Nursing Home Conditions in Chicago:
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. Janice D. Schakowsky, Bobby L. Rush, and Rod R. Blagojevich asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the Chicago metropolitan area. There are 290 nursing homes in the Chicago metropolitan area that accept residents covered by Medicaid or Medicare. These homes serve approximately 38,000 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 Chicago nursing homes. Only 21% of the nursing homes in Chicago were in full or substantial compliance with federal standards during their most recent annual inspection. Moreover, 15% percent of the nursing homes in Chicago -- more than one out of every seven -- 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 nursing homes in the Chicago metropolitan area, which comprises Cook, DuPage, and McHenry Counties. These inspections were conducted from July 1998 to January 2000. When a nursing home was reported to have serious violations, the report also examined the results from the prior round of inspections to assess the home's compliance history.

Because this report is based on recent annual inspections, the results are representative of current conditions in Chicago 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 Chicago nursing homes, not an analysis of current conditions in any specific home. Conditions could be better -- or worse -- at any

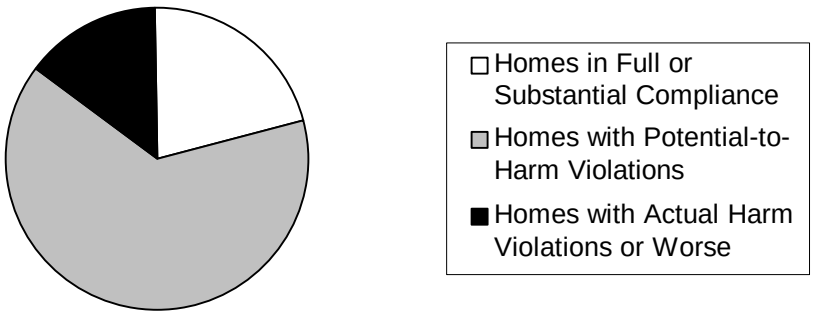
individual nursing home today than when the most recent annual inspection was conducted.

B. Findings

Nursing homes in Chicago 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 290 nursing homes in Chicago, only 61 homes (21%) were found to be in full or substantial compliance with the federal standards. In contrast, 229 nursing homes (79%) had at least one violation with the potential to cause more than minimal harm to residents. On average, each of these 229 nursing homes had 5.5 violations of federal quality of care requirements.

Many nursing homes in Chicago have violations that cause actual harm to residents. Of the 290 nursing homes in Chicago, 43 homes -- more than one out of seven -- 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, malnutrition, inadequate medical treatment, and preventable accidents. The most frequently cited violations causing actual harm were the failure to prevent or treat pressure sores and malnutrition. These 43 homes serve 6,780 residents and are estimated to receive $75 million each year in federal and state funds.

Figure 1: Compliance Status of Nursing Homes in Chicago



Many nursing homes in Chicago have multiple or repeat violations that cause actual harm. Eleven nursing homes in Chicago were cited for more than one violation that caused actual harm to residents or had the potential to cause death or serious injury. Moreover, 17 nursing homes --

40% of the 43 homes cited for actual harm violations in the most recent annual inspection -- also had an actual harm violation in the previous year's inspection.

An examination of a representative sample of homes with violations that cause actual harm 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 in detail the inspection reports from a sample of homes that had been cited for serious violations. The state inspections documented that the actual harm violations were for serious neglect and mistreatment of residents, including untreated pressure sores, severe weight loss, improper use of restraints, and preventable accidents. Moreover, the state inspections documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

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

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 34.6 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 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

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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).

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]

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

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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).

regulatory requirements are codified at 42 C.F.R. Part 483.

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

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

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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).

[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).

In light of the growing concern about nursing home conditions, Reps. Schakowsky, Rush, and Blagojevich, asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in Chicago nursing homes. This report presents the results of this investigation. It is the first report to comprehensively investigate nursing home conditions in the Chicago metropolitan area.

II. METHODOLOGY

To assess the conditions in Chicago 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) actual state inspection reports from a sample of nursing homes in the Chicago metropolitan area.

A. Analysis of the OSCAR Database

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.[18]

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.

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[18]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/nursing/home.asp) where the public can obtain data about individual nursing homes.

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 Chicago metropolitan area. These inspections were conducted between July 1998 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 Chicago nursing homes.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR database, this report analyzed a sample of the actual inspection reports prepared by state investigators surveying nursing homes in Chicago. These inspection reports, prepared on a HCFA form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

The minority staff selected for review the inspection reports from a sample of 33 nursing homes in Chicago. This sample comprised: (1) the nine homes in the congressional districts of Rep. Schakowsky, Rush, and Blagojevich that had been cited for actual harm violations during their most recent state inspection; and (2) an additional sample of 24 randomly selected homes that had been cited either for actual harm violations or multiple violations that had the potential to cause more than minimal harm.[19] For each of these 33 homes, the staff obtained the most recent state inspection report from the Illinois Department of Public Health. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

[19]This sample of 33 homes was based on the most recent annual inspections conducted between June 1998 and October 1999. Between the time this sample was selected by the minority staff and the issuance of this study, new annual inspections were conducted for a few of the 33 homes. These additional inspection reports also have been included in this study.

The results presented in this report are representative of current conditions in Chicago 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 Chicago. 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 CHICAGO

There are 290 nursing homes in the Chicago metropolitan area that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 49,150 beds that were occupied by 37,888 residents during the most recent round of inspections. The majority of these residents, 25,427, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 2,791 residents. Sixty-eight percent of the 290 nursing homes in Chicago 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 five nursing homes in Chicago was found by the state inspections to be in full or substantial compliance with federal standards of care. Only 31 of the 290 nursing homes (11%) met all federal requirements during the inspections. Another 30 of the 290 nursing homes (10%) 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 Chicago -- 229 out of 290 -- had at least one violation that had the potential to cause more than minimal harm to their residents. Forty-three homes had violations that caused actual harm or had the potential to cause death or serious injury. These 43 homes serve a total of 6,780 residents. Table 2 summarizes these results.

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

Table 2: Nursing Homes in Chicago 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)	31	11%	2,593
Substantial Compliance (Risk of Minimal Harm)	30	10%	3,546
Potential for More than Minimal Harm	186	64%	24,969
Actual Harm to Residents	42	14%	6,571
Actual or Potential Death/Serious Injury	1	0.3%	209

Many nursing homes had multiple violations. During the most recent annual inspections, state inspectors found a total of 1,262 violations in homes that were not in complete or substantial compliance with federal requirements, or an average of 5.5 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 the G-level or above. As shown in table 2, 43 nursing homes in Chicago had violations that fell into this category. Eleven nursing homes had two or more actual harm violations. In total, 15% of the nursing homes in Chicago -- more than one out of every seven -- caused actual harm to residents or had the potential to cause death or serious injury. These homes are estimated to receive over $75 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 Chicago nursing homes for 55 violations causing actual harm to residents or having the potential to cause death or serious injury. These 55 violations fell into 18 different deficiency areas.

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, 15 nursing homes in Chicago 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 failure to provide adequate nutrition to residents. Under federal regulations, nursing homes must ensure that a resident "[m]aintains acceptable parameters of nutritional status, such as body weight and protein levels" and "[r]eceive[s] a therapeutic diet when there is a nutritional problem."[22] Chicago nursing homes were cited for eight actual harm violations in this category.

Another frequently cited 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. Seven Chicago nursing homes were cited for this violation. Although this is a general violation, it can include serious harms such as failure to provide appropriate medical treatment, failure to assist residents with eating, and failure to clean and bathe residents.

In addition, six nursing homes were cited for failing to ensure that residents receive proper supervision and assistance devices to prevent accidents. Table 3 summarizes these results.

[21]42 C.F.R. §483.25(c).

[22]42 C.F.R. §483.25(i).

Table 3: Most Common Actual Harm Violations in Chicago 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	15	"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 maintain acceptable nutritional status	8	"Residents who receive insufficient nutrition to maintain body weight may be more susceptible to increase rates of infection, skin breakdown, cognitive impairment, and premature mortality."
Failure to provide each resident with the care and services necessary to maintain the highest achievable level of well-being	7	"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."
Failure to provide supervision or assistance devices to prevent accidents	6	"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."

Other actual harm violations cited more than once were: failure to provide services that meet professional standards of quality; failure to provide appropriate treatment and services to prevent a decline in each resident's abilities; and failure to keep residents free from physical restraints.

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 43 nursing homes in the most recent inspections with violations at the actual harm level or higher, 17 homes were also found to be causing actual harm or worse in the immediately preceding inspection. Overall, 6% of the nursing homes in Chicago were cited for a violation that caused actual harm or had the potential for death or serious injury in two consecutive annual inspections.

E. Potential for Underreporting of Violations

The minority staff's analysis of the prevalence of nursing home violations was 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."[23] One problem, according to GAO, was that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."[24] A second problem was 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.[25] 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 THE INSPECTION REPORTS

Representatives for the nursing home industry have alleged that the actual harm violations cited by state inspectors are often insignificant. The American Health Care Association (AHCA), which represents for-profit nursing homes, has stated that the "overwhelming majority of nursing facilities in America meet or exceed government standards for quality."[26] 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."[27] As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.[28]

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

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

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

[25]*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).

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

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

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

death."[29] 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.[30]

This report undertook a similar analysis at the local level. To assess the severity of violations at Chicago nursing homes, the minority staff examined the state inspection forms for a sample of 33 nursing homes in Chicago with a deficiency of G-level or above or with multiple violations at the D, E, and F levels. These inspection forms contained numerous examples of neglect and mistreatment of residents. The violations documented in the reports included untreated pressure sores, severe weight loss, failure to clean and care for residents, failure to provide proper medical care, improper use of restraints, and preventable accidents.

One of the most disturbing findings from the review of the inspection reports was that the serious violations were not limited to violations cited at the G-level and above. To the contrary, many of the violations classified as having a "potential for more than minimal harm" (violations at the D, E, or F levels) involved conditions and mistreatment that would be regarded by most families of residents as unacceptable. The severity of these violations indicates that serious deficiencies can exist even at nursing homes that are not cited for actual harm violations.

The following discussion summarizes examples of the potential-to-harm and actual harm violations documented in the inspection reports reviewed by the minority staff.

A. Failure to Prevent or Properly Treat Pressure Sores

Many violations documented in the inspection reports 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 Chicago nursing homes. The violations included: leaving bedridden residents in the same position for hours,

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[29]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 2. 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]GAO, *Nursing Homes: Proposal to Enhance Oversight, supra* note 13, at 6.

instead of regularly repositioning them, as required by standard medical procedures;[31] failing to provide protective padding to residents at risk of developing pressure sores;[32] and failing to properly clean and dress sores.[33]

In one case, a nursing home left some residents to provide their own care for pressure sores. An 84-year-old resident told inspectors that "she changes her own dressing because the nurses do not want to change the dressing," causing the sores to worsen. Another resident at the same home had some sores which had no dressing at all and other sores that had dressings that had not been changed in so long that they had a "foul odor." On weekends, the facility had no nurse at all to provide treatments for pressure sores.[34]

At another home, a resident developed serious pressure sores because the staff had left an immobilizer on her leg for 15 weeks -- nine weeks longer than her physician had prescribed.[35]

B. Inadequate Nutrition

Some of the most serious violations cited by inspectors in Chicago involved the failure to provide proper nutrition to residents. For example:

- At one home, inspectors found a resident who weighed just 68 lbs -- barely half of the resident's ideal body weight. Although this resident's weight had dropped from 96 lbs. to 68 lbs in just one month, the home did not contact the resident's physician until the inspectors intervened. When the physician was finally contacted, he ordered that the resident be hospitalized.[36]

- At another home, inspectors found residents who weighed up to 70 lbs. below their ideal body weight. Despite their low weight, the residents were not assisted by staff members in

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[31]HCFA Form 2567 for Nursing Home in Bensenville (Oct. 1, 1998) (E-level violation); HCFA Form 2567 for Nursing Home in Oak Park (Nov. 19, 1998) (D-level violation).

[32]HCFA Form 2567 for Nursing Home in Chicago (Feb. 4, 1999) (G-level violation); HCFA Form 2567 for Nursing Home in Oak Park (Nov. 19, 1998) (D-level violation).

[33]HCFA Form 2567 for Nursing Home in Chicago (Feb. 4, 1999) (G-level violation); HCFA Form 2567 for Nursing Home in Palos Heights (Oct. 1, 1998) (D-level violation).

[34]HCFA Form 2567 for Nursing Home in Chicago (Apr. 15, 1999) (D-level violation).

[35]HCFA Form 2567 for Nursing Home in Lansing (June 4, 1999) (G-level violation).

[36]HCFA Form 2567 for Nursing Home in Chicago (Aug. 21, 1998) (G-level violation).

eating, nor did the staff provide any encouragement to the residents in eating.[37]

State inspectors frequently observed instances where nursing homes failed to assist needy residents during eating. In one case, a resident who had difficulty grasping utensils could not bring food to his mouth. Inspectors observed him trying to eat lunch "but . . . raking the food into his lap." Staff members made no effort to help him until, after 45 minutes, they were prompted by inspectors.[38]

In other cases, the homes did not thicken liquids for residents with swallowing problems,[39] failed to feed residents at the proper angle,[40] did not take appropriate precautions to prevent aspiration,[41] and neglected to give residents recommended nutritional supplements for months.[42]

C. 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."[43] These standards reflect the expectations of families that residents will be properly cared for and cleaned. The inspection reports documented, however, that even this basic level of care was not being provided in many Chicago nursing homes.

At one home, a resident was observed wearing the same soiled and urine-soaked clothing for three consecutive days. When the state inspectors investigated, they learned that the resident had not been showered in three weeks. The resident's roommate told inspectors that "the room window needs to be opened in order to air out the foul smell in the room." At this home, inspectors discovered at least five other residents who had not been showered in over two

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[37]HCFA Form 2567 for Nursing Home in Chicago (Apr. 22, 1999) (E-level violation). One resident who should have weighed between 117 and 146 lbs. weighed only 84 lbs.; another resident who should have weighed between 171 and 209 lbs. weighed only 103 lbs.; and another resident who should have weighed between 112 and 138 lbs. weighed only 82 lbs.

[38]HCFA Form 2567 for Nursing Home in Chicago (July 15, 1999) (E-level violation).

[39]HCFA Form 2567 for Nursing Home in Chicago (May 21, 1999) (G-level violation).

[40]HCFA Form 2567 for Nursing Home in Bridgeview (May 20, 1999) (D-level violation).

[41]HCFA Form 2567 for Nursing Home in Chicago (May 6, 1999) (D-level violation).

[42]HCFA Form 2567 for Nursing Home in Des Plaines (March 25, 1999) (G-level violation).

[43]42 C.F.R. §483.25(a)(3).

weeks.[44]

The inspection reports contained numerous other instances of improper care and cleaning of residents. For example:

- Inspectors observed residents smelling of "foul urine odor" and wearing "visibly stained" clothes;[45] residents with "dirty, long fingernails," "eyes with dry matted material," and "dry crusty material around the mouth";[46] and residents pacing the hallway with soiled clothes and no underwear.[47]

- A resident at one home was found sitting in the dining room wearing pants and socks wet with urine. A "puddle" of urine was under the resident's chair. Later in the day, the resident was observed in the dining room wearing the same urine-soaked socks and slippers, even after the staff had purportedly changed the resident's clothes.[48]

- A common shower and tub room used by residents at one home was observed to have "an odor of feces; brown feces looking lumps; and . . . brown smears."[49]

These violations sometimes created risks of spreading infectious diseases. For example, at one home, inspectors found linens that had come in contact with residents with infectious diseases being placed next to clean linens for other residents. Staff at this home also failed to wash their hands after handling soiled linens.[50]

D. Failure to Provide Proper Medical Care

In addition to failing to provide basic cleaning and bathing care for residents, the nursing homes in the sample also sometimes failed to provide necessary proper medical care. Doctor's instructions were ignored, warning signs were neglected, and necessary medications were not properly administered.

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[44]HCFA Form 2567 for Nursing Home in Chicago (Feb. 4, 1999) (E-level violation).

[45]HCFA Form 2567 for Nursing Home in Oak Park (Nov. 19, 1998) (E-level violation).

[46]HCFA Form 2567 for Nursing Home in Chicago (Dec. 10, 1998) (E-level violation).

[47]HCFA Form 2567 for Nursing Home in Chicago (Apr. 22, 1999) (D-level violation).

[48]HCFA Form 2567 for Nursing Home in Bensenville (Oct. 1, 1998) (D-level violation).

[49]HCFA Form 2567 for Nursing Home in Chicago (Nov. 19, 1998) (D-level violation).

[50]HCFA Form 2567 for Nursing Home in Chicago (Dec. 23, 1998) (D-level violation).

For example, at one facility state inspectors found several examples of inadequate medical care. According to the inspectors, swelling in a resident's foot was not properly monitored, and as a result the resident was later hospitalized and died of heart failure. Another resident was not provided pain medication after all his top teeth had been extracted. A third resident injured his elbow, losing control of his hand, fingers, and wrist, yet the facility failed to follow a physician's orders to provide physical therapy for the resident. And, when another resident repeatedly vomited a green substance, the staff did not promptly call a physician or check vital signs; the resident was later admitted to the hospital with pneumonia and pancreatitis.[51]

At another nursing home, inspectors found a resident with a large, gaping wound on her abdomen that was leaking bile drainage on her clothes and bed. Upon investigation, the inspectors found that the resident's dressing was "haphazardly done" because staff had allowed the resident to change her own dressings, even though there had been no authorization from a doctor. The failure to properly care for the wound caused tremendous pain. The resident said: "I was in so much pain, I was miserable. . . . My skin is burning right now from this bile drainage."[52]

Other homes were cited for failure to provide prescribed medications[53] and administering the wrong dosages of drugs to residents.[54]

E. Improper Use of Physical and Chemical 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. For example, at one home, inspectors found 23 residents in physical restraints. In many cases, these restraints had been applied in violation of federal standards because less restrictive alternatives had not been considered.[55]

At another facility, inspectors reviewed the records of 12 residents taking anti-psychotic medications. In seven of the cases, inspectors concluded that the facility had not taken steps to reduce medication use, despite the fact that the residents were not exhibiting behavioral problems

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[51]HCFA Form 2567 for Nursing Home in Chicago (Oct. 29, 1999) (G-level violation).

[52]HCFA Form 2567 for Nursing Home in Chicago (Apr. 15, 1999) (G-level violation).

[53]HCFA Form 2567 for Nursing Home in Chicago (Aug. 21, 1998) (D-level violation).

[54]HCFA Form 2567 for Nursing Home in Chicago (March 19, 1999) (D-level violation).

[55]HCFA Form 2567 for Nursing Home in Chicago (Apr. 15, 1999) (G-level violation).

warranting continued use of the same drug dosages.[56]

F. Failure to Prevent Falls and Accidents

Preventable falls and accidents were another common type of violation documented in the state inspection reports. Often, these accidents were the result of staff trying to transfer patients by themselves, instead of seeking assistance from other staff members:

- In one case, an 80-year-old resident suffering from Parkinson's disease fractured her femur when a nurse aide improperly attempted to transfer her without assistance and trapped her leg in the foot pedals of a wheelchair. In two other cases at the same facility, residents injured their arms and shoulders when nurse aides tried to transfer them in and out of bed without first getting assistance from another staff member.[57]

- A resident at another facility fell to the floor while being transferred by a staff member from his bed to a chair. The resident sustained a one-inch laceration on his left eyebrow and a three-inch laceration on his right forehead. The forehead laceration required 36 stitches.[58]

- At another facility, a resident fell three times on three consecutive days, once fracturing her nose, because the facility did not take sufficient precautions to prevent accidents.[59]

Inspectors also found homes which failed to take adequate precautions to prevent residents from leaving the facility:

- An 84-year-old resident who suffered from Alzheimer's disease was found missing from a nursing home one evening. The facility, which had "high risk dementia residents with wandering behaviors," was located on a "very heavily traveled street" without sidewalks. The police found the resident a mile and a half away, with injuries sustained from climbing over a fence.[60]

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[56]HCFA Form 2567 for Nursing Home in Indian Head Park (Nov. 18, 1999) (E-level violation).

[57]HCFA Form 2567 for Nursing Home in Bensenville (Oct. 1, 1998) (G-level violation).

[58]HCFA Form 2567 for Nursing Home in Niles (Oct. 20, 1999) (G-level violation).

[59]HCFA Form 2567 for Nursing Home in Indian Head Park (Oct. 30, 1998) (G-level violation).

[60]HCFA Form 2567 for Nursing Home in Homewood (Aug. 26, 1999) (J-level violation).

- At another facility, staff heard the alarm from an exterior door being opened at 2:45 a.m. but did not take sufficient steps to determine whether any residents had left the facility. Later that morning, an 86-year-old resident suffering from dementia was found by police wandering along a busy street 200 yards from the facility.[61]

G. Other Violations

Other violations, while not necessarily causing immediate harm to residents, exemplified the disregard sometimes displayed towards residents. In many cases, the indifferent attitudes documented in the reports occurred despite the fact that state inspectors were on-site observing conditions in the homes.

For example, at one facility state inspectors heard a resident calling out from her room, "Help me! Somebody please come and help me." Although the inspectors observed two staff members in the area, the staff did not respond to the resident's cries. After five minutes, the inspectors checked on the resident and discovered the resident "wedged between a bed rail and mattress."

Earlier that same day, the inspectors had checked the response of the home's staff to resident call lights. When the call light in one of the rooms was activated by an inspector, there was no response at all. The inspector walked to the nurse's station and observed no one monitoring the system. While the call light was still on, a nurse walked into the station but did not respond to the activated light.[62]

In other homes, state inspectors documented a wide range of indifference towards the well-being of residents. For example:

C Inspectors were told by a bedridden resident that at night "when the call light is turned on, staff will come in, turn off the light, and leave without meeting the request."[63]

C Inspectors observed a resident who was being isolated as a medical precaution "in essentially the same position in bed without any form of stimulation or entertainment available" for three days. The resident had no visitors or in-room activities and "[n]ot even a radio or television was on in the room during the three days."[64]

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[61]HCFA Form 2567 for Nursing Home in Bensenville (Nov. 19, 1999) (G-level violation).

[62]HCFA Form 2567 for Nursing Home in Lansing (June 4, 1999) (D-level violation).

[63]HCFA Form 2567 for Nursing Home in Indian Head Park (Oct. 30, 1998) (D-level violation).

[64]HCFA Form 2567 for Nursing Home in Niles (Sept. 3, 1998) (D-level violation).

C Inspectors observed a blind resident being wheeled to the day room by staff for morning activities. The blind resident was "positioned at table and asked to color a picture." When the resident stated, "I can't do that," the staff member colored the picture for the resident.[65]

C Inspectors observed construction workers doing work in a room occupied by residents. Although dust was being created by the work and the workers were wearing face masks, the residents were neither moved from the room nor even provided face masks.[66]

In yet other cases, the violations involved -- or had the potential to involve -- physical abuse of residents. For example:

- Inspectors found that a facility failed to report allegations of staff abuse against a resident. Although the resident had been checked for bruises caused by abuse on two occasions, state authorities were not notified of these incidents in violation of legal requirements. On a third occasion, a staff member actually observed the resident being slapped by another staff member but did not notify anyone of the incident.[67]

- Inspectors discovered that a facility had hired a nurse aide who had been convicted of battery and sentenced to six months in prison. The facility claimed that the state had issued a waiver allowing for the nurse aide to be hired. When inspectors checked with the state, it was revealed that no such waiver had been issued.[68]

H. Inadequate Staffing

An underlying cause of many of the violations was inadequate staffing. At one home, for example, a single nurse aide was left to care for an entire floor of 68 residents in the middle of the afternoon. As a result of staff shortages, residents with pressure sores were left in the same position and in soiled diapers for hours, "stool incontinence . . . oozing out on legs." Inspectors also found that range of motion exercises and orthotic devices were not provided; food delivery was so slow that residents had to eat cold food; and feeding tubes were not monitored resulting in inadequate nutrition.

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[65]HCFA Form 2567 for Nursing Home in Chicago (Nov. 19, 1998) (E-level violation).

[66]HCFA Form 2567 for Nursing Home in Palos Heights (Oct. 1, 1998) (D-level violation).

[67]HCFA Form 2567 for Nursing Home in Niles (Sept. 3, 1998) (D-level violation).

[68]HCFA Form 2567 for Nursing Home in Palos Heights (Nov. 24, 1999) (D-level violation).

Prompted by this incident, inspectors reviewed the home's records and found that on at least 40 previous occasions, the floor's day shift was staffed by only two nurses, and on two occasions, a nurse was staffing the shift alone. Nurses interviewed by the inspectors indicated that when only two nurses were working, "they are doing medication passes only, and that it's not humanly possible to do treatments also." Even though the understaffing had existed for a year, the home had done nothing to alleviate the problem.[69]

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 Chicago nursing homes has been poor. This report reviewed the OSCAR database and a sample of actual state inspection reports. The same conclusion emerges from both analyses: many nursing homes in Chicago are failing to provide the care that the law requires and that families expect.

[69]HCFA Form 2567 for Nursing Home in Bridgeview (May 20, 1999) (H-level violation).