



**Nursing Home Conditions in Oklahoma:
Many Homes Fail to Meet Federal Standards for Adequate Care**

Prepared for Rep. Brad Carson

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U.S. House of Representatives**

April 9, 2001

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EXECUTIVE SUMMARY

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

To address these growing concerns, Rep. Brad Carson asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in Oklahoma. There are 393 nursing homes in Oklahoma that accept residents covered by Medicaid or Medicare. These homes serve 23,791 residents. This is the first congressional report to evaluate their compliance with federal nursing home standards.

The report finds that there are serious deficiencies in many of the nursing homes in Oklahoma. Over 85% of the nursing homes in Oklahoma violated federal health and safety standards during recent state inspections. Moreover, 17% of the nursing homes in Oklahoma -- more than one out of every six nursing homes -- 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 and to investigate nursing home complaints. These inspections assess whether nursing homes are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents.

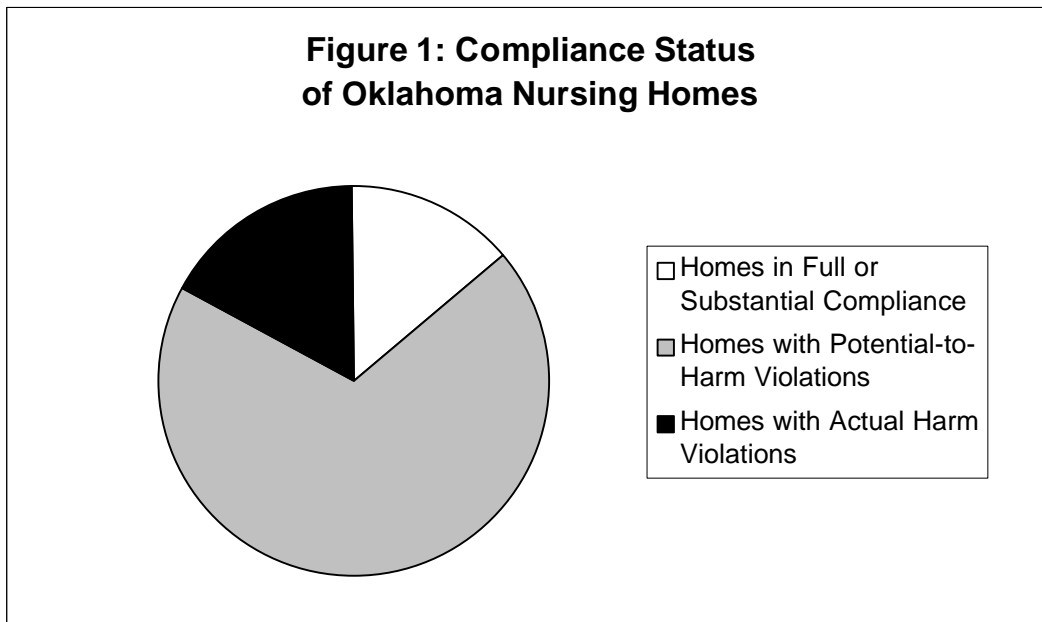
This report is based on an analysis of these state inspections. It examines the most recent annual inspections of nursing homes in Oklahoma, conducted from March 1999 to December 2000. In addition, the report examines the results of any complaint investigations conducted during this time period.

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

B. Findings

Most nursing homes in Oklahoma violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health and safety standards if no violations are detected during the annual inspection or complaint investigation. They consider a home to be in “substantial compliance” with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 393 nursing homes in Oklahoma, only 56 homes (14%) were found to be in full or substantial compliance with the federal standards. In contrast, 337 nursing homes (86%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 337 nursing homes had 7.5 violations of federal quality of care requirements.

Many Oklahoma nursing homes had violations that caused actual harm to residents. Of the 393 nursing homes in Oklahoma, 68 facilities -- more than one out of every six -- 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 provide proper medical care to residents and the failure to prevent and treat pressures sores. The 68 homes with actual harm violations or worse serve 4,895 residents and are estimated to receive over \$60 million each year in federal and state funds.



An examination of the homes with significant violations showed serious care problems. Representatives of nursing homes argue that the “overwhelming majority” of nursing homes meet government standards and that many violations are actually trivial in nature. To assess these claims, this report examined in detail the annual inspection reports from 32 nursing homes in Oklahoma with actual harm violations. The inspection reports for these homes documented that the actual harm violations cited by state inspectors were for serious neglect and mistreatment of residents. Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations. For example, Oklahoma inspectors classified some violations involving improper medical care, untreated pressure sores, malnutrition, dehydration, and abuse as not causing actual harm.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

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

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

This aging population will increase demands for long-term care. There are currently 1.6 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. By 2050, the total number of nursing home residents is expected to quadruple from the current 1.6 million to 6.6 million.⁶

Most nursing homes are run by private for-profit companies. Of the 17,000 nursing homes in the United States, over 11,000 (65%) are operated by for-profit companies. In the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up

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

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

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

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

⁵HCFA 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).

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

smaller chains and independent homes. As of December 1999, the six largest nursing home chains in the United States operated 2,241 facilities with over 266,000 beds.⁷

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

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

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or

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

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

⁹Committee 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.

¹⁰42 U.S.C. §1396r(b)(2).

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 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that “more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury”;¹² that these incidents of actual harm “represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death”;¹³ and that “[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months.”¹⁴

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

¹¹The 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).

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

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

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

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

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

the quality of care in many nursing homes may be “seriously impaired” by inadequate staffing.¹⁷

In light of the growing concern about nursing home conditions, Rep. Carson asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in nursing homes in Oklahoma. Rep. Carson represents the 2nd congressional district of Oklahoma, which is located in the northeastern portion of the state. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in Oklahoma.

II. METHODOLOGY

To assess the conditions in Oklahoma nursing homes, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) state inspection reports from 32 nursing homes cited for actual harm violations.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in Oklahoma come from the OSCAR database and the complaint database. These databases are compiled by the Health Care Financing Administration (HCFA), a division of HHS. HCFA contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal standards observed by the inspectors are cited by the inspection team, reported by the states to HCFA, and compiled in the OSCAR and complaint databases.¹⁸

The OSCAR and complaint databases use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, each violation is given a letter rank, A to L, with A being the least serious (an

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

¹⁸In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the home accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, HCFA maintains a website (<http://www.medicare.gov/nhcompare/home.asp>) where the public can obtain data about individual nursing homes.

isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or has the potential to cause death or serious injury). Homes with violations in categories A, B, or C are considered to be in “substantial compliance” with the law. Homes with violations in categories D, E, or F have the potential to cause “more than minimal harm” to residents. Homes with violations in categories G, H, or I are causing “actual harm” to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

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

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

To assess the compliance status of nursing homes in Oklahoma, this report analyzed the OSCAR database to determine the results of the most recent annual inspection of each nursing home in the state. These inspections were conducted between March 1999 and December 2000. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

B. Analysis of State Inspection Reports

In addition to analyzing the data in the OSCAR and complaint databases, this report analyzed a sample of the actual inspection reports prepared by state inspectors of Oklahoma nursing homes. These inspection reports, prepared on a HCFA form called “Form 2567,” contain the inspectors’ documentation of the conditions at the nursing home.

The Special Investigations Division selected for review the inspection reports from 32 nursing homes that were cited for actual harm violations. For each of these homes, the most recent state inspection report was obtained from the Oklahoma State Department of Health. For several of these nursing homes, the Special Investigations Division also obtained reports of other inspections and investigations conducted by the Oklahoma State Department of Health over the past two years. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

C. Interpretation of Results

The results presented in this report are representative of current conditions in Oklahoma nursing homes as a whole. In the case of any individual home, however, current conditions may differ from those documented in the most recent inspection report, especially if the report is more than a few months old. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a “yo-yo pattern” of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.¹⁹

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

The report also should not be used to compare violation rates in Oklahoma nursing homes with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect violations. According to GAO, “[c]onsiderable inter-state variation still exists in the citation of serious deficiencies.”²⁰

III. NURSING HOME CONDITIONS IN OKLAHOMA

There are 393 nursing homes in Oklahoma that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 34,279 beds that were occupied by 23,791 residents during the most recent round of annual inspections. The majority of these residents, 15,320, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 1,339 residents. Eighty-three percent of the 393 nursing homes in Oklahoma 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 about one out of every seven nursing homes in Oklahoma was found to be in full or

¹⁹GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 12-14.

²⁰GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (Sept. 2000).

substantial compliance with federal standards of care. Only 49 of the 393 homes met all federal health and safety requirements. Another seven homes were in substantial compliance with federal standards, meaning that they were cited only for deficiencies that posed a minimal risk of harm to residents. The rest of the nursing homes in Oklahoma -- 337 out of 393 -- had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Table 2 summarizes these results.

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

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	49	12%	2,281
Substantial Compliance (Risk of Minimal Harm)	7	1.8%	324
Potential for More than Minimal Harm	269	68%	16,291
Actual Harm to Residents	65	17%	4,665
Actual or Potential Death/Serious Injury	3	0.8%	230

Many nursing homes had multiple violations. State inspectors found a total of 2,513 violations in homes that were not in complete or substantial compliance with federal requirements, an average of 7.5 violations per noncompliant home.

B. Prevalence of Violations Causing Actual Harm to Residents

According to the GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. These are homes with violations ranked at the G-level or above. As shown in Table 2, 68 nursing homes in Oklahoma had violations that fell into this category. Twenty-six nursing homes had two or more actual harm violations. In total, 17% of the nursing homes in Oklahoma -- more than one out of every six -- caused actual harm or worse to residents. These 68 nursing homes serve a total of 4,895 residents and are estimated to receive over \$60 million in federal and state funds each year.

C. Most Frequently Cited Violations Causing Actual Harm

During the most recent annual inspections and complaint investigations, state inspectors cited Oklahoma nursing homes for 109 violations causing actual harm or worse to residents. These 109 violations fell into several deficiency areas.

The most common actual harm violation cited by Oklahoma inspectors was the failure to provide proper medical care. This violation included: the failure to follow physician orders for treatments and tests; the failure to promptly notify physicians of changes in resident conditions; the failure to properly administer medications (including pain medications); and the failure to provide necessary restorative therapy. A total of 31 nursing homes in Oklahoma were cited for

this violation.

The second most frequently cited violation causing actual harm involved the failure to treat or prevent 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, 22 nursing homes in Oklahoma were cited for their failure to prevent or properly treat pressure sores.

Another actual harm violation found in multiple Oklahoma nursing homes involved the failure to ensure that residents receive nutritional diets. 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]eceives a therapeutic diet when there is a nutritional problem.”²¹ Eight nursing homes in Oklahoma were cited for actual harm violations in this category.

Other actual harm violations cited more than once by state inspectors included: the unnecessary use of physical restraints; the failure to protect residents from abuse, mistreatment, and neglect; the failure to prevent infections from spreading; and the failure to provide sufficient fluids to residents to prevent dehydration.

D. Potential for Underreporting of Violations

The report’s analysis of the prevalence of nursing home violations was based in large part on the data reported to 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.”²² One problem, according to GAO, is that “homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations.”²³ A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more

²¹42 C.F.R. §483.25(i)

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

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

violations of federal health and safety standards.²⁴ Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

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

At the national level, these assertions have proven to be erroneous. In response to AHCA’s criticisms, GAO undertook a review of 201 random actual harm violations from 107 nursing homes around the country. GAO found that nearly all of these deficiencies posed a serious harm to residents. Of the 107 homes surveyed, 98% were found to have a deficiency that caused actual harm, including “pressure sores, broken bones, severe weight loss, burns, and death.”²⁸ GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes had been cited for violations that were as severe as or even more severe than violations cited in previous or subsequent annual inspections.²⁹

²⁴*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, *supra* note 20, at 43.

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

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

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

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

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

This report undertook a similar analysis at the state level. To assess the severity of violations at Oklahoma nursing homes, the Special Investigations Division examined the annual inspection reports for 32 nursing homes with actual harm violations. These inspection reports showed that the actual harm violations cited by state inspectors involved numerous examples of serious neglect and mistreatment of residents.

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

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

A. Failure to Provide Proper Medical Care

The most common actual harm violation cited in Oklahoma nursing homes was the failure to provide necessary medical care. In the inspection reports reviewed for this report, nursing homes were cited for a wide range of medical errors, including improperly administering medications, failing to provide necessary therapy, ignoring obvious warning signals, and failing to follow physician orders.

State inspectors found numerous instances in which nursing homes gave residents the wrong dosages of medications or failed to provide needed medications altogether.³⁰ For example, several nursing homes were cited by state inspectors for failing to provide pain medication to residents:

- At one facility, inspectors found three residents who were not given proper pain medication and whose physicians were not notified about the residents' unrelieved pain. In one instance, a resident was "crying and tearful" and screamed whenever she was turned because of several blistered areas on her legs and pressure sores on her buttocks and right ankle. Inspectors found that the resident received physician-ordered pain medication only once during the previous month and a half.³¹

³⁰HCFA Form 2567 for Nursing Home in Fairland (July 6, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Hugo (June 1, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Tulsa (Apr. 6, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Pauls Valley (March 20, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Jones (March 2, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Nowata (Dec. 22, 1999) (E-level violation).

³¹HCFA Form 2567 for Nursing Home in Tulsa (Feb. 17, 2000) (G-level violation).

- At another nursing home, a resident recovering from a fractured right femur was supposed to receive pain medication every four hours. According to inspectors, there was no indication that the resident received any pain medication for four months, even though the resident “cried” and “hollered” whenever she was moved, lifted, or cleaned.³²
- At a third nursing home, inspectors found that a resident suffering from arthritis and bone fractures was not regularly provided pain medication ordered by a physician, despite “frequent, severe pain of the back, bone, and joints.” The pain was so severe that the resident could not even turn herself.³³

Another type of medication error cited by Oklahoma inspectors was the failure to properly administer antipsychotic medication. At one nursing home, two residents received the antipsychotic drug, Haldol, although neither exhibited behaviors necessitating use of the drug.³⁴ A second facility failed to monitor the side effects of psychotropic medications for residents for months.³⁵

Several other facilities failed to regularly perform blood sugar tests on diabetic residents. Even when the tests were performed, the prescribed amount of insulin either was provided in the wrong quantity or was not provided at all.³⁶

State inspectors found that some facilities failed to provide necessary restorative therapy or therapeutic devices to residents in order to maintain flexibility and prevent contractures -- a tightening of the muscles, tendons, or ligaments that prevents normal movement.³⁷ At one facility, only 12 of 53 residents identified as having limited range of motion were provided

³²HCFA Form 2567 for Nursing Home in Hugo (June 1, 2000) (G-level violation).

³³HCFA Form 2567 for Nursing Home in Cherokee (Sept. 28, 2000) (D-level violation).

³⁴HCFA Form 2567 for Nursing Home in Shawnee (Aug. 24, 2000) (D-level violation) (this home subsequently closed).

³⁵HCFA Form 2567 for Nursing Home in Cherokee (Sept. 28, 2000) (E-level violation).

³⁶HCFA Form 2567 for Nursing Home in Henryetta (Oct. 5, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Tulsa (July 20, 2000) (B-level violation); HCFA Form 2567 for Nursing Home in Tulsa (Apr. 6, 2000) (E-level violation).

³⁷HCFA Form 2567 for Nursing Home in Henryetta (Oct. 5, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Tulsa (July 20, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Oklahoma City (July 6, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Del City (Apr. 21, 2000) (E-level violation).

necessary therapy.³⁸ Due to the lack of therapy at two other facilities, residents who had previously been able to walk with assistance completely lost the ability to walk.³⁹

Another facility had only two aides to provide restorative services for 79 residents. The facility records indicated that each resident received therapy five times a week, which the inspectors determined was impossible given the limited staffing. When inspectors asked one aide why the records had been falsified, the aide said “that is what I was told to do.”⁴⁰

B. Failure to Prevent or Properly Treat Pressure Sores

The inspection reports documented a wide array of violations involving pressure sores, the second most common actual harm violation among Oklahoma nursing homes. The violations included: leaving immobile residents in the same position instead of regularly repositioning them, as required by standard medical procedures; failing to notify physicians about changes in resident conditions; failing to provide pressure relieving devices; failing to dress sores in accordance with physician orders; and failing to maintain the nutritional status of at-risk residents.⁴¹

At one nursing home, a resident had four pressure sores on her feet and legs that had not been identified or treated by the facility. The resident also had a sore on her back that was covered with a dressing “saturated with bloody drainage.” There was no indication when the dressing had last been changed. State inspectors also observed the resident being left on her back in the same position for over four hours. A second resident who had a pressure sore on her buttocks was left in a wheelchair for almost five hours. Her feet, which had three pressure sores, were “dragging” on the floor and had “a large amount of bloody drainage and a strong odor.” According to state inspectors, the wounds appeared to be infected, yet the facility had not notified

³⁸HCFA Form 2567 for Nursing Home in Hugo (June 1, 2000) (E-level violation).

³⁹HCFA Form 2567 for Nursing Home in Cherokee (Sept. 28, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Oklahoma City (Aug. 3, 2000) (G-level violation).

⁴⁰HCFA Form 2567 for Nursing Home in Claremore (Nov. 30, 2000) (E-level violation).

⁴¹HCFA Form 2567 for Nursing Home in Fairland (July 6, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Hugo (June 1, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Tulsa (Apr. 6, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Oklahoma City (Feb. 24, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Tulsa (Feb. 17, 2000) (D and G-level violations); HCFA Form 2567 for Nursing Home in Bartlesville (Jan. 13, 2000) (G-level violation); HCFA Form 2567 for Nursing Home in Lawton (Oct. 21, 1999) (G-level violation); HCFA Form 2567 for Nursing Home in Tulsa (Oct. 20, 1999) (H-level violation); HCFA Form 2567 for Nursing Home in Edmond (Sept. 2, 1999) (G-level violation).

the resident's physician.⁴²

Other pressure sore violations cited by state inspectors included the following:

- At one facility, both lower legs of a resident were observed to be covered in pustules and blisters, "swollen and oozing fluid." The resident also had four pressure sores on the legs and feet. There was no indication that physician-ordered treatments had been provided over the previous month.⁴³
- At another facility, two residents with pressure sores on their buttocks were left in the same position for more than seven hours while state inspectors were present. Both residents were found by the state inspectors to be sitting in diapers and clothing saturated with urine.⁴⁴
- At a third facility, inspectors observed that the facility failed to reposition a resident with a pressure sore, even though the resident's wrists were strapped to the bed and she could not turn herself.⁴⁵
- A resident at one facility was admitted to the hospital after her physician visited her and discovered the severe nature of the resident's pressure sores -- one which was 2.5 inches in diameter and another which had "copious amounts of purulent drainage." Even after the resident was treated at the hospital and returned to the nursing home, inspectors found that the nursing home failed to perform physician-ordered treatments to the sores.⁴⁶

C. Failure to Provide Adequate Nutrition and Hydration

The failure to provide adequate food and liquids to residents is another common actual harm violation in Oklahoma nursing homes. Several examples of these violations were documented in the inspection reports:

- At one facility, state inspectors examined the nutrition records of 18 residents and found that the facility had failed to provide adequate nutrition to 10 of those residents. One resident was 6'4" tall but weighed only 97 lbs. Another resident's weight dropped from

⁴²HCFA Form 2567 for Nursing Home in Tulsa (Apr. 6, 2000) (G-level violation).

⁴³HCFA Form 2567 for Nursing Home in Newkirk (Apr. 12, 2000) (E-level violation).

⁴⁴HCFA Form 2567 for Nursing Home in Hugo (June 1, 2000) (G-level violation).

⁴⁵HCFA Form 2567 for Nursing Home in Bartlesville (Jan. 13, 2000) (G-level violation).

⁴⁶HCFA Form 2567 for Nursing Home in Tulsa (Oct. 20, 1999) (H-level violation).

104 lbs. to 78 lbs. in a two-month period.⁴⁷

- At another facility, state inspectors found several residents who were not receiving extra food or liquids as required by physician orders. The nurses' notes for one of these residents stated that the resident's weight was "within a normal range," even though inspectors found that he was 34 lbs. to 74 lbs. below his ideal body weight.⁴⁸
- At a third facility, a resident on a feeding tube lost 20 lbs in one month because the facility failed to ensure that the tube was functioning properly. Another resident who suffered from Alzheimer's disease and was completely dependent on staff was receiving as little as 13.5 oz. of fluids a day, well below the 67 oz. required by the resident's care plan.⁴⁹
- Inspectors found numerous instances in which nursing homes were not monitoring the fluid requirements of at-risk residents. In one case, a resident's fluid intake was not monitored even though "[h]er feet and legs were so dry they were observed to be cracking" and the resident's skin was "sloughing off in areas on her hips and legs."⁵⁰ Another facility failed to monitor the fluid intake of a resident who had recently been hospitalized for dehydration and a urinary tract infection and who also suffered from fecal impactions after returning to the facility.⁵¹

One reason for the weight loss experienced by some residents was the quality of food served to them. State inspectors found the food at one nursing home to be so poor in flavor, texture, and temperature that one resident "clamped her mouth shut at times rather than eat the food she was served."⁵² At another facility, the breakfast was so cold that inspectors found it to be unpalatable. When inspectors procured a replacement food tray for one resident, she responded, "Thank you, Jesus! Thank you, Jesus!"⁵³

State inspectors also found that some facilities were not providing the proper foods to

⁴⁷HCFA Form 2567 for Nursing Home in Tulsa (Oct. 20, 1999) (G-level violation).

⁴⁸HCFA Form 2567 for Nursing Home in Henryetta (Oct. 5, 2000) (E-level violation).

⁴⁹HCFA Form 2567 for Nursing Home in Newkirk (Apr. 12, 2000) (D and G-level violations).

⁵⁰HCFA Form 2567 for Nursing Home in Tulsa (Feb. 17, 2000) (E-level violation).

⁵¹HCFA Form 2567 for Nursing Home in Claremore (Nov. 30, 2000) (G-level violation).

⁵²HCFA Form 2567 for Nursing Home in Oklahoma City (Feb. 24, 2000) (E-level violation).

⁵³HCFA Form 2567 for Nursing Home in Jones (March 2, 2000) (E-level violation).

residents. For example, one nursing home failed to provide special meals to diabetic residents, instead serving them the ordinary meals served to other residents.⁵⁴ Another facility failed to provide pureed food and thickened liquids to residents at risk of choking. Inspectors observed one such resident choking when he was given unthickened liquid by a nurse aide who was unaware of the dietary restriction. The aide said the resident “does that all the time.”⁵⁵

D. Failure to Protect Residents from Abuse or Mistreatment

The inspection reports contained several examples in which residents were the victims of abuse or mistreatment. At one facility, there were reports that a 99-year-old resident had been hit by a nurse aide and suffered a laceration, yet the facility did not conduct an investigation or report the allegation to the proper authorities. At the same facility, residents were subject to verbal abuse from staff. When a resident asked for her medications, a nurse aide told her that the medications “may kill you, and further stated she hoped the resident choked on them.” According to another resident, a staff member was overheard saying that “the residents they didn’t want to die did, and those they wanted to die didn’t.”⁵⁶

State inspectors found that two residents of another nursing home had been bruised as a result of “rough” treatment from staff. One of the residents had a large bruise on her right arm that she received when staff pulled her off a bedside commode. She had not reported the incident because she said, “I don’t want them to stop helping me.” Inspectors found a nurse aide feeding another resident by “repeatedly shoving the resident’s head to an upright position” and “thrusting” a spoon into the resident’s mouth, “without allowing the resident time to swallow, causing the food to run out of her mouth.”⁵⁷

At another nursing home, there were seven instances of residents being physically abused by other residents during a one-month period, including an incident in which a resident pushed another resident to the floor, causing a fractured hip that required hospitalization. In another incident at the facility, a resident was hit in the head with dishware by another resident. According to inspectors, the facility also failed to control aggressive behavior by a resident who hit another resident seven times in the face.⁵⁸

⁵⁴HCFA Form 2567 for Nursing Home in Vinita (June 24, 1999) (E-level violation).

⁵⁵HCFA Form 2567 for Nursing Home in Tulsa (July 20, 2000) (G-level violation).

⁵⁶HCFA Form 2567 for Nursing Home in Pauls Valley (Nov. 23, 1999) (complaint investigation).

⁵⁷HCFA Form 2567 for Nursing Home in Okemah (March 30, 2000) (G-level violation).

⁵⁸HCFA Form 2567 for Nursing Home in Jones (March 2, 2000) (E-level violation).

Another nursing home failed to intervene to control an Alzheimer's resident who was described in nurses notes as "entering other resident rooms uninvited," "pilfering" items from these rooms, and "swinging at other residents." Inspectors found that the facility had failed to implement an effective plan to minimize the resident's antisocial behavior.⁵⁹

E. Failure to Follow Proper Infection Control Procedures

Oklahoma inspectors found several instances in which nursing homes did not follow proper procedures to prevent infections from spreading. Infections pose a particular risk for elderly residents whose immune systems are already fragile.

In the most serious case, state inspectors found that a facility created a "high risk of infection" in its care of a resident suffering from multiple pressure sores, paraplegia, and hemophilia. Among the problems noted by inspectors were: the resident's urinary catheter bag was dragged on the floor on several occasions; staff used soiled gloves during wound care; the resident was sitting on a towel soiled with red wound drainage from two severe pressure sores on the buttocks; the resident's undershirt was soiled from drainage from a feeding tube; the resident was bathed in a whirlpool that was not cleaned prior to bathing; and the resident was washed and dried off with a washcloth that was soiled with drainage from the resident's wounds.⁶⁰

Other examples of improper infection control procedures included the following:

- At one nursing home, a resident with a contagious infection was not isolated from other residents nor did the staff wear gowns during treatment -- both of which were required by standard medical procedures.⁶¹
- State inspectors found that one facility failed to provide proper catheter care or use proper cleaning methods after resident urination and bowel movements. As a result, several residents developed urinary tract infections caused by E. coli.⁶²
- Nurse aides at a third nursing home did not remove their gloves after cleaning residents of urine and feces before touching the residents' clothing, bed linens, bed rails, and door

⁵⁹HCFA Form 2567 for Nursing Home in Shawnee (August 24, 2000) (E-level violation) (this home subsequently closed).

⁶⁰HCFA Form 2567 for Nursing Home in Del City (Apr. 21, 2000) (J-level violation).

⁶¹HCFA Form 2567 for Nursing Home in Muskogee (July 20, 2000) (E-level violation).

⁶²HCFA Form 2567 for Nursing Home in Oklahoma City (June 22, 2000) (E-level violation).

handles.⁶³

F. 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.”⁶⁴ These standards reflect the expectations of families that residents will be properly cared for and cleaned. However, state inspectors found that many nursing homes in Oklahoma violated even these basic standards.

State inspectors found that many nursing homes did a poor job of toileting and cleaning residents. At some facilities, residents were observed sitting in urine-soaked clothing or urine-soaked incontinence pads for hours.⁶⁵ For example:

- At one facility, a resident was found lying in “urine soaked sheets.” The resident, who “had on occasions been observed handling her bowel movements with her hands,” was observed with “fingernails encrusted with dark brown colored material.”⁶⁶
- At another facility, numerous residents were observed sitting in the dining room in urine-soaked clothing. Puddles of urine were observed on the floor under several residents.⁶⁷
- Incontinent residents at another facility were not even given diapers or underwear. A staff member said, “They just go in their pants and we change ‘em.”⁶⁸

Oklahoma inspectors found several facilities that smelled like urine.⁶⁹ At one nursing home, inspectors noticed “persistent and pervasive urine and body odors throughout the entire

⁶³HCFA Form 2567 for Nursing Home in Cherokee (Sept. 28, 2000) (E-level violation).

⁶⁴42 C.F.R. § 483.25(a)(3).

⁶⁵HCFA Form 2567 for Nursing Home in Henryetta (Oct. 5, 2000) (H-level violation); HCFA Form 2567 for Nursing Home in Nowata (Dec. 22, 1999) (E-level violation).

⁶⁶HCFA Form 2567 for Nursing Home in Shawnee (August 24, 2000) (E-level violation) (this home subsequently closed).

⁶⁷HCFA Form 2567 for Nursing Home in Nowata (Dec. 22, 1999) (E-level violation).

⁶⁸HCFA Form 2567 for Nursing Home in Newkirk (Apr. 12, 2000) (G-level violation).

⁶⁹HCFA Form 2567 for Nursing Home in Bartlesville (Jan. 13, 2000) (C-level violation); HCFA Form 2567 for Nursing Home in Midwest City (Dec. 9, 1999) (G-level violation); HCFA Form 2567 for Nursing Home in Vinita (June 24, 1999) (E-level violation).

facility” during all days of their inspection.⁷⁰

State inspectors also observed that residents did not receive proper oral hygiene care. At one nursing home, residents were observed with “strong mouth odor” and tongue and lips that were “dried and cracked.”⁷¹ When inspectors pointed out the unclean teeth of one resident at another facility, a staff member was unable to locate the resident’s toothbrush. The aide told inspectors: “The residents are lucky just to get a bath.”⁷²

G. Other Violations

Other incidents, while not causing immediate harm, reveal the indifferent attitude sometimes displayed by nursing homes toward residents. For example, at several facilities, naked residents were exposed to others:

- At one nursing home, inspectors observed residents being pushed in wheelchairs through hallways and the lobby without clothing, covered only in sheets. Staff members also failed to close the window curtains in the room of a female resident who was not wearing any clothes, leaving her exposed to the parking lot and a busy street.⁷³
- At another facility, inspectors walking through the hallway observed one resident on a bedside commode and another unclothed resident in the shower. Residents in the dining room at meal times were also observed with full urinary catheter bags uncovered and exposed to other residents.⁷⁴
- A resident at another nursing home was observed with his pants pulled down past his buttocks and his colostomy bag exposed for almost two hours.⁷⁵

Oklahoma inspectors found other examples of indifference towards the needs of residents:

⁷⁰HCFA Form 2567 for Nursing Home in Tulsa (Apr. 6, 2000) (F-level violation).

⁷¹HCFA Form 2567 for Nursing Home in Del City (Apr. 21, 2000) (E-level violation).

⁷²HCFA Form 2567 for Nursing Home in Oklahoma City (Feb. 24, 2000) (E-level violation).

⁷³HCFA Form 2567 for Nursing Home in Edmond (Sept. 2, 1999) (E-level violation).

⁷⁴HCFA Form 2567 for Nursing Home in Oklahoma City (June 22, 2000) (E-level violation).

⁷⁵HCFA Form 2567 for Nursing Home in Nowata (Dec. 22, 1999) (E-level violation).

- At one facility, a resident was wearing pants that were so small that they could not be fastened together at the waistline. When the resident stood up from his wheelchair, his slacks fell below his knees, and he tripped over his pants. Staff members confirmed that the resident had no clothing that fit him.⁷⁶
- Several residents at another facility were only given thin sheets on their beds, without any blankets or bedspreads. Inspectors also found that washcloths used to clean residents were “stained, torn, thin, and many were made from torn up towels.” Some washcloths were observed to have paint stuck to them. Staff said that “these are our ‘butt rags.’”⁷⁷
- Residents at a third nursing home were awakened and dressed between 4:00 a.m. and 4:45 a.m. and brought to the dining room by 7 a.m., even though many them were not fed until 8:30 a.m. and several as late as 9:40 a.m.⁷⁸

H. Failure to Provide Adequate Staffing

An underlying reason for the poor care provided by some Oklahoma nursing homes is inadequate staffing and training. State inspectors found that, contrary to federal law, one facility had no registered nurse on duty for many days. As a result of the understaffing, the facility was not able to provide necessary nursing services to residents.⁷⁹

Another nursing home was staffed by a licensed nurse and four nurse aides, three of whom either were not certified or had worked in the facility for only a few weeks. Each of the three nurse aides were responsible for an entire wing of the facility, without any assistance or observation. As a result of the inadequate staffing, inspectors found that residents were not being properly cleaned or fed. While the inspectors were observing residents eating in the dining room, they saw two residents who choked several times during the meal but were not assisted due to inadequate staffing.⁸⁰

A common manifestation of inadequate staffing is an inability to properly supervise residents, thus increasing the potential for accidents and injuries. At one facility, a resident who

⁷⁶HCFA Form 2567 for Nursing Home in Oklahoma City (Feb. 24, 2000) (G-level violation).

⁷⁷HCFA Form 2567 for Nursing Home in Newkirk (Apr. 12, 2000) (E-level violation).

⁷⁸HCFA Form 2567 for Nursing Home in Edmond (Sept. 2, 1999) (E-level violation).

⁷⁹HCFA Form 2567 for Nursing Home in Pauls Valley (June 2, 2000) (complaint investigation).

⁸⁰HCFA Form 2567 for Nursing Home in Noble (Apr. 20, 2000) (E-level violation).

had no control over her arms and legs was left on a shower chair without a safety belt. The resident fell off the chair when a nurse aide turned away to tend to another resident, suffering a laceration that required emergency room treatment.⁸¹ At another facility, state inspectors found that one resident was able to wander away from the facility three times in one week -- twice walking across the street -- because of insufficient staff to monitor residents.⁸²

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

⁸¹HCFA Form 2567 for Nursing Home in Midwest City (May 22, 2000) (G-level violation).

⁸²HCFA Form 2567 for Nursing Home in Oklahoma City (May 20, 2000) (complaint investigation).