



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

# FAX COVER SHEET

## HCFA'S OFFICE OF LEGISLATION

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**GAO**

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United States General Accounting Office  
Washington, DC 20548

Health, Education, and  
Human Services Division

B-284751

September 28, 2000

The Honorable Charles E. Grassley  
Chairman  
The Honorable John B. Breaux  
Ranking Minority Member  
Special Committee on Aging  
United States Senate

The Honorable Christopher S. Bond  
United States Senate

Since 1997, the Senate Special Committee on Aging has focused considerable attention on the need to improve the quality of care for the nation's 1.6 million nursing home residents, a highly vulnerable population of elderly and disabled individuals. In a series of reports and testimonies prepared at the Committee's request, we found significant weaknesses in federal and state survey and oversight activities designed to detect and correct quality problems.<sup>1</sup> For example, we reported that about 15 percent of the nation's 17,000 nursing homes—an unacceptably high number—repeatedly had serious care problems that caused actual harm to residents or placed them at risk of death or serious injury (immediate jeopardy). Our key findings on the nursing home survey process included the following:

- The results of state surveys understated the extent of serious care problems, reflecting procedural weaknesses in the surveys and their predictability.
- Serious complaints by residents, family members, or staff alleging harm to residents remained uninvestigated for weeks or months.
- When serious deficiencies were identified, federal and state enforcement policies did not ensure that the deficiencies were addressed and remained corrected.
- Federal mechanisms for overseeing state monitoring of nursing home quality were limited in their scope and effectiveness.

Concurrent with the Committee's July 1998 hearing, the President announced a series of initiatives intended to address many of the weaknesses we identified. Since that time, the Administration has expanded the number of initiatives to about 30 and the

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<sup>1</sup>See related GAO products listed at end of this report.

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Congress has appropriated additional funds to support the increased workload associated with implementing the initiatives. To determine the effect of the initiatives, you asked us to assess (1) progress in improving the detection of quality problems and changes in measured nursing home quality, (2) the status of efforts to strengthen states' complaint investigation processes and federal enforcement policies, and (3) additional steps taken at the federal level to improve oversight of states' quality assurance activities.

In conducting our review, we analyzed data from the federal On-Line Survey, Certification, and Reporting (OSCAR) System, which compiles the results of state nursing home surveys. We visited California, Missouri, Tennessee, and Washington, interviewing officials in state survey agencies and their district offices.<sup>2</sup> California and Missouri represented states that were about average in terms of the number of actual harm and immediate jeopardy deficiencies cited in state surveys prior to the initiatives. Tennessee represented the low end of the range and Washington the high end. We also contacted officials in Maryland and Michigan, states that were included in our prior work. In addition, we interviewed Health Care Financing Administration (HCFA) officials at both headquarters and regional offices. HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for ensuring that each state establishes and maintains the capability to periodically survey nursing homes that receive federal payments in order to ensure that the homes provide quality care to residents. Finally, we reviewed relevant documents from both state agencies and HCFA. We conducted our review from January to August 2000 in accordance with generally accepted government auditing standards.

### RESULTS IN BRIEF

Overall, the introduction of the recent federal quality initiatives has generated a range of nursing home oversight activities that need continued federal and state attention to reach their full potential. The states are in a period of transition with regard to the implementation of the quality initiatives, in part because HCFA is phasing them in and in part because states did not begin their efforts from a common starting point. Efforts at the federal level toward improving the oversight of states' quality assurance activities have commenced but are unfinished or need refinement.

Federal initiatives were introduced to strengthen the rigor with which states conduct required annual nursing home surveys. The states we visited have begun to use the new methods introduced by the initiatives to spot serious deficiencies when conducting surveys, but HCFA is still developing important additional steps that may not be introduced until 2002 or 2003. Likewise, efforts to reduce the predictable timing of the surveys—that is, to minimize the opportunity for homes so inclined to cover up problems—have been modest to date. To measure the effect of the survey

<sup>2</sup>State surveyors are typically assigned to local district offices (sometimes referred to as regional offices) that are responsible for conducting nursing home surveys and complaint investigations. In Missouri, separate state offices are responsible for overseeing hospital-based and all other nursing homes. We focused our work on the Missouri office that oversees the approximately 85 percent of all nursing homes that are not hospital-based.

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process improvements, we analyzed the change in the number of nursing homes cited for serious deficiencies in the periods before and after the introduction of the quality initiatives. Our results showed a marginal increase nationwide in the proportion of homes with documented actual harm and immediate jeopardy deficiencies, although there was considerable variation across states, with some states experiencing a decrease in homes with these deficiencies. These results suggest that states may have become more rigorous in their identification and classification of serious deficiencies. The results could also indicate that the volume of such deficiencies has actually increased slightly nationwide, a situation consistent with states' heightened concerns about potential facility staff shortages during this same time period.

The states we contacted also have made strides in improving their investigations of and follow-up to complaints, but not enough time has elapsed to consider these efforts complete. For example, the states in our review were not yet investigating all complaints that allege actual harm to a resident within 10 days, as HCFA now requires, but were working toward that goal by hiring additional surveyors to staff the investigations, establishing procedures that make it easier to file complaints, or developing new tracking systems to improve their oversight of complaint investigations by local district offices. For some states, the provision of federal funding to support the nursing home initiatives came too late in the state budget cycle for agencies to capitalize on the additional funds for fiscal year 1999. HCFA also has strengthened the enforcement tools available to sanction nursing homes that are cited for actual harm and immediate jeopardy violations, but too little time has elapsed to assess the application of these tools. Early indications from some states are that their referrals of homes to HCFA for sanctions are on the rise. Finally, additional funds were provided in fiscal years 1999 and 2000 to hire new HHS staff in order to reduce the large number of pending appeals by nursing homes and to collect assessed fines faster. The expectation is that the more expeditious resolution of appeals will heighten the deterrent effect of civil fines. It is too early to assess the effect of the additional funding on the number of pending appeals because the new staff were only hired within the past year and other changes in enforcement policy are expected to increase the volume of nursing home appeals.

To improve nursing home oversight at the federal level, HCFA has made recent organizational changes to address past consistency and coordination problems between its central office and 10 regional offices. It also intends to intensify its use of management information data systems and reports to verify and assess states' oversight activities and view more closely the performance of the homes themselves. Our review showed that an examination of previously available information could have identified shortcomings in a state's survey activities even before they came to light as the result of a criminal investigation.

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**BACKGROUND**

Oversight of nursing homes is a shared federal and state responsibility. On the basis of statutory requirements, HCFA defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs and contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations. The "annual" standard survey, which must be conducted on average every 12 months and no less than once every 15 months at each home, entails a team of state surveyors spending several days in the home to determine whether care and services meet the assessed needs of the residents and whether the home is in compliance with long-term-care facility requirements. HCFA establishes specific protocols, or investigative procedures, for state surveyors to use in conducting these comprehensive surveys. In contrast, complaint investigations, also conducted by state surveyors but following the individual state's procedures, within certain federal guidelines and time frames, target a single area, typically in response to a complaint filed against a home by a resident, the resident's family or friends, or nursing home employees. Quality-of-care problems identified during either standard surveys or complaint investigations are classified in one of 12 categories according to their scope (the number of residents potentially or actually affected) and their severity. An A-level deficiency is the least serious and is isolated in scope, while an L-level deficiency is the most serious and is considered to be widespread in the nursing home (see table 1). At some homes, state surveyors identify no deficiencies.

**Table 1: Scope and Severity of Deficiencies**

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy <sup>a</sup>	J	K	L
Actual harm	G	H	I
Potential for more than minimal harm	D	E	F
Potential for minimal harm <sup>b</sup>	A	B	C

<sup>a</sup>Actual or potential for death/serious injury.

<sup>b</sup>Nursing home is considered to be in "substantial compliance."

Ensuring that documented deficiencies are corrected is likewise a shared responsibility. HCFA is responsible for enforcement actions involving homes with Medicare certification—about 86 percent of all homes.<sup>3</sup> The scope and severity of a deficiency determines the applicable enforcement action and whether it is optional or mandatory. Enforcement actions can involve, among other things, requiring corrective action plans; monetary fines; denying the home Medicare and Medicaid payments; and, ultimately, terminating the home from participation in these programs. Sanctions are imposed by HCFA on the basis of state referrals. HCFA normally accepts a state's recommendations for sanctions or other corrective actions but can modify them. Before a sanction is imposed, federal policy generally gives

<sup>3</sup>Included in this percentage are homes certified for both Medicaid and Medicare.

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nursing homes a grace period of 30 to 60 days to correct a deficiency. With HCFA approval, states may impose their own sanctions, and some prefer to do so because they may impose them immediately, without giving the home a grace period to correct the deficiency.<sup>4</sup> States may also use their state licensure authority to impose state sanctions. States are responsible for enforcing standards in homes with Medicaid-only certification—about 14 percent of the total. They may use the federal sanctions or rely upon their own state licensure authority and nursing home sanctions.

HCFA also is responsible for overseeing each state survey agency's performance in ensuring quality of care in its nursing homes. Its primary oversight tools are the federal comparative and observational surveys conducted annually in at least 5 percent of the nation's certified Medicare and Medicaid nursing homes. A comparative survey involves a federal survey team conducting a complete, independent survey of a home within 2 months of the completion of a state's survey in order to compare and contrast the findings.<sup>5</sup> In an observational survey, one or two federal surveyors accompany a state survey team to a nursing home to watch the team conduct survey tasks, give immediate feedback, and later rate the team's performance. The vast majority of federal surveys are observational. Additionally, in 1996 HCFA initiated the State Agency Quality Improvement Program (SAQIP), which requires states to self-report their compliance with seven performance standards and to implement quality improvement plans to address any deficiencies identified in their survey processes.

In its federal monitoring role, HCFA directs the states' implementation of the Administration's nursing home initiatives, which are intended to improve nursing home oversight and quality of care. Many of the initiatives address previous problems identified by us, HCFA, and others. This report focuses on selected initiatives from the following three areas:

- Improving nursing home reviews. These initiatives are intended to strengthen states' periodic surveys and complaint investigations, enabling surveyors to better detect quality-of-care deficiencies.
- Ensuring compliance. These initiatives are intended to ensure that homes with serious deficiencies or homes that repeatedly cause harm to residents promptly correct deficiencies and sustain compliance with federal requirements thereafter.

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<sup>4</sup>If a state has a unique enforcement sanction, it may obtain HCFA approval to use it in lieu of a federal remedy. The state must satisfy HCFA that its sanction is as effective as a federal remedy in deterring noncompliance and correcting deficiencies. In addition, state sanctions must meet several general requirements, including timing and notice requirements in federal regulations and, according to HCFA, consistency with statutory intent.

<sup>5</sup>The Omnibus Budget Reconciliation Act of 1987 requires HCFA to conduct comparative surveys within 2 months of states' surveys. In August 1999, HCFA urged its regional offices to commence comparative surveys within 14 to 28 days after a state's survey.

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- Improving federal monitoring. These initiatives are intended to ensure that HCFA and its regional offices use appropriate oversight mechanisms and data systems to assess the effectiveness of states' survey activities.

Appendix I provides a chronology of and summarizes the key quality initiatives discussed in this report. Though many initiatives were announced in July 1998, some important changes were not implemented until the second half of 1999 and others are still in the planning phase.

#### PROGRESS MADE IN IMPROVING ANNUAL SURVEYS, BUT MEASURING THE EFFECT IS PROBLEMATIC

HCFA and the six states we contacted have taken important steps toward improving the rigor of nursing home surveys. HCFA has begun a major redesign of its nursing home survey methodology, but only phase one of the overall plan has been implemented by state survey agencies. When phase two is completed, HCFA should have significantly improved the tools for effectively identifying the scope and severity of care problems. However, the second phase is not expected to be implemented until 2002 or 2003. Despite the progress to date in improving surveyors' ability to detect deficiencies, the timing of nursing home surveys in some states continues to be predictable, allowing facilities to mask certain deficiencies if they choose to do so. Recognizing the need for self-improvement in the type and extent of oversight, the states we visited are beginning to identify and address other weaknesses in the survey process not covered by the Administration's initiatives. Consistent with the expectation that improvements in the survey process would lead to the identification of more problems, the proportion of homes with serious deficiencies increased in many states after the introduction of survey methodology improvements. Although the identification of more deficiencies could be the result of better detection, growing reports of problems with nursing home staffing raise concerns that the actual proportion of homes with deficiencies may have increased. This possibility underscores the importance of adequate federal and state oversight of nursing homes.

#### Survey Methodology Strengthened and Further Improvements Are in the Planning Phase

Annual standard surveys provide states the opportunity to systematically and comprehensively assess nursing home quality. In our prior work, we found that surveyors often missed significant care problems—such as pressure sores, malnutrition, and dehydration—because the methods they used lacked sufficient rigor.<sup>6</sup> In addition, problems went undetected because nursing homes were able to predict the timing of their next survey and, if so inclined, conceal problems such as routinely having too few staff to care for residents.

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<sup>6</sup>California Nursing Homes: Care Problems Persist Despite Federal and State Oversight (GAO/HEHS-98-202, July 27, 1998).

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**Table 4: Homes With Actual Harm and Immediate Jeopardy Deficiencies Before and After Implementation of the Quality Initiatives**

State (includes only those in which 100 or more homes were surveyed since 1/99)	Number of homes surveyed (1/99 to 7/00)	Percentage of homes with actual harm and immediate jeopardy deficiencies		Percentage point difference
		Before initiatives (1/97 to 7/98)	After initiatives (1/99 to 7/00)	
<i>Increase of 5 percentage points or greater</i>				
Arizona	125*	17.2	36.8	19.6
Arkansas	253*	14.7	30.8	16.1
New York	606	13.3	27.6	14.3
Tennessee	353	11.1	24.1	13.0
North Carolina	409	31.0	42.1	11.1
New Jersey	336*	13.0	23.8	10.8
Oregon	157	43.9	53.5	9.6
Massachusetts	541	24.0	32.9	8.9
West Virginia	144	12.3	20.1	7.8
Indiana	581	40.5	48.2	7.7
Louisiana	365*	12.7	20.3	7.6
Georgia	364	17.8	25.0	7.2
Mississippi	196*	24.8	31.6	6.8
Oklahoma	394*	8.4	15.0	6.6
Colorado	229	11.1	16.6	5.5
Maryland	188*	19.0	24.5	5.5
Missouri <sup>b</sup>	565	21.0	25.7	4.7
<i>Change of less than 5 percentage points</i>				
Maine	124	7.4	10.5	3.1
Minnesota	437	29.6	32.5	2.9
Texas	1,313	22.2	24.9	2.7
Michigan	442	43.7	45.9	2.2
Nation	16,854	27.7	29.5	1.8
Pennsylvania	774	29.3	30.7	1.4
Illinois	891	29.8	31.1	1.3
South Carolina	176	28.6	29.5	0.9
Connecticut	260	52.9	53.5	0.6
Montana	105	38.7	39.0	0.3
California	1,301*	28.2	28.2	0.0
Wisconsin	424	17.1	14.6	-2.5
Ohio	995	31.2	28.6	-2.6
Kentucky	306	28.6	25.2	-3.4
<i>Decrease of 5 percentage points or greater</i>				
Virginia	282	24.7	19.5	-5.2
Washington	281	63.2	57.7	-5.5
Nebraska	241	32.3	26.6	-5.7
Alabama	225	51.1	41.3	-9.8
Kansas	404*	47.0	36.9	-10.1
South Dakota	112*	40.3	29.5	-10.8
Florida	746	36.3	21.7	-14.6
Iowa	428*	39.2	22.7	-16.5

\*Compared with the period before the initiatives, there was more than a 10-percent difference in the number of homes analyzed for these states. In part, these differences are explained by the fact that some states have still not recorded the results of a home's most recent survey in OSCAR.

<sup>b</sup>Although our work in Missouri focused on the agency responsible for oversight of non-hospital-based nursing homes, hospital-based facilities in the state were included in developing this table.

Source: HCFA Staffing Report to Congress.

APPENDIX B2: Distribution of Staffing by State, 1996-1999

Table B2.a: Staffing levels in U.S. Nursing Homes: By State, 1996-1999

State	Mean hours per resident day											
	1996			1997			1998			1999		
	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide
AK	1.11	0.66	3.19	1.45	0.62	3.42	1.15	0.54	3.23	0.98	0.67	3.09
AL	0.26	0.93	2.36	0.26	0.93	2.37	0.26	0.99	2.47	0.25	0.97	2.37
AR	0.25	0.80	1.72	0.33	0.83	1.86	0.31	0.83	1.97	0.35	0.89	1.94
AZ	0.68	0.77	2.07	0.84	0.85	2.01	0.78	0.80	2.16	0.56	0.72	1.97
CA	0.58	0.74	2.20	0.62	0.73	2.22	0.58	0.73	2.21	0.55	0.72	2.14
CO	0.74	0.70	1.83	0.74	0.76	1.90	0.64	0.70	1.96	0.60	0.69	1.93
CT	0.53	0.47	2.00	0.53	0.48	2.10	0.57	0.50	2.09	0.52	0.52	2.11
DE	0.71	0.67	2.35	0.77	0.68	2.37	1.03	0.65	2.73	0.75	0.66	2.47
FL	0.58	0.88	2.14	0.65	0.87	2.12	0.64	0.88	2.06	0.59	0.84	2.06
GA	0.21	0.82	2.00	0.21	0.82	2.06	0.24	0.84	2.01	0.24	0.85	1.97
HI	0.83	0.67	2.43	0.90	0.63	2.61	0.88	0.55	2.68	0.78	0.82	2.24
IA	0.49	0.48	1.70	0.47	0.49	1.69	0.52	0.51	1.66	0.53	0.55	1.66
ID	0.62	0.81	2.54	0.72	0.96	2.59	0.65	0.75	2.65	0.57	0.86	2.84
IL	0.57	0.53	1.76	0.62	0.53	1.78	0.65	0.54	1.83	0.67	0.54	1.88
IN	0.41	0.84	1.55	0.45	0.85	1.53	0.46	0.87	1.54	0.49	0.87	1.58
KS	0.40	0.54	1.62	0.44	0.57	1.61	0.48	0.57	1.59	0.50	0.53	1.66
KY	0.49	0.96	2.05	0.58	0.98	2.16	0.56	0.92	2.11	0.58	0.96	2.06
LA	0.34	0.87	1.87	0.39	0.91	1.91	0.34	0.85	1.96	0.37	0.94	1.83
MA	0.62	0.59	2.24	0.69	0.56	2.21	0.74	0.58	2.24	0.70	0.58	2.18
MD	0.51	0.60	1.96	0.57	0.64	1.99	0.62	0.63	2.08	0.73	0.60	2.10
ME	0.53	0.47	2.62	0.65	0.47	2.60	0.71	0.49	2.68	0.57	0.48	2.65
MI	0.35	0.60	2.25	0.43	0.61	2.29	0.42	0.61	2.29	0.43	0.67	2.22
MN	0.35	0.67	1.83	0.36	0.66	1.84	0.37	0.66	1.80	0.33	0.68	1.81
MO	0.46	0.80	1.81	0.50	0.77	1.78	0.49	0.76	1.76	0.49	0.76	1.84
MS	0.42	0.88	2.00	0.55	0.95	2.02	0.51	0.91	2.03	0.45	0.84	1.99
MT	0.60	0.56	2.35	0.61	0.60	2.26	0.63	0.59	2.35	0.66	0.53	2.21

Table B2.a: Staffing levels in U.S. Nursing Homes: By State, 1996-1999

State	Mean hours per resident day											
	1996			1997			1998			1999†		
	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide	RN	LPN	Nurse aide
NC	0.48	0.74	2.24	0.53	0.76	2.35	0.55	0.83	2.32	0.52	0.81	2.25
ND	0.43	0.63	2.18	0.43	0.64	2.21	0.38	0.58	2.25	0.54	0.70	2.28
NE	0.42	0.67	1.74	0.47	0.68	1.79	0.51	0.66	1.81	0.56	0.72	1.76
NH	0.60	0.50	2.39	0.62	0.56	2.43	0.65	0.55	2.53	0.70	0.57	2.56
NJ	0.55	0.56	2.05	0.56	0.55	2.08	0.62	0.57	2.08	0.66	0.66	2.05
NM	0.59	0.59	2.09	0.76	0.56	2.08	0.59	0.55	2.09	0.46	0.53	2.05
NV	1.01	0.91	1.98	1.04	0.75	1.91	1.14	0.74	1.94	1.67	0.55	2.52
NY	0.38	0.64	1.99	0.36	0.65	1.99	0.37	0.66	2.03	0.38	0.66	2.02
OH	0.52	0.81	2.10	0.57	0.82	2.09	0.55	0.80	2.05	0.58	0.85	2.09
OK	0.22	0.64	1.45	0.28	0.78	1.59	0.30	0.75	1.57	0.21	0.73	1.53
OR	0.55	0.40	2.24	0.55	0.42	2.18	0.57	0.42	2.11	0.54	0.42	2.11
PA	0.67	0.71	2.05	0.75	0.75	2.07	0.80	0.78	2.11	0.75	0.76	2.08
RI	0.51	0.35	2.01	0.60	0.31	2.09	0.65	0.32	2.06	0.73	0.31	2.07
SC	0.41	0.89	2.26	0.46	0.88	2.31	0.50	0.92	2.25	0.59	0.84	2.23
SD	0.48	0.31	1.86	0.49	0.34	1.89	0.53	0.34	1.90	0.49	0.32	1.85
TN	0.33	0.80	1.80	0.34	0.79	1.89	0.44	0.87	1.90	0.37	0.85	1.84
TX	0.43	0.87	1.83	0.45	0.90	1.86	0.40	0.88	1.83	0.34	0.89	1.78
UT	0.70	0.64	1.87	0.73	0.59	1.96	0.76	0.69	2.01	1.06	0.79	1.98
VA	0.40	0.81	1.99	0.41	0.84	2.06	0.41	0.91	2.07	0.43	0.94	2.04
VT	0.38	0.72	2.20	0.49	0.66	2.17	0.38	0.75	2.21	0.41	0.70	2.23
WA	0.66	0.60	2.30	0.77	0.59	2.44	0.72	0.58	2.45	0.73	0.62	2.38
WI	0.52	0.43	2.07	0.60	0.44	2.14	0.60	0.44	2.10	0.53	0.44	2.02
WV	0.34	0.91	2.12	0.51	1.01	2.17	0.43	0.72	2.20	0.43	0.86	2.12
WY	0.82	0.68	2.03	0.64	0.65	1.96	0.70	0.56	2.02	0.66	0.58	2.00

†: 1999 data were available only for assessments completed before July 1, 1999

Note: Sample sizes can be found in Table 3.7

Source: OSCAR

*Nursing Home RL*

AVERAGE 1999 MEDICAID RATES \*

12/20/99

ALASKA	\$224.50	1
DISTRICT OF COLUMBIA	\$185.06	2
NEW YORK	\$173.85	3
HAWAII	\$155.56	4
CONNECTICUT ***	\$130.00	5
PENNSYLVANIA	\$120.50	6
WASHINGTON	\$116.49	7
MASSACHUSETTS	\$116.00	8
MAINE	\$115.77	9
NEW HAMPSHIRE	\$115.33	10
OHIO	\$112.49	11
MARYLAND **	\$111.93	12
RHODE ISLAND	\$111.75	13
DELEWARE	\$111.70	14
NEW JERSEY **	\$110.24	15
COLORADO	\$106.72	16
MINNESOTA	\$106.65	17
WEST VIRGINIA	\$106.48	18
VERMONT	\$105.12	19
MICHIGAN	\$105.00	20
NEVADA	\$104.61	21
ALABAMA	\$103.86	22
FLORIDA	\$102.38	23
IDAHO	\$102.29	24
WISCONSIN	\$98.97	25
NORTH DAKOTA	\$97.68	26
NORTH CAROLINA ***	\$95.12	27
IOWA	\$95.00	28
ARIZONA	\$94.51	29
WYOMING	\$94.38	30
MONTANA	\$93.39	31
KENTUCKY	\$93.01	32
INDIANA	\$92.20	33
NEW MEXICO ***	\$92.10	34
MISSOURI	\$90.04	35
OREGON ***	\$89.05	36
SOUTH CAROLINA	\$87.01	37
NEBRASKA	\$86.06	38
UTAH	\$85.53	39
TENNESSEE	\$85.37	40
MISSISSIPPI	\$84.54	41
GEORGIA	\$83.64	42
CALIFORNIA ***	\$83.04	43
ILLINOIS	\$81.44	44
TEXAS	\$81.22	45
SOUTH DAKOTA	\$78.92	46
KANSAS	\$77.25	47
VIRGINIA	\$75.08	48
LOUISIANA	\$67.48	49
OKLAHOMA	\$66.38	50
ARKANSAS	\$64.33	51
NATIONAL AVERAGE:		\$103.27

\* BASED ON HCIA'S (HEALTH CARE INVESTMENT ANALYSTS/ARTHUR ANDERSON) 2000 GUIDE TO THE NURSING HOME INDUSTRY.

\*\* 1999 RATES UNAVAILABLE; RATES ARE 1998 RATES, AS LISTED IN HCIA'S 1998-1999 GUIDE TO THE NURSING HOME INDUSTRY.

\*\*\* WEIGHTED AVERAGE WEIGHTS UNAVAILABLE; RATES LISTED ARE BASED UPON AHCA'S 1998 FACTS & TRENDS: THE NURSING FACILITY SOURCEBOOK

BASED UPON THESE ASSUMPTIONS, TEXAS RANKS 45th IN THE NATION IN TERMS OF ITS NF MEDICAID RATE, WITH A RATE THAT IS \$21.83 OR 21.1% BELOW THE NATIONAL AVERAGE.

**Q: Although today's study focuses on the states' role in assuring nursing home quality, you have always advocated a strong federal role. What has the federal government done in the Clinton-Gore Administration to improve quality? Aren't you equally responsible for the poor results outlined in today's results?**

**A: Protecting the 1.6 million residents in the nation's 17,000 nursing homes has been and will continue to be one of the highest priorities of the Clinton-Gore Administration.** Since we have been in office, our commitment and financial investment have yielded (1) a substantial increase in the number of surveys conducted on nights and weekends; (2) more citations being applied to nursing homes providing sub-standard care and failing to prevent problems like bed sores; (3) the vast majority of facilities with serious problems identified by surveyors are being referred for immediate sanctions; and (4) the broad use of our award winning Nursing Home Compare web site by consumers who can now immediately access information about the safety record, staffing level, number and types of residents, and comparisons of its performance to state and national averages.

**Issued veto threat of Republican effort to repeal Federal nursing home standards.**

In 1995, the Administration issues a veto threat of congressional Republican proposal to eliminate federal nursing home standards and vetoed legislation that would have blocked granted the Medicaid program. That year we also we began enforcing the toughest nursing home regulations ever. These new regulations led to several improvements, including reductions in improper use of anti-psychotic drugs and physical restraints.

**Implemented unprecedented Nursing Home Initiative to beef up enforcement and oversight.**

In 1998, in response to new reports about shortcomings in quality, we initiated the Administration's Nursing Home Initiative (NHI) that provided for swift and strong penalties for nursing homes failing to comply with standards, strengthened oversight of state enforcement mechanisms, and implemented unprecedented efforts to improve nutrition and prevent bed sores.

**Budgeted and successfully advocated for nursing home quality budget increases.**

Since the beginning of this Administration, we have requested, budgeted, and received significant increases from Congress in appropriations for enforcement and inspection activities. In this year's budget, we have requested and expect to receive new funding increases for this priority responsibility. As a result, we expect our nursing home quality initiative will be funded in excess of \$85 million this year.

*# needs to be updated to reflect higher increases (not just NHI #'s)*

**Proposed for historic new nursing home staffing improvement legislation.**

And finally, Al Gore has proposed a landmark initiative to improve staffing levels. The Institute of Medicine has recently documented a significant correlation between nursing home staffing levels and quality outcomes. Gore's initiative, which has been endorsed by the President and has receive bipartisan support in the Congress (Senator Grassley, R-Iowa) would: (1) invests \$1 billion over 5 years in a new grant program to increase staffing levels nationwide and improve quality of nursing home care; (2) imposes immediate penalties on nursing facilities placing residents at risk and reinvests these

funds in the new grant program; (3) directs the Health Care Financing Administration to establish national minimum staffing requirements and complete recommendations for appropriate reimbursement within two years; and (4) helps families make informed decisions by providing accurate information on staffing levels.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington D.C. 20201 - 0001

# FAX COVER SHEET

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

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**Prepared for Rep. Ciro D. Rodriguez**

**Minority Staff  
Special Investigations Division  
Committee on Government Reform  
U.S. House of Representatives**

**October 31, 2000**

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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, Representative **Ciro D. Rodriguez** asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the state of Texas. There are 1,230 nursing homes in Texas that accept residents covered by Medicaid or Medicare. These homes serve approximately 86,000 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 Texas. Over 80% of the nursing homes in Texas violated federal health and safety standards during recent state inspections. Moreover, over 50% of the nursing homes in Texas had violations that caused actual harm to residents or placed them at risk of death or serious injury.

One of the causes of these deficiencies appears to be the low rate of state Medicaid reimbursement in Texas and the low level of staffing in Texas nursing homes. Texas ranks 44th in the nation in Medicaid reimbursements, 40th in the nation in total nursing home staffing, and 46th in the nation in staffing by registered nurses. Over 90% of the nursing homes in Texas do not meet the preferred minimum staffing levels identified by the U.S. Department of Health and Human Services.

### A. Methodology

Under federal law, the U.S. Department of Health and Human Services (HHS) 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. During the annual inspections, the state inspectors also record the staffing levels in the nursing homes.

This report analyzed the most recent annual inspections of Texas nursing homes. These inspections were conducted from March 1998 to August 2000. In addition, the report examined 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 conditions in Texas nursing homes 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 Texas 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 inspection was conducted.

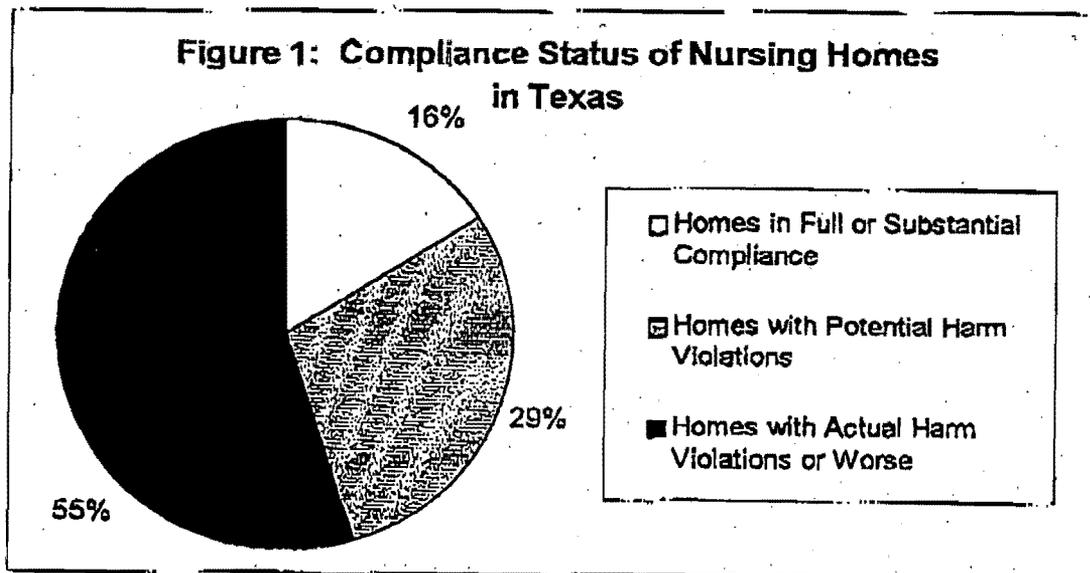
**B. Findings**

**Many nursing homes in Texas violate 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 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 nursing homes in Texas, only 186 homes (16%) were found to be in full or substantial compliance with the federal standards. The other 1,044 nursing homes (84%) had at least one violation with the potential to cause more than minimal harm to residents. On average, each of these 1,044 nursing homes had 12.9 violations of federal quality of care requirements.

**Many nursing homes in Texas have violations that cause actual harm to residents.**

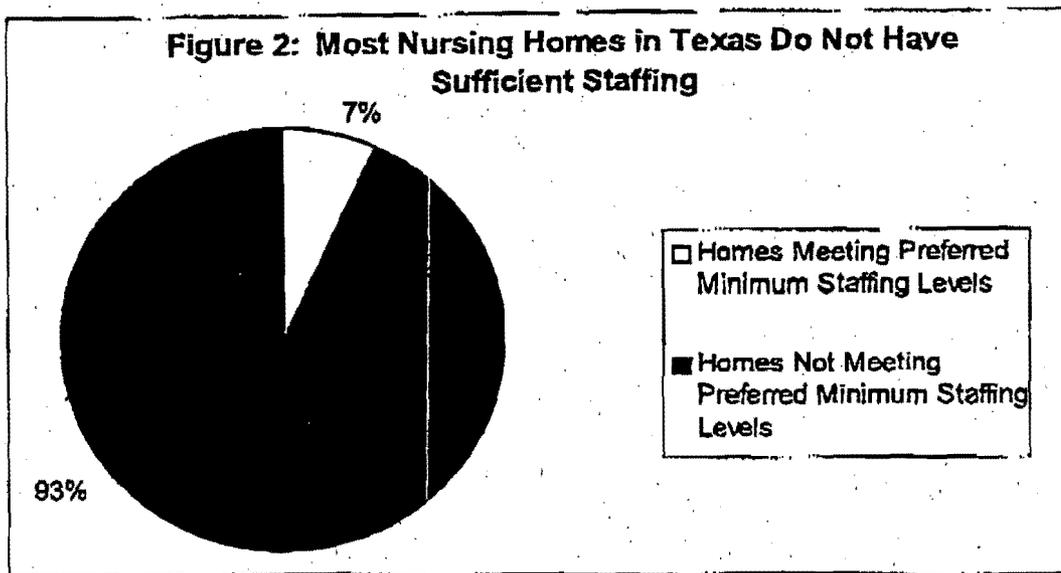
Of the 1,230 nursing homes in Texas, 680 homes (55%) had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). These violations involved serious problems, such as untreated pressure sores, preventable accidents, and inadequate nutrition and hydration. Over 450 nursing homes in Texas were cited for more than one violation that caused actual harm to residents or had the potential to cause death or serious injury.



**Texas pays low reimbursement rates and has low staffing levels in nursing homes.**

One of the underlying causes of the poor conditions in Texas nursing homes appears to be the low level of reimbursements paid by the state under the Medicaid program and the low level of staffing that the nursing homes are able to afford. Texas currently pays its nursing homes only \$81 a day per resident under the Medicaid program, an amount that places Texas 44th among the 50 states in

reimbursement levels. One consequence of the low reimbursement rates is that Texas nursing homes ranked 40th in the nation in total nursing home staffing and 46th in staffing by registered nurses. Over 90% of the nursing homes in Texas do not meet the preferred minimum staffing levels identified by HHS (Figure 2).



**An examination of a random sample of nursing homes 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 random sample of 29 Texas nursing homes cited for actual harm violations and 5 Texas nursing homes cited for multiple, potential-to-harm violations. The inspection reports documented that the actual harm violations cited by state inspectors were for serious neglect and mistreatment of residents, including improper use of restraints, the failure to protect residents from abuse, and medical errors. 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.

## 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.<sup>1</sup> That figure has now risen to 34.6 million Americans, or 13% of the population.<sup>2</sup> In 25 years, the number of Americans aged 65 and older will increase to 62 million, nearly 20% of the population.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

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 United States

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

<sup>2</sup>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).

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

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

<sup>5</sup>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).

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

operated over 2,000 facilities and had revenues of nearly \$14 billion in 1998.<sup>7</sup>

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).<sup>8</sup> 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.<sup>9</sup> 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."<sup>10</sup>

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

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<sup>7</sup>Thomas J. Cole, *Awash in Red Ink*, Albuquerque Journal, A1 (Aug. 3, 1999).

<sup>8</sup>All 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-Proj1998/tables/table14a.htm>).

<sup>9</sup>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.

<sup>10</sup>42 U.S.C. §1396r(b)(2).

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.<sup>11</sup> 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";<sup>12</sup> that these incidents of actual harm "represented serious care issues ... such as pressure sores, broken bones, severe weight loss, and death";<sup>13</sup> and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."<sup>14</sup>

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."<sup>15</sup> In March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to quality of resident care.<sup>16</sup>

Most recently, a report by HHS identified minimum staffing levels below which quality of

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<sup>11</sup>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 V of this report.

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

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

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

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

<sup>16</sup>HHS Office of Inspector General, *Nursing Home Survey and Certification* (Mar. 1999).

care in nursing homes may be "seriously impaired."<sup>17</sup> According to the HHS report, many nursing homes in the United States do not meet these staffing levels. The HHS report found that residents in nursing homes that did not meet these minimum staffing levels were more likely to suffer from serious health problems than residents in nursing homes that met the minimum staffing levels. According to the HHS report, for example, residents in nursing homes with inadequate staffing were almost four times more likely to develop pressure sores and nearly twice as likely to suffer extensive weight loss as residents of nursing homes with higher staffing levels.

In light of the growing concern about nursing home conditions, Rep. Ciro D. Rodriguez asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in Texas nursing homes. Rep. Rodriguez represents the 28<sup>th</sup> Congressional District of Texas, which includes part of San Antonio. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in the state of Texas.

## II. METHODOLOGY

To assess the conditions in Texas nursing homes, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which contains the results of annual nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) actual state inspection reports from a random sample of 34 nursing homes.

### A. Determination of Compliance Status

Data on the compliance status of nursing homes in Texas comes 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, 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.<sup>18</sup>

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<sup>17</sup>HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (Summer 2000).

<sup>18</sup>In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership (e.g., for-profit or nonprofit); whether the home accepts 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 the information in the OSCAR database,

Source: HCFA Quality Report

Table D-1. Mean Number of Citations Received by Nursing Homes with Health Deficiencies, by Calendar Year<sup>1,2</sup>

STATE	1996				1997				1998				1999			
	Q1-Q2*		Q3-Q4**		Q1-Q2*		Q3-Q4**		Q1-Q2*		Q3-Q4**		Q1-Q2*		Q3-Q4**	
	mean no. health deficiencies	no. providers														
AK	4.0	2	3.0	5	2.9	3	4.1	7	4.6	7	4.8	6	7.1	7	5.8	8
AL	7.1	103	6.7	70	5.7	83	6.9	99	6.4	104	6.3	102	7.7	105	8.6	83
AR	8.3	104	8.7	104	7.9	115	7.6	118	7.3	113	8.1	106	7.8	113	7.9	85
AZ	6.0	67	6.0	62	5.5	51	5.6	51	5.5	62	7.9	49	8.7	39	7.3	38
CA	11.1	657	10.7	537	11.3	677	11.1	563	10.8	622	11.0	608	11.8	571	11.8	507
CO	4.0	41	3.9	56	4.0	67	3.9	66	2.9	65	4.0	76	4.1	91	3.8	84
CT	3.3	42	2.6	62	2.5	75	3.6	88	3.2	90	3.6	95	3.8	114	5.5	98
DC	6.5	8	7.0	6	5.2	10	4.6	11	4.5	6	4.7	10	6.8	9	3.5	4
DE	8.8	19	11.4	14	8.8	17	8.4	19	10.3	15	12.5	11	9.0	20	8.3	11
FL	7.0	194	7.3	242	7.3	285	7.1	290	8.0	314	8.4	301	7.9	331	6.9	322
GA	4.4	78	4.5	113	4.3	109	3.9	122	3.7	123	5.4	167	6.4	156	4.7	137
HI	6.2	12	4.2	18	7.3	14	8.1	19	7.4	16	8.6	25	6.7	20	7.8	19
IA	5.8	122	5.4	140	6.2	160	5.5	176	6.0	197	4.9	188	5.6	176	4.7	153
ID	7.5	27	6.9	28	7.6	35	6.5	35	7.4	38	8.4	39	7.7	42	9.8	32
IL	6.4	265	6.7	359	6.5	365	6.4	413	6.2	388	6.4	383	6.9	402	6.9	369
IN	6.4	188	7.6	210	6.6	232	7.9	234	7.9	243	8.4	247	8.0	233	8.5	251
KS	5.3	82	6.3	120	7.0	214	6.9	171	6.1	206	7.5	145	7.0	197	7.7	159
KY	5.4	51	4.9	58	4.8	49	6.6	88	6.2	137	7.6	129	7.6	128	8.5	131
LA	5.7	48	4.9	78	5.4	114	5.3	103	5.1	111	5.5	115	7.1	122	5.3	132
MA	5.1	129	4.8	176	4.9	139	4.7	140	4.8	123	4.8	145	4.9	173	7.2	148
MD	3.9	61	3.8	71	4.0	70	3.2	73	4.0	70	3.9	58	5.2	61	4.9	31
ME	3.0	29	3.3	40	3.4	35	4.2	46	4.1	57	4.2	55	4.0	51	5.3	47
MI	9.9	209	9.7	176	9.3	227	8.0	176	9.7	184	9.7	199	9.8	173	10.2	215
MN	3.9	129	4.0	122	4.0	157	3.8	140	5.1	178	4.8	160	4.3	149	4.9	187
MO	6.0	140	5.1	176	4.9	195	4.8	186	5.2	189	6.0	210	6.0	221	6.5	201
MS	7.6	56	5.3	63	6.3	67	5.2	61	5.1	87	6.3	78	6.2	76	6.7	90
MT	7.3	44	5.6	29	4.7	39	4.0	38	6.5	42	6.3	41	5.9	49	5.7	46
NC	5.3	109	4.4	133	5.5	120	5.1	138	5.3	144	6.6	163	7.1	158	6.9	159
ND	6.1	22	7.1	42	6.6	41	9.6	38	7.4	37	8.5	46	6.7	43	5.3	37
NE	5.3	63	5.2	70	4.1	68	5.0	59	4.3	63	4.7	68	4.3	62	4.9	85
NH	5.0	17	6.6	27	5.7	29	4.6	31	5.0	27	4.3	20	6.0	25	5.3	21
NJ	3.8	84	4.7	90	4.3	116	3.9	80	3.6	98	4.1	85	4.2	104	3.7	21
NM	4.8	15	3.1	19	3.4	22	5.4	20	4.9	35	6.1	27	6.6	34	5.9	30
NV	14.1	20	11.2	21	13.7	16	16.0	19	17.9	15	14.3	24	10.1	18	14.0	20
NY	4.4	217	3.8	231	3.5	204	3.2	176	2.7	167	3.7	182	4.1	229	5.3	182
OH	6.3	432	5.1	368	5.0	402	5.8	303	5.4	317	6.5	394	6.6	331	6.6	315
OK	4.6	122	5.9	118	6.3	148	5.0	129	5.4	134	5.3	143	6.0	128	7.2	49
OR	6.0	54	6.6	44	6.3	46	8.7	52	5.0	59	6.5	54	6.1	60	8.9	52
PA	4.7	216	4.0	265	4.2	290	4.4	303	4.7	327	4.8	322	5.0	335	5.4	277
RI	4.5	30	3.2	29	4.6	39	3.8	35	4.8	39	4.6	35	4.5	39	4.6	33
SC	7.8	64	7.0	70	8.1	77	8.7	82	8.3	80	8.5	75	8.0	86	9.8	56
SD	6.2	40	4.5	39	4.1	42	4.3	32	3.7	35	4.6	41	4.6	42	6.1	36
TN	6.8	92	6.1	134	3.4	113	4.0	134	4.8	127	4.8	155	5.3	146	5.5	168
TX	5.3	289	5.4	387	5.7	450	5.3	432	5.3	487	5.5	472	5.4	511	6.2	457
UT	5.8	25	4.1	33	4.9	39	4.0	30	5.8	29	5.1	41	4.6	38	4.6	22
VA	4.8	65	6.2	70	4.8	78	5.1	73	4.6	77	5.3	87	5.4	129	4.6	68
VT	3.8	9	2.5	17	3.0	10	2.9	15	2.4	17	3.9	9	3.2	13	4.9	14
WA	7.8	82	8.2	117	9.0	131	8.4	139	8.7	140	9.6	125	9.7	132	10.2	134
WI	3.8	103	4.1	156	5.2	165	4.3	170	4.8	169	5.4	165	4.8	169	4.4	125
WV	6.0	49	4.9	31	6.7	37	6.6	36	4.9	33	7.0	36	5.7	75	6.5	54
WY	1.5	6	5.8	17	5.9	18	6.0	17	4.1	18	6.5	17	6.6	18	4.3	14
National Total	6.6	5150	6.1	5661	6.3	6303	6.2	6076	6.2	6471	6.2	6532	6.7	6784	7.0	6037

<sup>1</sup> Source: OSCAR, April 2000  
<sup>2</sup> Excludes facilities with zero health deficiencies  
\*Quarters 1 and 2 (January 1 through June 30)  
\*\*Quarters 3 and 4 (July 1 through December 31)

**Table D-2. Number and Percentage of Nursing Homes Without Health Deficiencies, by Calendar Year<sup>1</sup>**

State	1996				1997				1998				1999			
	Q1-Q2 <sup>**</sup>		Q3-Q4 <sup>**</sup>		Q1-Q2 <sup>**</sup>		Q3-Q4 <sup>**</sup>		Q1-Q2 <sup>**</sup>		Q3-Q4 <sup>**</sup>		Q1-Q2 <sup>**</sup>		Q3-Q4 <sup>**</sup>	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
AK	2	20.0	2	28.6	2	25.0	1	12.5	1	12.5	2	25.0	1	12.5	0	0.0
AL	12	9.0	8	9.8	8	8.8	6	5.6	15	12.6	5	4.7	7	6.3	8	8.8
AR	4	2.5	3	2.2	4	2.9	7	4.9	5	4.2	4	3.6	5	4.2	4	4.5
AZ	3	3.8	1	1.4	2	3.3	4	6.9	3	4.6	3	5.8	3	7.1	4	9.5
CA	15	2.0	25	4.1	19	2.6	19	3.1	11	1.7	10	1.6	20	3.4	13	2.5
CO	24	21.1	28	29.2	38	35.2	55	42.3	48	42.5	26	25.5	24	20.9	37	30.6
CT	40	32.5	60	44.8	65	43.6	34	27.0	36	28.6	19	16.7	18	13.6	13	11.7
DC	1	7.7	0	0.0	2	15.4	0	0.0	0	0.0	0	0.0	1	10.0	0	0.0
DE	0	0.0	0	0.0	4	18.2	3	13.0	1	6.3	1	8.3	2	9.1	2	15.4
FL	36	10.4	41	13.1	37	10.8	32	9.6	31	9.0	36	10.7	28	7.8	58	15.3
GA	33	15.9	56	28.7	59	32.8	57	31.1	53	30.1	35	17.3	34	17.9	32	18.9
HI	1	5.3	0	0.0	1	5.6	3	12.5	1	5.9	0	0.0	1	4.8	1	5.0
IA	30	13.0	52	21.8	36	16.4	41	17.7	38	16.9	37	18.4	38	17.8	36	19.0
ID	1	2.2	4	10.8	5	11.1	4	10.0	2	5.0	3	7.1	5	10.6	3	8.6
IL	23	5.2	41	9.4	32	7.6	29	6.3	38	8.9	33	7.9	45	10.1	40	9.3
IN	30	9.9	22	8.5	26	9.3	26	9.3	20	7.6	19	7.1	27	10.4	26	9.4
KS	10	3.9	18	8.6	26	9.2	20	9.7	56	21.4	26	15.2	35	15.1	19	10.7
KY	70	42.9	89	58.2	85	60.3	41	31.3	23	14.4	21	14.0	20	13.5	5	3.7
LA	18	9.4	25	15.9	38	18.4	34	19.3	56	33.5	38	24.8	49	28.7	44	25.0
MA	72	26.2	108	34.4	114	41.9	146	48.8	105	46.1	106	42.2	96	35.7	58	28.2
MD	28	27.7	50	38.8	43	34.7	46	37.4	41	36.9	38	40.4	25	29.1	13	29.5
ME	15	22.1	23	33.8	24	35.8	18	26.1	8	12.3	10	15.4	11	17.7	12	20.3
MI	7	2.7	4	2.1	7	2.9	8	4.1	4	2.1	7	3.4	6	3.4	5	2.3
MN	48	21.1	42	23.1	66	28.7	52	26.7	39	18.0	64	28.6	49	24.7	44	19.0
MO	51	17.8	73	25.3	85	27.6	83	28.4	77	28.9	45	17.6	57	20.5	32	13.7
MS	21	20.0	17	17.5	29	26.4	25	25.8	18	17.1	14	15.2	11	12.6	9	9.1
MT	2	3.5	10	25.0	13	24.5	10	20.0	3	6.7	8	16.3	7	12.5	1	2.1
NC	31	14.8	44	23.3	82	39.4	60	29.7	68	32.1	47	22.4	31	16.4	38	19.3
ND	3	8.7	1	2.3	3	6.8	0	0.0	5	11.9	4	8.0	4	8.5	10	21.3
NE	31	24.4	24	21.4	51	39.8	45	39.1	38	31.4	39	36.4	29	24.0	26	23.4
NH	10	22.2	8	22.2	15	33.3	11	26.2	12	30.8	21	51.2	15	37.5	6	22.2
NJ	66	33.8	50	29.8	63	32.8	77	48.4	87	47.0	72	45.9	47	31.1	12	36.4
NM	15	34.9	14	32.6	20	45.5	19	44.2	8	18.6	10	27.0	7	17.1	8	21.1
NV	0	0.0	0	0.0	0	0.0	0	0.0	1	6.3	2	7.7	2	10.0	1	4.8
NY	100	28.7	96	29.0	98	31.9	110	38.3	131	44.0	96	34.5	77	25.2	55	23.2
OH	74	12.8	85	17.4	113	20.7	83	20.7	102	24.3	105	21.0	87	20.8	63	16.7
OK	33	15.8	49	23.8	40	17.9	48	25.1	53	28.3	37	20.6	57	30.8	14	22.2
OR	16	17.0	19	25.7	22	27.8	16	21.1	22	27.2	11	16.9	10	14.3	14	21.2
PA	83	21.4	106	25.4	96	23.5	95	22.6	73	18.3	68	17.4	68	16.9	60	17.8
RI	7	13.7	16	34.0	9	18.4	15	29.4	15	27.8	9	20.5	11	22.0	15	31.3
SC	4	4.3	4	4.8	3	3.4	7	7.6	3	3.6	5	6.3	4	4.4	3	5.1
SD	12	21.8	7	13.7	10	17.2	11	25.6	5	12.5	5	10.9	6	12.5	4	10.0
TN	8	4.4	19	11.9	60	33.0	46	24.7	51	28.7	28	15.3	22	13.1	15	8.2
TX	87	12.6	135	20.8	126	18.5	141	21.7	104	17.6	117	19.9	123	19.4	112	19.7
UT	3	8.1	9	16.7	10	18.5	9	22.5	8	21.6	13	24.1	14	26.9	6	21.4
VA	49	33.3	38	30.9	51	37.2	44	36.1	46	37.4	29	25.0	45	25.9	34	33.3
VT	4	17.4	4	17.4	7	38.9	7	31.8	8	32.0	7	43.8	15	53.6	7	33.3
WA	14	9.2	6	4.4	9	6.2	3	2.0	4	2.8	9	6.7	2	1.5	2	1.5
WI	54	23.8	42	19.4	41	19.3	46	20.8	46	21.4	45	21.4	42	19.9	67	34.9
WV	8	11.6	5	11.6	4	9.3	3	7.3	3	8.3	3	7.7	4	5.1	1	1.8
WY	5	27.8	2	9.5	1	5.3	0	0.0	5	21.7	2	10.5	2	10.0	4	22.2
National Total	1314	14.6%	1585	19.4%	1804	20.5%	1700	20.9%	1631	20.1%	1394	17.7%	1349	16.6%	1096	15.4%

<sup>1</sup>Source: OSCAR, April 2000

<sup>\*\*</sup>Quarters 1 and 2 (January 1 through June 30)

<sup>\*\*</sup>Quarters 3 and 4 (July 1 through December 31)

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse in Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
AK	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	0.0	0.0	0.0	12.5	12.5	12.5
		Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.0
		Restraint Use	0.0	0.0	25.0	25.0	37.5	50.0	25.0	62.5
		Pressure Sores	0.0	0.0	0.0	0.0	0.0	0.0	12.5	12.5
	Total Number of Facilities		10	7	8	8	8	8	8	8
AL	Percentage of Facilities cited for	Sub. Quality of Care	2.2	0.0	2.2	4.7	0.8	0.9	2.7	6.6
		Abuse	9.0	14.6	7.5	10.3	9.2	16.8	11.6	22.0
		Restraint Use	24.6	18.3	16.1	16.8	10.9	11.2	10.7	11.0
		Pressure Sores	21.6	25.6	41.9	60.7	26.9	19.6	26.8	26.4
	Total Number of Facilities		134	82	93	107	119	107	112	91
AR	Percentage of Facilities cited for	Sub. Quality of Care	3.8	3.7	1.4	2.8	8.5	5.5	10.2	13.5
		Abuse	3.8	7.5	4.3	1.4	7.6	7.3	11.0	16.9
		Restraint Use	8.2	16.4	15.8	11.8	16.1	20.0	27.1	21.3
		Pressure Sores	25.8	36.6	32.4	25.0	28.0	17.3	23.7	18.0
	Total Number of Facilities		159	134	139	144	118	110	118	89
AZ	Percentage of Facilities cited for	Sub. Quality of Care	0.0	1.4	3.3	0.0	3.1	5.8	2.4	4.8
		Abuse	1.3	2.9	4.9	0.0	7.7	9.6	9.5	23.8
		Restraint Use	19.0	17.1	21.3	19.0	16.9	13.5	21.4	16.7
		Pressure Sores	5.1	4.3	4.9	1.7	15.4	11.5	21.4	11.9
	Total Number of Facilities		79	70	61	58	65	52	42	42
CA	Percentage of Facilities cited for	Sub. Quality of Care	8.0	5.2	7.1	6.3	7.3	7.8	6.6	5.4
		Abuse	15.3	12.7	13.2	13.8	15.2	16.2	20.5	27.5
		Restraint Use	29.0	22.7	28.0	22.0	22.6	22.5	23.9	17.3
		Pressure Sores	20.8	18.3	21.1	25.4	24.2	26.4	27.9	23.7
	Total Number of Facilities		758	616	736	615	633	618	591	520
CO	Percentage of Facilities cited for	Sub. Quality of Care	2.6	3.1	0.9	0.8	1.8	1.0	1.7	1.7
		Abuse	0.0	1.0	2.8	1.5	4.4	1.0	1.7	5.0
		Restraint Use	5.3	8.3	5.6	14.6	4.4	9.8	10.4	7.4
		Pressure Sores	12.3	25.0	11.1	11.5	8.8	12.7	10.4	9.9
	Total Number of Facilities		114	96	108	130	113	102	115	121
CT	Percentage of Facilities cited for	Sub. Quality of Care	0.0	3.0	2.0	4.0	4.0	3.5	2.3	3.6
		Abuse	0.8	5.2	5.4	11.1	8.7	19.3	16.7	26.1
		Restraint Use	2.4	2.2	2.0	5.6	3.2	3.5	5.3	9.9
		Pressure Sores	17.9	9.0	12.8	23.8	23.8	21.9	15.2	19.8
	Total Number of Facilities		123	134	149	126	126	114	132	111
DC	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	0.0	7.7	0.0	10.0	0.0	0.0
		Abuse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	25.0
		Restraint Use	0.0	0.0	0.0	7.7	0.0	10.0	0.0	0.0
		Pressure Sores	15.4	28.6	15.4	7.7	0.0	10.0	10.0	0.0
	Total Number of Facilities		13	7	13	13	6	10	10	4
DE	Percentage of Facilities cited for	Sub. Quality of Care	4.5	6.7	0.0	0.0	0.0	8.3	0.0	7.7
		Abuse	45.5	93.3	36.4	21.7	37.5	50.0	59.1	23.1
		Restraint Use	31.8	6.7	22.7	0.0	31.3	25.0	27.3	0.0
		Pressure Sores	9.1	20.0	36.4	47.8	31.3	16.7	18.2	15.4
	Total Number of Facilities		22	15	22	23	16	12	22	13

<sup>1</sup> Source: OSCAR, April 2000

\* The first and second quarters of the year (January 1 through June 30).

\*\* The third and fourth quarters of the year (July 1 through December 31).

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse in Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
FL	Percentage of Facilities cited for	Sub. Quality of Care	9.0	10.8	7.8	8.7	9.0	11.9	7.8	6.6
		Abuse	9.9	13.7	13.7	13.1	18.0	20.2	17.5	18.4
		Restraint Use	18.0	15.6	14.5	11.3	15.7	16.3	11.1	8.4
		Pressure Sores	14.8	15.3	15.4	17.9	21.7	20.5	17.8	10.0
	Total Number of Facilities		345	314	344	335	345	337	359	380
GA	Percentage of Facilities cited for	Sub. Quality of Care	8.7	10.8	7.2	4.9	1.7	7.4	5.8	2.4
		Abuse	1.9	1.5	1.7	2.2	1.1	11.4	10.0	5.9
		Restraint Use	3.9	2.1	2.8	3.8	1.1	4.5	7.9	5.3
		Pressure Sores	9.7	9.2	10.0	7.1	9.1	11.4	13.7	12.4
	Total Number of Facilities		207	195	180	183	176	202	190	169
HI	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	5.6	8.3	0.0	16.0	4.8	25.0
		Abuse	5.3	13.0	0.0	16.7	17.6	12.0	14.3	15.0
		Restraint Use	15.8	4.3	16.7	8.3	0.0	24.0	28.6	25.0
		Pressure Sores	15.8	4.3	16.7	16.7	11.8	36.0	9.5	25.0
	Total Number of Facilities		19	23	18	24	17	25	21	20
IA	Percentage of Facilities cited for	Sub. Quality of Care	2.2	0.8	3.7	4.3	4.4	3.1	1.9	2.6
		Abuse	0.4	1.3	0.9	0.4	0.9	1.8	0.0	2.1
		Restraint Use	8.3	8.4	8.7	9.5	11.6	5.8	1.9	1.1
		Pressure Sores	25.2	16.4	21.0	13.8	16.0	14.2	12.6	13.8
	Total Number of Facilities		230	238	219	232	225	225	214	189
ID	Percentage of Facilities cited for	Sub. Quality of Care	2.2	8.1	13.3	5.0	17.5	7.1	8.5	14.3
		Abuse	15.6	8.1	13.3	22.5	22.5	31.0	25.5	51.4
		Restraint Use	11.1	16.2	22.2	25.0	10.0	16.7	6.4	20.0
		Pressure Sores	2.2	8.1	17.8	15.0	25.0	31.0	14.9	37.1
	Total Number of Facilities		45	37	45	40	40	42	47	35
IL	Percentage of Facilities cited for	Sub. Quality of Care	1.1	1.8	3.5	2.0	2.3	7.2	5.1	2.1
		Abuse	2.7	2.1	3.3	5.0	6.3	8.9	4.9	12.6
		Restraint Use	14.8	15.9	19.4	14.0	15.5	10.3	16.1	8.9
		Pressure Sores	15.0	13.8	22.2	20.5	24.4	26.0	27.7	27.0
	Total Number of Facilities		446	434	423	458	426	416	447	429
IN	Percentage of Facilities cited for	Sub. Quality of Care	4.3	9.7	5.7	3.2	5.7	10.9	9.2	6.5
		Abuse	9.9	18.5	15.7	19.2	17.1	23.3	23.5	21.3
		Restraint Use	9.2	13.1	23.5	26.0	27.0	25.2	18.1	13.0
		Pressure Sores	16.2	20.5	13.2	12.8	16.7	21.1	16.9	17.3
	Total Number of Facilities		303	259	281	281	263	266	260	277
KS	Percentage of Facilities cited for	Sub. Quality of Care	3.9	4.8	11.6	11.2	8.8	13.5	6.0	3.9
		Abuse	5.1	6.2	11.3	8.7	12.6	11.7	11.2	8.4
		Restraint Use	15.6	14.8	18.3	18.4	13.4	16.4	13.8	16.9
		Pressure Sores	34.2	30.0	28.9	29.1	25.6	38.6	25.0	30.3
	Total Number of Facilities		257	210	284	206	262	171	232	178
KY	Percentage of Facilities cited for	Sub. Quality of Care	3.1	2.6	1.4	6.9	6.9	11.3	6.8	10.3
		Abuse	5.5	0.7	2.8	8.4	8.1	10.0	8.8	15.4
		Restraint Use	10.4	9.2	8.5	14.5	16.3	14.7	14.2	11.8
		Pressure Sores	4.9	2.6	5.7	9.9	11.9	15.3	15.5	22.8
	Total Number of Facilities		163	153	141	131	160	150	148	136

<sup>1</sup> Source: OSCAR, April 2000

\* The first and second quarters of the year (January 1 through June 30).

\*\* The third and fourth quarters of the year (July 1 through December 31).

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse In Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
LA	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	0.5	0.6	1.8	3.3	5.8	2.3
		Abuse	2.1	2.5	1.9	4.5	1.8	7.2	5.8	6.3
		Restraint Use	3.1	6.4	3.4	2.3	2.4	3.9	2.3	1.1
		Pressure Sores	9.9	5.7	7.3	9.7	11.4	10.5	12.3	10.8
	Total Number of Facilities		191	157	206	176	167	153	171	176
MA	Percentage of Facilities cited for	Sub. Quality of Care	2.9	1.9	4.0	4.7	1.8	3.6	3.0	3.9
		Abuse	3.6	4.5	4.4	4.7	6.1	8.8	7.4	16.0
		Restraint Use	17.8	25.8	18.8	10.7	14.9	10.0	10.0	15.0
		Pressure Sores	6.5	7.3	5.9	8.4	10.1	9.6	7.8	12.6
	Total Number of Facilities		275	314	272	299	228	251	269	206
MD	Percentage of Facilities cited for	Sub. Quality of Care	4.0	3.1	8.1	2.4	1.8	2.1	7.0	6.8
		Abuse	6.9	2.3	0.8	4.9	5.4	3.2	11.6	2.3
		Restraint Use	9.9	3.1	4.0	0.8	1.8	0.0	10.5	6.8
		Pressure Sores	5.9	10.9	14.5	8.9	10.8	7.4	19.8	13.6
	Total Number of Facilities		101	129	124	123	111	94	86	44
ME	Percentage of Facilities cited for	Sub. Quality of Care	1.5	5.9	3.0	7.2	3.1	9.2	6.5	10.2
		Abuse	8.8	4.4	3.0	2.9	6.2	4.6	16.1	18.6
		Restraint Use	2.9	14.7	6.0	7.2	21.5	9.2	8.1	5.1
		Pressure Sores	4.4	5.9	4.5	5.8	1.5	6.2	19.4	3.4
	Total Number of Facilities		68	68	67	69	65	65	62	59
MI	Percentage of Facilities cited for	Sub. Quality of Care	7.8	5.2	3.3	3.6	4.3	7.8	6.1	8.2
		Abuse	11.3	17.7	9.6	10.3	14.4	10.7	9.5	11.4
		Restraint Use	21.5	28.1	22.6	13.4	19.7	31.1	19.0	18.2
		Pressure Sores	38.3	32.3	38.5	30.4	33.5	29.6	33.5	30.0
	Total Number of Facilities		256	192	239	194	188	206	179	220
MN	Percentage of Facilities cited for	Sub. Quality of Care	1.8	0.5	1.3	2.1	8.8	7.6	3.0	5.2
		Abuse	1.8	1.1	1.3	2.6	5.5	2.7	4.5	7.8
		Restraint Use	10.1	17.6	22.6	27.7	26.7	12.9	3.5	1.7
		Pressure Sores	13.2	9.3	8.7	8.2	17.1	12.9	13.6	13.4
	Total Number of Facilities		228	182	230	195	217	224	198	231
MO	Percentage of Facilities cited for	Sub. Quality of Care	2.4	4.2	3.6	1.4	3.0	9.0	5.0	6.0
		Abuse	4.2	2.4	0.6	0.7	1.5	2.4	4.0	14.2
		Restraint Use	11.9	10.7	7.8	6.2	6.0	6.3	7.6	3.4
		Pressure Sores	17.8	11.1	13.6	12.3	12.4	18.8	21.9	19.7
	Total Number of Facilities		286	289	308	292	266	255	278	233
MS	Percentage of Facilities cited for	Sub. Quality of Care	5.7	2.1	4.5	5.2	3.8	7.6	5.7	5.1
		Abuse	16.2	7.2	10.0	8.2	9.5	12.0	11.5	5.1
		Restraint Use	11.4	8.2	8.2	2.1	3.8	7.6	11.5	9.1
		Pressure Sores	15.2	12.4	18.2	20.6	16.2	18.5	17.2	19.2
	Total Number of Facilities		105	97	110	97	105	92	87	99
MT	Percentage of Facilities cited for	Sub. Quality of Care	5.3	5.0	3.8	2.0	11.1	4.1	0.0	2.1
		Abuse	5.3	10.0	7.5	6.0	2.2	4.1	1.8	21.3
		Restraint Use	29.8	2.5	0.0	10.0	33.3	12.2	21.4	19.1
		Pressure Sores	22.8	12.5	15.1	18.0	17.8	16.3	33.9	34.0
	Total Number of Facilities		57	40	53	50	45	49	56	47

<sup>1</sup> Source: OSCAR, April 2000

\* The first and second quarters of the year (January 1 through June 30).

\*\* The third and fourth quarters of the year (July 1 through December 31).

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse In Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
NC	Percentage of Facilities cited for	Sub. Quality of Care	2.4	2.6	5.3	2.0	1.9	4.8	2.6	3.6
		Abuse	8.6	3.2	7.2	6.4	5.2	8.6	11.6	9.1
		Restraint Use	13.9	5.3	5.8	7.9	7.1	12.4	9.0	6.1
		Pressure Sores	11.5	8.5	4.3	7.4	9.0	15.2	15.3	14.2
	Total Number of Facilities		209	189	208	202	212	210	189	197
ND	Percentage of Facilities cited for	Sub. Quality of Care	0.0	2.3	4.5	5.3	2.4	6.0	6.4	0.0
		Abuse	8.9	11.6	18.2	18.4	7.1	20.0	8.5	19.1
		Restraint Use	17.8	27.9	15.9	18.4	7.1	22.0	6.4	0.0
		Pressure Sores	26.7	23.3	25.0	34.2	16.7	26.0	34.0	19.1
	Total Number of Facilities		45	43	44	38	42	50	47	47
NE	Percentage of Facilities cited for	Sub. Quality of Care	7.9	3.6	5.5	1.7	2.5	2.8	2.5	1.8
		Abuse	2.4	4.5	0.8	1.7	1.7	1.9	7.4	8.1
		Restraint Use	7.1	12.5	7.0	7.0	8.3	4.7	6.6	7.2
		Pressure Sores	14.2	24.1	12.5	8.7	18.2	18.7	15.7	10.8
	Total Number of Facilities		127	112	128	115	121	107	121	111
NH	Percentage of Facilities cited for	Sub. Quality of Care	0.0	11.1	4.4	9.5	7.7	2.4	7.5	7.4
		Abuse	0.0	5.8	8.9	7.1	2.6	4.9	10.0	14.8
		Restraint Use	2.2	8.3	6.7	2.4	5.1	0.0	2.5	7.4
		Pressure Sores	15.6	22.2	22.2	19.0	20.5	9.8	20.0	25.9
	Total Number of Facilities		45	36	45	42	39	41	40	27
NJ	Percentage of Facilities cited for	Sub. Quality of Care	3.1	3.0	4.2	3.1	1.1	3.2	4.6	0.0
		Abuse	5.6	4.8	7.3	3.1	3.2	5.1	5.3	9.1
		Restraint Use	4.1	5.4	9.4	3.8	2.7	7.0	5.3	0.0
		Pressure Sores	3.6	7.7	4.7	6.9	4.3	10.2	9.3	6.1
	Total Number of Facilities		195	168	192	159	185	157	151	33
NM	Percentage of Facilities cited for	Sub. Quality of Care	2.3	0.0	2.3	2.3	0.0	5.4	7.3	7.9
		Abuse	4.7	4.7	2.3	2.3	7.0	13.5	9.8	7.9
		Restraint Use	16.3	7.0	13.6	16.3	4.7	10.8	17.1	10.5
		Pressure Sores	9.3	2.3	0.0	9.3	4.7	8.1	7.3	0.0
	Total Number of Facilities		43	43	44	43	43	37	41	38
NV	Percentage of Facilities cited for	Sub. Quality of Care	4.3	0.0	4.8	4.8	12.5	19.2	0.0	9.5
		Abuse	56.5	28.0	57.1	38.1	25.0	34.6	15.0	42.9
		Restraint Use	60.9	52.0	47.6	57.1	31.3	23.1	20.0	19.0
		Pressure Sores	26.1	12.0	23.8	23.8	37.5	23.1	20.0	23.8
	Total Number of Facilities		23	25	21	21	16	26	20	21
NY	Percentage of Facilities cited for	Sub. Quality of Care	3.4	0.0	0.7	0.3	0.0	1.1	2.9	2.5
		Abuse	2.0	0.6	1.0	0.7	0.7	1.1	2.9	9.7
		Restraint Use	11.5	9.4	12.1	6.3	7.0	8.6	11.1	8.0
		Pressure Sores	16.3	10.0	11.7	12.9	8.7	16.5	19.3	21.9
	Total Number of Facilities		349	331	307	287	298	278	306	237
OH	Percentage of Facilities cited for	Sub. Quality of Care	6.4	3.5	5.3	8.0	5.3	10.4	6.2	6.9
		Abuse	4.5	4.7	6.1	5.5	7.2	8.4	9.3	11.9
		Restraint Use	18.8	13.9	11.2	15.7	10.3	12.0	9.6	8.5
		Pressure Sores	19.3	16.0	21.5	23.7	19.8	22.0	24.4	20.6
	Total Number of Facilities		580	488	545	401	419	499	418	378

<sup>1</sup> Source: OSCAR, April 2000

\* The first and second quarters of the year (January 1 through June 30).

\*\* The third and fourth quarters of the year (July 1 through December 31).

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse In Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
OK	Percentage of Facilities cited for	Sub. Quality of Care	1.9	1.5	1.8	0.0	2.7	2.2	2.7	6.3
		Abuse	1.0	1.0	0.4	1.0	2.1	1.1	3.8	0.0
		Restraint Use	16.3	18.4	24.1	17.8	25.7	21.7	23.8	15.9
		Pressure Sores	9.1	13.6	14.3	7.9	12.3	10.6	11.4	12.7
	Total Number of Facilities		209	206	224	191	187	180	185	63
OR	Percentage of Facilities cited for	Sub. Quality of Care	8.5	9.5	7.6	5.3	7.4	13.8	18.6	18.2
		Abuse	13.8	17.6	13.9	23.7	19.8	23.1	32.9	37.9
		Restraint Use	12.8	13.5	12.7	11.8	14.8	16.9	11.4	19.7
		Pressure Sores	14.9	27.0	13.9	23.7	13.6	16.8	32.9	30.3
	Total Number of Facilities		94	74	79	76	81	65	70	66
PA	Percentage of Facilities cited for	Sub. Quality of Care	2.6	1.0	2.2	3.6	2.5	3.3	2.5	1.5
		Abuse	5.4	6.5	4.2	6.9	7.3	9.0	8.9	8.6
		Restraint Use	18.6	16.5	15.2	13.6	12.5	12.6	11.2	9.8
		Pressure Sores	10.8	12.0	11.3	10.7	19.5	13.8	13.9	16.0
	Total Number of Facilities		388	417	408	420	400	390	403	337
RI	Percentage of Facilities cited for	Sub. Quality of Care	0.0	4.3	2.0	2.0	1.9	6.8	4.0	4.2
		Abuse	3.9	2.1	6.1	3.9	7.4	9.1	0.0	4.2
		Restraint Use	7.8	8.5	16.3	11.8	20.4	2.3	14.0	14.6
		Pressure Sores	3.9	10.6	6.1	11.8	11.1	9.1	14.0	8.3
	Total Number of Facilities		51	47	49	51	54	44	50	48
SC	Percentage of Facilities cited for	Sub. Quality of Care	6.4	3.6	5.7	4.3	3.6	5.0	6.7	10.2
		Abuse	10.6	8.3	16.1	16.3	14.5	21.3	11.1	10.2
		Restraint Use	26.6	22.6	18.4	17.4	10.8	11.3	12.2	16.9
		Pressure Sores	28.7	20.2	28.7	18.5	30.1	27.5	18.9	23.7
	Total Number of Facilities		94	84	87	92	83	80	90	59
SD	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	0.0	0.0	0.0	0.0	2.1	0.0
		Abuse	3.6	0.0	1.7	2.3	2.5	0.0	2.1	0.0
		Restraint Use	14.5	29.4	24.1	16.3	22.5	23.9	27.1	22.5
		Pressure Sores	21.8	17.6	6.9	7.0	15.0	17.4	16.7	12.5
	Total Number of Facilities		55	51	58	43	40	46	48	40
TN	Percentage of Facilities cited for	Sub. Quality of Care	2.7	5.0	0.5	1.6	1.7	7.1	3.6	5.5
		Abuse	3.3	5.0	3.3	1.1	3.4	4.9	3.6	12.0
		Restraint Use	20.3	11.3	4.9	5.4	3.9	3.8	3.6	3.8
		Pressure Sores	17.0	10.0	12.1	16.1	9.6	14.2	14.3	16.4
	Total Number of Facilities		182	160	182	186	178	183	168	183
TX	Percentage of Facilities cited for	Sub. Quality of Care	4.2	4.6	4.9	4.6	6.8	3.7	5.4	4.7
		Abuse	6.4	3.5	5.7	5.4	5.2	4.8	8.8	10.4
		Restraint Use	7.5	6.8	11.0	7.5	8.3	8.7	7.3	8.4
		Pressure Sores	12.2	10.3	14.1	12.0	12.2	12.6	10.4	10.4
	Total Number of Facilities		691	649	680	650	591	589	634	569
UT	Percentage of Facilities cited for	Sub. Quality of Care	0.0	1.9	0.0	0.0	10.8	1.9	1.9	7.1
		Abuse	0.0	1.9	1.9	0.0	8.1	3.7	0.0	7.1
		Restraint Use	10.8	3.7	0.0	2.5	0.0	5.6	1.9	3.6
		Pressure Sores	10.8	5.6	11.1	5.0	16.2	9.3	9.6	14.3
	Total Number of Facilities		37	54	54	40	37	54	52	28

<sup>1</sup> Source: OSCAR, April 2000

\* The first and second quarters of the year (January 1 through June 30).

\*\* The third and fourth quarters of the year (July 1 through December 31).

**Table D-3. Citation Rates for Substandard Quality of Care, Pressure Sores, Restraint Use and Abuse in Nursing Homes, by Calendar Year<sup>1</sup>**

State	Citations		1996		1997		1998		1999	
			Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	3-Q4*	Q1-Q2*	Q3-Q4**
VA	Percentage of Facilities cited for	Sub. Quality of Care	3.4	11.4	8.8	2.5	0.8	3.4	2.9	2.0
		Abuse	10.9	11.4	15.3	8.2	7.3	12.1	13.8	12.7
		Restraint Use	9.5	24.4	3.6	7.4	12.2	14.7	16.1	8.8
		Pressure Sores	10.9	15.4	13.9	18.9	10.6	16.4	13.8	12.7
	Total Number of Facilities		147	123	137	122	123	116	174	102
VT	Percentage of Facilities cited for	Sub. Quality of Care	0.0	0.0	0.0	4.5	0.0	6.3	0.0	4.8
		Abuse	0.0	0.0	0.0	4.5	0.0	0.0	7.1	0.0
		Restraint Use	26.1	13.0	22.2	18.2	8.0	6.3	3.6	9.5
		Pressure Sores	17.4	4.3	27.8	9.1	12.0	12.5	7.1	14.3
	Total Number of Facilities		23	23	18	22	25	16	28	21
WA	Percentage of Facilities cited for	Sub. Quality of Care	5.3	3.7	9.6	7.4	9.7	9.0	3.7	8.1
		Abuse	21.1	24.4	26.7	26.8	26.4	34.3	30.6	33.8
		Restraint Use	17.8	19.3	17.8	12.1	16.7	21.6	26.1	11.8
		Pressure Sores	31.6	28.1	41.1	26.2	31.9	29.1	23.9	31.6
	Total Number of Facilities		152	135	146	149	144	134	134	136
WI	Percentage of Facilities cited for	Sub. Quality of Care	0.0	3.2	4.7	2.3	2.3	2.4	2.4	1.6
		Abuse	7.5	8.3	13.2	13.6	13.0	14.8	10.9	15.6
		Restraint Use	11.9	16.1	19.8	14.0	13.0	12.9	12.3	8.9
		Pressure Sores	11.9	8.3	14.2	7.7	11.2	8.6	13.3	9.9
	Total Number of Facilities		227	217	212	221	215	210	211	192
WV	Percentage of Facilities cited for	Sub. Quality of Care	4.3	4.7	4.7	7.3	0.0	2.6	3.8	0.0
		Abuse	14.5	9.3	16.3	24.4	27.8	23.1	10.1	29.1
		Restraint Use	8.7	14.0	23.3	17.1	8.3	17.9	16.5	10.9
		Pressure Sores	2.9	7.0	14.0	4.9	0.0	5.1	7.6	7.3
	Total Number of Facilities		69	43	43	41	36	39	79	55
WY	Percentage of Facilities cited for	Sub. Quality of Care	5.6	0.0	5.3	5.6	0.0	5.3	5.0	0.0
		Abuse	0.0	0.0	5.3	11.1	0.0	5.3	5.0	16.7
		Restraint Use	0.0	0.0	15.8	16.7	4.3	36.8	35.0	11.1
		Pressure Sores	0.0	14.3	10.5	16.7	4.3	10.5	5.0	5.6
	Total Number of Facilities		18	21	19	18	23	19	20	18
National Total- Percentage of Facilities Cited for Substandard Quality of Care			4.1	3.8	4.5	4.1	4.5	6.3	5.0	5.0
National Total- Percentage of Facilities Cited for Abuse			6.7	6.5	7.1	7.5	8.3	10.1	10.4	14.1
National Total- Percentage of Facilities Cited for Restraint Use			14.4	13.9	14.5	12.5	12.9	13.0	12.4	9.9
National Total- Percentage of Facilities Cited for Pressure Sores			16.0	14.3	16.4	16.1	17.0	17.9	18.2	17.7
National Total- Number of Facilities			9047	8231	8803	8239	8102	7826	8133	7133

<sup>1</sup>Source: OSCAR, April 2000

\*The first and second quarters of the year (January 1 through June 30).

\*\*The third and fourth quarters of the year (July 1 through December 31).

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*This is NOT part of the report - Use w/ discretion*

October 30, 2000

## State Violation Rates

Prepared by Minority Staff  
Special Investigations Division  
Committee on Government Reform  
U.S. House of Representatives

The following table shows the percentage of nursing homes in each state that have been cited for actual harm violations in their most recent annual inspections or in recent complaint investigations (1998 - 2000). Comparisons of violation rates among states are problematic because state inspections can vary considerably from state to state in their thoroughness and ability to detect violations.

State	% of Homes With Actual Harm Violations	State	% of Homes With Actual Harm Violations
OK	15%	MS	40%
RJ	21%	GA	41%
WV	22%	FL	41%
VA	23%	MT	42%
DC	25%	OH	43%
HI	27%	KY	43%
WI	27%	MA	47%
SD	31%	AR	47%
SC	31%	PA	48%
CO	33%	OR	50%
CA	33%	NV	50%
MD	33%	WY	50%
VT	34%	MO	51%
IA	35%	NM	51%
NY	35%	KS	55%
NE	35%	TX	55%
AZ	35%	IL	56%
ND	35%	NC	59%
LA	35%	IN	63%
ME	36%	DE	63%
MN	36%	MI	71%
UT	37%	ID	74%
NH	39%	WA	75%
NJ	39%	CT	78%
TN	39%		



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

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**Prepared for Rep. Ciro D. Rodriguez**

**Minority Staff  
Special Investigations Division  
Committee on Government Reform  
U.S. House of Representatives**

**October 31, 2000**

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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, Representative Ciro D. Rodriguez asked the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the state of Texas. There are 1,230 nursing homes in Texas that accept residents covered by Medicaid or Medicare. These homes serve approximately 86,000 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 Texas. Over 80% of the nursing homes in Texas violated federal health and safety standards during recent state inspections. Moreover, over 50% of the nursing homes in Texas had violations that caused actual harm to residents or placed them at risk of death or serious injury.

One of the causes of these deficiencies appears to be the low rate of state Medicaid reimbursement in Texas and the low level of staffing in Texas nursing homes. Texas ranks 44th in the nation in Medicaid reimbursements, 40th in the nation in total nursing home staffing, and 46th in the nation in staffing by registered nurses. Over 90% of the nursing homes in Texas do not meet the preferred minimum staffing levels identified by the U.S. Department of Health and Human Services.

### A. Methodology

Under federal law, the U.S. Department of Health and Human Services (HHS) 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. During the annual inspections, the state inspectors also record the staffing levels in the nursing homes.

This report analyzed the most recent annual inspections of Texas nursing homes. These inspections were conducted from March 1998 to August 2000. In addition, the report examined the results of any complaint investigations conducted during this time period.

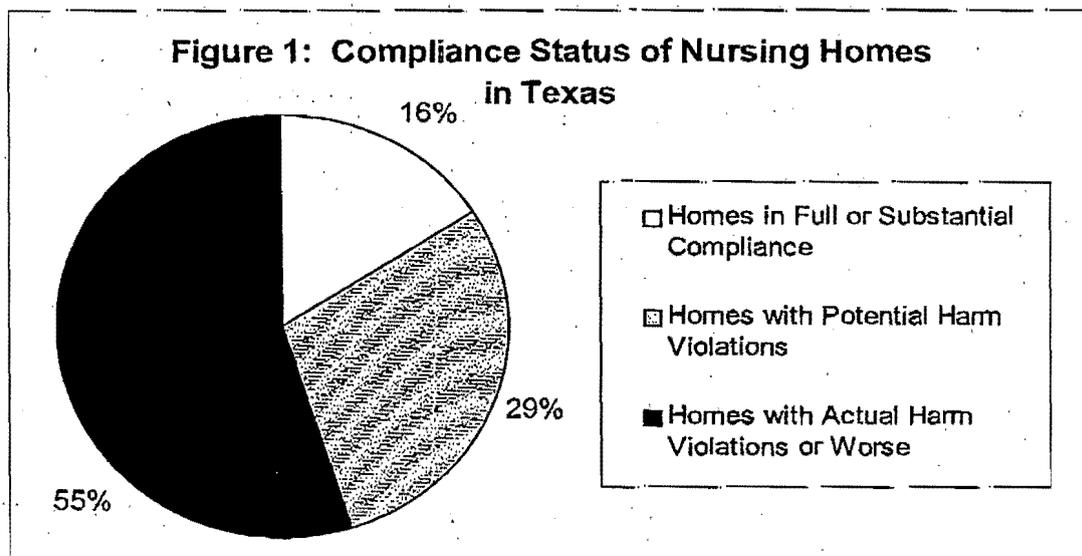
Because this report is based on recent state inspections, the results are representative of current conditions in Texas nursing homes as a whole. However, conditions in individual homes can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative "snapshot" of overall conditions in Texas 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 inspection was conducted.

## B. Findings

### Many nursing homes in Texas violate 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 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 nursing homes in Texas, only 186 homes (16%) were found to be in full or substantial compliance with the federal standards. The other 1,044 nursing homes (84%) had at least one violation with the potential to cause more than minimal harm to residents. On average, each of these 1,044 nursing homes had 12.9 violations of federal quality of care requirements.

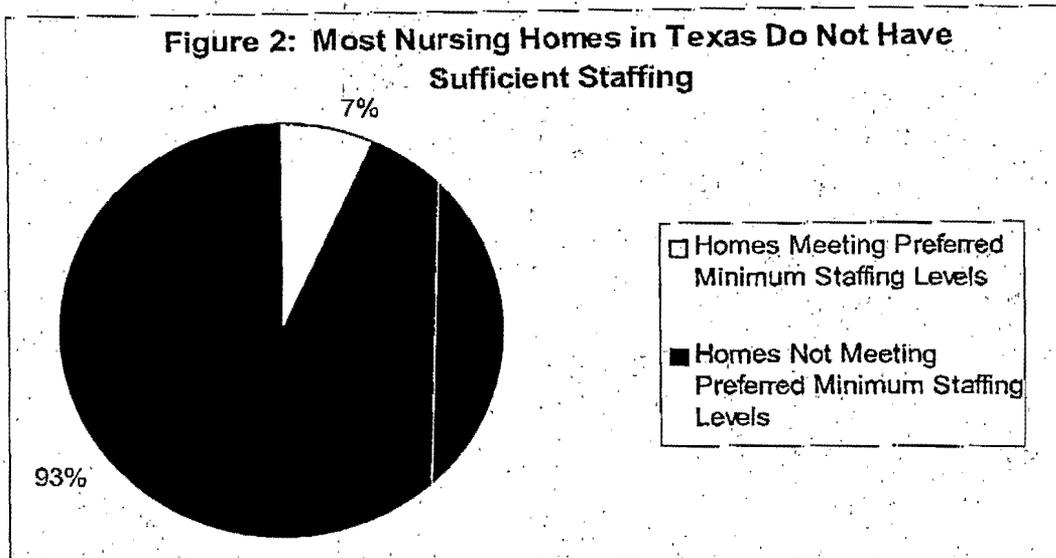
Many nursing homes in Texas have violations that cause actual harm to residents. Of the 1,230 nursing homes in Texas, 680 homes (55%) had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). These violations involved serious problems, such as untreated pressure sores, preventable accidents, and inadequate nutrition and hydration. Over 450 nursing homes in Texas were cited for more than one violation that caused actual harm to residents or had the potential to cause death or serious injury.



### Texas pays low reimbursement rates and has low staffing levels in nursing homes.

One of the underlying causes of the poor conditions in Texas nursing homes appears to be the low level of reimbursements paid by the state under the Medicaid program and the low level of staffing that the nursing homes are able to afford. Texas currently pays its nursing homes only \$81 a day per resident under the Medicaid program, an amount that places Texas 44th among the 50 states in

reimbursement levels. One consequence of the low reimbursement rates is that Texas nursing homes ranked 40th in the nation in total nursing home staffing and 46th in staffing by registered nurses. Over 90% of the nursing homes in Texas do not meet the preferred minimum staffing levels identified by HHS (Figure 2).



**An examination of a random sample of nursing homes 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 random sample of 29 Texas nursing homes cited for actual harm violations and 5 Texas nursing homes cited for multiple, potential-to-harm violations. The inspection reports documented that the actual harm violations cited by state inspectors were for serious neglect and mistreatment of residents, including improper use of restraints, the failure to protect residents from abuse, and medical errors. 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.

## 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.<sup>1</sup> That figure has now risen to 34.6 million Americans, or 13% of the population.<sup>2</sup> In 25 years, the number of Americans aged 65 and older will increase to 62 million, nearly 20% of the population.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

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 United States

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

<sup>2</sup>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).

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

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

<sup>5</sup>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).

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

operated over 2,000 facilities and had revenues of nearly \$14 billion in 1998.<sup>7</sup>

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).<sup>8</sup> 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.<sup>9</sup> 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."<sup>10</sup>

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

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<sup>7</sup>Thomas J. Cole, *Awash in Red Ink*, Albuquerque Journal, A1 (Aug. 3, 1999).

<sup>8</sup>All 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>).

<sup>9</sup>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.

<sup>10</sup>42 U.S.C. §1396r(b)(2).

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.<sup>11</sup> 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";<sup>12</sup> that these incidents of actual harm "represented serious care issues ... such as pressure sores, broken bones, severe weight loss, and death";<sup>13</sup> and that "[s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."<sup>14</sup>

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."<sup>15</sup> In March 1999, the inspector general of HHS found an increasing number of serious deficiencies relating to quality of resident care.<sup>16</sup>

Most recently, a report by HHS identified minimum staffing levels below which quality of

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<sup>11</sup>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 V of this report.

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

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

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

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

<sup>16</sup>HHS Office of Inspector General, *Nursing Home Survey and Certification* (Mar. 1999).

care in nursing homes may be "seriously impaired."<sup>17</sup> According to the HHS report, many nursing homes in the United States do not meet these staffing levels. The HHS report found that residents in nursing homes that did not meet these minimum staffing levels were more likely to suffer from serious health problems than residents in nursing homes that met the minimum staffing levels. According to the HHS report, for example, residents in nursing homes with inadequate staffing were almost four times more likely to develop pressure sores and nearly twice as likely to suffer extensive weight loss as residents of nursing homes with higher staffing levels.

In light of the growing concern about nursing home conditions, Rep. Ciro D. Rodriguez asked the minority staff of the Government Reform Committee to investigate the prevalence of health and safety violations in Texas nursing homes. Rep. Rodriguez represents the 28<sup>th</sup> Congressional District of Texas, which includes part of San Antonio. This report presents the results of this investigation. It is the first congressional report to comprehensively investigate nursing home conditions in the state of Texas.

## II. METHODOLOGY

To assess the conditions in Texas nursing homes, this report analyzed three sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which contains the results of annual nursing home inspections; (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations; and (3) actual state inspection reports from a random sample of 34 nursing homes.

### A. Determination of Compliance Status

Data on the compliance status of nursing homes in Texas comes 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, 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.<sup>18</sup>

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<sup>17</sup>HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (Summer 2000).

<sup>18</sup>In addition to tracking the violations at each home, the OSCAR database compiles the following information about each home: the number of residents and beds; the type of ownership (e.g., for-profit or nonprofit); whether the home accepts 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 the information in the OSCAR database,

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

**Table 1: 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 Death/Serious Injury	J	K	L

To assess the compliance status of Texas nursing homes, this report analyzed the OSCAR database to determine the results of the most recent annual inspection of each nursing home in Texas. These inspections were conducted between March 1998 and August 2000.<sup>19</sup> 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. Determination of Staffing Levels**

Data on the staffing levels in Texas nursing homes also comes from the OSCAR database. During the annual inspections, the nursing homes provide the state inspectors with data on their

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HCFA maintains a website (<http://www.medicare.gov/nhcompare/home.asp>) where the public can obtain data about individual nursing homes.

<sup>19</sup>No inspection data was available after January 1998 for sixteen Texas nursing homes in the OSCAR database. This lack of recent inspection data appears to indicate that these nursing homes are no longer in operation. As a result, they were excluded from this analysis.

staffing levels during the two weeks prior to the inspections.<sup>20</sup> This information on staffing levels is then reported by the states to HCFA and entered into the OSCAR database.<sup>21</sup>

The report compared these staffing levels to the preferred minimum staffing levels identified by HHS. These preferred minimum staffing levels require 3.45 hours of nursing care for each resident each day, with 2.0 hours of this care provided by nursing assistants, 1.0 hours by registered or licensed nurses, and 0.45 hours by registered nurses. HHS found that for nursing homes that met these preferred minimum staffing levels, "quality of care was improved across the board."<sup>22</sup>

### C. 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 inspectors of nursing homes in Texas. These inspection reports, prepared on a HCFA form called "Form 2567," contain the inspectors' documentation of the conditions at the nursing home.

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<sup>20</sup>According to some experts, this data may overestimate the number of staff involved in resident care. Researchers have suggested that nursing homes may increase their staff during the period around the state inspection, meaning that reported staffing levels would be higher than the staffing levels found at the nursing homes during most periods of the year. Charlene Harrington, et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, 17 (Aug. 1999). HHS research also suggests that the OSCAR data may overestimate actual staffing levels in some instances. HHS compared the staffing data in the OSCAR database with the staffing data contained in "Medicare Cost Reports," which are audited cost statements that are prepared by nursing homes in order to receive Medicare payments. Although the HHS analysis found that in the aggregate, average staffing levels in the OSCAR database and in the Medicare Cost Reports were similar, the analysis also found that for homes with lower staffing levels, the staffing levels reported in the OSCAR database were higher than the staffing levels reported in the Medicare Cost Reports. This indicates that for homes with lower staffing levels, the OSCAR database could overestimate actual staffing levels. See *Report to Congress, supra* note 17, at 8-7, 8-8.

<sup>21</sup>In order to ensure the accuracy of the data for this comparison, HCFA analysts eliminated data from all nonhospital-based nursing homes with less than 50% occupancy; all facilities that reported more residents than beds; all facilities that reported more than 24 hours of daily care by registered nurses, licensed nurses, or nursing assistants per resident; and the 2% of facilities that reported the highest staffing by registered nurses, licensed nurses, or nursing assistants. In addition, all nursing homes that reported staffing levels of less than 0.5 hours per resident or reported no registered or licensed nursing staff were eliminated. See *Report to Congress, supra* note 17.

<sup>22</sup>See *Report to Congress, supra* note 17, at 12-4.

The minority staff selected for review the inspection reports from a random sample of 34 nursing homes in Texas that were cited for violations. To obtain geographical diversity, the staff randomly identified two nursing homes with actual harm violations from each of 17 congressional districts within Texas. If there were not two nursing homes with actual harm violations in a congressional district, nursing homes with multiple potential-to-harm violations were identified instead. In total, the minority staff identified 29 nursing homes with actual harm violations and 5 nursing homes with multiple, potential-to-harm violations.

For each of these homes, the most recent annual inspection report was obtained from the Texas Department of Human Services. These reports were then reviewed to assess the severity of the violations documented by the state inspectors.

#### D. Interpretation of Results

The results presented in this report are representative of current conditions in Texas 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 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.<sup>23</sup>

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

The report should also not be used to compare violation rates in Texas nursing homes with violation rates in other states. Available data allow comparisons among states to be made based on Medicaid reimbursement rates and nursing home staffing levels. But, the data about 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."<sup>24</sup> For this reason, comparing violation rates among states can be misleading.

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<sup>23</sup>GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 12-14.

<sup>24</sup>GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (Sept. 2000).

### III. HEALTH AND SAFETY VIOLATIONS IN TEXAS NURSING HOMES

There are 1,230 nursing homes in the Texas that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 125,676 beds that were occupied by 86,286 residents during the most recent round of annual inspections. Medicaid paid the cost of care for the majority of these residents, 64,319. Medicare paid the cost of care for 6,808 residents. Eighty-one percent of the nursing homes in Texas 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 16% of the nursing homes in Texas were found by the state inspections to be in full or substantial compliance with federal standards of care. The other 84% of the nursing homes in the state (1,044 out of 1,230) had at least one violation that had the potential to cause more than minimal harm to their residents. Over 650 nursing homes -- more than one out of every two nursing homes in Texas -- had violations that caused actual harm to residents or had the potential to cause death or serious injury. Table 2 summarizes these results.

**Table 2: Nursing Homes in Texas 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)	105	9%	3,620
Substantial Compliance (Risk of Minimal Harm)	81	7%	3,634
Potential for More than Minimal Harm	364	30%	23,257
Actual Harm to Residents	583	47%	47,668
Actual or Potential Death/Serious Injury	97	8%	8,107

Many nursing homes had multiple violations. State inspectors found a total of 13,505 violations in Texas nursing homes that were not in compliance with federal standards, an average of 12.9 violations in each noncompliant nursing 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, over 650 nursing homes in Texas had violations that fell into this category. In total, 55% of the nursing homes in Texas were cited for violations that caused actual harm to residents or worse. These

homes serve 55,775 residents and are estimated to receive over \$680 million in federal and state funds each year.

Many Texas nursing homes had multiple actual harm violations. In total, 454 homes – more than one out of every three – had at least two violations that caused actual harm or had the potential to cause death or serious injury to residents.<sup>25</sup>

### C. Most Frequently Cited Violations Causing Actual Harm

During the most recent annual inspections and complaint investigations, state inspectors cited the nursing homes in Texas for 2,421 violations that caused actual harm to residents. These violations fell into 101 different deficiency areas.

The most common actual harm violation in Texas nursing homes was the failure to ensure that residents receive proper supervision and assistance devices to prevent falls and accidents. These violations are serious because falls and accidents can result in severe injuries and even death. A total of 373 nursing homes in Texas were cited for actual harm violations in this category.

The second 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 cleaning, 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, 317 nursing homes in Texas were cited for actual harm violations for their failure to prevent or properly treat pressure sores.

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<sup>25</sup>Actual harm violations were common in both the annual inspection reports and the reports from complaint investigations. During the most recent annual inspections, which were conducted from March 1998 to August 2000, 26.1% of the nursing homes in Texas were cited for violations that caused actual harm to residents or had the potential to cause death or serious injury. During the same period, 47.1% of the nursing homes in Texas were cited for violations that caused actual harm or had the potential to cause death or serious injury during complaint investigations. A recent GAO report reached a similar finding about the results of annual inspections of Texas nursing homes, reporting that 24.9% of Texas nursing homes were cited for actual harm or immediate jeopardy violations during annual inspections between January 1999 and July 2000. The GAO report did not analyze violations rates in complaint investigations. *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, *supra* note 24, at 18.

Another common actual harm violation 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.”<sup>26</sup> A total of 177 nursing homes in Texas were cited for actual harm violations in this category.

Other actual harm violations cited multiple times included: the failure to prevent physical, mental, or verbal abuse of residents (82 homes); the failure to provide sufficient staff (65 homes); and the failure to keep residents free from physical restraints (24 homes).

#### **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.”<sup>27</sup> 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.”<sup>28</sup> A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors inspect nursing homes after state inspectors, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health and safety standards.<sup>29</sup> Consequently, the prevalence of violations causing potential or actual harm to residents may be higher than what is reported in this study.

### **IV. TEXAS REIMBURSEMENT RATES AND STAFFING LEVELS**

The largest single source of payment for nursing home care is the joint, federal-state Medicaid program. Unlike Medicare rates which are established by the federal government, individual states determine the amount of reimbursement under Medicaid. Both nursing home operators and resident advocates agree that the Medicaid reimbursement rate in Texas is too low

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<sup>26</sup>42 C.F.R. § 483.25(i).

<sup>27</sup>GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 12, at 30.

<sup>28</sup>GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

<sup>29</sup>*Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, *supra* note 24, at 43

and may adversely impact the quality of care provided to residents.<sup>30</sup>

Texas ranks 44th in the country in the amount of its Medicaid reimbursement.<sup>31</sup> The current reimbursement rate in Texas is only \$81.22 a day per patient.<sup>32</sup> According to HCFA data, the federal government pays approximately 62% of this amount, with the state of Texas paying the remainder.<sup>33</sup> Total Medicaid payments to Texas nursing homes were \$1.56 billion in 1999.<sup>34</sup>

Although Texas's current Medicaid rate represents a 3.7% increase from the 1999 rate, it is still over \$20 below the national average.<sup>35</sup> Informed observers have stated that the increase does not offset rising labor and liability insurance costs.<sup>36</sup> In fact, according to the nursing home industry, the Texas Medicaid rate is \$40 less than the daily cost of caring for the average Medicaid patient.<sup>37</sup> Currently, 235 nursing homes in Texas -- 22% of all nursing homes -- are in bankruptcy, with 29,268 residents living in these facilities.<sup>38</sup>

As a result of the low reimbursement rate, Texas nursing homes have low levels of nursing home staff. Texas ranks 40th among the 50 states in the median number of daily hours of nursing care provided to residents, and 46th among the 50 states in the median number of daily hours of

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<sup>30</sup>See *Nursing-Home Group Calls for Aid*, Dallas Morning News (Oct. 3, 2000); *State of Elder Care Draws Criticism*, Dallas Morning News (July 31, 2000); *Nursing Home Operators Want Bigger Increase in Medicaid Payments*, Associated Press (Feb. 11, 2000).

<sup>31</sup>Data from Texas Health Care Association. This figure excludes the District of Columbia.

<sup>32</sup>Texas Department of Human Services, *Texas Medicaid Nursing Facility Case Mix Rates* (available at <http://www.dhs.state.tx.us/programs/rad/NF/nfrates.html>).

<sup>33</sup>Medicaid Financial Management -- Medical Assistance Payments, Fiscal Year 1999.

<sup>34</sup>*Id.*

<sup>35</sup>Data from Texas Health Care Association.

<sup>36</sup>*Boost in Aid Sought for Staffing at Nursing Homes*, Austin American-Statesman (July 28, 2000); *Texas Nursing Home Financial Crisis Seen*, New York Times (July 4, 2000).

<sup>37</sup>*Sonora Nursing Home Closes as Pleas to Save It Fall Short*, San Antonio Express-News (Sept. 15, 2000).

<sup>38</sup>American Health Care Association, *Real Cuts, Real People: The Facts* (advertisements appearing in Roll Call (Oct. 9, 2000; Oct. 12, 2000)).

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care provided by registered nurses.<sup>39</sup> In Texas, the median nursing home provides only 22 minutes of daily care by registered nurses to each resident. Nationally, the median home provides over one-half of an hour of care by registered nurses for each resident -- almost 50% more than the median nursing home in Texas.

The vast majority of nursing homes in Texas fail to meet the preferred minimum staffing levels identified by HHS. Overall, 1,079 of the 1,157 nursing homes in Texas for which there is adequate staffing data (93%) failed to meet one or more of the preferred minimum staffing levels identified by HHS in their most recent annual inspections.

HHS identified a preferred minimum staffing level of 1.45 hours of daily care for each resident by registered and licensed nurses, with at least 0.45 hours of this care provided by registered nurses. One thousand and thirteen of the nursing homes in Texas (88%) failed to meet this preferred minimum staffing level. In addition, HHS also identified a preferred minimum staffing level of 2.0 hours of daily care for each resident by nursing assistants. A total of 719 homes in Texas (62%) did not provide this level of care.

## V. DOCUMENTATION OF VIOLATIONS IN THE STATE 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."<sup>40</sup> 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."<sup>41</sup> As an example of such a technical violation, AHCA has claimed that the cancellation of a painting class would constitute a serious deficiency.<sup>42</sup>

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

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<sup>39</sup>Committee on Government Reform, Minority Staff, *Analysis of Nursing Home Staffing Levels by State* (Oct. 2000).

<sup>40</sup>Statement of Linda Kcegan, Vice President, AHCA, regarding Senate Select Committee on Aging Forum: "Consumers Assess the Nursing Home Initiatives" (Sept. 23, 1999).

<sup>41</sup>AHCA Press Release, *AHCA Responds to Release of General Accounting Office Study on Enforcement* (March 18, 1999).

<sup>42</sup>Letter from Sen. Charles E. Grassley to William Scanlon (GAO), 1 (May 27, 1999).

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."<sup>43</sup> GAO found that many of the deficiencies affected multiple residents and that two-thirds of these homes were cited for other violations causing actual harm or worse in previous or subsequent annual inspections.<sup>44</sup>

This report undertook a similar analysis at the state level. To assess the severity of violations at nursing homes in Texas, the minority staff examined the state inspection forms for 29 nursing homes cited for actual harm violations and 5 nursing homes cited for multiple, potential-to-harm violations. These inspection forms contained numerous examples of actual harm violations that involved serious neglect and mistreatment of residents. Moreover, the inspection reports documented many other serious violations that would be of great concern to families, but were not classified as causing actual harm, indicating that serious deficiencies can exist at nursing homes cited for potential-to-harm violations.

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

**A. Failure to Prevent or Properly Treat Pressure Sores**

One of the most common actual harm violations in Texas nursing homes involves 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.

The 34 inspection reports reviewed for this analysis documented a wide array of violations involving pressure sores. The violations included: leaving immobile residents in the same position instead of regularly repositioning them, as required by standard medical procedures; failing to provide protective devices to residents at risk of developing pressure sores; and failing to properly

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<sup>43</sup>GAO, *Nursing Homes: Proposal to Enhance Oversight*, *supra* note 13, at 6.

<sup>44</sup>*Id.* at 7. In another study in August 1999, GAO examined several examples provided by AHCA of serious deficiencies cited by state inspectors that, according to AHCA, were of questionable merit. For those deficiencies which it had sufficient facts to analyze, GAO concluded that the regulatory actions taken against the homes were merited. The GAO report stated: "In our analysis of the cases that AHCA selected as 'symptomatic of a regulatory system run amok,' we did not find evidence of inappropriate regulatory actions." Letter from Kathryn G. Allen (GAO) to Sen. Charles E. Grassley, 2 (Aug. 13, 1999).

monitor and treat existing sores on residents.<sup>45</sup>

State inspectors at one facility observed a number of residents with untreated pressure sores. One resident with six pressure sores on his buttocks was observed to be "lying in dry feces which was all over his pad and gown." There was also feces on the dressing covering the sores. Another resident with multiple pressure sores on her heels was found lying in semi-dried feces with her feet directly on the mattress despite a sign near the bed specifically stating that her heels should be kept off the mattress. One of the residents had an open sore on his heel and was observed being pushed around the facility in a wheelchair with his feet dragging on the floor.<sup>46</sup>

At another nursing home, a resident whose left foot had been amputated due to pressure sores did not receive proper treatment for the pressure sores on his right foot. As a result, the resident had a severe pressure sore on his outer ankle and another pressure sore on his foot that could not be evaluated because of the large amount of yellow and black "dead tissue."<sup>47</sup>

#### **B. Failure to Provide Adequate Nutrition and Hydration**

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

- A female resident at one facility lost 75 lbs. in one year. Upon investigating, the state inspectors learned that the facility failed to adequately monitor the resident's nutritional status and failed to encourage the resident to eat. While the inspectors were present, they observed that a nurse did not bring the resident orange juice that was ordered by her physician, stating, "Oh, she won't drink it."<sup>48</sup>
- At another nursing home, a resident weighed only 75 lbs. Upon investigating, the inspectors found that no nutritional assessment had been done for months.<sup>49</sup>

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<sup>45</sup>HCFA Form 2567 for Nursing Home in Friendswood (G-level violation) (Apr. 27, 2000); HCFA Form 2567 for Nursing Home in San Antonio (G-level violation) (Jan. 28, 2000); HCFA Form 2567 for Nursing Home in Tyler (L-level violation) (Dec. 23, 1999); HCFA Form 2567 for Nursing Home in Houston (H-level violation) (Aug. 23, 1999).

<sup>46</sup>HCFA Form 2567 for Nursing Home in Tyler (L-level violation) (Dec. 23, 1999).

<sup>47</sup>HCFA Form 2567 for Nursing Home in Temple (D-level violation) (Feb. 10, 2000).

<sup>48</sup>HCFA Form 2567 for Nursing Home in Fort Worth (G-level violation) (Jan. 7, 2000).

<sup>49</sup>HCFA Form 2567 for Nursing Home in Tyler (K-level violation) (Dec. 23, 1999).

- At the same facility, state inspectors found that there was no monitoring of the fluid intake of several residents. As a result, three residents had to be hospitalized for dehydration, including one resident who was hospitalized twice in one month.<sup>50</sup>

### **C. Failure to Prevent Falls or Accidents**

The sample of state inspection reports reviewed for this report documented several instances of preventable falls and accidents, the most common type of actual harm violation in Texas nursing homes. At one facility, for example, multiple residents suffered serious injuries due to falls, including head injuries, hip fractures, and leg injuries. One resident alone was involved in 31 accidents in an eight-month period.<sup>51</sup>

At another nursing home, state inspectors found that the facility failed to implement protective measures for a male resident with a history of falls. The resident broke his femur after one fall – an injury that was not identified by the facility for nearly two weeks.<sup>52</sup>

In some cases, residents in Texas nursing homes were injured while being transferred by staff members. At one nursing home, a resident suffered a leg fracture when a nurse aide dropped the resident on the ground while trying to transfer the resident by herself. State inspectors found that the resident's care plan clearly stated that two nurse aides were required to transfer the resident.<sup>53</sup>

### **D. 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 nationally, the inspection reports documented that improper restraints continue to be a serious problem in Texas.

Texas inspectors cited several of the 34 facilities whose records were reviewed for using physical restraints or sedating medications without medical justification or without first attempting

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<sup>50</sup>HCFA Form 2567 for Nursing Home in Tyler (J-level violation) (Dec. 23, 1999).

<sup>51</sup>HCFA Form 2567 for Nursing Home in Longview (H-level violation) (Dec. 16, 1999).

<sup>52</sup>HCFA Form 2567 for Nursing Home in Houston (G-level violation) (Feb. 17, 2000).

<sup>53</sup>HCFA Form 2567 for Nursing Home in Austin (H-level violation) (Oct. 22, 1999).

less restricting alternatives.<sup>54</sup> For example:

- At one nursing home, a resident was observed with both hands covered with socks and his wrists crossed and tied to the bed with wrist restraints. He was only released from the restraints when he was turned every two hours; the socks were only removed when he was bathed. According to a nurse, the resident was restrained in this manner to prevent him from scratching and injuring himself. But the state inspectors found that the facility had not tried to implement a less restrictive restraint.<sup>55</sup>
- At another facility, a resident who was independent, continent, and non-aggressive when she was admitted became "totally dependent, debilitated and unresponsive" over a four-month period. Inspectors discovered that soon after the resident was admitted, the facility gave her an antipsychotic medication without any supporting diagnosis. As the resident's condition worsened, the facility simply increased the dosage of the antipsychotic medication, never evaluating the cause of the decline.<sup>56</sup>
- At a third nursing home, a resident who was taking five different antipsychotic and antidepressant medications was so sedated that she had her eyes closed and her head down during meals. Upon investigating, the state inspectors found that the resident did not have sufficient symptoms to justify use of these drugs.<sup>57</sup>

#### **E. Failure to Protect Residents from Abuse**

Some of the state inspection reports found that nursing homes were unable to protect vulnerable residents from abuse. For example, a resident at one facility was stabbed in the head with silverware by another resident. Less than a month later, the same abusive resident hit another resident, causing that resident to fall and fracture his hip – an injury that required hospitalization. Facility records indicated that the abusive resident was involved in a total of 24 incidents of physically aggressive behavior over a five-month period. When the state inspectors investigated, they learned that the facility failed to take appropriate measures to protect residents from abuse.<sup>58</sup>

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<sup>54</sup>HCFA Form 2567 for Nursing Home in Clarksville (D-level violation) (Jan. 26, 2000); HCFA Form 2567 for Nursing Home in Longview (G-level and L-level violations) (Dec. 16, 1999).

<sup>55</sup>HCFA Form 2567 for Nursing Home in Cameron (D-level violation) (Mar. 23, 2000).

<sup>56</sup>HCFA Form 2567 for Nursing Home in Dallas (G-level violation) (Sept. 24, 1999).

<sup>57</sup>HCFA Form 2567 for Nursing Home in Longview (G-level violation) (Dec. 16, 1999).

<sup>58</sup>HCFA Form 2567 for Nursing Home in Houston (L-level violation) (Aug. 23, 1999).

At another nursing home, residents were sexually abused by other residents. On two occasions, a male resident was found fondling female residents who were described as confused. Another male resident was found squeezing a female resident's breast. State inspectors found that the facility did not have an effective system in place to protect residents from sexual abuse.<sup>59</sup>

**F. Failure to Provide Proper Medical Care**

The inspection reports contained many examples of nursing homes failing to provide necessary medical care. Nursing homes were found to have ignored obvious warning signals, failed to notify physicians of changes in residents' medical conditions, and improperly administered medications.

An audit of the medical directives for residents at one facility revealed errors in the instructions for 46 out of 109 residents. Inspectors found that many residents who were supposed to have "full code" orders, meaning that they should receive CPR in an emergency, had "do not resuscitate" orders.<sup>60</sup>

Another facility failed to provide necessary psychiatric counseling to multiple residents, sometimes months after the physician ordered psychiatric counseling. The director of nursing described the facility's treatment program as "a system that isn't working."<sup>61</sup>

During their inspection of a third nursing home, state inspectors witnessed a resident having a seizure and asked staff members when a physician would be called. A nurse responded that they "don't notify the doctor because he doesn't do anything anyhow." But when the inspectors interviewed the physician, he said that the resident's seizure activity was unusual and he should have been notified.<sup>62</sup>

In yet another nursing home, the state inspectors met a young, alert male resident suffering paralysis of all four limbs. They found he had been left without a working motorized wheelchair for over a year.<sup>63</sup>

There were numerous examples of improper medication documented in the inspection reports:

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<sup>59</sup>HCFA Form 2567 for Nursing Home in Dallas (H-level violation) (Oct. 11, 1999).

<sup>60</sup>HCFA Form 2567 for Nursing Home in Baytown (E-level violation) (March 9, 2000).

<sup>61</sup>HCFA Form 2567 for Nursing Home in Dallas (H-level violation) (Oct. 11, 1999).

<sup>62</sup>HCFA Form 2567 for Nursing Home in Ennis (G-level violation) (Oct. 14, 1999).

<sup>63</sup>HCFA Form 2567 for Nursing Home in Pasadena (D-level violation) (Dec. 3, 1999).

- At one facility, inspectors observed a resident "crying and screaming with pain." Upon investigation, the inspectors learned that the facility had failed to provide the resident with pain medication for an entire month.<sup>64</sup>
- At another facility, state inspectors had to intervene to prevent a nurse from administering an undiluted dose of potassium chloride, which can cause serious gastric complications.<sup>65</sup>
- In many instances, state inspectors found that nursing homes failed to administer medication in accordance with physician or manufacturer instructions.<sup>66</sup>

In one case described in the inspection reports, the failure to provide proper medical care contributed to the death of a resident. In this instance, a resident wandered out of the facility and fell in the parking lot, sustaining a head injury. Her condition declined sharply after the fall. She was no longer able to walk safely or go to the bathroom, and she was extremely lethargic and complained of a headache. Despite her clearly declining condition, the facility did nothing to assess her or address the condition. Twelve days after the fall, she was found unresponsive and died soon thereafter.<sup>67</sup>

#### **G. Failure to Provide Basic Care**

Federal standards require that nursing homes provide residents with "the necessary services

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<sup>64</sup>HCFA Form 2567 for Nursing Home in Friendswood (E-level violation) (May 14, 1999). A more recent inspection report identified additional violations relating to untreated pressure sores and medication errors. HCFA Form 2567 for Nursing Home in Friendswood (E-level violation) (Apr. 27, 2000).

<sup>65</sup>HCFA Form 2567 for Nursing Home in Houston (E-level violation) (Feb. 17, 2000).

<sup>66</sup>HCFA Form 2567 for Nursing Home in Friendswood (D-level and E-level violations) (Apr. 27, 2000); HCFA Form 2567 for Nursing Home in Baytown (March 9, 2000) (E-level violation); HCFA Form 2567 for Nursing Home in Temple (D-level violation) (Feb. 10, 2000); HCFA Form 2567 for Nursing Home in San Antonio (D-level violation) (Jan. 28, 2000); HCFA Form 2567 for Nursing Home in Pasadena (E-level violation) (Dec. 3, 1999); HCFA Form 2567 for Nursing Home in El Paso (B-level violation) (Apr. 9, 1999); HCFA Form 2567 for Nursing Home in Granbury (D-level violation) (May 21, 1999); HCFA Form 2567 for Nursing Home in Houston (G-level violation) (July 23, 1999) (a change in ownership is pending at this home); HCFA Form 2567 for Nursing Home in Baytown (D-level violation) (Oct. 7, 1999).

<sup>67</sup>HCFA Form 2567 for Nursing Home in El Paso (G-level violation) (Oct. 16, 1999).

to maintain good . . . grooming and personal and oral hygiene.<sup>68</sup> Nursing homes are also required to provide residents with a clean and safe living environment.<sup>69</sup> 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 by many nursing homes. For example:

- At one facility, state inspectors observed that “[a] strong odor of urine was evident upon entry into the facility.” Inspectors observed residents wearing briefs that “were saturated with urine,” leaving the residents with “macerated” skin. A resident’s room had a “strong odor of stool.”<sup>70</sup>
- At another facility, state inspectors found that one-third of the residents that they examined had not received proper cleaning and grooming. They found one totally dependent and incontinent male resident whose pants were “soaked wet down to both legs.” The resident smelled of a “strong ammonia odor,” his soiled pants had already begun to dry, and his skin was red and excoriated.<sup>71</sup>
- At a third facility, inspectors saw residents lying in urine and dried feces. One resident who was wet with urine and had dried feces on him had four pressure sores on his buttocks. The nurse aide had to scrub the resident’s buttock to remove the dried feces, causing the resident to cry out, “it hurts, it burns.”<sup>72</sup>

When state inspectors visited other Texas nursing homes, they found unsafe living conditions. For example:

- At two nursing homes, the water in some bathrooms and showers was so hot that it could produce a first degree burn in five seconds and a second or third degree burn in 25 seconds.<sup>73</sup>
- At another facility, inspectors found that the fire alarm system was disengaged. In the event

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<sup>68</sup>42 C.F.R. § 483.25(a)(3).

<sup>69</sup>42 C.F.R. § 483.70(h).

<sup>70</sup>HCFA Form 2567 for Nursing Home in Austin (B-level violation) (Oct. 22, 1999).

<sup>71</sup>HCFA Form 2567 for Nursing Home in Houston (E-level violation) (Feb. 17, 2000).

<sup>72</sup>HCFA Form 2567 for Nursing Home in Tyler (F-level violation) (Dec. 23, 1999).

<sup>73</sup>HCFA Form 2567 for Nursing Home in Clarksville (J-level violation) (Jan. 26, 2000); HCFA Form 2567 for Nursing Home in Graham (F-level violation) (Dec. 22, 1999).

of a fire, residents would not be notified, and the facility's smoke control features would not be activated. Inspectors found that the facility knew that the alarm was disengaged but had failed to promptly address the problem.<sup>74</sup>

- At a third facility, inspectors found that contaminated syringes were protruding from a cart left in a hallway frequented by cognitively impaired residents.<sup>75</sup>

#### H. Failure to Provide Adequate Staffing

An underlying reason for the poor care provided by some Texas nursing homes is inadequate staffing. As described above, Texas nursing homes have virtually the lowest staffing levels in the nation. The inspection reports documented several examples of grossly deficient staffing.

At one nursing home, state inspectors found that only three nurse aides were on duty to care for 74 residents, 41 of whom were either totally dependent on staff or required assistance with toileting. As a result of the understaffing, inspectors found that residents were left in clothes "saturated with urine and/or soiled with feces," and unsupervised residents were allowed to fall and sustain serious injuries. Residents were also able to wander away from the facility because staff members said it was "not humanly possible" to supervise everyone.<sup>76</sup>

At a second facility, state inspectors found that one nursing home was so understaffed that a single nurse aide was assigned to care for 26 residents in one unit of the home. The aide was responsible for providing up to ten showers each day, providing other residents with bed baths, serving meal trays, assisting residents with eating, transferring residents, and providing incontinence care. When the state inspectors interviewed residents, they learned that residents were often left in bed for long periods of time, residents were not regularly bathed, residents were not assisted with eating, and linen was not changed.<sup>77</sup>

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<sup>74</sup>HCFA Form 2567 for Nursing Home in San Antonio (F-level violation) (Sept. 22, 1999).

<sup>75</sup>HCFA Form 2567 for Nursing Home in San Antonio (E-level violation) (Jan. 28, 2000).

<sup>76</sup>HCFA Form 2567 for Nursing Home in Austin (H-level violation) (Oct. 22, 1999).

<sup>77</sup>HCFA Form 2567 for Nursing Home in Baytown (E-level violation) (Jan. 15, 1999). A more recent inspection did not identify similar staffing problems but did identify other serious violations, including inadequate medical care and medication errors. HCFA Form 2567 for Nursing Home in Baytown (E-level violations) (March 9, 2000).

## 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 Texas nursing homes has been poor. This report reviewed the OSCAR and complaint databases and a sample of actual state inspections reports. The same conclusion emerges from both analyses: many Texas nursing homes are failing to provide the care that the law requires and that families expect. The causes of the poor conditions in Texas nursing homes include the low Medicaid reimbursement rate established by the state and the low level of nursing home staffing.

**FAX COVER**

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DATE: 10-31-00TO: Chris JenningsFAX: 456-5557 PHONE: \_\_\_\_\_FROM: Karen Lightfoot

SUBJECT: \_\_\_\_\_

NO. OF PAGES (INCLUDING COVER SHEET): \_\_\_\_\_

COMMENT:

~~See Executive Summary in particular.~~

- \* Info on Average Medicaid rates - not published data - from industry
- \* Info from aec staffing on rankings of staffing levels

AVERAGE 1999 MEDICAID RATES \*

12/20/99

ALASKA	\$224.50	1
DISTRICT OF COLUMBIA	\$185.06	2
NEW YORK	\$173.85	3
HAWAII	\$155.56	4
CONNECTICUT ***	\$130.00	5
PENNSYLVANIA	\$120.50	6
WASHINGTON	\$116.49	7
MASSACHUSETTS	\$116.00	8
MAINE	\$115.77	9
NEW HAMPSHIRE	\$115.33	10
OHIO	\$112.49	11
MARYLAND **	\$111.93	12
RHODE ISLAND	\$111.75	13
DELEWARE	\$111.70	14
NEW JERSEY **	\$110.24	15
COLORADO	\$106.72	16
MINNESOTA	\$106.65	17
WEST VIRGINIA	\$106.48	18
VERMONT	\$105.12	19
MICHIGAN	\$105.00	20
NEVADA	\$104.61	21
ALABAMA	\$103.86	22
FLORIDA	\$102.38	23
IDAHO	\$102.29	24
WISCONSIN	\$98.97	25
NORTH DAKOTA	\$97.88	26
NORTH CAROLINA ***	\$95.12	27
IOWA	\$95.00	28
ARIZONA	\$94.51	29
WYOMING	\$94.38	30
MONTANA	\$93.39	31
KENTUCKY	\$93.01	32
INDIANA	\$92.20	33
NEW MEXICO ***	\$92.10	34
MISSOURI	\$90.04	35
OREGON ***	\$89.05	36
SOUTH CAROLINA	\$87.01	37
NEBRASKA	\$86.06	38
UTAH	\$85.53	39
TENNESSEE	\$85.37	40
MISSISSIPPI	\$84.54	41
GEORGIA	\$83.64	42
CALIFORNIA ***	\$83.04	43
ILLINOIS	\$81.44	44
TEXAS	\$81.22	45
SOUTH DAKOTA	\$78.92	46
KANSAS	\$77.25	47
VIRGINIA	\$75.08	48
LOUISIANA	\$67.48	49
OKLAHOMA	\$66.38	50
ARKANSAS	\$64.33	51

NATIONAL AVERAGE: \$103.27

\* BASED ON HCIA'S (HEALTH CARE INVESTMENT ANALYSTS/ARTHUR ANDERSON) 2000 GUIDE TO THE NURSING HOME INDUSTRY.

\*\* 1999 RATES UNAVAILABLE; RATES ARE 1998 RATES, AS LISTED IN HCIA'S 1998-1999 GUIDE TO THE NURSING HOME INDUSTRY.

\*\*\* WEIGHTED AVERAGE WEIGHTS UNAVAILABLE; RATES LISTED ARE BASED UPON AHCA'S 1998 FACTS & TRENDS: THE NURSING FACILITY SOURCEBOOK

BASED UPON THESE ASSUMPTIONS, TEXAS RANKS 45th IN THE NATION IN TERMS OF ITS NF MEDICAID RATE, WITH A RATE THAT IS \$21.83 OR 21.1% BELOW THE NATIONAL AVERAGE.

### State Rankings by Median Staffing Level

Total Staff		Registered Nurses	
Rank	State	Rank	State
1	AK	1	AK
2	HI	2	ME
3	ME	3	HI
4	ID	4	DE
5	DE	5	WA
6	AL	6	NV
7	NV	7	NH
8	WA	8	MA
9	VT	9	WY
10	ND	10	MT
11	KY	11	CT
12	NC	12	PA
13	OH	13	RI
14	MA	14	SD
15	SC	15	ID
16	MT	16	CO
17	PA	17	OR
18	UT	18	WI
19	CT	19	VT
20	MD	20	OH
21	WY	21	NJ
22	CA	22	AZ
23	OR	23	NC
24	FL	24	MI
25	AZ	25	NM
26	NY	26	UT
27	NH	27	ND
28	MO	28	IL
29	MI	29	MD
30	WV	30	FL
31	CO	31	CA
32	NJ	32	NE
33	MS	33	KY
34	WI	34	NY
35	RI	35	IA
36	NE	36	KS
37	VA	37	IN
38	NM	38	MN
39	MN	39	WV
40	TX	40	SC
41	GA	41	VA
42	SD	42	MO
43	KS	43	MS
44	IN	44	AL
45	TN	45	TN
46	AR	46	TX
47	OK	47	GA
48	IA	48	OK
49	LA	49	AR
50	IL	50	LA

*Use registered nurses stat.*

*TX* (circled)

*TX* (circled)