

**Statement of Nursing Home Resident & Family Representatives:  
Urgent Need for Effective Oversight to Counter Persistent Abuse and  
Neglect of Nursing Home Residents**

April 11, 2017

U.S. nursing homes provide essential care, support services and homes to approximately 1.3 million people every day. In fact, 40% of Americans who reach age 65 will need nursing home care at some point. Given that most of these individuals are highly vulnerable and dependent on their nursing homes for necessary care and services, and that a majority of these services are paid for by the public through Medicare or Medicaid, the quality of nursing home care and the safety of residents is of critical public interest. It is for these reasons that, 30 years ago, Congress passed and President Reagan signed into law the 1987 Nursing Home Reform Act. The Reform Law established standards to ensure that every resident receives decent care and is able to live with dignity.

Unfortunately, though there have been improvements in nursing home care since passage of the Reform Law, abuse, neglect and substandard care persist. Too often, there is little accountability when residents are harmed – or even die – because the care they received was substandard. Quality of life standards – which provide for basic human dignity and respect – are, too often, ignored with impunity.

That is why we, as advocates for nursing home residents, are deeply troubled by recent nursing home industry efforts to delay and undermine implementation of vital safety standards. We are especially dismayed by claims that the nursing home industry is facing a “spike” in enforcement actions. In fact, both empirical and anecdotal evidence indicate that this is a gross mischaracterization which belies the true conditions that too many residents and families face.

Following are highlights from the substantial body of evidence supporting the need for stronger – not weaker – accountability for nursing home resident safety, care and dignity.

Richard Mollot, Executive Director  
Long Term Care Community Coalition  
[www.nursinghome411.org](http://www.nursinghome411.org)

Toby Edelman, Senior Policy Attorney  
Center for Medicare Advocacy  
[www.medicareadvocacy.org](http://www.medicareadvocacy.org)

Lori Smetanka, Executive Director  
Robyn Grant, Director of Public Policy &  
Advocacy  
National Consumer Voice for Quality Long-  
Term Care  
[www.theconsumervoice.org](http://www.theconsumervoice.org)

Patricia McGinnis, Executive Director  
Michael Connors, Advocate  
Janet Wells, Public Policy Consultant  
California Advocates for Nursing Home Reform  
[www.canhr.org](http://www.canhr.org)

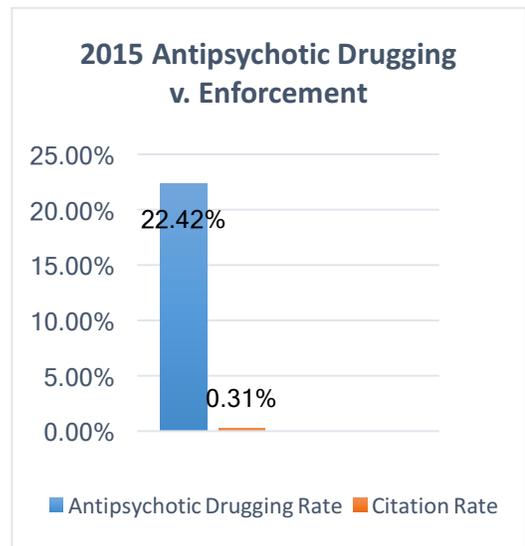
## I. Longstanding Weaknesses in Monitoring and Enforcement Result in Persistent Abuse, Neglect and Fraud

Fundamentally, standards are only relevant to the extent that they are meaningfully enforced. Though the Reform Law and implementing regulations provide a strong basis for decent care and life with dignity for residents, lack of enforcement has made it too easy for poorly performing providers to flout minimum standards with impunity. Numerous reports over the years, from analyses by government agencies (GAO, HHS OIG) to academic studies, have documented the widespread persistence of resident abuse and neglect as well as provider fraud (including billing for services that are so substandard as to be “worthless”).

- **33% of Medicare Short-Term Residents in Nursing Homes are Harmed.** A 2014 Office of Inspector General study, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*,<sup>1</sup> found that an astounding one-third of residents who went to a nursing home for short-term care were harmed, and that almost 60% of that harm was preventable and likely to be attributable to poor care. As a result, 6% of those who were harmed died, and more than half were rehospitalized at an annualized cost of \$2.8 billion in 2011.
- **20% of Residents Are Given Dangerous Antipsychotic Drugs.** The FDA imposes its strongest safety warning (“black box warning”) on antipsychotic drugs, emphasizing an increased risk of serious side-effects, including death, when administered to elderly people with dementia. Importantly, antipsychotic drugs are *not* indicated for “dementia-related psychosis.”<sup>2</sup>

Nevertheless, 20% of U.S. nursing home residents currently receive antipsychotics, despite the fact that less than 2% of the population will ever have a diagnosis that CMS criteria identify as potentially appropriate.<sup>3</sup> Following a 2011 OIG review,<sup>4</sup> which found that 88% of Medicare claims for atypical antipsychotics for elderly nursing home residents were contraindicated by the FDA boxed warning, CMS began a national campaign to reduce inappropriate antipsychotic drugging in nursing homes. Though, in launching the campaign, CMS promised to improve enforcement of standards to protect residents from inappropriate drugging and chemical restraints (standards which have been in place for more than 25 years), Nursing Home

Compare data indicate that enforcement never substantively improved and the CMS campaign focused, instead, on the education initiatives favored by the nursing home industry. As a result (as noted above), hundreds of thousands of residents are still receiving these dangerous drugs in



<sup>1</sup> <https://oig.hhs.gov/oei/reports/oei-06-11-00370.asp>.

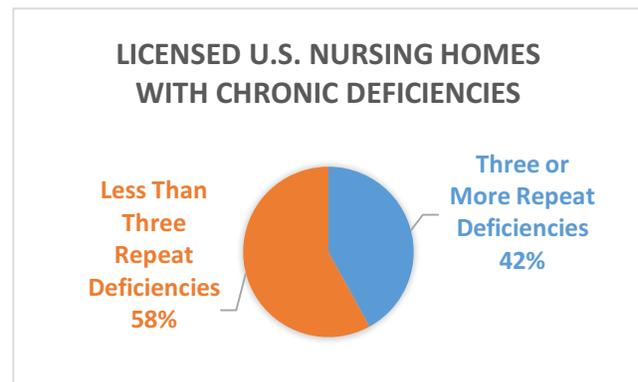
<sup>2</sup> See, for example, [https://www.accessdata.fda.gov/drugsatfda\\_docs/nda/2008/020592orig1s049.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/nda/2008/020592orig1s049.pdf).

<sup>3</sup> <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report.html>.

<sup>4</sup> *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents*, OEI-07-08-00150. Available at <https://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf>.

2017, at untold personal costs to them and their families (as well as hundreds of millions of dollars in unnecessary expense for taxpayers).<sup>5</sup>

- **Serious Problems Don't Result in Vigorous Enforcement.** In 2015, the Long Term Care Community Coalition (LTCCC) conducted an analysis of nursing home citations and penalties.<sup>6</sup> Reviewing three years of federal data, LTCCC found that state survey agencies identify resident harm less than 5% of the time that they cite a facility for failing to meet minimum health care standards. Furthermore, though the average antipsychotic drugging rate in U.S. nursing homes was 22.42% at the time,<sup>7</sup> the average state citation rate for any inappropriate drugging was 0.31%. These data confirmed the serious disconnection between the large-scale inappropriate use of antipsychotic drugs on residents in U.S. nursing homes – acknowledged by government, providers, researchers and consumers – and the dearth of enforcement actions in the years following the OIG review.
- The failure to ensure quality and accountability for nursing home resident care is, perhaps, most strikingly demonstrated in the case of pressure ulcers. Pressure ulcers are a serious problem for nursing home residents. According to the *Journal of Wound, Ostomy & Continence Nursing*, “[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation.”<sup>8</sup> Nevertheless, in 2015, over 86,000 residents (over 7% of the nursing home population) had pressure ulcers. Though they are largely preventable, LTCCC found that states cite nursing homes the equivalent of less than 3% of the time when a resident has a pressure ulcer. Even 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. When is a pressure ulcer – by definition an invasive injury – not harm?
- **42% of U.S. Nursing Homes Have “Chronic Deficiencies” in Care.** The Social Security Act requires that “any nursing home that does not achieve substantial compliance with the Federal requirements within six months be terminated from participation in Medicare and/or Medicaid.”<sup>9</sup> Nevertheless, a February 2017 LTCCC report and analysis of Nursing Home Compare data found that over 6,000 U.S. nursing homes have what LTCCC identifies as “chronic deficiencies” -- three or more repeat citations for the *same* safety standard in the three-year period covered on Nursing Home Compare.<sup>10</sup> As noted in the report, it is



<sup>5</sup> For the six month period in 2007 analyzed by OIG, reviewers found that “Fifty-one percent of Medicare atypical antipsychotic drug claims for elderly nursing home residents were erroneous, amounting to \$116 million.”

<sup>6</sup> *Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance*. Available at <http://nursinghome411.org/national-report-safeguarding-nursing-home-residents-program-integrity/>.

<sup>7</sup> Non-risk-adjusted rate derived from 2014 Q4 MDS Frequency Reports.

<sup>8</sup> [http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable\\_Pressure\\_Injury\\_State\\_of\\_the\\_Science.6.aspx](http://journals.lww.com/jwocnonline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science.6.aspx).

<sup>9</sup> <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/Nursing-Home-Enforcement.html>.

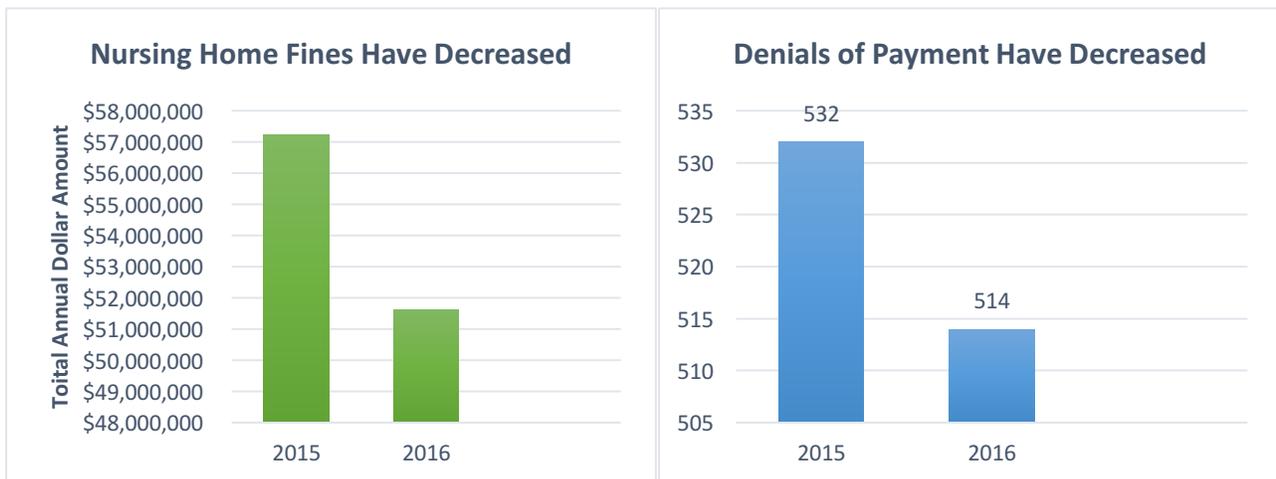
<sup>10</sup> *Chronic Deficiencies in Care: The Persistence of Recurring Failures to Meet Minimum Safety & Dignity Standards in U.S. Nursing Homes*. The report and data, compiled from Nursing Home Compare by the non-profit Voices for Quality Care, are available at <http://nursinghome411.org/nursing-homes-with-chronic-deficiencies/>.

...hard to understand how a 42% rate of substantiated failures three years in a row can be acceptable for any nursing home entrusted with caring for frail elderly individuals. In fact, these data also indicate something that is, overall, far worse: a 42% failure rate year after year after year for the very same regulatory requirements. Though regulations can vary substantially (in terms of the extent to which they impact a resident's well-being, whether they are broadly or narrowly defined, etc...), in general they pertain to a well-defined subject. Given the persistence of nursing home problems in general, this high rate of recidivism is troubling.

## II. Enforcement Actions Against Nursing Homes are Decreasing, *Not* Increasing.

Nursing home industry lobbyists claim that Immediate Jeopardy (IJ) citations have “spiked.” In fact, that is not true. In addition (and most importantly), a review of enforcement actions, which indicate the extent to which providers are held accountable for abuse or neglect, shows that accountability for poor care has actually *decreased* in recent years.

- **Actual accountability for meeting minimum standards has decreased.**<sup>11</sup>
  - **Nursing Home Fines Have Decreased.** Total fines decreased from \$57,242,134 in 2015 to \$51,613,644 in 2016. This represents a 9.83% decrease.
  - **Nursing Home Denials of Payment Have Decreased.** Denials of payment decreased from 532 in 2015 to 514 in 2016. This is a decrease of 3.38%.



- **Immediate Jeopardy citations have, in fact, increased only slightly in the last two years.** In 2015 there were 1,838 IJ citations and in 2016 there were 1,942. This is a 5.6% increase, not what most people would consider a “spike.” Importantly, and unfortunately for residents and families, putting a resident in immediate jeopardy due to substandard care, abuse or neglect does *not* necessarily mean that the facility will face any penalty.

<sup>11</sup> US State Penalty Counts. Accessed at <https://data.medicare.gov>.

### III. Summaries of a Few Recent (2017) Reports on Nursing Home Care

- ***Sick, dying and raped in America's nursing homes*** (CNN Investigation, Feb. 2017).<sup>12</sup>

The unthinkable is happening at facilities throughout the country: Vulnerable seniors are being raped and sexually abused by the very people paid to care for them. It's impossible to know just how many victims are out there. But through an exclusive analysis of state and federal data and interviews with experts, regulators and the families of victims, CNN has found that this little-discussed issue is more widespread than anyone would imagine.... In cases reviewed by CNN, victims and their families were failed at every stage. Nursing homes were slow to investigate and report allegations because of a reluctance to believe the accusations -- or a desire to hide them. Police viewed the claims as unlikely at the outset, dismissing potential victims because of failing memories or jumbled allegations. And because of the high bar set for substantiating abuse, state regulators failed to flag patterns of repeated allegations against a single caregiver.
- ***Intolerable Care: A snapshot of the Texas nursing home quality crisis*** (AARP TX, Jan. 2017).<sup>13</sup>

Nursing homes in Texas are escaping accountability for hurting residents and jeopardizing their health, according to a new report by AARP Texas. The report... finds that the quality of roughly 1,200 nursing facilities where 93,000 Texans reside, is shamefully poor and worse than what exists in most other states. It identifies numerous, long-standing, and severe problems that can be rectified with stronger state enforcement powers. ...
- ***Editorial: Iowa's nursing homes demand relief: Deaths, violations pile up, but industry lobbyists plead for mercy*** (*DesMoines Register*, Jan. 2017).<sup>14</sup>

Robert Nipp appeared to be dead when the nurse aide walked into his room at The Abbey nursing home in LeMars. He had just turned 89, having grown up during the Great Depression helping out on his parents' farm not too far from the nursing home. After serving in the Marine Corps, he took a job with the U.S. Department of Agriculture.... But now, on the morning of Oct. 15, 2016, Robert lay motionless in bed, with no detectable pulse, his eyes fixed in place, his mouth wide open, and his skin drained of color. ... According to the inspectors' report, the aide opted not to summon a nurse or call 911. Instead, she proceeded to change his urine-soiled bed clothes. It was a difficult process, she told inspectors, because Robert's limbs were already stiff. ... Inspectors later determined Robert had been having trouble breathing in the preceding days. His doctor had been notified, but only by a fax that was sent to his office on a Friday afternoon, roughly 16 hours before Robert was found dead by the aide. ... One of the home's other caregivers told inspectors he provided Robert with respiratory treatment just 20 minutes before his colleague entered the room and found the former Marine stiff and unresponsive. State records indicate that when inspectors challenged that claim, the worker changed his story several times, eventually claiming the director of nursing had told him he "had better document something" in the way of treatment for Robert....

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<sup>12</sup> <http://www.cnn.com/interactive/2017/02/health/nursing-home-sex-abuse-investigation/>.

<sup>13</sup> <http://states.aarp.org/texas-nursing-facilities-found-shamefully-poor-quality/>.

<sup>14</sup> <http://www.desmoinesregister.com/story/opinion/editorials/2017/01/21/editorial-iowas-nursing-homes-demand-relief/96742886/>.