Safeguarding NH Residents & Program Integrity

A National Review of State Survey Agency Performance

by

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NOTE: The charts in this report are posted in Excel on our website https://nursinghome411.org/national-report-safeguarding-nh-residents-program-integrity-a-national-review-of-state-survey-agency-performance/.

The charts provide information for all of the states on their nursing home populations; number and amount of annual fines levied; citations; and rates and rankings on the three important indicators which are the focus of our assessment: antipsychotic drugging rates, pressure ulcer rates and direct care staffing levels.

The Excel format allows for easy sorting of the state data, for instance to see how a state ranks on a given criteria. The various rates and relative rankings enable one to get a useful snapshot of how any state is performing in terms of protecting its residents and how that performance compares against that of other states and the national average.

Introduction

Background

US nursing homes provide care, support services and home to well over one million people every day. In addition to those individuals, their families and loved ones have a substantial personal stake in the quality of care and quality of life nursing homes provide. And, with the advent of the aging "Baby Boomer" generations, these numbers will undoubtedly rise. As reported in *U.S. News and World Report*, "[a] majority of people over age 65 will require some type of long-term care services during their lifetime, and over 40 percent of people will need a period of care in a nursing home."[1]

In addition to the personal stake many of us have – or will have – in nursing home care there is the financial stake which we all share. Spending on care in US nursing homes and continuing care retirement communities was $155.8 billion in 2013.[2] The average rate for nursing home care in the US is now over $200 per day.[3] The large share of these costs is paid by taxpayers through Medicaid and Medicare.

Despite the significant need for both long-term and short-term nursing home care, and the billions of dollars spent on this care every year, significant problems in resident care, quality of life and dignity are pervasive across the country. Our laws and regulatory standards are strong, providing that each resident be treated with dignity and receive the care and services that he or she needs to attain, and maintain, his or her highest practicable physical, emotional and social well-being. The fact that this level of care is the exception, rather than the rule, is a result of the failure (in fact multiple failures, every day) to adequately enforce those standards and protections. In short, nursing homes often have inadequate care staff and fail to provide appropriate care with dignity because there is nothing stopping them from doing otherwise. As the data in this report indicate, there is often little or no punishment when nursing homes fail to provide care that meets the standards they are paid to achieve, even when such failures result in significant suffering.

Over 40% of the population will need nursing home care at some point.

In addition to perpetuating resident neglect and abuse, the systemic acceptance of subpar care has a significant financial cost as well. As noted above, taxpayers pay for the majority of nursing

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[1] Mullin, Emily, U.S. News and World Report, *How to Pay For Nursing Home Costs* (February 26, 2013). Accessed February 2015 at http://health.usnews.com/health-news/best-nursing-homes/articles/2013/02/26/how-to-pay-for-nursing-home-costs.

[2] Centers for Medicare & Medicaid Services (2011), *Health Expenditures by State of Provider* (December 2011). Retrieved at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. Note: CMS does not provide separate data for nursing homes and continuing care retirement communities.

[3] Genworth, *2015 Cost of Care Survey*. Accessed April 2015 at https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html.

home care and we count on CMS and the State Survey Agencies (SAs) to assure that public monies are spent appropriately. When care is poor it means we are not getting good value for the money we are spending. And when that poor care results in the need for additional care, whether it be medication to fight an unnecessary infection or hospitalization due to a medication error, the public foots the bill for that too.

This report provides for the first time (to our knowledge) a review of nursing home quality assurance indicators that is centered on nursing home residents as individual people. Typically, oversight issues are looked at on a facility basis. For instance, the federal government's Nursing Home Compare[4] and non-governmental resources like ProPublica's Nursing Home Inspect[5] report on citations on a per facility basis.

Thus, Nursing Home Compare's Five Star rating (which is based, in large part, on the number of citations a facility has received as compared to other facilities) has a significant bias. Likewise, ProPublica's Nursing Home Inspect data tool, through which one can "…compare nursing homes in a state based on the deficiencies cited by regulators and the penalties imposed in the past three years," does not address the fact that three care deficiencies in a 70 bed facility means something quite different than three care deficiencies in a 700 bed facility (all other things being equal).

> As the data in this report indicate, there is often little or no punishment when nursing homes fail to provide care that meets the standards they are paid to achieve, even when such failures result in significant suffering.

All things are not, of course, equal; there are variations in the efficacy of state survey systems (which, due to widespread weaknesses in state oversight, overwhelmingly tend to favor the provider industry).[6] While not perfect, these tools are all valuable. However, here we endeavor to bring the assessment a bit closer to the resident by connecting relevant statistical data about quality and oversight to the individual level (wherever possible). Our goal, fundamentally, is to reflect the language and spirit of the requirements in the 1987 federal Nursing Home Reform Law. Those requirements put the focus on the individual residents, not the individual businesses.

About This Report

This report presents the national results of a study LTCCC conducted on government oversight of nursing homes. With funding from The New York Community Trust, LTCCC assessed the

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[4] Centers for Medicare and Medicaid Services, Nursing Home Compare. Accessed February 2015 at http://www.medicare.gov/nursinghomecompare/search.html.

[5] Ornstein, C. and Groeger, L., ProPublica, Nursing Home Inspect. Accessed February 2015 at http://projects.propublica.org/nursing-homes/.

[6] Several U.S. Government Accountability Office (GAO) and other reports over the years have identified systemic under-identification of nursing home problems. See, for example, GAO, *Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment*, GAO-10-70: (November 2009). Accessed February 2015 at http://www.gao.gov/products/GAO-10-70.

various New York State agencies responsible for protecting nursing home residents and assuring integrity of the public programs (Medicaid and Medicare) that pay for the majority of nursing home care. In doing so, we collected a significant amount of performance data on all US state Survey Agencies (SAs).[7] In our New York State report, we use these data to compare New York's performance with that of other states on a variety of criteria which we identified as important to quality of care and program integrity.[8] We thought that publishing these data in a national report would be useful for the public and policy makers. In particular, we hope that the present report is useful to support our and other organizations' efforts to improve nursing home care and accountability on both the national and state levels.

In the following sections we first provide a brief discussion on SAs – what they are and their essential role as the principal agency responsible for nursing home quality and safety assurance in each state. We then present data on all states in respect to their nursing home population, annual citation rates, number and amount of fines, etc…. These data are presented in charts that can be used to find out specific state information as well as to compare states against each other and national averages. All of the charts are available as interactive Excel files at https://nursinghome411.org/national-report-safeguarding-nh-residents-program-integrity-a-national-review-of-state-survey-agency-performance. The Excel format allows one to view and compare information for different states, rank them, etc….

State Survey Agencies

Introduction

State Survey Agencies (SAs) are the principal agencies responsible for overseeing care in nursing homes and responding to complaints about care. SAs are paid under contract to the federal government to ensure that all nursing homes that are licensed under Medicare and/or Medicaid (virtually every facility in the country) meets or exceeds federal standards of care for all of its residents. [This includes residents whose care is paid for by other sources.]

When resident neglect or abuse occur, whenever a facility fails to ensure that each resident attains and maintains his or her highest practicable physical, emotional and social well-being, it is a failure to comply with the minimum legal and regulatory standards which the SA is charged with enforcing. Fundamentally, the persistent and widespread problems that

Two Critical Questions for State & Federal Agencies:

1. Are neglect & other care problems being identified?
2. When problems are identified, is the harm to the resident recognized?

[7] Fifty states and Washington, DC.

[8] *Safeguarding Residents & Program Integrity in New York State Nursing Homes: An Assessment of Government Agency Performance* (April 2015). Available at http://nursinghome411.org/ny-state-report-safeguarding-residents-program-integrity-in-new-york-state-nursing-homes-an-assessment-of-government-agency-performance/. This report also provides an assessment of the NY State Medicaid Fraud Control Unit and the NY State Office of the Medicaid Inspector General.

exist in nursing homes across the country, including those that result in serious resident harm, are an outcome of failures to enforce minimum standards.[9]

Essentially, a state's oversight of nursing home care boils down to two components: (1) its ability to identify when a failure to meet standards (i.e., a deficiency) exists and (2) its ability to appropriately rate the deficiencies it finds in terms of their "scope and severity." To help states *identify* deficiencies, CMS provides guidance on what surveyors are supposed to look for, the questions they are supposed to ask, etc…. To help them *rate* deficiencies, CMS provides both guidance (instructions) and a scope and severity grid.[10]

The grid is crucial because it is used to signify how extensive the problem is in the facility (its 'scope') and its seriousness or 'severity'. Is it a minor problem that did not affect any residents or was it a serious problem that could or did cause harm? If there was harm, was it limited to one resident or more widespread?

The rating of a deficiency in terms of its scope and severity is very important for two reasons: (1) it affects the star rating for that facility on Nursing Home Compare and individual states' nursing home information website (and, thus, public perceptions of the nursing home and the quality of care it provides) and (2) it is a determining factor in whether or not the nursing home is penalized for the deficiency.

Generally speaking, nursing homes are not penalized for deficiencies unless they are rated as having caused harm to one or more residents. Thus, deficiencies that are not rated at a harm level are virtually meaningless, from a public safety perspective, since they are extremely unlikely to have any negative repercussions for the facility. Furthermore, because fines tend to be low, especially for harm that is not rated as widespread and/or extremely egregious, it is not enough to just identify when there is harm; in order to be effective the survey system must impose a fine that is substantial enough to make preventing the abuse or neglect at issue worthwhile for the nursing home.

[9] Another serious outcome of this failure is the large scale misuse and inappropriate use of public funds.
[10] For more on certification and compliance, *see* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs.html. The scope and severity grid can be found in the appendix of this report.

Chart: Identifying Nursing Home Problems

State	Number of Residents	Number of Citations on NHC (3 yrs)	Annual Per Capita Citation Rate	Rank: Per Capita Citation Rate (Higher = More Citations)
RI	8012	624	3%	1
NH	6760	892	4%	2
MA	41302	5711	5%	3
NY	105200	15051	5%	4
NJ	45204	6939	5%	5
GA	33952	7097	7%	6
NC	37142	8301	7%	7
SC	16780	3791	8%	8
FL	73505	16783	8%	9
PA	79589	18916	8%	10
AL	22725	5777	8%	11
MS	16132	4304	9%	12
ME	6248	1694	9%	13
CT	24254	7009	10%	14
LA	25880	7600	10%	15
HI	3663	1080	10%	16
TN	28976	8880	10%	17
ND	5620	1738	10%	18
VA	28566	8864	10%	19
NM	5462	1702	10%	20
OH	76372	24219	11%	21
KY	22976	7507	11%	22
AR	17664	5911	11%	23
MN	26702	9175	11%	24
SD	6384	2201	11%	25
VT	2686	951	12%	26
MO	38273	14328	12%	27
MD	24408	9570	13%	28
AZ	11261	4530	13%	29
IL	72715	29593	14%	30
DC	2557	1080	14%	31
TX	93098	40937	15%	32
MI	39391	17597	15%	33
WA	17007	7727	15%	34
IN	38821	18092	16%	35
NV	4819	2317	16%	36
DE	4150	2045	16%	37
WI	27526	13668	17%	38
IA	24858	12447	17%	39
WV	9528	4958	17%	40
CA	102093	58129	19%	41
CO	16266	9633	20%	42
NE	12068	7165	20%	43
MT	4587	3084	22%	44
OR	7337	5213	24%	45
UT	5502	3918	24%	46
OK	19118	14128	25%	47
KS	18403	14241	26%	48
WY	2353	1894	27%	49
ID	3844	3197	28%	50
AK	608	615	34%	51
US Total	1368347	482823	12%	

We first looked at the citations per capita for each state. In other words, how many deficiencies are states identifying based not on the number of facilities in the state but, rather, on the state's nursing home resident population?

This chart provides the following information for each state: number of nursing home residents (column 2), total number of citations on Nursing Home Compare for the last three years (column 3), annual rate of citations per nursing home resident (column 4) and the state's rank in terms of per capita citations (column 5).

The chart is printed here in order of lowest to highest in per capita citations. Interestingly, all of the five lowest states in terms of overall citations are in the north east, CMS Regions 1 and 2.

CLICK HERE to download the interactive Excel chart with these data. (Note: This Excel file includes information on citations, fines and citations at harm.)

Why Are Citations Per Capita Important?

Because it puts the focus on whether (or not) residents are being protected.

Chart: Identifying Resident Harm

State	Number of Citations on NHC (3 yrs)	Number Cited as Harm+ (3 yrs)	Percent Deficiencies Cited as Harm	Rank: % Citations Harm+ (Higher = More I.D. of Harm)
CA	58129	663	1.14%	1
AL	5777	66	1.14%	2
PA	18916	246	1.30%	3
MD	9570	137	1.43%	4
WY	1894	36	1.90%	5
MT	3084	59	1.91%	6
MN	9175	183	1.99%	7
OH	24219	493	2.04%	8
NE	7165	148	2.07%	9
MO	14328	330	2.30%	10
HI	1080	25	2.31%	11
VA	8864	228	2.57%	12
FL	16783	452	2.69%	13
ME	1694	47	2.77%	14
CO	9633	276	2.87%	15
AZ	4530	136	3.00%	16
NH	892	27	3.03%	17
DE	2045	63	3.08%	18
NV	2317	72	3.11%	19
IL	29593	927	3.13%	20
IN	18092	581	3.21%	21
UT	3918	127	3.24%	22
NY	15051	501	3.33%	23
KS	14241	478	3.36%	24
WV	4958	186	3.75%	25
NC	8301	313	3.77%	26
GA	7097	269	3.79%	27
DC	1080	43	3.98%	28
OK	14128	572	4.05%	29
WI	13668	571	4.18%	30
OR	5213	218	4.18%	31
IA	12447	522	4.19%	32
AK	615	26	4.23%	33
TX	40937	1732	4.23%	34
AR	5911	259	4.38%	35
TN	8880	398	4.48%	36
NJ	6939	312	4.50%	37
LA	7600	383	5.04%	38
ID	3197	168	5.25%	39
ND	1738	95	5.47%	40
MI	17597	991	5.63%	41
CT	7009	412	5.88%	42
RI	624	37	5.93%	43
SD	2201	131	5.95%	44
WA	7727	471	6.10%	45
VT	951	61	6.41%	46
MS	4304	313	7.27%	47
KY	7507	646	8.61%	48
MA	5711	499	8.74%	49
SC	3791	364	9.60%	50
NM	1702	184	10.81%	51
US Total	482823	16477	3.41%	

As discussed earlier, when a nursing home is cited for a deficiency, the deficiency is rated in terms of its scope and severity. The chart on this page provides information on the rate each state identifies that a deficiency has caused harm (or greater injury) to a resident.

The chart is sorted by states' rank in citing harm (column 5). California and Alabama are tied for lowest in the country, both citing harm at roughly 1/3 the national average of 3.41% of the time.

As the chart indicates, states rarely find that a deficiency has caused harm to a resident. Because, generally speaking, only findings of harm result in a penalty against the nursing home, this means that penalties for deficiencies in care or services are exceedingly rare.

CLICK HERE to download the interactive Excel chart with this information. (Note: This Excel file includes information on citations, fines and citations at harm.)

Following are two examples of survey findings of "no harm." One is an example of a finding of no harm which we believe, based solely on the findings in the Statement of Deficiency (SoD), is inappropriate. The second is an example of a no harm finding which appears (also based on the SoD) to be appropriate.[11]

These examples were identified by conducting a search of non-harm deficiencies (F and below) on ProPublica's Nursing Home Inspect website and reviewing a number of them to find two that we felt were illustrative. Since we were looking only for illustrative examples, it is important to note that this is an informal sampling of SoDs and not meant to be considered representative. That being said, we found it difficult to identify a no harm finding which we did not think was, in fact, harm. These included failure to provide necessary medication, providing the wrong medication, failure to provide a privacy curtain (so that the resident was constantly exposed to others, including during her treatment), etc….[12]

Example of finding of "no harm" that appears inappropriate

In November 2014, surveyors at Medford Multicare Center for Living on Long Island found that it violated several federal minimum standards related to unnecessary drugging of residents. The SoD states that the violation

> …was **evident for three of five residents reviewed** for Unnecessary Drugs in a total Stage 2 sample of 38 residents. Specifically, 1) Resident # 30 was administered an Antipsychotic medication without a documented adequate clinical indication/justification/diagnosis its use 2) Resident # 187 was being administered Antianxiety and Antipsychotic medications without an adequate clinical indication for use or that appropriate gradual dose reductions were attempted 3) Resident # 234 was administered Antipsychotic and Antianxiety medications without adequate indication for use and no attempts at gradual dose reduction.
>
> [Emphasis added.]

In addition to being cited at no harm the survey identified the violation as "isolated." Following are the findings for one of the three residents.

> 1) **Resident #30 was admitted with diagnose including Senile Dementia, Alzheimer's Disease, Diabetes Mellitus and Depression**.

[11] Both of these samples are from our report on New York oversight and, thus, are from New York nursing homes. However, based on our knowledge and experience (including reviews of many Statements of Deficiencies from across the country over the years), we believe that they are illustrative of the nationwide problem in proper identification of resident harm.

[12] Numerous previous studies have identified the under-identification of serious problems. *See*, for examples, the *GAO Studies* and *Nursing Home Residents at Risk,* referenced earlier.

A Comprehensive Care Plan (CCP) dated 6/30/13 - 11/2014 titled Psychotropic Medication use documented a diagnosis of Dementia.

The Admission Minimum Data Set (MDS) dated 9/9/14 documented a Brief Interview For Mental Status (BIMS) score of 3 (cognition impaired). The MDS also had **no documented evidence of mood disorder, Psychosis or behavior concerns**. The MDS also (under section I active diagnoses) no documented Psychosis, mood disorder or behavior concerns.

A POFs [**Physician's Order Form] dated 11/12/14 documented Haldol 0.5 mg for a diagnosis of Personality Disorder**.

A **Psychiatry Consultation Report** (PCR) dated 12/2/13 documented that the consultation was for a follow up for Dementia with behaviors. The PCR also **documented that the resident has diagnosis of Dementia with behavior and to start Haldol** 0.5 milligrams (mg) two times a day for Paranoia.

A **Physician's Order Form (POF) dated 12/23/13 documented Haldol 0.5 mg two times a day for a diagnosis of Dementia. Haldol (Haldol has a black box warning and not Federal Drug Administration (FDA) approved for elderly residents with a diagnosis of Alzheimer's Disease/Dementia because there is a higher risk for death**.)

A POFs dated 12/30/13 **documented a diagnosis of Dementia with behavior for the Haldol use**.

A PCR dated 12/30/13 documented a diagnosis of Dementia with behaviors and to continue the Haldol for Paranoia.

Summary of this "No Harm" Citation:

(1) NY DOH finds three out of five residents being given antipsychotic drugs "without adequate clinical indication."
(2) FDA Black-Box Warning notes increased risk of falls, stroke, death, etc… with antipsychotic drugging.
(3) NYDOH finds "no actual harm."
(4) Facility has no penalties in three years, according to NH Compare (as of Apr. 4, 2015).

A POF dated 1/13/14, 5/28/14, 7/21/14, and 11/12/14 documented a diagnosis of personality disorder for the use of Haldol.

A **Pharmacy Consultant Review Form** (PCRF) dated 1/17/14 **documented that the resident is receiving Haldol for a diagnosis of Dementia. The PCRF documented to please change the diagnosis to an appropriate Federal Drug Administration (FDA) approved diagnosis for Haldol** (schizophrenia/Tourett's Syndrome). **The PCRF also documented that this is the focus of the Department of Health and the change to an appropriate diagnosis will keep the facility in compliance**.

A PCR dated 1/27/14 documented that the staff report that the resident can be easily redirected and has diagnosis of Dementia Senile type.

A PCR dated 4/22/14 documented to continue Haldol for a diagnosis of Psychosis.

A POF dated 4/28/14, 6/25/14, 9/17/14 and 10/16/14 documented a diagnosis of Psychosis for the Haldol use.

A PCR dated 5/9/14 documented that the resident is followed for her sad mood, periods of restlessness and wandering and to continue Haldol for Psychosis

A POF dated 5/28/14, 7/21/14, and 11/12/14 documented a diagnosis of Personality Disorder for the Haldol use.

A PCR dated 10/6/14 documented that the consultation was for restlessness and that the resident is followed for sad mood, periods of restlessness and wandering and to continue Haldol for Psychosis.

Physician's Assessment and Plan of Care (PAAPOC) dated 12/2013 through 11/2014 **documented that the resident was receiving Psychotropic medication for the diagnosis of Dementia**.

There is **no documented evidence in the medical record that the resident had symptoms of Psychosis Paranoia or Personality Disorder or a clinical indication for the use of an antipsycotic medication (Haldol**).

An **interview was held with the Licensed Practical Nurse (LPN) Charge Nurse** on 11/18/14 at 10:30 AM. **The LPN stated that Resident # 30 does not exhibit any behavior symptoms**.

An interview was held with the Medical Director on 11/18/14 at 2:30 PM. The **Medical Director reviewed the medical record and stated that he would expect that if the resident was not exhibiting any behavioral symptoms that she should not be on the antipsycotic medication Haldol**.

An interview was held with the Psychiatrist on 11/18/14 at 2:45 PM. The **Psychiatrist stated that the resident stated that she did not belong here and was trying to pack her bags to go home that is why the resident was started on Haldol**.[13, 14]

[Emphases added.]

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[13] Statement of Deficiency for Medford Multicare, survey date November 18, 2014. Accessed at http://www.nursinghomes.nyhealth.gov/nursing_homes/deficiency/637/2YQK.

[14] Antipsychotic drugs carry an FDA black box warning against use on elderly individuals with dementia due to their increased risk of serious harm and death. For more information, *see* LTCCC's Learning Center and Dementia Care Advocacy Toolkit at http://nursinghome411.org/learning-center/.

Example of finding of "no harm" that appears appropriate

Many deficiencies identified by surveyors are, of course, appropriately cited. For example, in May 2014, McAuley Manor At Mercycare in Hornell, NY was cited for having steam trays of food out where residents, including those with dementia, could access them and that the tray handled were extremely hot. This clearly posed a hazardous situation but, since no resident had touched the steam trays, there had been no harm.

Chart: Penalizing Facilities When Substandard Care & Services are Uncovered

The chart on this page provides several important points of information regarding the extent to which states fine facilities when they are found to be providing substandard care or otherwise failing to achieve minimum standards. As noted earlier, we believe that fining is critical, since providers are unlikely to change practices unless there is a financial incentive for them to do so.

State	Total # Fines on NHC	Total Amount of Fines on NHC	Average Fine on NHC	Rank: Average Fine (Higher = Larger Per Deficiency)
ND	0	$0.00	$0	1
SD	0	$0.00	$0	2
WY	0	$0.00	$0	3
MT	6	$18,949.00	$3,158	6
HI	9	$26,980.00	$2,998	5
AK	7	$44,591.00	$6,370	15
ME	15	$69,228.00	$4,615	7
NH	19	$90,219.00	$4,748	8
NE	12	$113,348.00	$9,446	20
RI	6	$190,925.00	$31,821	40
ID	45	$224,526.00	$4,989	10
OR	121	$234,718.00	$1,940	4
NV	13	$243,097.00	$18,700	32
NM	48	$244,521.00	$5,094	11
UT	54	$319,402.00	$5,915	14
WA	74	$400,391.00	$5,411	13
MN	80	$431,508.00	$5,394	12
VT	14	$479,233.00	$34,231	42
KS	62	$541,330.00	$8,731	18
DC	9	$577,912.00	$64,212	49
AZ	25	$604,406.00	$24,176	33
CO	90	$610,663.00	$6,785	16
NJ	35	$636,952.00	$18,199	31
MO	88	$673,146.00	$7,649	17
CT	139	$679,310.00	$4,887	9
WV	28	$799,576.00	$28,556	37
NY	73	$888,675.00	$12,174	24
DE	24	$908,154.00	$37,840	44
IA	102	$957,191.00	$9,384	19
AL	40	$1,056,475.00	$26,412	35
MD	19	$1,146,978.00	$60,367	48
VA	35	$1,174,309.00	$33,552	41
PA	48	$1,274,948.00	$26,561	36
IN	152	$1,476,631.00	$9,715	21
AR	169	$1,925,912.00	$11,396	23
MS	54	$2,488,529.00	$46,084	46
MA	213	$2,744,327.00	$12,884	26
WI	188	$2,858,156.00	$15,203	29
GA	63	$3,128,563.00	$49,660	47
OH	346	$3,408,537.00	$9,851	22
OK	197	$3,548,541.00	$18,013	30
CA	155	$3,811,287.00	$24,589	34
IL	265	$3,870,354.00	$14,605	27
LA	136	$3,928,831.00	$28,888	38
SC	94	$4,272,573.00	$45,453	45
TN	64	$6,126,700.00	$95,730	51
MI	448	$6,627,851.00	$14,794	28
NC	181	$6,692,132.00	$36,973	43
FL	263	$7,771,290.00	$29,549	39
TX	693	$8,853,146.00	$12,775	25
KY	141	$9,701,492.00	$68,805	50
US Total	5162	$98,896,513.00	$19,159	

The states are listed in order of the amount of total fines they have imposed over the last three years (third column).[15]

Important Note: These are the fines posted on NH Compare and do not include state fines (if any).

CLICK HERE to download the interactive Excel chart with this information. (Note: This Excel file includes information on overall citations, fines and citations at harm.)

[15] NH Compare provides information on nursing homes for the previous three years, or "cycles." Data were accessed end of January 2015.

Inappropriate Antipsychotic Drugging

Background

The above comparisons of performance in citation rates, identification of harm and imposition of penalties provide a number of valuable insights into state agency performance and how they compare against one another. However, these insights are limited by the fact that they do not take into account variations that may exist in quality between states. For example, if State A's nursing homes are better, overall, than State B's, it is unfair to use the number of penalties each imposes as a basis for comparison of the efficacy of their survey agencies.

To address possible variations in quality, in this and the following sections we assess State Survey Agency (SA) performance in terms of three criteria which we believe are important indicators of nursing home quality: antipsychotic drugging, pressure ulcers (also known as bed sores) and direct care staffing levels.

Inappropriate antipsychotic drugging is a serious and widespread problem in nursing homes across the United States. As the example discussed earlier of a "no harm" citation that appears inappropriate indicates, residents who do not have a diagnoses of a psychotic condition may be given antipsychotics to make them easier to care for or for other reasons for which there are not clinical indications. In addition, being diagnosed with a psychotic condition does not – or at least should not – mean that an individual can be given these drugs with impunity. Frequently, these drugs are administered as a form of chemical restraint, and as a substitute for good care.

Frequently, these drugs are administered as a form of chemical restraint, and as a substitute for good care.

Federal standards have long prohibited inappropriate drugging and chemical restraint use. Since March 2012, the federal government has had a national campaign focusing specifically on reducing the inappropriate and dangerous use of antipsychotics on residents with dementia. Last year, we conducted two evaluations of the campaign. One focused on New York and assessed the state's record in reducing and holding providers accountable for inappropriate drugging.[16] The other assessed the national impact on nursing home residents of the failure of the federal campaign to meet its self-identified goal.[17]

In the following sections, we look at antipsychotic drugging rates and citations for unnecessary drugging, which are coded in the federal system as F-329. While F-329 is imprecise, in that it is not limited to antipsychotics (it includes inappropriate administration of other drugs), one

[16] Mollot, R., Long Term Care Community Coalition, Antipsychotic Drug Use in NY State Nursing Homes: An Assessment of New York's Progress in the National Campaign to Reduce Drugs and Improve Dementia Care (April 2014). Available at http://nursinghome411.org/antipsychotic-drug-use-in-ny-state-nursing-homes-an-assessment-of-new-yorks-progress-in-the-national-campaign-to-reduce-drugs-and-improve-dementia-care/.

[17] Mollot, R., Long Term Care Community Coalition, *Left Behind: The Impact Of The Failure To Fulfill The Promise of The National Campaign To Improve Dementia Care* (December 2014). Available at http://nursinghome411.org/left-behind-the-impact-of-the-failure-to-fulfill-the-promise-of-the-national-campaign-to-improve-dementia-care/.

would expect, given that this is a drugging problem and F-329 has been a focus of the federal campaign, that we would find robust citing of this F-tag if efforts to improve accountability for inappropriate off-label drugging have been successful.

About the Data

Data on antipsychotic (AP) drugging are published in two ways:

1. **Nursing Home Compare**. The rates published on Nursing Home Compare are risk-adjusted. Specifically, they are risk-adjusted to exclude individuals who are given AP drugs in the nursing home and who have a diagnosis of schizophrenia, Tourette's syndrome or Huntington's disease. This is a blanket exclusion, meaning that it does not distinguish whether or not these individuals received the drug appropriately or even whether or not their diagnoses are appropriate.
2. **Minimum Data Set (MDS)**. Nursing home AP drugging rates are also recorded in the MDS Frequency Report, which are the actual percentages of residents who are given antipsychotics, as reported by the facilities. These data are not risk-adjusted.

The national MDS drugging rate is 18.3% higher than the NH Compare rate.[18] According to the MDS data, 22.42% of US nursing home residents receive antipsychotic drugs. Given that the United States has roughly 1,368,000 nursing home residents, this means that about 306,705 residents are currently being administered antipsychotics. The NH Compare (risk-adjusted) rate is 18.95%. Thus, the NH Compare drugging rate (which exclude residents with the aforementioned conditions) equals about 259,236 residents. It is important to note that approximately two percent (2%) of the population suffers from a psychotic disorder. Two percent of the US nursing home population is approximately 27,360 people.

Chart: State Antipsychotic Drugging Rates, NH Compare vs. MDS Frequency Reports

The following chart presents data we collected on each states' average antipsychotic drugging rates (both risk-adjusted on NH Compare and the more "raw" data in the MDS Frequency Reports), states' citations for F-329 on NH Compare and the numbers of these citations identified as having caused harm or higher (G or higher on the scope and severity matrix).

We ranked states in respect to their average drugging on both NH Compare and the MDS Frequency Report. Variations between the MDS and NH Compare data (particularly when they are significant) should, we believe, raise questions about the appropriateness of diagnostic and medical supervision practices. Essentially, the gap between the NH Compare number and the MDS number reflect the number of residents receiving antipsychotic drugs who have a diagnosis of Huntington's disease, Schizophrenia or Bipolar Disorder.[19] If that number is

[18] 22.42 - 18.95 = 3.47. 3.47 is 18.31% of 18.95.

[19] Approximately one percent (1%) of the population is estimated to have schizophrenia, according to the National Institute of Mental Health (http://www.nimh.nih.gov/health/publications/schizophrenia/index.shtml) and .01% of the population is estimated to have Huntington's Disease, according to the Huntington's Disease Society of America (*HDSA Fast Facts*, http://www.hdsa.org/new-to-hd-1/new-to-hd.html). The adult and senior populations

significantly larger than the percentage of the population that legitimately have those conditions, it might indicate that individuals are being given these diagnoses in order to give them the drugs with impunity.[20] While not dispositive, this can (and should, we believe) signal to policymakers and program integrity agencies that further investigation is called for.

CLICK HERE to download the interactive Excel chart with information on states' antipsychotic drugging rates and citations.

with Tourette's syndrome are more difficult to quantify. According to the National Tourette Syndrome Association, "The best estimate for the prevalence of TS is 6 cases per 1,000 (0.6%) children…. There are currently no reliable prevalence estimates of TS and other Tic Disorders in adults, but are expected to be substantially less than in children as tics often decline with aging." *The Spectrum of Tourette Syndrome and Tic Disorders*, downloaded from http://www.tsa-usa.org/Medical/whatists_cov.html in February 2015).

[20] It is important to note, again, that diagnosis with one of these conditions, even when appropriate, does not mean that antipsychotic drugs are necessary or being given appropriately.

State	Number of Residents	Average AP Drugging on NHC (Q1-3) (Higher = More Drugging)	RANK: AP Drugging on NHC (Higher = More Drugging)	MDS % of Residents Given AP Drugs	RANK: AP Drugs on MDS (Higher = More Drugging)
AK	608	13.34%	2	15.11%	2
AL	22725	22.38%	45	25.57%	45
AR	17664	21.70%	40	21.19%	32
AZ	11261	19.11%	29	21.06%	31
CA	102093	15.41%	8	20.76%	27
CO	16266	16.63%	13	19.61%	15
CT	24254	20.55%	34	23.98%	39
DC	2557	14.83%	5	19.51%	13
DE	4150	15.56%	9	17.83%	9
FL	73505	21.16%	37	22.87%	35
GA	33952	20.81%	36	24.23%	40
HI	3663	10.87%	1	9.76%	1
IA	24858	19.43%	31	19.93%	20
ID	3844	18.80%	25	19.45%	11
IL	72715	24.02%	49	30.04%	51
IN	38821	20.03%	33	20.59%	24
KS	18403	21.98%	42	25.29%	44
KY	22976	21.52%	38	23.35%	37
LA	25880	26.07%	51	29.66%	50
MA	41302	20.61%	35	23.26%	36
MD	24408	16.24%	12	18.20%	10
ME	6248	18.97%	28	20.82%	28
MI	39391	13.89%	3	16.66%	5
MN	26702	15.56%	10	17.00%	6
MO	38273	22.33%	44	25.75%	46
MS	16132	23.89%	48	26.34%	49
MT	4587	16.79%	15	19.99%	22
NC	37142	15.22%	7	17.59%	7
ND	5620	18.31%	22	20.59%	25
NE	12068	22.24%	43	23.63%	38
NH	6760	19.38%	30	20.85%	29
NJ	45204	14.81%	4	19.48%	12
NM	5462	18.80%	26	19.74%	16
NV	4819	19.77%	32	19.96%	21
NY	105200	18.04%	19	21.36%	33
OH	76372	21.76%	41	26.13%	48
OK	19118	21.54%	39	24.56%	42
OR	7337	17.57%	18	19.75%	17
PA	79589	18.40%	24	20.59%	26
RI	8012	17.00%	17	19.75%	18
SC	16780	15.67%	11	17.65%	8
SD	6384	18.21%	20	19.99%	23
TN	28976	23.39%	46	24.51%	41
TX	93098	25.97%	50	25.94%	47
UT	5502	23.55%	47	24.68%	43
VA	28566	18.81%	27	20.89%	30
VT	2686	18.34%	23	21.62%	34
WA	17007	18.25%	21	19.55%	14
WI	27526	15.08%	6	16.19%	3
WV	9528	16.75%	14	19.90%	19
WY	2353	16.97%	16	16.51%	4
US	1368347	18.95%		22.42%	

Chart: US AP Drugging Rates on NH Compare vs. MDS

Chart: US Antipsychotic Drugging Rates and Citations for F-329

The following chart provides information on enforcement of the federal standard prohibiting inappropriate drugging, F-329. As noted earlier, this standard applies to any drug that is given inappropriately or unnecessarily. Thus, the numbers include any citation for unnecessary antipsychotic drug use plus other drugs given unnecessarily. Nevertheless, given especially that F-329 has been a major focus of the national campaign, we believe that citations to it are a good measure of a state's enforcement in regard to this important criteria.

To facilitate understanding of state performance, we included in the chart the Nursing Home Compare antipsychotic drugging rate for each state. This essentially gives nursing homes the "benefit of the doubt" in terms of appropriate use of the drugs for people with a condition that might merit its use. Comparing these drugging rates with the rate of citation for F-329, one can see that, overall, the states do a very poor job in citing for F-329. The average risk-adjusted state drugging rate is 18.95% while the average state citation rate is 0.31%. This indicates that there is a significant amount of inappropriate antipsychotic drugging that is not being cited by the states.

The average risk-adjusted state drugging rate is 18.95% while the average state citation rate is 0.31%. This indicates that there is a significant amount of inappropriate antipsychotic drugging that is not being cited by the states.

Next we looked at state citations for F-329 that were cited as having caused harm to one or more residents (G or higher on the scope and severity matrix). The data indicate that, on average, states only find two percent (2%) of all F-329 violations as having caused any harm to residents. Given the known significant dangers of these drugs, widely publicized since the FDA's "Black Box Warning" ten years ago, we believe this is a striking and troublesome finding. If giving residents drugs that are both highly dangerous and not clinically indicated is not harm, what is?

CLICK HERE to download the interactive Excel chart with information on states' antipsychotic drugging rates and citations.

State	Number of Residents	Average AP Drugging on NHC (Q1-3) (Higher = More Drugging)	RANK: AP Drugging on NHC (Higher = More Drugging)	MDS % of Residents Given AP Drugs	RANK: AP Drugs on MDS (Higher = More Drugging)	F-329 Deficiencies on NHC (3 yrs)	Annual Per Resident F-329 Citation Rate	RANK: Citations Per Resident (Higher = More Citations)	F-329 Deficiencies on NHC at G+ (3 yrs)	Percent F-329 Deficiencies G+	RANK: Percent Citations at G+ (Higher = Greater % Deficiencies Cited as Causing Harm)
AK	608	13.34%	2	15.11%	2	4	0.22%	18	0	0.00%	1
AL	22725	22.38%	45	25.57%	45	24	0.04%	1	1	4.17%	41
AR	17664	21.70%	40	21.19%	32	73	0.14%	13	1	1.37%	19
AZ	11261	19.11%	29	21.06%	31	186	0.55%	45	1	0.54%	12
CA	102093	15.41%	8	20.76%	27	1201	0.39%	35	19	1.58%	23
CO	16266	16.63%	13	19.61%	15	257	0.53%	43	2	0.78%	13
CT	24254	20.55%	34	23.98%	39	200	0.27%	24	1	0.50%	11
DC	2557	14.83%	5	19.51%	13	29	0.38%	33	0	0.00%	3
DE	4150	15.56%	9	17.83%	9	73	0.59%	48	1	1.37%	18
FL	73505	21.16%	37	22.87%	35	511	0.23%	20	9	1.76%	26
GA	33952	20.81%	36	24.23%	40	61	0.06%	5	2	3.28%	38
HI	3663	10.87%	1	9.76%	1	34	0.31%	28	1	2.94%	36
IA	24858	19.43%	31	19.93%	20	217	0.29%	25	13	5.99%	47
ID	3844	18.80%	25	19.45%	11	130	1.13%	50	2	1.54%	22
IL	72715	24.02%	49	30.04%	51	469	0.21%	17	6	1.28%	17
IN	38821	20.03%	33	20.59%	24	533	0.46%	38	23	4.32%	42
KS	18403	21.98%	42	25.29%	44	631	1.14%	51	5	0.79%	14
KY	22976	21.52%	38	23.35%	37	36	0.05%	4	2	5.56%	46
LA	25880	26.07%	51	29.66%	50	212	0.27%	23	3	1.42%	21
MA	41302	20.61%	35	23.26%	36	109	0.09%	8	2	1.83%	27
MD	24408	16.24%	12	18.20%	10	277	0.38%	34	6	2.17%	33
ME	6248	18.97%	28	20.82%	28	50	0.27%	22	1	2.00%	30
MI	39391	13.89%	3	16.66%	5	432	0.37%	32	8	1.85%	28
MN	26702	15.56%	10	17.00%	6	405	0.51%	42	2	0.49%	10
MO	38273	22.33%	44	25.75%	46	177	0.15%	15	2	1.13%	15
MS	16132	23.89%	48	26.34%	49	25	0.05%	3	0	0.00%	9
MT	4587	16.79%	15	19.99%	22	57	0.41%	36	3	5.26%	45
NC	37142	15.22%	7	17.59%	7	163	0.15%	14	13	7.98%	51
ND	5620	18.31%	22	20.59%	25	41	0.24%	21	2	4.88%	44
NE	12068	22.24%	43	23.63%	38	182	0.50%	40	0	0.00%	8
NH	6760	19.38%	30	20.85%	29	9	0.04%	2	0	0.00%	7
NJ	45204	14.81%	4	19.48%	12	155	0.11%	11	0	0.00%	2
NM	5462	18.80%	26	19.74%	16	49	0.30%	27	2	4.08%	40
NV	4819	19.77%	32	19.96%	21	60	0.42%	37	1	1.67%	25
NY	105200	18.04%	19	21.36%	33	259	0.08%	7	6	2.32%	34
OH	76372	21.76%	41	26.13%	48	815	0.36%	31	13	1.60%	24
OK	19118	21.54%	39	24.56%	42	333	0.58%	47	4	1.20%	16
OR	7337	17.57%	18	19.75%	17	118	0.54%	44	3	2.54%	35
PA	79589	18.40%	24	20.59%	26	396	0.17%	16	0	0.00%	6
RI	8012	17.00%	17	19.75%	18	24	0.10%	9	0	0.00%	4
SC	16780	15.67%	11	17.65%	8	54	0.11%	10	1	1.85%	29
SD	6384	18.21%	20	19.99%	23	42	0.22%	19	3	7.14%	49
TN	28976	23.39%	46	24.51%	41	62	0.07%	6	3	4.84%	43
TX	93098	25.97%	50	25.94%	47	348	0.12%	12	22	6.32%	48
UT	5502	23.55%	47	24.68%	43	132	0.80%	49	10	7.58%	50
VA	28566	18.81%	27	20.89%	30	254	0.30%	26	8	3.15%	37
VT	2686	18.34%	23	21.62%	34	28	0.35%	29	0	0.00%	5
WA	17007	18.25%	21	19.55%	14	282	0.55%	46	6	2.13%	32
WI	27526	15.08%	6	16.19%	3	390	0.47%	39	8	2.05%	31
WV	9528	16.75%	14	19.90%	19	144	0.50%	41	2	1.39%	20
WY	2353	16.97%	16	16.51%	4	25	0.35%	30	1	4.00%	39
US	1368347	18.95%		22.42%		10778	0.26%		224	2.08%	

Chart: US AP Drugging Rates & Inappropriate Drugging Citation Rates

Citing for Failure to Prevent and Treat Pressure Ulcers

According to the Centers for Disease Control and Prevention,

> Pressure ulcers, also known as bed sores, pressure sores, or decubitus ulcers, are wounds caused by unrelieved pressure on the skin. They usually develop over bony prominences, such as the elbow, heel, hip, shoulder, back, and back of the head. Pressure ulcers are serious medical conditions and one of the important measures of the quality of clinical care in nursing homes.[21] [Endnotes deleted from original.]

While some pressure ulcers are unavoidable, research and experience indicate that,"[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."[22] In fact, the need to reduce pressure ulcers in nursing homes has been one of the key areas identified for quality improvement by the nursing home industry's quality improvement campaign, Advancing Excellence, which is now in its ninth year.[23]

Chart: US Unhealed Pressure Ulcer Rates and F-314 Citations

The following chart provides information for all states on unhealed pressure ulcer rates and related citations in nursing homes. We selected pressure ulcers (PUs) as a key criterion on which to focus in this report because, as noted above, it is an important indicator of a nursing home's quality of care.

The chart uses data from MDS reports and NH Compare to compare states' rates of nursing home PUs and rates of citations against nursing homes for failing to provide adequate services to prevent and treat PUs. We found that the average rates for PUs among the states vary considerable: from a low of 4.2% in New Hampshire to a high of 11.09% in Nevada. The national average is 7.38%. It should be noted that, given the seriousness of this problem, the rates overall should be much lower and would be, we believe, if appropriate care was more widely provided in nursing homes. For instance, regular monitoring and evaluation of all residents, and pro-active care for residents identified as "high-risk," would likely result in a substantial reduction in PU rates across the nation.

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[21] NCHS Data Brief, No. 14 (February 2009), which incorporates *Pressure Ulcers Among Nursing Home Residents: United States, 2004*. Accessed in March 2015 from www.cdc.gov/nchs/data/databriefs/db14.pdf (PDF).

[22] Edsberg, L.; Langemo, D.; Baharestani, M.; Posthauer, M.; and Goldberg, M., "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313–334. Abstract accessed in February 2017 at http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable_Pressure_Injury__State_of_the_Science.6.aspx. Henceforth *Unavoidable Pressure Injury*.

[23] Advancing Excellence in America's Nursing Homes, https://www.nhqualitycampaign.org/default.aspx.

This chart provides information on states' citations for inadequate pressure ulcer care (F-314) in two important ways:

1. Annual rates of citations have been computed for each state based on the number of residents with PUs. We thought that this was critical in order to gain insights into a fundamental question: what are the states doing in response to the pressure ulcers suffered by their citizens? Our findings indicate that, nationally, the citation rates are very low, averaging only 2.96%. This means that there is only about one F-314 citation for every 33 cases of a resident with pressure ulcers. From an advocate's perspective, this is a long way from the idea that in the "vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."[24] Though the average is low overall, we found significant variation among the states. In addition to providing each state's percentages, we have ranked the states.
2. Numbers of citations at harm or above (G+ on the scope and severity matrix) are provided for each state. As noted earlier, a facility is unlikely to be penalized unless a deficiency is cited as having caused harm or immediate jeopardy to one or more residents. Since pressure ulcers are, by definition, a wound and are well-recognized as a serious problem, one might consider that any case of a pressure ulcer developing is harmful and, therefore, any time poor care is responsible the facility will be cited at a level of harm or above. Instead, our findings indicate that states cite F-314 at a level of harm less than 25% of the time. Here, too, we found a wide disparity among the states, ranging from zero (0%) to over 80%.

Fast Facts:

(1) Pressure ulcers are a problem for over 86,000 nursing home residents.
(2) Though pressure ulcers are largely preventable, States cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer.
(3) When States *do* cite a facility for inadequate pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.

CLICK HERE to download the following chart as an interactive Excel chart.

[24] As previously cited from *Unavoidable Pressure Injury.*

State	Number of Residents	MDS % Residents Unhealed Pressure Ulcers	Number of Residents with Pressure Ulcers	RANK: Percent of Residents with Pressure Ulcers (Higher = Greater % PUs)	F-314 Deficiencies on NHC (3 yrs)	Annual F-314 Citation Rate Per Resident with Pressure Ulcers	RANK: F-314 Citations (Higher = More Citations Per Res. w/PU)	Number F-314 Deficiencies Cited as Harm (G+)	Percent F-314 Deficiencies Cited as Harm (G+)	RANK: Percent Citations at G+ (Higher = Greater % Deficiencies Cited as Causing Harm)
AK	608	7.06%	43	30	5	3.88%	31	1	20.00%	17
AL	22725	6.48%	1473	24	95	2.15%	20	3	3.16%	2
AR	17664	5.34%	943	11	267	9.44%	49	18	6.74%	5
AZ	11261	8.61%	970	43	81	2.78%	27	38	46.91%	44
CA	102093	9.75%	9954	50	645	2.16%	21	48	7.44%	6
CO	16266	5.08%	826	7	127	5.12%	41	36	28.35%	28
CT	24254	5.48%	1329	13	189	4.74%	38	60	31.75%	32
DC	2557	9.34%	239	48	20	2.79%	28	12	60.00%	48
DE	4150	5.44%	226	12	44	6.50%	46	12	27.27%	24
FL	73505	9.07%	6667	47	200	1.00%	4	13	6.50%	4
GA	33952	7.98%	2709	37	109	1.34%	11	12	11.01%	7
HI	3663	5.75%	211	15	16	2.53%	25	2	12.50%	9
IA	24858	4.21%	1047	2	163	5.19%	42	57	34.97%	36
ID	3844	5.85%	225	18	111	16.45%	51	71	63.96%	49
IL	72715	6.42%	4668	22	626	4.47%	36	109	17.41%	15
IN	38821	6.67%	2589	26	325	4.18%	34	89	27.38%	25
KS	18403	5.69%	1047	14	291	9.26%	48	115	39.52%	42
KY	22976	7.38%	1696	34	64	1.26%	10	10	15.63%	12
LA	25880	7.19%	1861	32	84	1.50%	13	13	15.48%	11
MA	41302	6.17%	2548	19	72	0.94%	3	36	50.00%	46
MD	24408	9.00%	2197	46	77	1.17%	7	5	6.49%	3
ME	6248	5.79%	362	16	26	2.40%	23	0	0.00%	1
MI	39391	7.17%	2824	31	407	4.80%	39	135	33.17%	34
MN	26702	5.27%	1407	9	226	5.35%	44	39	17.26%	14
MO	38273	5.05%	1933	6	349	6.02%	45	72	20.63%	18
MS	16132	7.41%	1195	35	40	1.12%	6	16	40.00%	43
MT	4587	6.39%	293	21	18	2.05%	19	9	50.00%	45
NC	37142	8.47%	3146	41	113	1.20%	8	17	15.04%	10
ND	5620	4.79%	269	5	41	5.08%	40	15	36.59%	39
NE	12068	4.39%	530	3	85	5.35%	43	26	30.59%	31
NH	6760	4.20%	284	1	14	1.64%	15	5	35.71%	37
NJ	45204	9.36%	4231	49	105	0.83%	1	22	20.95%	19
NM	5462	6.49%	354	25	11	1.03%	5	9	81.82%	51
NV	4819	11.09%	534	51	29	1.81%	17	5	17.24%	13
NY	105200	8.76%	9216	44	243	0.88%	2	30	12.35%	8
OH	76372	6.89%	5262	28	391	2.48%	24	118	30.18%	30
OK	19118	6.80%	1300	27	159	4.08%	33	54	33.96%	35
OR	7337	8.85%	649	45	61	3.13%	30	18	29.51%	29
PA	79589	6.90%	5492	29	206	1.25%	9	49	23.79%	22
RI	8012	6.18%	495	20	23	1.55%	14	5	21.74%	20
SC	16780	8.55%	1435	42	62	1.44%	12	17	27.42%	26
SD	6384	5.14%	328	8	43	4.37%	35	33	76.74%	50
TN	28976	8.31%	2408	38	119	1.65%	16	38	31.93%	33
TX	93098	7.34%	6833	33	377	1.84%	18	106	28.12%	27
UT	5502	6.45%	355	23	48	4.51%	37	12	25.00%	23
VA	28566	8.37%	2391	39	195	2.72%	26	44	22.56%	21
VT	2686	5.28%	142	10	17	4.00%	32	10	58.82%	47
WA	17007	7.70%	1310	36	119	3.03%	29	47	39.50%	41
WI	27526	5.81%	1599	17	484	10.09%	50	95	19.63%	16
WV	9528	8.45%	805	40	56	2.32%	22	22	39.29%	40
WY	2353	4.72%	111	4	25	7.50%	47	9	36.00%	38
US	1368347	7.38%	86603		7703	2.96%		1837	23.85%	

Chart: US Pressure Ulcer Rates & Citations

Citing When There is Insufficient Care Staff

Staffing levels are one of the most (if not the most) important indicators of a nursing home's quality and safety. A landmark federal study in 2001 found that 97% of facilities failed to meet one or more staffing requirements and 52% failed to meet all staffing requirements necessary to prevent avoidable harm to residents. [25] The analysis determined that 91% lacked sufficient staff to provide decent care. Unfortunately, this situation continues today. A March 2014 study by the US Inspector General found that an astonishing one-third of the people who go to nursing homes for Medicare rehab services are harmed and that 59% of the time that harm is "clearly or likely preventable."[26]

Despite the widespread – and widely acknowledged – insufficiency of care staff in US nursing homes, and the known correlation between low staffing and poor outcomes for both residents and staff, insufficient staff is rarely cited in the US. As the national chart below indicates, only 1478 staffing deficiencies have been cited in the last three years in the entire country.[27] With a national total of 15,465 nursing homes, this means that about one in 31 nursing homes are cited for insufficient staffing each year.[28]

Fast Facts:

(1) Though sufficient staff has been identified as critical to good care, and insufficient staffing is known to be a widespread problem, insufficient staffing is rarely cited.
(2) The annual rate of staffing deficiencies per resident is infinitesimal: 0.036%.
(3) Less than 5% of those deficiencies are identified as resulting in harm.

More importantly, from a resident perspective, is the fact that despite our knowledge that insufficient staffing is a widespread problem with serious repercussions for resident care, quality of life and dignity, the annual percentage of staffing deficiencies per resident is infinitesimal: 0.036%.

While citing deficiencies is important, appropriately identifying when residents are harmed or put in immediate danger is critical, since (in general, as discussed earlier) facilities are only penalized when a deficiency is cited as having caused harm or immediate jeopardy. Here, our findings indicate that, nationally, less than five percent of staffing deficiencies are cited as having caused harm. These rates vary widely, from zero to fifty percent. For the three year period covered on Nursing Home Compare, 21 SAs *never* cited insufficient staffing as having resulted in harm to any nursing home resident in their state.

CLICK HERE to download the following chart as an interactive Excel chart.

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[25] Abt Associates (Prepared for the Centers for Medicare and Medicaid Services), *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, Report To Congress: Phase II Final (December 2001).
[26] *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries* (Feb. 2014).
[27] Nursing Home Compare F-353 deficiencies for last three cycles downloaded in January 2015.
[28] NH Compare total deficiencies were 1478 for three years or roughly 493 per year for the entire US. There are 15,465 nursing homes in the country (Kaiser Commission on Medicaid and the Uninsured analysis of 2011 Online Survey, Certification, and Reporting system (OSCAR) data). Accessed April 13, 2015 at http://kff.org/other/state-indicator/number-of-nursing-facilities/.

Chart: All US States' Staffing Levels and F-353 Citations

State	Number of Residents	Reported Total Nurse Staffing Hours per Resident per Day	F-353 Deficiencies on NHC (3 yrs)	Annual Per Resident F-353 Citation Rate	Number Cited as Harm	Percent Staffing Deficiencies Cited as Harm	Rank: Reported Staffing (Higher = More Staff)	Rank: Staffing Deficiencies Per Resident (Higher = More Deficiencies)	Rank: Percent Deficiencies Cited at Harm+ (Higher = Gtr ID at Harm+)
MO	38273	3.92	41	0.036%	0	0.0%	11	30	1
NY	105200	3.97	37	0.012%	0	0.0%	12	14	2
OH	76372	4.04	96	0.042%	0	0.0%	15	33	3
PA	79589	4.05	11	0.005%	0	0.0%	16	7	4
MN	26702	4.06	64	0.080%	0	0.0%	17	39	5
KS	18403	4.08	111	0.201%	0	0.0%	19	50	6
CT	24254	4.10	19	0.026%	0	0.0%	20	29	7
NJ	45204	4.10	2	0.001%	0	0.0%	21	2	8
NH	6760	4.21	1	0.005%	0	0.0%	28	8	9
MD	24408	4.27	10	0.014%	0	0.0%	32	16	10
AL	22725	4.30	3	0.004%	0	0.0%	34	5	11
AR	17664	4.33	3	0.006%	0	0.0%	35	10	12
NV	4819	4.36	8	0.055%	0	0.0%	37	34	13
SC	16780	4.37	1	0.002%	0	0.0%	38	3	14
ND	5620	4.40	4	0.024%	0	0.0%	39	24	15
AZ	11261	4.55	6	0.018%	0	0.0%	44	18	16
ME	6248	4.62	4	0.021%	0	0.0%	45	20	17
DE	4150	4.62	1	0.008%	0	0.0%	46	11	18
OR	7337	4.79	16	0.073%	0	0.0%	47	37	19
ID	3844	4.87	20	0.173%	0	0.0%	48	47	20
AK	608	6.69	0	0.000%	0	0.0%	51	1	21
MI	39391	4.26	124	0.105%	2	1.6%	31	44	22
WI	27526	4.16	61	0.074%	1	1.6%	25	38	23
IL	72715	3.79	56	0.026%	1	1.8%	4	27	24
CA	102093	4.53	53	0.017%	1	1.9%	43	17	25
IA	24858	3.78	145	0.194%	3	2.1%	2	48	26
IN	38821	4.18	72	0.062%	2	2.8%	27	35	27
NE	12068	4.11	30	0.083%	1	3.3%	22	40	28
TX	93098	3.79	64	0.023%	3	4.7%	6	22	29
FL	73505	4.50	55	0.025%	3	5.5%	42	26	30
VT	2686	4.30	16	0.199%	1	6.3%	33	49	31
KY	22976	4.36	16	0.023%	1	6.3%	36	23	32
WY	2353	4.04	15	0.212%	1	6.7%	14	51	33
UT	5502	4.49	28	0.170%	2	7.1%	41	46	34
WV	9528	3.87	24	0.084%	2	8.3%	10	41	35
CO	16266	4.25	46	0.094%	4	8.7%	29	43	36
NC	37142	4.07	11	0.010%	1	9.1%	18	13	37
VA	28566	4.17	11	0.013%	1	9.1%	26	15	38
HI	3663	4.87	10	0.091%	1	10.0%	49	42	39
OK	19118	3.87	75	0.131%	8	10.7%	9	45	40
MA	41302	4.12	7	0.006%	1	14.3%	23	9	41
WA	17007	4.48	37	0.073%	7	18.9%	40	36	42
LA	25880	3.79	29	0.037%	6	20.7%	5	32	43
NM	5462	3.79	4	0.024%	1	25.0%	7	25	44
MS	16132	4.26	10	0.021%	3	30.0%	30	19	45
GA	33952	3.78	3	0.003%	1	33.3%	3	4	46
MT	4587	4.14	3	0.022%	1	33.3%	24	21	47
SD	6384	3.66	7	0.037%	3	42.9%	1	31	48
RI	8012	3.84	2	0.008%	1	50.0%	8	12	49
TN	28976	3.99	4	0.005%	2	50.0%	13	6	50
DC	2557	5.09	2	0.026%	1	50.0%	50	28	51
US Total	1368347	4.13	1478	0.036%	66	4.5%			

Discussion & Recommendations

The State Survey Agencies, and CMS itself, have a history of under-identifying nursing home deficiencies and, for those deficiencies that they do identify and cite, too often failing to adequately identify when those violations harm or endanger residents. The nursing home industry has historically complained that the resulting system of uneven enforcement hurts them because they make for an inconsistent environment in which to do business; facilities do not know for what they are – or are not – going to be cited. Given that the federal regulations implementing the Nursing Home Reform Law have been effect for over two decades, we would argue that providers are – or should be – well aware of minimum requirements. The extent to which these standards are often not enforced, allowing too many nursing homes to provide substandard care to their residents, harms those residents and the public, not providers. Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?

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<u>Recommendations for the SAs and CMS</u>:

We have long called on CMS and its SA contractors to strengthen oversight of nursing homes. Our main concern, as consumer advocates, has been the tens of thousands of nursing home residents who are abused or neglected every day, with impunity, in nursing homes across the country. In addition, the persistence of substandard care in the nursing home industry (including services that are often worthless, if not harmful) is extremely costly to tax-payers, who too often foot the bill for care that falls below that which facilities agree to provide as Medicare and Medicaid contractors.

Fundamentally, we believe that there is a strong body of knowledge regarding how to effectively identify and cite deficiencies; the problem is, generally, due to three things: (1) lack of will, (2) lack of knowledge among survey staff and/or (3) lack of resources. To address these issues, we recommend that CMS and the SAs:

1. **Re-commit to their mission as enforcement agencies**. Residents and their loved ones depend on enforcement agencies to ensure that providers are meeting - or exceeding - standards of care. Tax payers depend on CMS and the SAs to assure financial integrity of the billions of dollars spent each year on nursing home care. However, too often (in our experience), CMS and the individual SAs treat the industry as their client, and its interests as paramount, rather than those of the residents, their families and tax payers.
2. **Improve resource allocation**. CMS and the SAs should be dedicating their limited resources to fostering vigorous oversight, not training, engaging or otherwise trying to encourage providers to attain the minimum standards of care for which they are already being paid to achieve. Providers are professionals who are expected to provide services in accordance

with established care standards. As professionals, they are expected to attain and maintain the skills and knowledge required to meet those standards independently, *in order* to provide services, *not after* they have been permitted to hold themselves out to the public as having the necessary skills and capacity (no matter entrusted and paid by the public to do so).

3. **Comply with federal Survey Agency requirements**. CMS and the SAs should focus efforts on achieving both the *letter* and the *spirit* of the law, regulations and the State Operations Manual.[29] For example, it is not adequate for an SA to conduct 100% of the federally required surveys per year if those surveys are not effectively ensuring that standards are met and deficiencies are appropriately cited and meaningfully corrected.
4. **Improve performance assessment & integrity**.
   a. CMS and the SAs should improve training and direction of surveyors. For instance, to reduce inappropriate and illegal antipsychotic drugging, survey teams should review all instances of off-label antipsychotic drugging. Is there a record of informed consent? Non-pharmacological interventions? Gradual dose reduction? The CMS mandatory surveyor training developed in 2013 is excellent, and the subsequent pilot testing of a dementia focused survey is promising, but many surveyors still lack the knowledge and/or ability to hold providers accountable when they chemically restrain residents.
   b. The SAs should collect and assess data on their survey teams' identification of deficiencies and identification of harm and assess these data in relation to relevant measures (including, inter alia, antipsychotic drug use, staffing levels and pressure ulcer rates). For example, if staffing is not being cited when facilities have low staffing and/or problems that are likely to be staffing related, the SA should conduct a data-driven assessment to determine if there are deficiencies that are being missed or under-rated (in terms of scope and severity). The results of these assessments should be made public in an annual report.
   c. CMS should conduct, on a regular basis, similar performance assessments of the SAs and the CMS Regional Offices to identify and address weaknesses in quality assurance and oversight. CMS should include in its assessment an analysis of SA complaint handling that includes review of a sampling of actual complaints to determine if they were appropriately investigated and resolved.

For more recommendations for CMS and the SAs, please visit our website Reports page at http://nursinghome411.org/news-reports/ltccc-reports/. This page includes the Coalition for Quality Care's policy brief, *Improving Nursing Home Care: Consumer Priorities for CMS* and several LTCCC reports of interest including *Government Monitoring & Oversight of Nursing Home Care: The Relationship Between Federal and State Agencies* and Nursing Home Surveillance in 10 States - A Comparison of Resources & Financing.

[29] CMS, Publication 100-07. Accessed March 2015 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.

Appendix I: Medicaid Fraud Control Units (MFCUs)

In our companion report on nursing home oversight in New York State, we also focused on the state's Medicaid Fraud Control Unit (MFCU). Here we are providing some background information on what MFCUs are and what they do, as well statistical information from the US Office of Inspector General on state MFCU operations for 2014.

MFCUs investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. The MFCU in the majority of states is housed in the state's attorney general's office.

According to federal regulations,

> (a) The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan. (b) (1) The unit will also review complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patient's private funds in such facilities. (2) If the initial review indicates substantial potential for criminal prosecution, the unit will investigate the complaint or refer it to an appropriate criminal investigative or prosecutive authority.[30]

Every year, each MFCU is required to submit an annual report to the federal government on its activities and accomplishments relating to:

> (a) The number of investigations initiated and the number completed or closed, categorized by type of provider; (b) The number of cases prosecuted or referred for prosecution; the number of cases finally resolved and their outcomes; and the number of cases investigated but not prosecuted or referred for prosecution because of insufficient evidence; (c) The number of complaints received regarding abuse and neglect of patients in health care facilities; the number of such complaints investigated by the unit; and the number referred to other identified State agencies; (d) The number of recovery actions initiated by the unit; the number of recovery actions referred to another agency; the total amount of overpayments identified by the unit; and the total

[30] 42 CFR § 1007.11, Duties and responsibilities of the unit. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

> amount of overpayments actually collected by the unit; (e) The number of recovery actions initiated by the Medicaid agency under its agreement with the unit, and the total amount of overpayments actually collected by the Medicaid agency under this agreement; (f) Projections for the succeeding 12 months for items listed in paragraphs (a) through (e) of this section; (g) The costs incurred by the unit; and (h) A narrative that evaluates the unit's performance….[31]

MFCU Stats for 2014

The following chart provides information for all of the state MFCUs.[32]

[31] *Id*. at § 1007.17.

[32] Office of Inspector General, U.S. Department of Health and Human Services, Medicaid Fraud Control Units Statistical Data for Fiscal Year 2014 (February 2015). Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/maps/interactive-map2014.asp.

MFCU STATISTICAL DATA FOR FISCAL YEAR 2014

State	Investigations[1]			Indicted/Charged			Convictions			Civil Settlements and Judgments	Recoveries[2]			Expenditures		Staff on Board
	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect	Total	Fraud	Abuse/ Neglect		Total	Criminal	Civil	MFCU Grant	Total Medicaid	
Alabama	44	16	28	11	7	4	6	4	2	10	$17,988,911.38	$249,298.54	$17,739,612.84	$1,253,192.56	$5,454,050,260.00	10
Alaska	173	160	13	35	35	0	44	44	0	4	$644,325.57	$535,433.49	$108,892.08	$1,105,990.03	$1,546,569,264.00	8
Arizona	309	228	81	54	36	18	40	28	12	4	$538,729.34	$209,276.83	$329,452.51	$2,316,273.90	$9,452,683,998.00	20
Arkansas	108	24	84	15	6	9	22	5	17	15	$2,228,764.66	$127,656.00	$2,101,108.66	$2,454,099.72	$5,154,278,818.00	22
California	1,194	671	523	114	53	61	97	59	38	20	$77,622,974.52	$22,713,170.28	$54,909,804.24	$26,158,835.03	$68,248,444,914.00	193
Colorado	260	255	5	6	6	0	10	9	1	26	$9,999,945.37	$84,090.00	$9,915,855.37	$1,615,524.84	$6,265,152,763.00	17
Connecticut	62	59	3	12	12	0	8	8	0	18	$3,030,886.46	$17,599.12	$3,013,287.34	$1,989,924.12	$7,167,946,629.00	13
Delaware	624	538	86	16	1	15	11	0	11	21	$1,949,633.53	$106,816.07	$1,842,817.46	$1,944,099.15	$1,805,108,123.00	17
D.C.	248	170	78	27	25	2	3	2	1	12	$3,973,338.22	$7,672.48	$3,965,665.74	$2,708,823.90	$2,524,458,778.00	21
Florida	665	600	65	81	55	26	60	42	18	34	$91,867,057.44	$3,989,921.37	$87,877,136.07	$15,506,673.66	$20,818,233,200.00	161
Georgia	414	410	4	4	4	0	9	9	0	23	$48,703,251.01	$7,776,456.19	$40,926,794.82	$4,523,319.47	$9,858,134,878.00	46
Hawaii	68	20	48	9	0	9	10	4	6	8	$3,079,615.23	$61,241.26	$3,018,373.97	$1,301,425.29	$2,049,769,576.00	13
Idaho	124	118	6	9	7	2	11	11	0	10	$801,857.53	$104,933.38	$696,924.15	$656,936.78	$1,692,361,521.00	8
Illinois	311	230	81	56	42	14	76	53	23	23	$90,872,897.09	$1,202,159.97	$89,670,737.12	$7,719,034.17	$17,726,308,920.00	45
Indiana	1,272	941	331	66	55	11	29	22	7	30	$54,591,556.99	$2,324,000.85	$52,267,556.14	$6,119,574.00	$9,600,134,668.00	55
Iowa	270	249	21	48	33	15	44	28	16	16	$24,403,657.64	$987,348.24	$23,416,309.40	$1,020,053.20	$4,110,153,654.00	8
Kansas	101	95	6	28	25	3	16	13	3	22	$27,437,135.25	$150,269.17	$27,286,866.08	$1,330,521.73	$2,933,837,600.00	14
Kentucky	145	118	27	27	14	13	18	14	4	18	$66,222,772.25	$1,141,643.13	$65,081,129.12	$2,989,940.10	$8,017,227,454.00	28
Louisiana	425	366	59	132	118	14	76	65	11	40	$245,305,060.00	$118,815,109.00	$126,489,951.00	$5,134,743.68	$7,337,796,633.00	52
Maine	39	31	8	10	6	4	7	5	2	12	$9,776,295.20	$19,168.00	$9,757,127.20	$728,261.61	$2,528,826,380.00	8
Maryland	314	283	31	13	6	7	12	6	6	22	$41,493,941.04	$48,049.37	$41,445,891.67	$3,510,342.00	$9,625,821,402.00	31
Massachusetts	612	500	112	7	7	0	22	19	3	21	$59,771,098.02	$4,658,134.34	$55,112,963.68	$5,470,721.00	$14,952,760,958.00	41
Michigan	531	483	48	39	32	7	25	17	8	16	$46,562,340.96	$116,478.70	$46,445,862.26	$5,392,508.51	$14,147,522,772.00	33
Minnesota	173	170	3	25	23	2	20	20	0	19	$18,518,275.21	$806,716.32	$17,711,558.89	$1,539,616.87	$10,429,856,324.00	16
Mississippi	668	79	589	34	3	31	41	5	36	11	$17,314,765.90	$299,775.38	$17,014,990.52	$3,318,064.00	$5,016,224,369.00	33
Missouri	230	207	23	10	9	1	8	8	0	23	$8,224,673.47	$176,420.80	$8,048,252.67	$2,047,671.44	$9,238,680,706.00	21
Montana	28	26	2	7	5	2	1	1	0	12	$438,209.11	$26,746.15	$411,462.96	$721,553.25	$1,146,046,567.00	8
Nebraska	130	104	26	16	8	8	7	4	3	15	$10,058,619.95	$19,542.16	$10,039,077.79	$881,048.80	$1,907,477,721.00	9
Nevada	23	21	2	8	8	0	14	12	2	15	$11,292,356.58	$1,080,006.72	$10,212,349.86	$1,887,577.46	$2,431,932,881.00	18
New Hampshire	40	33	7	2	1	1	3	0	3	4	$4,409,810.30	$22,780.47	$4,387,029.83	$724,113.05	$1,420,746,975.00	7
New Jersey	418	395	23	20	15	5	10	7	3	13	$45,632,565.79	$1,105,245.00	$44,527,320.79	$4,442,399.61	$13,193,930,655.00	31
New Mexico	195	192	3	4	4	0	4	4	0	21	$9,389,207.60	$29,693.02	$9,359,514.58	$1,851,072.67	$4,349,892,086.00	18
New York	746	618	128	142	62	80	118	53	65	66	$378,434,543.00	$2,452,239.00	$375,982,304.00	$45,814,464.43	$53,915,930,694.00	294
North Carolina	455	439	16	8	5	3	10	8	2	8	$72,432,176.86	$20,362,132.81	$52,070,044.05	$5,190,480.80	$12,655,046,228.00	44
Ohio	1,190	903	287	149	124	25	102	88	14	32	$71,166,458.65	$4,777,299.91	$66,389,158.74	$8,830,152.53	$20,223,303,745.00	89
Oklahoma	253	186	67	22	14	8	17	9	8	15	$18,368,761.23	$395,659.16	$17,973,102.07	$2,391,463.00	$4,925,190,754.00	22
Oregon	82	69	13	34	29	5	28	26	2	13	$17,025,308.47	$710,316.73	$16,314,991.74	$2,067,043.64	$7,291,147,501.00	15.5
Pennsylvania	328	315	13	66	66	0	46	46	0	12	$5,707,431.30	$1,354,491.20	$4,352,940.10	$5,352,554.37	$24,414,853,435.00	44
Rhode Island	51	32	19	12	5	7	20	13	7	7	$3,677,355.38	$18,417.41	$3,658,937.97	$1,192,427.99	$2,566,378,392.00	11
South Carolina	180	146	34	11	8	3	18	11	7	16	$27,403,805.39	$519,381.02	$26,884,424.37	$1,426,802.68	$5,596,632,601.00	16
South Dakota	49	46	3	1	1	0	1	1	0	6	$3,853,755.60	$566.00	$3,853,189.60	$409,564.00	$840,849,947.00	5
Tennessee	241	198	43	31	15	16	19	14	5	22	$62,298,836.50	$3,979,297.78	$58,319,538.72	$4,053,210.93	$9,654,242,145.00	35
Texas	1,303	1,177	126	122	100	22	90	85	5	17	$106,075,376.19	$82,758,688.05	$23,316,688.14	$16,502,689.27	$32,831,310,090.00	175
Utah	132	115	17	5	3	2	5	3	2	18	$23,725,403.00	$116,355.00	$23,609,048.00	$1,830,431.32	$2,234,539,587.00	13
Vermont	100	82	18	18	18	0	12	12	0	10	$976,625.85	$145,457.00	$831,168.85	$850,205.92	$1,570,053,514.00	7
Virginia	389	373	16	51	45	6	34	30	4	23	$64,755,506.27	$1,758,644.80	$62,996,861.47	$11,757,417.96	$7,980,183,305.00	93
Washington	175	167	8	14	13	1	11	10	1	14	$24,063,857.53	$245,904.04	$23,817,953.49	$3,905,815.00	$7,522,374,478.00	32
West Virginia	125	96	29	20	8	12	9	7	2	17	$19,608,914.14	$4,160,695.44	$15,448,218.70	$1,267,131.57	$3,488,266,696.00	21
Wisconsin	390	383	7	5	5	0	8	7	1	10	$49,010,312.00	$550,803.00	$48,459,509.00	$1,359,678.77	$7,783,215,463.00	12
Wyoming	57	55	2	3	3	0	6	5	1	10	$1,516,673.20	$46,988.59	$1,469,684.61	$485,828.73	$594,519,949.00	4
Grand Total	16,464	13,192	3,272	1,659	1,185	474	1,318	956	362	874	$2,004,245,629.17	$293,366,188.74	$1,710,879,440.43	$235,051,298.51	$488,240,409,971.00	1957.5

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Appendix II: Scope and Severity Matrix