyzing the data in the OSCAR database, this report examined summaries of state citations issued by the California Department of Health Services to nursing homes in the Bay Area in 1999. These citations, which carry fines ranging from $100 to $25,000, can be appealed by nursing homes.

These citations are compiled and summarized each year by the California Advocates for Nursing Home Reform (CANHR). Unpublished summaries of citations issued during 1999 were provided to the minority staff by CANHR.

C. Interpretation of Results

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

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

III. NURSING HOME CONDITIONS IN THE SAN FRANCISCO BAY AREA

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

There are 288 nursing homes in the San Francisco Bay Area that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 30,867 beds that were occupied by 22,667 residents during the most recent round of inspections. The majority of these residents, 13,976, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 1,616 residents. Seventy-three percent of the 288 nursing homes in the Bay Area 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

Only one out of every sixteen nursing homes in the Bay Area was found by state inspectors to be in full or substantial compliance with federal standards of care. Only 11 of the 288 nursing homes (3.8%) met all federal requirements during the inspections. Another seven of the 288 nursing homes (2.4%) were in substantial compliance with federal standards, meaning that they had no deficiencies that posed more than a minimal risk of harm.

The rest of the nursing homes in the Bay Area -- 270 out of 288 -- had at least one violation that had the potential to cause more than minimal harm to their residents. Moreover, 119 of these homes had violations that caused actual harm or had the potential to cause death or serious injury. These 119 homes served a total of 13,419 residents. Table 2 summarizes these results.

Table 2: Nursing Homes in the Bay Area Have Numerous Violations that Place Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	11	4%	514
Substantial Compliance (Risk of Minimal Harm)	7	2%	312
Potential for More than Minimal Harm	151	52%	10,126
Actual Harm to Residents	112	39%	11,150
Actual or Potential Death/Serious Injury	7	2%	565

Many nursing homes had multiple violations. During the most recent annual inspections, state inspectors found a total of 3,570 violations in homes that were not in complete or substantial compliance with federal requirements, or an average of 13.2 violations per non-compliant 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 G level or above. As shown in table 2, 119 nursing homes in the Bay Area had violations that fell into this category. Moreover, 76 nursing homes had two or more actual harm violations in their most recent annual inspection, 29 homes had five or more actual harm violations, and 10 homes had 10 or more actual harm violations. In total, 41% of the nursing homes in the Bay Area -- more than one out of every three -- caused actual harm to residents or had the potential to cause death or serious injury. These homes are estimated to receive $141 million in federal and state funds each year.

C. Most Frequently Cited Violations Causing Actual Harm

During the most recent annual inspections, state inspectors cited Bay Area nursing homes for 411 violations causing actual harm to residents or having the potential to cause death or serious injury.

The most frequently cited violation causing actual harm involved pressure sores. Pressure sores are open sores or bruises on the skin (usually on the hips, heels, buttocks, or bony areas) which result from friction or pressure on the skin. Not only are pressure sores painful, but they can lead to infection, increased debilitation, damage to muscle and bone, and even death. According to nursing home experts, good nursing care can often prevent pressure sores through simple precautions, such as regular cleanings, application of ointments and dressings, and frequent turning of residents to relieve pressure on one part of the body. Despite the availability of these precautions, 74 nursing homes in the Bay Area were cited for their failure to ensure that residents do not develop pressure sores or to provide "necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."[21]

The second most common violation at the actual harm level involved accidents to residents, such as falls that cause broken or fractured bones or skin lacerations. Forty-four nursing homes in the Bay Area were cited for violations of the federal requirement that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents."[22]

Another common violation causing actual harm or having the potential to cause death or serious injury involved the failure to provide each resident with the care and services necessary to maintain the highest achievable level of well-being (25 violations cited). Although this is a general category, it can include serious harms such as inadequate or improper medical treatment, failure to assist residents with

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[21] 42 C.F.R. §483.25(c).

[22] 42 C.F.R. §483.25(h).

eating, and failure to clean and bathe residents.[23] Table 3 summarizes these results.

Table 3: Most Common Actual Harm Violations in Bay Area Nursing Homes

Violation	Number of Homes	GAO Description of Health Consequences
Failure to provide each resident with proper treatment to prevent new pressure sores or heal old ones	74	"Without proper care, complications of pressure sores can occur and include pain, infection, increased debilitation, and skin loss with extensive destruction or damage to muscle and bone. The severity can range from skin redness to large wounds that can expose skin tissue and bone."
Failure to provide supervision or assistance devices to prevent accidents	44	"Without appropriate supervision and accident prevention devices, such as alarm devices or external hip protectors, accidental injury may be more likely to occur, especially for bed-bound residents, who are at the highest risk for falls because they may try to get out of bed on their own and fall, which often results in serious injury, such as hip fracture."
Failure to provide each resident with the care and services necessary to maintain the highest achievable level of well-being	25	"The quality of care that residents receive is largely dependent on assessment of their needs and developing and following the plan of care developed to meet these needs."

Other actual harm violations cited frequently include the failure to provide each resident with sufficient fluid intake to maintain proper hydration and health (19 homes cited), the failure to maintain acceptable nutritional status (15 homes cited), and the failure to protect residents against verbal, sexual, physical or mental abuse, corporal punishment, or involuntary seclusion (15 homes cited).

D. Nursing Homes with a History of Noncompliance

Many of the nursing homes found to be causing actual harm to residents in the most recent state inspections have a history of serious noncompliance. Of the 119 nursing homes in the most recent inspections with violations at the actual harm level or higher, 59 homes were also found to have caused actual harm or worse in the immediately preceding inspection. Overall, 20% of the nursing homes in the Bay Area were cited for a violation that caused actual harm or had the potential for death or serious injury in two consecutive annual inspections.

E. Comparison of Nursing Homes in Different Metropolitan Areas

[23]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 18-68.

Appendices A, B, C, D, and E provide information on nursing home conditions in five metropolitan areas within the San Francisco Bay Area. This data shows that many nursing homes in each of these five metropolitan areas fail to comply with federal standards of care.

The Oakland metropolitan area has 112 nursing homes, the most of the five metropolitan areas. Less than 5% of these homes were found to be in full or substantial compliance with federal health and safety standards. During the most recent annual inspections, 44% percent of the nursing homes in Oakland were cited for violations that caused actual harm to residents or placed them at risk of death or serious injury. Of the 50 Oakland homes with actual harm violations, 33 were cited for failing to properly treat or prevent pressure sores.

The San Francisco and San Jose metropolitan areas, which each have about 60 nursing homes, also have many noncompliant homes. In San Francisco, 8% of the nursing homes were found to be in full or substantial compliance with federal health and safety standards, while 44% of the nursing homes were cited for violations that caused actual harm to residents or placed them at risk of death or serious injury. Of the 27 San Francisco homes with actual harm violations, 20 were cited for failing to properly treat or prevent pressure sores.

In San Jose, less than 12% of the nursing homes were found to be in full or substantial compliance with federal health and safety standards, while 23% of the nursing homes were cited for violations that caused actual harm to residents or placed them at risk of death or serious injury.

The Vallejo and Santa Rosa metropolitan areas, while smaller in size than the other three metropolitan areas, had a higher percentage of homes providing substandard quality of care. In Vallejo, only one of the 29 nursing homes was in full or substantial compliance with federal standards, while 62% of homes were cited for violations that caused actual harm to residents or placed them at risk of death or serious injury. Of the 18 Vallejo homes with actual harm violations, 13 were cited for failing to properly treat or prevent pressure sores.

In Santa Rosa, only one of the 25 nursing homes was in full or substantial compliance with federal standards, while 40% of homes were cited for violations that caused actual harm to residents or placed them at risk of death or serious injury.

F. Potential for Underreporting of Violations

The analysis of nursing home violations in this report is based on the data reported to HCFA in the OSCAR database. According to GAO, even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[24] One problem, according to GAO, is that

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

"homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[25] A second problem is that when GAO inspectors accompanied state inspection teams, they found that the state inspectors sometimes missed significant violations, such as unexplained weight loss by residents and failure to prevent pressure sores.[26] Consequently, it is possible that the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN STATE CITATIONS

Representatives for the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[27] 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."[28] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[29]

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

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

[26]*Id.* at 18-19. Federal inspectors also independently inspect a select number of nursing homes after the states have completed their inspections. A recent GAO report found that in 69% of the instances in which this follow-up federal inspection was conducted, federal inspectors found more serious deficiencies than the state inspectors had found. GAO, *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, 9 (Nov. 1999).

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

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

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

"pressure sores, broken bones, severe weight loss, burns, and death."[30] GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe than violations cited in previous or subsequent annual inspections.[31]

This report undertook a similar analysis at the local level. To assess the severity of violations at nursing homes in the Bay Area, the minority staff of the House Government Reform Committee examined summaries of citations issued by the California Department of Health Services in 1999 for violations of nursing home standards that occurred in 1999 or late 1998. The citations contained many examples of neglect and mistreatment of nursing home residents. They indicate that contrary to AHCA's assertions, the violations in Bay Area nursing homes were for serious quality of care problems.

The following discussion summarizes some examples of these violations.

A. Failure to Prevent or Properly Treat Pressure Sores

Many violations documented in the state citations involved the improper prevention and treatment of pressure sores. This is a serious violation because pressure sores, if untreated or not properly treated, can lead to infection, muscle and bone damage, and even death.

Inspectors found a wide array of violations involving pressure sores in Bay Area nursing homes. The violations included: leaving bedridden residents in the same position for hours, instead of regularly repositioning them, as required by standard medical procedures; failing to provide protective padding to residents at risk of developing pressure sores; and failing to properly clean and dress sores.

In one case, an 80-year-old resident developed a Stage III pressure sore on her right ankle. As a result of the facility's failure to properly identify and treat the sore, the sore became infected, and

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[30]GAO, *Nursing Homes: Proposal to Enhance Oversight*, *supra* note 13, at 6.

[31]In another study in August 1999, GAO examined several examples provided by AHCA of serious deficiencies cited by state inspectors that, according to AHCA, were of questionable merit. For those deficiencies which it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against the 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).

the resident's right leg had to be amputated.[32]

In another case, a resident was admitted to a nursing home with three pressure sores. Due to improper care, she developed five more sores, which became severely infected. When the resident was transferred to a hospital, her condition had deteriorated so much that her husband and physician decided that only care and comfort measures would be provided and that aggressive treatment of the sores would not be pursued. She died nine days later.[33]

B. Failure to Provide Proper Medical Care

Many nursing homes also failed to provide basic medical care to their residents. Doctor's instructions were ignored, warning signs were neglected, and necessary medications were not properly administered. Some of these violations resulted in the deaths of nursing home residents. For example:

- Inspectors found that a facility had failed to monitor a resident's feeding tube. As a result, the resident was overfed and later died of cardiopulmonary arrest and aspiration pneumonia.[34]

- A 73-year-old resident was found slumped over in her wheelchair during mealtime by a nurse. The resident was not breathing and had no pulse. Rather than immediately performing CPR on the resident, the nurse wheeled the resident 100 yards down the hall and called 911. The resident suffered extensive brain damage and died.[35]

- A 61-year-old diabetic resident was admitted to a facility following leg surgery. Contrary to physician orders, the facility failed to provide insulin to the resident for over three days and failed to monitor the blood circulation in his leg. As a result, the resident went into a diabetic coma, and his leg had to be amputated.[36]

- One facility had orders to swab a stroke victim's mouth two or three times a day. However, the resident's son testified that whenever he visited his mother that she had a thick brownish substance in her mouth. The resident subsequently died from pneumonia due to aspiration of

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[32]State Citation Issued to Nursing Home in Burlingame (November 1, 1999). Pressure sores are evaluated on a scale ranging from Stage I (least serious) to Stage IV (most serious).

[33]State Citation Issued to Nursing Home in Pleasant Hill (June 2, 1999).

[34]State Citation Issued to Nursing Home in Livermore (July 26, 1999).

[35]State Citation Issued to Nursing Home in Hayward (July 12, 1999).

[36]State Citation Issued to Nursing Home in San Jose (Dec. 21, 1999).

oral secretions.[37]

- A resident complained of pain in her leg and would yell whenever the leg was touched. Although the staff noted that the resident's leg was cold and discolored, the resident's physician was not promptly notified. The condition of the leg worsened over the next few days to the point that it was "red up to the hip, marbled like basket weave, [and] freezing cold." When the resident was finally transferred to the hospital, it was determined that the leg had to be removed at the hip. The family declined to allow the operation, and the resident died.[38]

Inspectors also found that medications were not being properly administered to patients at some homes. One facility failed to provide 70 doses of an inhaler medication to a resident suffering from lung disease.[39] Another facility failed to provide a resident with phenobarbital, an antiseizure medication prescribed by his physician, causing the resident to suffer a seizure.[40]

At one facility, a resident was supposed to have morphine administered at a rate of 2 cc. per hour. However, before the first hour was over, 100 cc. of morphine had already been administered. According to family members, no staff members came in to check on the IV during that hour. The resident was found unconscious and later died.[41]

C. Failure to Prevent Abuse of Residents

Among the most troubling violations found by inspectors at Bay Area nursing homes were allegations of physical and sexual abuse against residents. For example:

- A male nurse aide molested two elderly female residents by putting his finger in their vaginas while bathing them. Both residents told the aide to stop, but in one case he continued the abuse while applying ointment to one of the resident's pelvic area. Inspectors found that the facility had failed to perform a complete background check of the staff member.[42]

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[37]State Citation Issued to Nursing Home in Menlo Park (Sept. 2, 1999).

[38]State Citation Issued to Nursing Home in Palo Alto (Apr. 21, 1999).

[39]State Citation Issued to Nursing Home in Gilroy (June 2, 1999) (this home has subsequently changed its ownership and name).

[40]State Citation Issued to Nursing Home in Mountain View (Dec. 15, 1999).

[41]State Citation Issued to Nursing Home in Saratoga (Aug. 10, 1999).

[42]State Citation Issued to Nursing Home in Walnut Creek (May 3, 1999).

- A nurse aide entered the room of a female resident suffering from senile dementia and found a male staff member on top of the resident with his pants down and the resident's legs spread. The sexual contact was not consensual, and the aide was arrested.[43]

- A 77-year-old resident told inspectors that a nurse aide had pulled her hair, slapped her face, and threw a soiled wet diaper at her head. The aide also held the resident's arm so tight that her arm starting bleeding. When the resident complained that she was "bleeding to death," the aide said, "Good. I hope you do."[44]

- A staff member was observed by three other staff members hitting an 86-year-old resident on the head with a water pitcher, leaving a large bump on the resident's head.[45]

- A 90-year-old female resident complained that a male nurse aide grabbed her arm. When she yelled, the aide squeezed harder, causing a three and a half inch skin tear on the resident's arm. A review of the aide's personnel record indicated that he had engaged in similar conduct with other residents.[46]

Inspectors found that some homes also failed to protect residents against abuse from other residents. For example, one facility did not properly monitor and control an 80-year-old male Alzheimer's resident who exhibited sexual aggressiveness towards female residents over a two-month period. The resident would unbutton the blouses of female residents, touch their breasts, and push them into his room.[47]

D. Failure to Prevent Falls and Accidents

Other serious violations cited by inspectors in the Bay Area involved the failure to prevent falls and accidents. Often, these accidents were the result of staff not taking sufficient precautions when transferring residents. At one home, even though a resident's care plan stated that she was to be transferred by two staff members, a nurse aide attempted to transfer her alone. The nurse aide

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[43]State Citation Issued to Nursing Home in Alameda (Oct. 27, 1999).

[44]State Citation Issued to Nursing Home in San Jose (May 7, 1999).

[45]State Citation Issued to Nursing Home in San Jose (Aug. 10, 1999).

[46]State Citation Issued to Nursing Home in Berkeley (June 10, 1999).

[47]State Citation Issued to Nursing Home in Concord (Oct. 6, 1999).

dropped the resident, resulting in a fractured tibia and fibula.[48]

At another home, an 81-year-old Alzheimer's resident was supposed to use a vest or lap restraint when seated in his wheelchair in order to prevent falls. However, instead of providing one of these devices, the facility attached a seat belt to the wheelchair. The resident was later found unconscious and not breathing, having slid down his wheelchair with the seat belt around his neck. Although paramedics were able to revive the resident, inspectors observed the resident days after the accident using a wheelchair with the same type of seat belt.[49]

E. Failure to Maintain an Acceptable Physical Environment

State inspectors found physical conditions at several homes to be so unacceptable that they created potential health hazards for residents living there.

Inspectors found that some facilities lacked an effective pest control program. For example, a resident of one such home was found with worm larvae infecting her Stage III pressure sore. The staff observed worms crawling on top of the wound and tunneling underneath the wound.[50]

At another facility, ants were found crawling on the face of an 83-year-old resident, moving in and out of her mouth. There were also hundreds of ants on the resident's body and bed where washcloths with food particles had been left.[51]

Inspectors found other types of unacceptable physical conditions at Bay Area homes. For example, the air conditioning at one facility had not worked for six months. The temperature in the residents' rooms ranged from 86.4 degrees to 89.7 degrees, and the facility had only four portable fans for over 65 residents. It was so hot inside the facility that the staff said they were afraid that residents would suffer heat stroke.[52]

F. Failure to Provide Sufficient Staff

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[48]State Citation Issued to Nursing Home in Santa Rosa (Jan. 15, 1999).

[49]State Citation Issued to Nursing Home in Concord (Apr. 12, 1999).

[50]State Citation Issued to Nursing Home in Petaluma (Aug. 19, 1999).

[51]State Citation Issued to Nursing Home in Hayward (Jan. 26, 1999).

[52]State Citation Issued to Nursing Home in Castro Valley (Aug. 6, 1999) (this home has subsequently closed).

Some of the violations cited by inspectors were the result of staff shortages. At one facility, the staff stopped coming to work because their paychecks were bouncing. When inspectors visited the home, they found only four staff members caring for 69 residents. According to inspectors, the scene was "chaotic and unorganized," and the residents were "frightened and withdrawn." Numerous residents were left in feces and urine-soaked diapers all day, and one confused resident was found wandering outside the facility. Inspectors also discovered that the home's administrator did not have a clear idea of how many staff would be reporting on a daily basis.[53]

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 Bay Area nursing homes has been poor. Many nursing homes in Bay Area are failing to provide the care that the law requires and that families expect.

[53]State Citation Issued to Nursing Home in Castro Valley (Aug. 23, 1999) (this home has subsequently closed).

APPENDIX A
Nursing Home Conditions in the San Francisco Metropolitan Area

	San Francisco Metropolitan Area
Number of Homes	62
Number of Residents	6,141
Homes in Complete Compliance (% of Total Homes)	4 (6%)
Homes in Substantial Compliance (% of Total Homes)	1 (2%)
Homes Not in Complete or Substantial Compliance	57 (92%)
Homes with Potential to Harm Violations (% of Total Homes)	30 (48%)
Homes with Actual Harm Violations (% of Total Homes)	26 (42%)
Homes with Immediate Jeopardy Violations (% of Total Homes)	1 (2%)
Average Number of Violations Per Non-compliant Home	9.3
Actual Harm Violations	
Homes with 2 or More Actual Harm Violations (% of Total Homes)	13 (21%)
Homes with 5 or More Actual Harm Violations (% of Total Homes)	5 (8%)
Homes with Actual Harm Violations in Each of the Last 2 Annual Inspections (% of Total Homes)	11 (18%)

Source: March 2000 OSCAR database

APPENDIX B
Nursing Home Conditions in the Oakland Metropolitan Area

	Oakland Metropolitan Area
Number of Homes	112
Number of Residents	7,516
Homes in Complete Compliance (% of Total Homes)	2 (2%)
Homes in Substantial Compliance (% of Total Homes)	2 (2%)
Homes Not in Complete or Substantial Compliance	108 (97%)
Homes with Potential to Harm Violations (% of Total Homes)	58 (52%)
Homes with Actual Harm Violations (% of Total Homes)	49 (44%)
Homes with Immediate Jeopardy Violations (% of Total Homes)	1 (1%)
Average Number of Violations Per Non-compliant Home	13.9
Actual Harm Violations	
Homes with 2 or More Actual Harm Violations (% of Total Homes)	34 (30%)
Homes with 5 or More Actual Harm Violations (% of Total Homes)	13 (12%)
Homes with Actual Harm Violations in Each of the Last 2 Annual Inspections (% of Total Homes)	26 (23%)

Source: March 2000 OSCAR database

APPENDIX C
Nursing Home Conditions in the San Jose Metropolitan Area

	San Jose Metropolitan Area
Number of Homes	60
Number of Residents	5,239
Homes in Complete Compliance (% of Total Homes)	3 (5%)
Homes in Substantial Compliance (% of Total Homes)	4 (7%)
Homes Not in Complete or Substantial Compliance	53 (88%)
Homes with Potential to Harm Violations (% of Total Homes)	39 (65%)
Homes with Actual Harm Violations (% of Total Homes)	13 (22%)
Homes with Immediate Jeopardy Violations (% of Total Homes)	1 (2%)
Average Number of Violations Per Non-compliant Home	12.5
Actual Harm Violations	
Homes with 2 or More Actual Harm Violations (% of Total Homes)	8 (13%)
Homes with 5 or More Actual Harm Violations (% of Total Homes)	2 (3%)
Homes with Actual Harm Violations in Each of the Last 2 Annual Inspections (% of Total Homes)	3 (5%)

Source: March 2000 OSCAR database

APPENDIX D
Nursing Home Conditions in the Vallejo - Fairfield - Napa Metropolitan Area

	Vallejo - Fairfield - Napa Metropolitan Area
Number of Homes	29
Number of Residents	2,023
Homes in Complete Compliance (% of Total Homes)	1 (3%)
Homes in Substantial Compliance (% of Total Homes)	0
Homes Not in Complete or Substantial Compliance	28 (97%)
Homes with Potential to Harm Violations (% of Total Homes)	10 (35%)
Homes with Actual Harm Violations (% of Total Homes)	16 (56%)
Homes with Immediate Jeopardy Violations (% of Total Homes)	2 (7%)
Average Number of Violations Per Non-compliant Home	19.8
Actual Harm Violations	
Homes with 2 or More Actual Harm Violations (% of Total Homes)	17 (59%)
Homes with 5 or More Actual Harm Violations (% of Total Homes)	8 (28%)
Homes with Actual Harm Violations in Each of the Last 2 Annual Inspections (% of Total Homes)	13 (45%)

Source: March 2000 OSCAR database

APPENDIX E
Nursing Home Conditions in the Santa Rosa Metropolitan Area

	Santa Rosa Metropolitan Area
Number of Homes	25
Number of Residents	1,790
Homes in Complete Compliance (% of Total Homes)	1 (4%)
Homes in Substantial Compliance (% of Total Homes)	0
Homes Not in Complete or Substantial Compliance	24 (96%)
Homes with Potential to Harm Violations (% of Total Homes)	14 (56%)
Homes with Actual Harm Violations (% of Total Homes)	8 (32%)
Homes with Immediate Jeopardy Violations (% of Total Homes)	2 (8%)
Average Number of Violations Per Non-compliant Home	11.5
Actual Harm Violations	
Homes with 2 or More Actual Harm Violations (% of Total Homes)	4 (16%)
Homes with 5 or More Actual Harm Violations (% of Total Homes)	1 (4%)
Homes with Actual Harm Violations in Each of the Last 2 Annual Inspections (% of Total Homes)	6 (24%)

Source: March 2000 OSCAR database