

LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Issue Brief

Animal Care Standards vs. Nursing Home Resident Experiences: Infection Control & Prevention

The quality and safety of nursing homes are longstanding public concerns. Numerous studies over the years have identified widespread and significant deficiencies in care, including serious abuse and neglect. It is such cases of degrading and inhumane conditions that led us to question the extent to which the experiences of residents in nursing homes actually fall below the standards and expectations for treatment of animals in zoos and other settings.

This is one issue in a series of briefs that provide the results of our assessment of the extent to which conditions in nursing homes fail to meet the standards of care for animals. Each brief focuses on an issue which we have identified as important. These briefs, and the [full report](#) on our assessment, are available at <https://nursinghome411.org/ltccc-report-animal-care-vs-nursing-home-care>.

The point of this work is not to trivialize the experiences of either nursing home residents or animals but, rather, to illustrate how systemic failures to hold nursing homes accountable for abuse and neglect too often subject residents to conditions that not only fall below the federal nursing home standards of care, but also below accepted standards for the humane treatment of animals.

EXAMPLE OF ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE



AZA standards state that “[i]nstitutions should be aware of, and prepared for periodic disease outbreaks in wild or other domestic or exotic animal populations that might affect the institution’s animals. . . . Plans should be developed that outline steps to be taken to protect the institution’s animals in these situations.”

-Accreditation Standards, AZA



A Massachusetts facility that had a gastrointestinal outbreak affecting 55 residents failed to provide and implement an infection prevention and control program. The facility did not consistently follow precautions related to use of personal protective equipment and did not ensure staff training on hand washing.

-Statement of Deficiencies, CMS

STANDARDS FOR NURSING HOME CARE

Federal nursing home requirements mandate that each nursing home “establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.” For more information, please see our infection prevention and control [fact sheet](#).

RELEVANT NURSING HOME STATISTICS

- **Deadly.** Infections in long term care facilities lead to [approximately 388,000 deaths each year](#).
- **Most cited.** Failure to provide sufficient infection control and prevention is the [number one cited deficiency in the United States](#).
- **Care staff fail to wash their hands.** Handwashing is the [most common issue that “surveyors keep tripping on”](#) when it comes to infection prevention.
- **Costly.** An [estimated 1.6 to 3.8 million infections](#) occur in residential care facilities across the nation each year, leading to annual costs ranging from \$673 million to \$2 billion.
- **Routinely ignored.** A [Kaiser Health News analysis](#) of four years of federal inspection records found that lapses in infection control were the most frequent health violation citation with 74 percent of nursing homes cited. Nonetheless, only one of 75 homes found deficient received a high-level citation that is likely to result in a financial penalty.

NURSING HOME STORIES

Deadly outbreak

An adenovirus outbreak at a New Jersey nursing home ([The Wanaque Center for Nursing & Rehabilitation](#)) left 12 children dead and many others sickened. The [facility was cited for failing “to evaluate resident population](#) and identify the resources needed to provide the necessary care and services required for residents during . . . [the] outbreak.”

Infection-control lapses

An 86-year-old resident fell ill to a virulent strain of Clostridium difficile, known as C-diff, at a California facility ([Astoria Nursing and Rehab Center](#)) cited numerous times for substandard infection control, [according to a Kaiser Health News report](#). Although inspectors could not definitively determine the cause of the resident’s infection, they identified numerous infection-control lapses at the California facility: a housekeeper cleaning a wall with the same cloth used to wipe the toilet; a patient with a dirty intravenous line left in longer than necessary; and a worker failing to wash her hands after delivering a breakfast tray to a contagious resident in isolation.

Gastrointestinal and flu outbreaks

[Life Care Center of Auburn](#) (MA) failed to [provide and implement an infection prevention and control program](#) during a gastrointestinal outbreak affecting 55 of its residents. The surveyor found that the facility did not consistently follow transmission-based precautions and did not ensure staff training on proper hand washing. Although numerous residents suffered from the outbreak, the surveyor still cited the violation as no harm.