LONG TERM CARE
COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Animal Care Standards

vs.

Nursing Home Resident Experiences

An Appraisal of the Extent to which Nursing Home Conditions Fail to Meet the Standards of Care for Animals in Zoos and Other Settings

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NOTE TO READERS

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.

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.

ABOUT THE LONG TERM CARE COMMUNITY COALITION

The Long Term Care Community Coalition (LTCCC) is a non-profit, non-partisan organization dedicated to improving care in nursing homes and other residential care settings. Please visit our website, **www.NursingHome411.org** for information on nursing home quality, staffing and safety, as well as a range of resources, including:

- The Dementia Care Advocacy Toolkit
- Fact Sheets on Residents' Rights and Care Standards
- Staffing & Quality Data (for all licensed U.S. nursing homes)
- The *Elder Justice Newsletter*
- Reports & Alerts on Important LTC Issues
- Informative Webinars & Podcasts

Introduction

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, and degrading, inhumane conditions. As a result, thousands of residents – primarily frail elderly individuals – suffer unnecessarily. Hundreds of thousands of nursing home residents are administered dangerous antipsychotic drugs every day, too often as a form of chemical restraint. On any given day, tens of thousands of residents suffer from pressure ulcers or are injured by falls. For far too many, life with basic dignity is out of reach.

Though federal standards are strong, providing for good care and life with dignity and choice, too often these standards are flouted with impunity. In addition to the decades of studies that have identified both the prevalence and persistence of substandard care, frequent reports in the news – from local television and newspapers to *The New York Times*, *Wall Street Journal*, and CNN – have shone a light on the abject neglect and inhumane treatment that nursing home residents too frequently face.

Numerous studies over the years have identified widespread and significant deficiencies in care, including serious abuse and neglect, and degrading, inhumane conditions.

A few recent examples include:

1. A *McKnight's LTC News* article detailed how a former nursing home operator treated residents "like cattle";[1]
2. A review of human rights law which "found extensive evidence of widespread and systematic abuse and neglect of nursing home residents in the United States that needs urgent government action to protect the basic human rights of residents";[2]
3. A stomach-churning investigative FairWarning report which uncovered "rampant safety violations in nursing home kitchens" and routinely unreported incidents that put resident at risk of injury and death;[3]

[1] Marty Stempniak, "Former SNF mogul 'sold his patients like cattle,' jurors told," *McKnight's Long-Term Care News*, February 14, 2019, https://www.mcknights.com/news/former-snf-mogul-sold-his-patients-like-cattle-jurors-told/.

[2] Charlene Harrington et al., "U.S. Nursing Home Violations of International and Domestic Human Rights Standards," *International Journal of Health Services* (2019). Abstract available at https://doi.org/10.1177/0020731419886196.

[3] Marjie Lundstrom, "Bugs, Mold and Unwashed Hands: Rampant Safety Violations in Nursing Home Kitchens Endanger Residents," FairWarning, October 3, 2019, https://www.fairwarning.org/2019/10/safety-violations-in-nursing-home/.

4. A Human Rights Watch report, *They Want Docile,* which found that, every week, nursing homes are administering powerful and dangerous antipsychotic drugs to over 179,000 residents who do *not* have diagnoses for which the drugs are approved;[4] and
5. An Inspector General report, *Adverse Events in Skilled Nursing Facilities*, which found that an astounding one-third of people who turn to a nursing home for Medicare rehab are harmed within an average of about two weeks. "Physician reviewers determined that 59 percent of these . . . events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care."[5]

PURPOSE OF THIS REPORT

Over the years, numerous distraught family members have told us that "they wouldn't treat a dog" the way their loved one was treated by their nursing home. As noted above, a report in an industry publication discussed allegations that a nursing home "mogul" "sold his patients like cattle."[6]

In light of these concerns, and the widespread persistence of substandard care and abuse, we undertook this analysis to compare the experiences of nursing home residents with the basic standards of care for animals. **Can *animals* in a zoo expect better treatment and conditions than that which many *human* nursing home residents actually receive?**

Though federal requirements for nursing homes are strong, our research and experience indicate that the nursing home industry often treats minimum regulatory standards of care as aspirational goals rather than actual requirements. State enforcement agencies and the federal Centers for Medicare and Medicaid Services (CMS) typically allow nursing homes to operate with numerous health violation citations every year, essentially sanctioning (and paying for) substandard care and abuse.

[4] "'They Want Docile' How Nursing Homes in the United States Overmedicate People With Dementia," *Human Rights Watch*, February 5, 2018, https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.

[5] "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries," U.S. Department of Health and Human Services Office of Inspector General, OEI-06-11-0037, February 2014. Available at https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.

[6] Marty Stempniak, "Former SNF mogul 'sold his patients like cattle,' jurors told," *McKnight's Long-Term Care News*, February 14, 2019, https://www.mcknights.com/news/former-snf-mogul-sold-his-patients-like-cattle-jurors-told/.

Please Note: We understand that not all animals live in conditions that meet the applicable standards of care identified in this report. Our report does not examine the extent to which these animal care standards are enforced.

Rather, the objective of this report is to illustrate how systemic failures in nursing home oversight too often allow residents to experience conditions that not only fall below the federal nursing home standards of care but also fall below accepted standards for the treatment of animals in zoos, kennels, and other settings where animals are housed.

HOW TO USE THIS REPORT

This report provides a comparison of animal standards versus the experiences of many nursing home residents and families in regard to 11 key categories of interest and concern. They are:

- Freedom from Abuse and Neglect
- General Care and Treatment
- Sufficient Staffing with Appropriate Skills/Competencies
- Nutrition and Hydration
- Safe Food Handling
- Medical Supervision
- Stimulating and Safe Environment
- Freedom from Restraints
- Treatment of Injuries
- Appropriate Medications
- Infection Control and Prevention

The report contains brief chapters for each category. Each chapter is divided into the following five sections to provide useful insights into how animal care standards and the experiences of nursing home residents compare:

1. **Animal Care Standard vs. Nursing Home Experience**. Compares an animal care standard[7] to an actual experience of a nursing home resident;

Short on time? An abridged version of this report can be read by reviewing the first section of each of the 11 categories. Visit the report's page on our website, www.NursingHome411.org, for individual issue briefs on each of the categories.

[7] Zoos and veterinary facilities operate under federal and industry standards and guidelines which are intended to ensure the health and wellbeing of the animals under their care.
Following are the principal standards referenced in this report and the acronyms used for each: (1) The United States Department of Agriculture's (**USDA**) "Animal Welfare Act;" (2) The Association of Zoos and Aquariums' (**AZA**) "Accreditation Standards and Related Policies;" (3) The American Association of Zoo Veterinarians' (**AAZV**) "Guidelines for Zoo and Aquarium Veterinary Medical Programs and Veterinary Hospitals;" and (4) The Global Federation of Animal Sanctuaries' (**GFAS**) "Standards for New World Primates."

2. **Standards for Animal Care**. Summarizes the applicable standards of care for animals in zoos or other settings;

3. **Standards for Nursing Home Care**. Brief summary of the applicable nursing home standards with a link to resources;

4. **Nursing Home Statistics**. Highlights nursing home data relevant to the category (to show the extent to which residents are affected when a nursing home fails to meet the animal care standard); and

5. **News and Reports**. Provides specific examples of the experiences of nursing home residents based on media reports, Statements of Deficiencies (SoDs, the written account of substantiated nursing home violations), and other reports.

Note: Some of the deficiencies discussed in the report are referred to as being "no harm." This term is an important signifier because the failure to identify resident harm typically results in a facility not facing any penalty for the deficient care. LTCCC has long been concerned that the failure to identify harm sends a message to the nursing home industry that it will not be held accountable for substandard care, abuse, and neglect.

For more information, please see the *Elder Justice Newsletter*, dedicated to highlighting the true impact of so-called "no harm" deficiencies. To search the deficiencies covered in the two years in which the newsletter has been published, see the Searchable Issue Guide.

1. FREEDOM FROM ABUSE AND NEGLECT

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Physical abuse, deprivation of food or water, aversive spraying with a hose, and other forms of negative reinforcement or punishment-based training are never used to train, shift or otherwise handle primates.
-Standards for New World Primates, GFAS

At a for-profit Iowa facility, an 87-year-old resident with dementia was denied water for several days and died after suffering extreme dehydration and extreme pain. The facility had a five-star rating at the time of the incident.
-U.S. Senate Finance Committee Hearing

STANDARDS FOR ANIMAL CARE

Primate-caregiver relationships. Global Federal of Animal Sanctuaries (GFAS) standards state that "[p]hysical abuse, deprivation of food or water, aversive spraying with a hose, and other forms of negative reinforcement or punishment-based training are never used to train, shift or otherwise handle primates. Note: This does not preclude the use of hoses or other watering devices in caring for the primates who enjoy this form of enrichment."[8]

Food and water deprivation. Federal requirements under the Animal Welfare Act (AWA) state that zoos cannot deprive their animals of food or water "to train, work, or otherwise handle animals."[9]

Handling of animals. The AWA states that zoo handling of "all animals shall be done as expeditiously and carefully as possible in a manner that does not cause trauma, overheating, excessive cooling, behavioral stress, physical harm, or unnecessary discomfort."[10]

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[8] "Standards for New World Primates," Global Federal of Animal Sanctuaries, W-5 (March 2013). Available at https://www.sanctuaryfederation.org/wp-content/uploads/2017/09/NewWorldMonkeyStandards_Dec2015.pdf.
[9] "Animal Welfare Act," U.S. Department of Agriculture, § 2.38. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[10] "Animal Welfare Act," U.S. Department of Agriculture, § 2.131. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.

Prevent physical abuse. According to the AWA, zoos are prohibited from using physical abuse "to train, work, or otherwise handle animals."[11]

STANDARDS FOR NURSING HOME CARE

Nursing home residents have the right to be from abuse and neglect. Strong federal standards have been implemented to protect residents from any kind of abuse. Unfortunately, they are often poorly enforced by the state and federal oversight agencies. For information on these standards and resources for resident-centered advocacy, see LTCCC's **Abuse, Neglect, & Crime Reporting Center**.[12]

RELEVANT NURSING HOME STATISTICS

- **Abuse prevalence.** A 2010 study found that 1 in 10 people age 60 or older experience some form of elder abuse in a given year, including emotional abuse, physical abuse, sexual abuse, potential neglect, and financial abuse.[13]
- **Abuse on the rise.** A July 2019 Government Accountability (GAO) report found that the number of nursing home abuse citations more than doubled between 2013 and 2017.[14]
- **Costs of abuse.** Elder financial abuse and fraud costs older Americans between $2.9 billion to $36.5 billion annually.[15]
- **Failure to report.** A June 2019 report by the HHS Office of the Inspector General (OIG) found that nursing homes failed to report 84 percent of the sampled 7,831 potential abuse and neglect incidents to state survey agencies.[16]
- **ER visits.** The OIG report also estimated that one in five Medicare claims for emergency room visits from nursing homes were the result of potential abuse or neglect.[17]

"My **final memories** of my mother's life now include watching her **bang uncontrollably** on her private parts for days after the rape, with **tears rolling down her eyes**…"

[11] *Id.*
[12] Available at https://nursinghome411.org/learning-center/abuse-neglect-crime/.
[13] Ron Acierno et al., "Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study," *American Journal of Public Health* 100, no. 2 (2010): 292-297. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/.
[14] "Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse, Government Accountability Office (June 2019). Available at https://www.gao.gov/assets/700/699721.pdf.
[15] "Elder Abuse Facts," *National Council on Aging,* https://ncoa.org/public-policy-action/elder-justice/elder-abuse-facts/.
[16] "Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated," U.S. Department of Health and Human Services Office of Inspector General, A-01-16-00509, June 2019. Available at https://oig.hhs.gov/oas/reports/region1/11600509.pdf.
[17] *Id.*

NEWS AND REPORTS

U.S. Senate Hearing: "Not Forgotten"

Numerous instances of nursing home abuse were detailed during a March 2019 hearing held by the U.S. Senate Committee on Finance, "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes."[18]

At Walker Methodist Health Center (MN), an 83-year-old resident with Alzheimer's disease was raped by a male caregiver who had been a main suspect in at least two sexual abuse cases at the facility. [19] The resident's daughter testified during the Senate Finance Committee hearing that "[m]y final memories of my mother's life now include watching her bang uncontrollably on her private parts for days after the rape, with tears rolling down her eyes, apparently trying to tell me what had been done to her but unable to speak due to her disease."[20]

At a for-profit Iowa facility, Timely Mission Nursing Home, an 87-year-old resident with dementia was denied water for several days and died after suffering extreme dehydration and extreme pain, according to the resident's daughter's testimony.[21] The facility had a five-star rating at the time of the incident, despite being fined for physical and verbal abuse a year before the resident's death.

A punch in the face

A resident at Briar Place Nursing, a for-profit Illinois facility, was punched in the face by a security officer. In an interview, the resident stated that she "had been drinking" when a social service assistant took her purse, "went through it and took [her] ID (identification) and never gave it back." The resident said she then pointed her finger at the security officer who punched her in the face. The resident's roommate, who witnessed the incident, stated "I was scared, I never saw anything like that before." The security officer told the surveyor that he/she did not have an altercation with the resident, also saying that the resident tried to hit him/her. The citation was classified by the state as no harm.[22]

Sexual abuse continues for months

Sunnyside Care Center (NY) failed to "ensure 5 of 7 residents reviewed for abuse, were free from abuse and neglect" including failing to protect a resident from several instances of

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[18] "Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes," Senate Finance Committee, March 6, 2019, https://www.finance.senate.gov/hearings/not-forgotten-protecting-americans-from-abuse-and-neglect-in-nursing-homes.

[19] Jacqueline Howard, "Senate hearing examines 'devastating' nursing home abuse," *CNN*, March 6, 2019, https://www.cnn.com/2019/03/06/health/nursing-home-abuse-senate-hearing-bn/index.html.

[20] "'Statement of Maya Fischer: Daughter of Sonja Fischer, Nursing Home Rape Victim,' in 'Not Forgotten: Protecting Americans From Abuse and Neglect in Nursing Homes,'" *Senate Finance Committee*, March 6, 2019, https://www.finance.senate.gov/imo/media/doc/Fischer%20Testimony.pdf.

[21] Amie Rivers, "Shell Rock woman who lost mother testifies to Congress," *The Courier,* March 5, 2019, https://wcfcourier.com/news/local/shell-rock-woman-who-lost-mother-testifies-to-congress/article_e3ed9b21-dc8f-5a34-9a50-3fdf06fe042a.html.

[22] "Statement of Deficiencies for Briar Place Nursing," Centers for Medicare & Medicaid Services, March 29, 2019 https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=145784&SURVEYDATE=03/29/2019&INSPTYPE=CMPL.

inappropriate sexual contact.[23] Staff members observed the perpetrator, documented as not "cognitively intact," going into the victim's room multiple times and touching the victim inappropriately, yet the sexual abuse continued for months. Based on staff interviews, the surveyor documented one incident when the victim was found crying with her blanket down, and her brief visible and undone after the perpetrator went into her room. Despite a six-page Statement of Deficiencies detailing the facility's failure to protect residents from abuse and neglect, the state classified this citation as no harm.[24]

[23] "Statement of Deficiencies for Sunnyside Care Center," Centers for Medicare & Medicaid Services, March 12, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335409&SURVEYDATE=03/12/2019&INSPTYPE=CMPL.
[24] *Id.*

2. GENERAL CARE AND TREATMENT

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

"[A]ll animals must be well cared for and presented in a manner reflecting modern zoological practices in exhibit design, balancing animals' welfare requirements with aesthetic and educational considerations."
-Accreditation Standards, AZA

A Maryland nursing home failed to properly implement baseline care plans for two residents. One resident was admitted to the facility for rehabilitation after surgery. Unfortunately, "the baseline care plan did not address the potential for pain/discomfort, potential for post-operative infection or other concerns specific to the medical condition . . . ."
-Elder Justice "No Harm" Newsletter

STANDARDS FOR ANIMAL CARE

Standard operating policies. American Association of Zoo Veterinarians (AAZV) guidelines state that "[a]ll procedures and treatments performed on animals must employ current professionally accepted methods of diagnosis and treatment" and that there should be "a standard operating policy of providing appropriate medical care for all sick and injured animals."[25]

24/7 care. AAZV guidelines state that veterinary coverage – including a primary (full-time or part-time) veterinarian and a backup emergency veterinarian – must be available seven days per week and 24 hours per day for any zoo or aquarium, and "appropriate contractual and schedule arrangements must be made at all zoos and aquariums to permit this availability."[26]

[25] "Guidelines for Zoo and Aquarium Veterinary Medical Programs and Veterinary Hospitals," American Association of Zoo Veterinarians, II. Veterinary Care (2016). Available at https://cdn.ymaws.com/www.aazv.org/resource/resmgr/files/aazvveterinaryguidelines2016.pdf.
[26] *Id.*

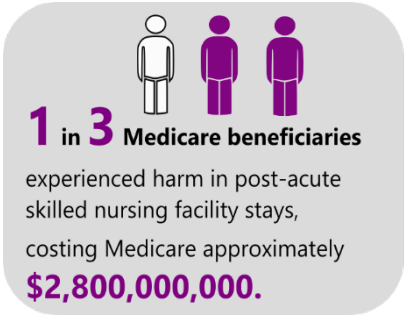
Modern zoological practices. AZA accreditation standards state that "[a]ll animals must be well cared for and presented in a manner reflecting modern zoological practices in exhibit design, balancing animals' welfare requirements with aesthetic and educational considerations."[27]

Geriatric animals. AZA standards state that "[m]anagement and treatment plans for each geriatric elephant should be developed by the elephant management team and veterinarian and revised regularly as the elephant ages."[28]

STANDARDS FOR NURSING HOME CARE

Though poorly enforced, there are strong federal standards to ensure that nursing home residents receive care that meets recognized professional standards and that is responsive to the needs and goals identified in the resident's assessment and individualized care plan. For more information and resources, including fact sheets on requirements for nursing home staff competency and resident assessment and care planning, visit the **Learning Center** of our website, www.NursingHome411.org.

RELEVANT NURSING HOME STATISTICS



- **Preventable harm.** In 2014, a federal study found that an astounding one in three Medicare beneficiaries who go to a nursing home for rehab are harmed within an average of about two weeks of entering a facility.[29] Hospital care associated with treating this harm – more than half (59 percent) of which was preventable – cost Medicare approximately $2.8 billion in a single year.[30]
- **High rates of pressure sores.** According to the U.S. Centers for Disease Control and Prevention (CDC), "[p]ressure ulcers, also known as bed sores, pressure sores, or decubitus ulcers, are wounds caused by unrelieved pressure on the skin. They . . . are serious medical conditions and one of the important measures of the quality of clinical care in nursing homes."[31] Though pressure ulcers are largely preventable with professional care and monitoring, close to 90,000 nursing home residents suffer from them every day.[32]

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[27] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 1.5.1 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.

[28] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 3.3.2.9 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.

[29] "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries," U.S. Department of Health and Human Services Office of Inspector General, OEI-06-11-0037, February 2014. Available at https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf.

[30] *Id.*

[31] NCHS Data Brief, No. 14 (February 2009), which incorporates *Pressure Ulcers Among Nursing Home Residents: United States, 2004*. Available at www.cdc.gov/nchs/data/databriefs/db14.pdf.

[32] MDS 3.0 Frequency Report (2017 Q4). Available at 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. Note: In 2018, CMS stopped publishing national MDS rates.

NEWS AND REPORTS

Regulators focus on Lewiston's Marshwood nursing home as problems mount

A 2019 *Sun Journal* (ME) report described a resident whose nursing home failed to provide essential pressure ulcer care, resulting in wounds that "seemed bigger and deeper . . . [and a] new wound [which] teemed with maggots. . . . Another patient's family found them in bed 'covered in dried feces and soaked in urine.' It happened multiple times a week."[33]

Resident deaths: both sudden and slow

According to a 2018 investigative report in *The Buffalo News* on conditions in a for-profit nursing home,

> Death came suddenly for Arturo Bucci. The 85-year-old retired machinist was in his motorized wheelchair when it toppled more than 12 feet down a creek embankment. The spill left him face down in the water outside an East Aurora nursing home.
>
> For Donna Bantle, death came more slowly. Her daughter noticed a large, ugly bedsore on Bantle's back when she was a resident at Absolut Center for Nursing and Rehabilitation at Aurora Park — the same facility where Bucci died.
>
> "This thing is going to kill me," she told her daughter. Months later, when Bantle died, the death certificate listed an infection in a lower back wound as a contributing factor.
>
> For four years, the Absolut nursing home has been one of the lowest-rated in Erie and Niagara counties and among the lowest-rated in New York.[34]

[33] Lindsay Tice, "Regulators focus on Lewiston's Marshwood nursing home as problems mount," *Sun Journal*, December 15, 2019. Available at https://www.sunjournal.com/2019/12/15/regulators-focus-on-lewistons-marshwood-nursing-home-as-problems-mount/.

[34] Lou Michel, "Inside one of WNY's worst nursing homes: Absolut at Aurora Park," *The Buffalo News*, November 18, 2018. Available at https://buffalonews.com/2018/11/18/inside-one-of-wnys-worst-nursing-homes-absolut-at-aurora-park/.

3. SUFFICIENT STAFFING WITH APPROPRIATE SKILLS/COMPETENCIES

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

A minimum of two qualified elephant keepers must be present any time a keeper is within trunk's reach of an elephant in order to allow a second person to intervene if required.
-Accreditation Standards, AZA

A resident suffered a fractured femur after the facility improperly transferred her with only one staff member despite the resident's care plan instructing staff to transfer the resident with assistance of two staff members.
-Statement of Deficiencies, CMS

STANDARDS FOR ANIMAL CARE

Numbers of staff. AZA accreditation standards state that "[t]here must be an adequate number of trained paid and unpaid staff to care for the animals and to manage the institution's diverse programs." Although there is no set formula for prescribing the size of the staff (paid and unpaid), some of the criteria that may be used to define what is considered "adequate" include the number and type of species within the institution, the general condition of the animals and exhibits, and past staffing practices.[35]

Full-time staff veterinarian. AZA standards recommend a full-time staff veterinarian. If a full-time veterinarian is deemed unnecessary due to the number and/or nature of the animals, there must be a consulting/part-time veterinarian under written contract "to make at least twice monthly inspections of the animals and to respond as soon as possible to any emergencies."[36]

[35] "The Accreditation Standards and Related Policies," Association of Zoos & Aquariums, 7.3 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[36] "The Accreditation Standards and Related Policies," Association of Zoos & Aquariums, 2.1.1 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.

Program coordinator. According to the AAZV, zoos or aquariums utilizing a part-time veterinarian "must have one staff person who serves as the veterinary program coordinator, and supervises the veterinary care program under the direction of the veterinarian." The program coordinator's responsibilities include: noting which animals require examination by the veterinarian and accompany the veterinarian during rounds and treatments, overseeing prescribed treatments, maintaining hospital equipment, and supervising drug inventories.[37]

Two at a time. The AZA states that at least two qualified elephant keepers must be present during any contact with elephants in order to allow a second person to intervene if required.[38]

Supervision of care staff. Under federal (USDA) standards for animal care, "employees who provide for husbandry and care . . . must be supervised by an individual who has the knowledge, background, and experience in proper husbandry and care of dogs and cats to supervise others. The employer must be certain that the supervisor and other employees can perform to these standards."[39]

Training of care staff. Federal standards state that "[t]rainers and handlers must meet professionally recognized standards for experience and training."[40]

STANDARDS FOR NURSING HOME CARE

Under federal law, nursing homes are required to have a registered nurse on duty eight hours a day, seven days a week. Additionally, nursing homes must have sufficient care staff to meet every resident's care, monitoring, and psycho-social needs. Unfortunately, "sufficient staff" is not a concept that is well-understood or enforced by many state surveyors, which is why so many nursing homes are woefully understaffed. For more information, see our *Fact Sheet: Requirements for Nursing Home Care Staff & Administration* for more information.[41]

RELEVANT NURSING HOME STATISTICS

- **Resident needs unmet.** Inadequate nursing home staffing is a widespread and persistent problem. A 2001 landmark federal study indicated that a typical resident needs at least 4.1 total staff hours per day and current research suggests 4.5 hours per day given increased resident needs.[42] Unfortunately, too many nursing homes fail to allocate the resources

[37] "Guidelines for Zoo and Aquarium Veterinary Medical Programs and Veterinary Hospitals," American Association of Zoo Veterinarians, II. Veterinary Care (2016). Available at https://cdn.ymaws.com/www.aazv.org/resource/resmgr/files/aazvveterinaryguidelines2016.pdf.
[38] "The Accreditation Standards and Related Policies," Association of Zoos & Aquariums, 5.2 (2020). https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[39] "Animal Welfare Act," U.S. Department of Agriculture, § 3.12. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[40] "Animal Welfare Act," U.S. Department of Agriculture, § 3.108. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[41] Available at https://nursinghome411.org/fact-sheet-requirements-for-nursing-home-care-staff-administration/.
[42] Charlene Harrington et al., "The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes," *Health Services Insights* 9 (2016): 13-19. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/.

necessary to maintain safe and sufficient staffing. Federal data indicate that the average nursing home maintains only 3.4 total care staff hours per day.[43]

- **Fluctuations.** A 2017 report in *The New York Times* revealed frequent and significant fluctuations in day-to-day staffing, particularly on weekends. The data showed that on the worst staffed days at an average facility, "on-duty personnel cared for nearly twice as many residents as they did when the staffing roster was fullest."[44]
- **Lack of compliance.** A 2019 *Health Affairs* study found that "75 percent of nursing homes were almost never in compliance with what CMS expected their RN staffing level to be, based on residents' acuity." Further, the study found that overall staffing levels were lower on weekends than on weekdays, making residents susceptible to "[a]dverse events such as falls and medication errors."[45]
- **Staffing goes up during inspections.** The *Health Affairs* study also found that staffing levels were high during the weeks closest to the time of inspection, but then greatly dropped after the survey week concluded.[46]

> **75%** of nursing homes are "almost never in compliance" with expected RN staffing levels identified as necessary to meet their residents' basic needs.
>
> - *Health Affairs*

Note: To help the public gain insights into the staffing levels of nursing homes in their communities, LTCCC publishes information and graphics on staffing levels for every licensed U.S. nursing home. For the latest updates, visit https://nursinghome411.org/nursing-home-data-information/staffing/.

NEWS AND REPORTS

Improper lift transfer

A resident at Prescott Nursing and Rehab Community (WI) suffered a fractured femur after the

[43] "Nursing Home Update: Latest Data Indicate Low Staffing is Persistent & Pervasive," LTCCC, November 18, 2019, https://nursinghome411.org/nursing-home-update-latest-data-indicate-low-staffing-is-persistent-pervasive/. Data are for the second quarter of 2019.
[44] Jordan Rau, "'Like A Ghost Town': Erratic Nursing Home Staffing Revealed Through New Records," *Kaiser Health News*, July 13, 2018, https://khn.org/news/like-a-ghost-town-erratic-nursing-home-staffing-revealed-through-new-records/.
[45] Fangli Geng et al., "Daily Nursing Home Staffing Levels Highly Variable, Often Below CMS Expectations," *Health Affairs* 38 no. 7 (2019). Abstract available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05322.
[46] *Id.*

facility improperly transferred her with only one staff member rather than two.[47] [48] The resident's care plan instructed staff to use a Hoyer lift (a lifting device) with the assistance of two staff members, but the certified nursing assistant (CNA) attempted to transfer the resident alone because the two "other aides were busy," according to the CNA's statement. During the transfer, the resident "lunged forward and began to slide out of her chair," and was later observed with a baseball-sized lump in her right leg. Despite the serious injury, the violation was cited as no harm.

Resident left waiting, despite staff's knowledge of resident's call for help

Riverview Manor Healthcare (IA) nursing home was cited for failing to "[h]ave enough nurses to care for every resident in a way that maximizes the resident's well-being."[49] A resident told one surveyor that there is usually a 30 minute wait no matter the time of day and that it could be up to an hour at times. The resident explained to the surveyors that s/he had an accident and had to sit in feces until the staff responded, which made the resident "feel awful."

[47] "Statement of Deficiencies for Prescott Nursing and Rehab Community," Centers for Medicare & Medicaid Services, November 21, 2017, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=525398&SURVEYDATE=11/21/2017&INSPTYPE=CMPL&profTab=1&state=WI&lat=0&lng=0&name=PRESCOTT%2520NURSING%2520AND%2520REHAB%2520COMMUNITY&Distn=0.0.

[48] "Elder Justice: What 'No Harm' Really Means for Residents," Center for Medicare Advocacy and Long Term Care Community Coalition, February 2018, https://www.medicareadvocacy.org/wp-content/uploads/2018/03/Elder-Justice-Newsletter-Feb-2018.pdf.

[49] "Statement of Deficiencies for Riverview Manor Healthcare," Centers for Medicare & Medicaid Services, October 26, 2017, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=165376&SURVEYDATE=10/26/2017&INSPTYPE=CMPL&profTab=1&state=IA&lat=0&lng=0&name=RIVERVIEW%2520MANOR%2520HEALTHCARE%252C%2520LLC&Distn=0.0.

4. NUTRITION AND HYDRATION

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Guinea pigs and hamsters shall be fed each day . . . The food shall be free from contamination, wholesome, palatable and of sufficient quantity and nutritive value to meet the normal daily requirements for the condition and size of the guinea pig or hamster.
-Animal Welfare Act, USDA

A New York facility failed to provide food of nutritive value, palatable and served at the proper temperature" with residents complaining that the food – including hot meals – were served cold.
-Statement of Deficiencies, CMS

STANDARDS FOR ANIMAL CARE

Wholesome and palatable. The AWA states that "[g]uinea pigs and hamsters shall be fed each day except as otherwise might be required to provide adequate veterinary care. The food shall be free from contamination, wholesome, palatable and of sufficient quantity and nutritive value to meet the normal daily requirements for the condition and size of the guinea pig or hamster."[50]

Appropriate meals. Under the AWA, "[i]f public feeding of animals is allowed, the food must be provided by the animal facility and shall be appropriate to the type of animal and its nutritional needs and diet."[51]

Nutrition programs. AZA standards state that institutions follow "a written nutrition program that meets the behavioral and nutritional needs of all species, individuals, and colonies/groups in the institution." Further, animal diets must meet the quality and quantity necessary to ensure each animal's nutritional and psychological needs.[52]

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[50] "Animal Welfare Act," U.S. Department of Agriculture, § 3.29. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[51] "Animal Welfare Act," U.S. Department of Agriculture, § 2.131. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[52] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 2.6.2 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.

STANDARDS FOR NURSING HOME CARE

Federal standards require that resident meals are healthy, appropriate for the individual, and appetizing. In addition, it is required that the dining experience fosters resident dignity. For more information on relevant regulatory standards, see **LTCCC's *Primer: Nursing Home Quality Standards***.[53] See our *Fact Sheet: Resident Dignity & Quality of Life Standards* for information on requirement in respect to promoting resident dignity and independence in dining.[54]

RELEVANT NURSING HOME STATISTICS

- **Food and fluid consumption concerns.** As noted in a *Journal of Gerontology* article, "[i]nadequate oral food and fluid intake is a common problem among nursing home (NH) residents." The article's authors note that multiple studies have found that 64 to 80 percent of nursing home residents' "mealtime food and fluid consumption is less than the federal criterion."[55]

- **Dehydration a significant risk.** Researchers have found that 46 percent of older people in long-term care (nursing homes and other residential care settings) had impending or current dehydration.[56] "Dehydration is associated with significant adverse outcomes in older people including increased risk of hospital admission, disability, infection, falls, acute ischaemic stroke and mortality despite being largely preventable and treatable."[57]

> "Inadequate oral food and fluid intake is a common problem among nursing home (NH) residents."
>
> - *Journal of Gerontology*

NEWS AND REPORTS

Failure to meet nutritional needs

A woman with dementia in an Ohio nursing home suffered "significant weight loss (greater than 5% in one month)" due to the facility's failure to carry out a dietician's order to provide snacks to counter decreases in her weight discussed and noted at the facility's weekly interdisciplinary meetings. A surveyor's investigation found falsification of records (to indicate that the resident had received and eaten food which she had neither received nor eaten) and, when interviewed, the LPN "denied that she was aware of [the resident] having had any weight loss."[58]

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[53] Available at https://nursinghome411.org/ltccc-primer-nursing-home-quality-standards/.

[54] Available at https://nursinghome411.org/fact-sheet-resident-dignity-quality-of-life-standards/.

[55] Sandra F. Simmons and John F. Schnelle, "Individualized Feeding Assistance Care for Nursing Home Residents: Staffing Requirements to Implement Two Interventions," *Journal of Gerontology* 59 no. 9 (2004): 966-973. Available at https://pdfs.semanticscholar.org/ce67/0ff9ea702b1fbd6198995de411e88918d11c.pdf.

[56] Cini Bhanu et al., "'I've never drunk very much water and I still don't, and I see no reason to do so': a qualitative study of the views of community-dwelling older people and carers on hydration in later life," *Age and Ageing*, 49 no. 1 (2020): 111-118. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6911653/. [Citing data from Diane Bunn et al., "Increasing Fluid Intake and Reducing Dehydration Risk in Older People Living in Long-Term Care: A Systematic Review," *Journal of the American Medical Directors Association* 16, no. 2 (2015): 101-113. Abstract available at https://www.ncbi.nlm.nih.gov/pubmed/25499399].

[57] *Id*.

[58] "Statement of Deficiencies for Arbors at Gallipolis," (October 27, 2016). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=365348&SURVEYDATE=10/27/2016&INSPTYPE=STD#.

A dish worst served cold

A New York facility failed to provide food "of nutritive value, palatable and served at the proper temperature" to its residents. Residents complained that the food served was too cold, and one resident said that most of the time, the hot meals are served cold. Even the ombudsman that served at the nursing home stated that "one of the main complaints he has heard is the food being served cold."[59]

[59] Statement of Deficiencies for Lutheran Retirement Home (Mar. 18, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335268&SURVEYDATE=03/18/2019&INSPTYPE=STD.

5. SAFE FOOD HANDLING

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Food should be stored in facilities which adequately protect against "spoilage or deterioration and infestation or contamination by vermin," and should be "stored in containers with tightly fitting lids or covers or in the original containers as received from the commercial sources of supply. . . ."
-Animal Welfare Act, USDA

Cockroach infestations, moldy ice machines, and mouse droppings were among the many food handling incidents detailed in a recent report on food safety violations in nursing homes. Such violations pose serious health risks, as demonstrated by the norovirus outbreak that sickened 29 residents and 32 staff members at a for-profit Wisconsin facility.
-FairWarning

STANDARDS FOR ANIMAL CARE

Storage of food. According to the AWA, food should be stored in facilities which adequately protect against "spoilage or deterioration and infestation or contamination by vermin," and should be "stored in containers with tightly fitting lids or covers or in the original containers as received from the commercial sources of supply. Refrigeration shall be provided for supplies of perishable food."[60]

Food and water sanitation. The AWA states that "[u]sed primary enclosures and food and water receptacles must be cleaned and sanitized in accordance with this section before they can be used to house, feed, or water another dog or cat, or social grouping of dogs or cats."[61]

[60] "Animal Welfare Act," U.S. Department of Agriculture, § 3.25. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[61] "Animal Welfare Act," U.S. Department of Agriculture, § 3.84. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.

STANDARDS FOR NURSING HOME CARE

Federal regulations require that nursing homes obtain food from government-approved sources and that they "[s]tore, prepare, distribute and serve food in accordance with professional standards for food service safety."[62]

RELEVANT NURSING HOME STATISTICS

- **Food storage.** A 2018 CMS survey found that food storage was the second-most cited deficiency in nursing homes.[63]
- **Virus outbreaks.** Nursing home residents are highly vulnerable to viral infections, particularly those involving the norovirus, which is the "leading cause of acute gastroenteritis and foodborne disease in the United States."[64] A study examining norovirus outbreaks from 2009 to 2012, published by the Centers for Disease Control and Prevention (CDC) found that "most (80%) nonfoodborne outbreaks occurred in long-term care facilities such as nursing homes."[65]

> "Across the country, 230 foodborne outbreaks were reported from 1998 to 2017 in long-term care settings. . . . The outbreaks resulted in 54 deaths and 532 hospitalizations, and sickened 7,648 people–figures experts say are almost certainly an undercount."
>
> - FairWarning

NEWS AND REPORTS

Of mice and mold

A 2019 report by FairWarning[66] detailed the often unreported poor conditions surrounding nursing home food safety, with issues such as cockroach infestations, moldy ice machines, and mouse droppings plaguing facilities. The report, citing a December 2018 Statement of Deficiencies, noted that 29 residents and 32 staff members at a for-profit Wisconsin facility (then-rated two stars) were sickened in a norovirus outbreak. The SoD stated that kitchen staff had failed to monitor and control sanitizer levels in the dishwasher.

'Dried brown food debris'

Accordius Health at Harrisonburg (VA) was cited for failing to safely store and prepare food.[67]

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[62] 42 CFR § 483.60(i). Available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=b9a224becafd6822ec36907085e5915e&ty=HTML&h=L&mc=true&r=SECTION&n=se42.5.483_160.

[63] Marty Stempniak, "'We have to do better' on infection prevention, CMS official tells LTC nurse managers during new survey update," *McKnight's*, June 29, 2018, https://www.mcknights.com/news/we-have-to-do-better-on-infection-prevention-cms-official-tells-ltc-nurse-managers-during-new-survey-update/.

[64] Aron Hall et al., "Vital Signs: Foodborne Norovirus Outbreaks — United States, 2009–2012," Centers for Disease Control and Prevention, 63 no. 22 (2014): 491-495. Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6322a3.htm?s_cid=mm6322a3_w.

[65] *Id.*

[66] Marjie Lundstrom, "Bugs, Mold and Unwashed Hands: Rampant Safety Violations in Nursing Home Kitchens Endanger Residents," FairWarning, October 3, 2019, https://www.fairwarning.org/2019/10/safety-violations-in-nursing-home/.

[67] "Statement of Deficiencies for Accordius at Harrisonburg Transitional Care & Rehab Center," Centers for Medicare & Medicaid Service, March 7, 2019,

Its freezer was not sealed properly, and ice formed on the food stored near the freezer door. The dietary manager told the surveyor that they were "having a lot of maintenance issues with [their] freezer." The surveyor found many of the food products covered with ice due to the malfunctioning freezer. The surveyor also found a can opener covered in "dried brown food debris," which the dietary manager said had not been washed in a while.

https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=495146&SURVEYDATE=03/07/2019&INSPTYPE=STD.

6. MEDICAL SUPERVISION

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

The attending veterinarian shall conduct on-site evaluations of each cetacean at least once a month. The evaluation shall include a visual inspection of the animal; examination of the behavioral, feeding, and medical records of the animal; and a discussion of each animal with an animal care staff member familiar with the animal.
-Animal Welfare Act, USDA

A physician at a for-profit Buffalo nursing home inappropriately administered insulin injections to a diabetic resident despite a hospital discharge note stating, "PLEASE AVOID GIVING THIS PATIENT INSULIN." The physician, who signed an order to administer insulin, blamed a nurse for inaccurately reading to him the resident's discharge directives.
-The Buffalo News

STANDARDS FOR ANIMAL CARE

Veterinarian or trained scientist. Under the AWA, an animal's housing, feeding, and nonmedical care should be directed by the attending veterinarian or a scientist trained and experienced in the proper care, handling, and use of that animal's species.[68]

Monthly veterinarian evaluations. The AWA states that the "attending veterinarian shall conduct on-site evaluations of each cetacean at least once a month. The evaluation shall include a visual inspection of the animal; examination of the behavioral, feeding, and medical records of the animal; and a discussion of each animal with an animal care staff member familiar with the animal."[69]

Role of doctor. According to the AWA, a "veterinarian shall conduct a complete physical examination of each cetacean [marine animal] at least once every 6 months." Requirements

[68] "Animal Welfare Act," U.S. Department of Agriculture, § 2.3.1. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[69] "Animal Welfare Act," U.S. Department of Agriculture, § 3.111. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.

and expectations for this examination are specific so as to ensure that it is not a cursory examination, but rather one that is thorough and addresses a range of potential issues and concerns, including "identification (name and/or number, sex, and age), weight, length, axillary girth, appetite, and behavior. The attending veterinarian shall also conduct a general examination to evaluate body condition, skin, eyes, mouth, blow hole and cardio-respiratory system, genitalia, and feces (gastrointestinal status). The examination shall also include a complete blood count and serum chemistry analysis."[70]

Visual examinations. The AWA states that "[a]ll marine mammals must be visually examined by the attending veterinarian at least semiannually and must be physically examined under the supervision of and when determined to be necessary by the attending veterinarian . . . Examinations include hands-on physical examination, hematology and blood chemistry, and other diagnostic tests."[71]

STANDARDS FOR NURSING HOME CARE

Though too often residents lack access to a doctor (especially one of their choosing), in fact nursing homes are required under federal rules to "ensure that the medical care of each resident is supervised by a physician. . .[and to] be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter." Federal rules also dictate that a resident has the right to choose his or her attending physician.[72] For more information, see LTCCC's *Fact Sheet: Requirements for Nursing Home Physician, Rehab & Dental Services*.[73]

RELEVANT NURSING HOME STATISTICS

- **Adequate Nursing and Physician Services**. In 2018, there were 3,876 citations for failing to provide sufficient nursing and physician services.[74]
- **Effective Administration**. There are an average of 300 citations per year for failure to administer a nursing home in a way that maintains the well-being of each resident.[75]
- **Competent Care Staff**. In 2018, there were 938 citations for failure to ensure that nursing staff have the appropriate competencies and/or skills to care for residents in the facility.[76]

[70] "Animal Welfare Act," U.S. Department of Agriculture, § 3.111. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[71] "Animal Welfare Act," U.S. Department of Agriculture, § 3.110. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[72] 42 CFR 483.10(d).
[73] Available at https://nursinghome411.org/fact-sheet-requirements-for-nursing-home-physician-rehab-dental-services/.
[74] Data derived from Nursing Home Compare December 30, 2019 for F-tags 490 and 835. Average based on the last three years of data published on Nursing Home Compare in November 2019. Available at https://data.medicare.gov/Nursing-Home-Compare/Health-Deficiencies/r5ix-sfxw.
[75] *Id*.
[76] *Id*.

NEWS AND REPORTS

The blame game

A physician at a for-profit Buffalo nursing home, Humboldt House Rehabilitation and Nursing Center, inappropriately administered insulin injections to a diabetic resident despite a hospital discharge note stating, "PLEASE AVOID GIVING THIS PATIENT INSULIN," in capital letters.77 The physician said he failed to follow through on his practice of reading the discharge summary, but also blamed a nurse for inaccurately reading to him the resident's discharge directives. The incident occurred days after the resident had been hospitalized after being "twice found unresponsive in her bed and had to be revived with medications and fruit juice." The federal government fined the facility $47,827, the sixth-largest nursing home fine in New York in 2018.[78]

A failure to communicate

Heritage Green Rehab & Skilled Nursing (NY) failed to notify the family and physician of a resident who refused medications for 12 days in a month.[79] Though the lapse in communication regarding the resident's refusals led staff to administer inappropriate medication dosages, the surveyor still cited the violation as no harm.

Improper assessment and evaluation

The Lighthouse at Hancock Health and Rehab (MI) "failed to appropriately assess, monitor and re-evaluate, intravenous (IV) therapy" for a newly admitted resident.[80] Though this deficient practice resulted in the potential for "clinical complications, including electrolyte imbalances and neurological decline," the surveyor cited the violation as no harm.

Out of range

Portland Health & Rehabilitation Center (OR) "failed to provide appropriate services and devices" to increase range of motion for one resident and prevent further decrease in range of motion for another resident.[81] Both residents had left hand contractures but were observed not wearing splint devices despite records indicating they should. While the surveyor determined the residents were at risk for worsening contractures and conditions, the violation was cited as no harm.

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[77] Lou Michel, "Buffalo nursing home fined $47,827 over medication mistake," *Buffalo News*, June 13, 2019, http://buffalonews.com/2019/06/13/buffalo-nursing-home-fined-47827-over-medication-mistake/.

[78] *Id.*

[79] "Statement of Deficiencies for Heritage Green Rehab & Skilled Nursing," Centers for Medicare & Medicaid Service, March 29, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335721&SURVEYDATE=03/29/2019&INSPTYPE=STD.

[80] "Statement of Deficiencies for The Lighthouse at Hancock Health and Rehab," Centers for Medicare & Medicaid Service, April 2, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235552&SURVEYDATE=04/02/2019&INSPTYPE=STD.

[81] "Statement of Deficiencies for Portland Health and Rehabilitation Center," Centers for Medicare & Medicaid Service, March 13, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=385228&SURVEYDATE=03/13/2019&INSPTYPE=STD.

Untimely testing

Galion Pointe Inc (OH) failed to provide timely, quality laboratory services and tests to meet the needs of a resident.[82] According to the surveyor, a resident's physician ordered laboratory testing was not completed in a timely manner, with the resident's culture being obtained seven days after the order was received. Despite the untimely treatment of a resident in isolation due to an infection, the surveyor still cited the violation as no harm.

[82] "Statement of Deficiencies for Galion Pointe, Inc," Centers for Medicare & Medicaid Service, March 28, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=365385&SURVEYDATE=03/28/2019&INSPTYPE=STD.

7. STIMULATING AND SAFE ENVIRONMENT

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

The physical environment in the primary enclosures must be enriched by providing means of expressing noninjurious species-typical activities. Species differences should be considered when determining the type or methods of enrichment.
-Animal Welfare Act, USDA

At a Minnesota facility, a resident who was unable to communicate had a care plan which called for "daily independent activities" and interventions including "stimulating music, television and other activities." Instead, the surveyor observed several days in which the resident "was lying in bed with the lights on without any music, television or interaction from staff."
-Statement of Deficiencies, CMS

STANDARDS FOR ANIMAL CARE

Environmental enrichment. The AWA states that an animal's physical environment "must be enriched by providing means of expressing noninjurious species-typical activities" and that differences in species should be considered when determining forms of enrichment (i.e., perches, swings, mirrors, and other increased cage complexities; providing objects to manipulate; varied food items; foraging or task-oriented feeding methods; interaction with caregivers).

Special considerations. AWA standards state that certain nonhuman primates should be provided special considerations with regards to environmental enhancement including infants and young juveniles; animals showing signs of psychological distress; those in Committee-approved research that require restricted activity; individually housed nonhuman primates unable to see and hear nonhuman primates of their own or compatible species; and great apes weighing over 110 lbs.

Adequate transport space. Under the AWA, primary enclosures transporting nonhuman primates must be large enough so that each animal has enough space to "turn around freely in a normal manner and to sit in an upright, hands down position without its head touching the top of the enclosure."[83]

Sufficient containment space. The AWA also states that "[m]arine mammals must be housed in primary enclosures that comply with the minimum space requirements . . . These enclosures must be constructed and maintained so that the animals contained within are provided sufficient space, both horizontally and vertically, to be able to make normal postural and social adjustments with adequate freedom of movement, in or out of the water."[84]

Safe housing. According to the AZA, "[a]ll animals must be housed in enclosures which are safe for the animals and meet their physical and psychological needs."[85]

> "[S]tudies have found that nursing home residents with dementia spend the majority of their time engaged in no activity at all. . . ."
>
> - *Aging & Mental Health*

Protection from harmful weather conditions. Under AZA standards, zoos are required to protect animals "from weather or other conditions clearly known to be detrimental to their health or welfare" and must provide animals "with an environment in which they can acclimate sufficiently to remain healthy and support their well-being."[86] For example, animals that are "not normally exposed to cold weather in their natural habitats" require an environment that is heated. Similarly, animals used to living in cold climates should have "protection from excessive heat."[87]

STANDARDS FOR NURSING HOME CARE

There are numerous federal standards that require both a safe environment and one that meets residents' psycho-social needs and goals. Importantly, these requirements relate to service for all residents, irrespective of their cognitive status or physical abilities. More information on these standards can be found in LTCCC's ***Primer: Nursing Home Quality Standards***[88] as well as in various fact sheets and webinars in LTCCC's **Learning Center**.[89] The Learning Center also has easy-to-use forms that can be used to record a resident's preferences and personal goals.

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[83] "Animal Welfare Act," U.S. Department of Agriculture, § 3.87. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[84] "Animal Welfare Act," "Animal Welfare Act," U.S. Department of Agriculture, § 3.104. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[85] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 1.5.2 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[86] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 1.5.7 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[87] *Id*.
[88] Available at https://nursinghome411.org/ltccc-primer-nursing-home-quality-standards/.
[89] Available at https://nursinghome411.org/learning-center/.

RELEVANT NURSING HOME STATISTICS

- **Boredom and depression.** A CDC study estimated that about half of nursing home residents have a diagnosis of depression, approximately twice the rate found in adult day services centers (24%) and residential care communities (25%).[90]
- **No place like home?** A 2018 study comparing three nursing homes found that residents spent significantly less time in their own room when residing in the facility with the least homelike rooms (9%) compared to the residents in the two facilities with more homelike rooms (34% and 57%).[91]
- **Activities.** The same study also found that when nursing homes had activities available, most residents would participate.
- **Engaging residents with dementia**. A 2010 *Aging & Mental Health* article noted that "studies have found that nursing home residents with dementia spend the majority of their time engaged in no activity at all, with unstructured time accounting for two-thirds of the day or more. . . ."[92]

NEWS AND REPORTS

Resident's care plan ignored

A resident in a Minnesota nursing home "had altered socialization due to the inability to communicate." To address this, his care plan called for "daily independent activities" and interventions including "stimulating music, television and other activities." Instead, the surveyor observed several days in which the resident "was lying in bed with the lights on without any music, television or interaction from staff." An interview with a family member, who visited the resident almost daily, indicated that the resident "was always lying in bed without any music or television."[93]

'Whatever it would take'

A Kansas City nursing home's ceiling collapsed and its water stopped running after it was taken over by the Centers Health Care,[94] a New York-based post-acute health care provider which recently purchased the facility and turned over its management. Months earlier, Centers Health

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[90] "QuickStats: Percentage of Users of Long-Term Care Services with a Diagnosis of Depression," Centers for Disease Control and Prevention, January 31, 2014, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6304a7.htm.

[91] Bram de Boer et al., "The Physical Environment of Nursing Homes for People with Dementia: Traditional Nursing Homes, Small-Scale Living Facilities, and Green Care Farms." *Healthcare (Basel, Switzerland)* 6 no. 4 (2018): 137. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6315793/.

[92] Jiska Cohen-Mansfield et al., "Engaging nursing home residents with dementia in activities: The effects of modeling, presentation order, time of day, and setting characteristics," *Aging & Mental Health*, May 2010. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3139216/.

[93] "Statement of deficiencies for The Estates at Twin Rivers, LLC," Centers for Medicare & Medicaid Service, December 1, 2017, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=245298&SURVEYDATE=12/01/2017&INSPTYPE=STD#.

[94] Andy Marso, "Ceiling collapse, no hot water: Despite new owner, KC-area nursing homes struggle," *Kansas City Star*, January 27, 2019, https://www.kansascity.com/news/business/health-care/article224957840.html.

Care COO Amir Abramchik told *Skilled Nursing News* that the company would "do whatever it would take to save these homes."[95]

Cracked ceiling and broken commode

Shenandoah Valley Health and Rehab (VA) failed to ensure that its residents resided in a homelike environment.[96] One resident's room had a cracked ceiling, and the resident said she felt unsafe in her room, thinking that the ceiling could fall on her. The resident also told staff that a commode was "not functioning properly," and the staff had not properly addressed it. This lack of a homelike environment can make residents feel unsafe and unsecure in their own rooms, preventing them from enjoying a stimulating and free environment.

Stimulating environment

Accordius Health at Harrisonburg (VA) failed to include any mention of nursing home activities in one resident's care plan.[97] Nursing homes are required to provide programs involving activities that promote their residents' health and wellbeing.

[95] Maggie Flynn, "Centers Looks to Continue Skilled Nursing Turnaround Work in Missouri," *Skilled Nursing News*, July 25, 2019, https://skillednursingnews.com/2018/07/centers-looks-continue-skilled-nursing-turnaround-work-missouri/.

[96] "Statement of Deficiencies for Shenandoah Valley Health and Rehab," Centers for Medicare & Medicaid Service, March 14, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=495168&SURVEYDATE=03/14/2019&INSPTYPE=STD.

[97] "Statement of Deficiencies for Accordius at Harrisonburg Transitional Care & Rehab Center," Centers for Medicare & Medicaid Service, March 7, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=495146&SURVEYDATE=03/07/2019&INSPTYPE=STD.

8. FREEDOM FROM RESTRAINTS

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Nonhuman primates must not be maintained in restraint devices unless required for health reasons as determined by the attending veterinarian or by a research proposal approved by the Committee at research facilities. Maintenance under such restraint must be for the shortest period possible.
-Animal Welfare Act, USDA

A resident's death at a non-profit Massachusetts facility serves as a cautionary tale for the dangers of bed rails. Staff at the facility recalled that the resident's head was twisted sideways and stuck between the bottom of the bed rail and the bedframe.
-Statement of Deficiencies, CMS

STANDARDS FOR ANIMAL CARE

Limited physical restraints. AAZV guidelines state that physical restraint of animals "without sedation or anxiolytics should be limited to short, nonpainful procedures or longer procedures in species that are exceptionally tolerant to manual restraint."

The guidelines state that "[p]hysical or mechanical restraint can be stressful to nondomesticated species and conscious sedation can reduce stress in the animal and decrease risk of injury to the animal and humans. In the case of invasive procedures, restraint without consideration for analgesia may be grossly inappropriate and anesthesia or local analgesia should be used."[98]

Restraint devices. The AWA states that restraint devices should not be used to maintain nonhuman primates unless required for health reasons or by a research proposal approved by

[98] "Guidelines for Zoo and Aquarium Veterinary Medical Programs and Veterinary Hospitals," American Association of Zoo Veterinarians, II. Veterinary Care (2016). Available at https://cdn.ymaws.com/www.aazv.org/resource/resmgr/files/aazvveterinaryguidelines2016.pdf.

the Committee at research facilities. Under such circumstances, restraint must be for the shortest period possible. When long-term (more than 12 hours) restraint is required, the primate must be granted the opportunity for daily unrestrained activity for at least one continuous hour unless continuous restraint is required by the Committee-approved research proposal.[99]

STANDARDS FOR NURSING HOME CARE

Under federal requirements, every resident in a certified nursing home has the "right to be treated with respect and dignity, including. . .[t]he right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."[100] LTCCC's **Learning Center** has fact sheets and other resources with information and tips on reducing the use of both physical and chemical restraints.[101]

RELEVANT NURSING HOME STATISTICS

- **Bed rails.** The use of bed rails is linked with heightened risk of preventable harm and death for nursing home residents. Residents may harm themselves when attempting to climb over, under, through, or around bed rails. Without a proper assessment, bed rails may place residents in immediate risk of serious injury or death.[102]
- **Deaths from restraints.** About 550 bed rail-related deaths occurred from 1995 through 2012, according to a *New York Times* review of FDA data, lawsuits, state nursing home inspection reports, and interviews.[103]

550 bed rail-related deaths occurred from 1995 through 2012, according to a *New York Times* estimate.

- **Inappropriate drugging**. Approximately 20 percent of nursing home residents are administered powerful and dangerous antipsychotic drugs, despite a US FDA "black-box" warning not to use these drugs on elderly individuals with dementia.[104]
- **Chemical restraints.** A Human Rights Watch report, *They Want Docile*, states that in a typical week, "nursing facilities in the United States administer antipsychotic drugs to over 179,000 people who do not have diagnoses for which the drugs are approved."[105] As detailed in the report, many of these residents have Alzheimer's disease or another form of dementia and are administered antipsychotic drugs as a form of chemical restraint, in place of appropriate care and services.

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[99] "Animal Welfare Act," U.S. Department of Agriculture, § 3.81. Available at https://www.govinfo.gov/content/pkg/CFR-2016-title9-vol1/xml/CFR-2016-title9-vol1-chapI-subchapA.xml.
[100] 42 CFR 483.10(e).
[101] https://nursinghome411.org/learning-center/.
[102] "Consumer Fact Sheet: Bed Rail Standards," LTCCC, https://nursinghome411.org/fact-sheet-bed-rails/.
[103] Ron Nixon, "After Dozens of Deaths, Inquiry Into Bed Rails," *The New York Times*, November 25, 2012, https://www.nytimes.com/2012/11/26/health/after-dozens-of-deaths-inquiry-into-bed-rails.html.
[104] "US Nursing Home Drugging Citations: Fall 2018," LTCCC, https://nursinghome411.org/us-nursing-home-drugging-citations-fall-2018/.
[105] "'They Want Docile'" How Nursing Homes in the United States Overmedicate People With Dementia," Human Rights Watch, February 5, 2018, https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.

NEWS AND REPORTS

Death by bed rail

The Statement of Deficiencies (SoD) for Julian J. Levitt Family Nursing Home (MA) identified two residents who were entrapped in their bed rails. Care staff reported that, for one resident, the resident's body appeared "to be outside the bed with his/her head on the bed with the bottom of the side rail across his/her neck and [the resident] just hanging there, looked terrified. . . ." [106] In respect to the second resident, staff told surveyors that the resident's head was twisted sideways and stuck between the bottom of the bed rail and the bedframe. His/her "face was observed to be swollen and his/her lips were cyanotic (a bluish discoloration of the skin due to low levels of oxygen in the blood). . . ." The resident "was determined to be deceased."[107]

Care staff reported that, for one resident, the resident's body appeared "to be outside the bed with his/her head on the bed with the bottom of the side rail across his/her neck and [the resident] just hanging there, looked terrified. . . ."

- Statement of Deficiencies, CMS

"You can take comfort in knowing that your loved one is in good hands. . . ."

- Nursing Home's Website

In respect to the resident who died entrapped in the bedrail, surveyors determined that the nursing home "failed to ensure that the Medical Director was provided with accurate information" about the incident and "failed to follow acceptable standards related to notification of the Medical Examiner."[108]

The website of the nursing home states: "You can take comfort in knowing that your loved one is in good hands. . . ."[109]

Chemical restraint

A resident at Heritage Green Rehab & Skilled Nursing (NY) documented as having decision-making impairment and who would yell at staff workers was recommended to receive medication for his/her behaviors.[110] Such actions may be viewed as nursing home staff implementing chemical restraints on a resident against their will.

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[106] "Statement of Deficiencies for Julian J. Leavitt Family Jewish Nursing Home," Centers for Medicare & Medicaid Service, August 31, 2017, https://www.medicare.gov/nursinghomecompare/inspectionreportdetail.aspx?ID=225040&SURVEYDATE=08/31/2017&INSPTYPE=CMPL.

[107] *Id*.

[108] *Id*.

[109] The website, https://jgslifecare.org/services/leavitt-family-jewish-home/, was accessed January 4, 2020.

[110] "Statement of Deficiencies for Heritage Green Rehab & Skilled Nursing Facility," Centers for Medicare & Medicaid Service, March 29, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335721&SURVEYDATE=03/29/2019&INSPTYPE=STD.

9. TREATMENT OF INJURIES

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

An elephant's skin must be thoroughly inspected on a daily basis and cared for as needed through bathing, removal of dead skin, and treatment of dry skin or other skin problems. The elephant's skin should be supple, free of dead skin buildup, not cracked or dry and free of folliculitis.
-Accreditation Standards, AZA

Several residents at a for-profit Tennessee nursing home were harmed after the facility failed to prevent and treat their pressure ulcers. One resident, who had not received body audits 35 days of the 37 days since admission, developed a Stage 4 pressure ulcer on their left buttock.
-Statement of Deficiencies, CMS

STANDARDS FOR ANIMAL CARE

Skin care standards. Accreditation standards for the AZA state that "[e]lephants must be trained to accept regular skin care and staff must be trained to provide that care. . .: Each elephant facility must have a written protocol for routine skin care and show evidence of its implementation."[111]

Daily inspections. AZA skin care standards state that "[a]n elephant's skin must be thoroughly inspected on a daily basis and cared for as needed through bathing, removal of dead skin, and treatment of dry skin or other skin problems. The elephant's skin should be supple, free of dead skin buildup, not cracked or dry and free of folliculitis."[112]

STANDARDS FOR NURSING HOME CARE

Federal nursing home standards specifically require that facilities ensure that every "resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and [that a] resident with pressure ulcers receives necessary treatment and

[111] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 3.3.2.3 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[112] *Id.*

services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing."[113] For more information, please see our fact sheet.

RELEVANT NURSING HOME STATISTICS

- **Pressure ulcers.** Over 93,000 current U.S. nursing home residents – 7.3 percent – have pressure ulcers and about 85 percent of nursing home residents are at risk of developing them.[114]
- **Facility-level data:** LTCCC periodically publishes the pressure ulcer rates for every licensed U.S. nursing home and updates on which facilities have been cited for inadequate pressure ulcer care. For the latest data, visit https://nursinghome411.org/other-nursing-home-information/.

NEWS AND REPORTS

Unstageable pressure ulcer

Several residents at a for-profit Tennessee nursing home, The Waters of Robertson, LLC, were harmed because the facility failed to prevent and treat their pressure ulcers.[115] One resident developed an unstageable pressure ulcer on top of their right buttock. Another resident who developed a Stage 4 pressure ulcer on their left buttock had not received body audits 35 days of the 37 days since admission. According to the surveyor, the facility's failure to notify a physician about newly identified pressure ulcers put residents in "Immediate Jeopardy."

Improper skin care

Advanced Subacute Rehabilitation Center at Sewell (NJ) failed to provide appropriate pressure ulcer care and prevent new ulcers from developing for a resident.[116] The facility failed to comply with a physician's orders to apply antipressure heel protective devices to a resident at risk for impaired skin integrity. The resident experienced redness on their right heel following the observation of improper skin care, but the surveyor still cited the violation as no harm.

Failure to initiate treatment

Resthave Home-Whiteside County (IL) failed to prevent and initiate treatment for a wound behind a resident's left ear.[117] The wound, caused by an oxygen tube resting on the ear, could have been prevented by loosening the oxygen tubing and by using foam padding on the tubing, according to the Director of Nursing. Though the resident had the sore for several weeks, the surveyor still cited the violation as no harm.

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[113] 42 C.F.R. § 483.25(b)(1). For more information, see LTCCC's *Fact Sheet: Pressure Ulcers*, available at https://nursinghome411.org/fact-sheet-pressure-ulcers/.

[114] "Issue Alert: Pressure Ulcers," LTCCC, https://nursinghome411.org/ltccc-issue-alert-pressure-ulcers/.

[115] "Statement of Deficiencies for The Waters of Robertson, LLC," Centers for Medicare & Medicaid Service, March 26, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=445137&SURVEYDATE=03/26/2019&INSPTYPE=STD.

[116] "Statement of Deficiencies for Advanced Subacute Rehabilitation Center at Sewell," Centers for Medicare & Medicaid Service, April 11, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=315516&SURVEYDATE=04/11/2019&INSPTYPE=STD.

[117] "Statement of Deficiencies for Resthave Home-Whiteside County," Centers for Medicare & Medicaid Service, March 27, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=146177&SURVEYDATE=03/27/2019&INSPTYPE=STD.

10. APPROPRIATE MEDICATIONS

ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Written, formal procedures must be available to paid and unpaid animal care staff for the use of animal drugs for veterinary purposes, and appropriate security of the drugs must be provided.
-Accreditation Standards, AZA

A certified nursing aide at an Indiana nursing home was accused of administering her own prescription narcotic to three patients who were acting 'disruptively,' reportedly putting her personal Clonazepam (Klonopin) into their food.
-Evansville Courier & Press

STANDARDS FOR ANIMAL CARE

Drug administration. AZA accreditation standards state that "[w]ritten, formal procedures must be available to paid and unpaid animal care staff for the use of animal drugs for veterinary purposes, and appropriate security of the drugs must be provided."[118] Such procedures should include:

- Those persons authorized to administer animal drugs;
- Situations in which drugs are to be utilized;
- Location of animal drugs and the individuals with access to them; and
- Emergency procedures in the event of accidental human exposure.[119]

Storage. According to AZA accreditation standards, "[o]utdated drugs must be marked as such and stored separately from all other drugs. All controlled substances must be stored in a

[118] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 2.2.1 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.
[119] *Id.*

securely locked container of substantial construction appropriate for the types of drugs in the inventory."[120]

STANDARDS FOR NURSING HOME CARE

There are numerous strong standards to ensure that residents receive appropriate medications, free from medication errors, and are not administered antipsychotics (or any drugs) for the convenience of staff. Unfortunately, these requirements are poorly enforced by the state and federal oversight agencies. LTCCC's ***Primer: Essential Nursing Home Quality Standards*** and other materials in our Learning Center provide information and tools to help overcome these challenges.[121]

RELEVANT NURSING HOME STATISTICS

- **Medication errors.** A systematic review published in the *Journal of the American Geriatrics Society* found that 16 to 27 percent of residents in studies were victims of medication errors.[122]
- **Underreporting.** A 2018 study found that nursing homes underreport antipsychotic prescribing. Nursing homes did not identify up to 6,000 residents per calendar quarter as having received antipsychotics despite these prescriptions being paid by Medicare and dispensed by a pharmacy.[123]
- **Pneumonia risk.** A 2019 study found that nursing home residents with Parkinson's disease who were taking inappropriate atypical antipsychotics had an increased risk of pneumonia compared to residents taking appropriate atypical antipsychotics.[124]

NEWS AND REPORTS

Abundance of errors

Lutheran Retirement Home (NY) did not ensure that all medications were administered to residents properly, resulting in a medication error rate greater than five percent.[125] The surveyor detailed several of the facility's medication errors, including one in which staff

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[120] *Id.*

[121] Available at https://nursinghome411.org/ltccc-primer-nursing-home-quality-standards/.

[122] Noha Ferrah et al., "Systematic Review of the Prevalence of Medication Errors Resulting in Hospitalization and Death of Nursing Home Residents," *Journal of American Geriatrics Society* 65 no. 2 (2017): 433-442. Abstract available at https://onlinelibrary.wiley.com/doi/abs/10.1111/jgs.14683.

[123] Becky A. Briesacher et al., "Nursing homes underreport antipsychotic prescribing," *Aging & Mental Health* (2019): 1-5. Abstract available at https://www.ncbi.nlm.nih.gov/pubmed/30724582.

[124] Farid Chekani et al., "Risk of pneumonia associated with atypical antipsychotic use in nursing home residents with Parkinson's disease," *Journal of Psychiatric Research*. 117 (2019): 116-121. Abstract available at https://www.ncbi.nlm.nih.gov/pubmed/31377483.

[125] "Statement of Deficiencies for Lutheran Retirement Home," Centers for Medicare & Medicaid Services, March 18, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335268&SURVEYDATE=03/18/2019&INSPTYPE=STD.

recurringly administered insulin to a diabetic resident after breakfast rather than before.

Galion Pointe, Inc (OH) also recorded a medication error rate greater than five percent.[126] One error occurred when a licensed practical nurse failed to properly prime a FlexPen (a fast-acting insulin) before administering 15 units of insulin. Another error occurred when a resident did not receive artificial tears solution because the medication was not available.

Aide drugs residents with own meds

A certified nursing aide at an Indiana nursing home (Golden Living Center-Woodbridge) was accused of administering her own prescription narcotic to three patients who were acting 'disruptively,' reportedly putting her personal Clonazepam (Klonopin) into their food.[127] [128]

Unaccounted for medication

The Grove at North Huntingdon, a Special Focus Facility in Pennsylvania, failed to account for all medication administered to its residents.[129] The nursing home uses an automated dispensing unit (ADU) which provided packaged medication for residents. A few of these medications were dispensed from the machine but not accounted for in the nursing home's records and were thus susceptible to being abused. Still, the violation was cited as no harm.

[126] "Statement of Deficiencies for Galion Pointe, Inc," Centers for Medicare & Medicaid Services, March 28, 2019, Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=365385&SURVEYDATE=03/28/2019&INSPTYPE=STD.

[127] Jill Lyman, "Former aide at Evansville nursing home accused of drugging residents with own meds," *14 News*, February 20, 2019 https://www.14news.com/2019/02/20/former-aide-evansville-nursing-home-accused-drugging-patients-with-own-meds/.

[128] Tori Fater, "Evansville ex-nursing home employee sentenced for drugging patients," *Evansville Courier & Press*, June 13, 2019, https://www.courierpress.com/story/news/crime/2019/06/13/evansville-ex-nursing-home-employee-sentenced-drugging-patients/1444158001/.

[129] "Statement of Deficiencies for The Grove at North Huntingdon," Centers for Medicare & Medicaid Services, March 7, 2019, Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=395382&SURVEYDATE=03/07/2019&INSPTYPE=CMPL

11. INFECTION CONTROL AND PREVENTION

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 ANIMAL CARE

Infection control. AZA policy for animal contact with the general public states that "[i]t is important to evaluate the risks of zoonotic diseases in a rational context" and that "[m]ost zoonotic diseases of concern in public areas can be prevented with reasonable testing and quarantine programs and proper hand-washing techniques.

Though disease risk, and thus disease control programs, vary by area, "the most effective method for disease prevention is a complete and thorough veterinary program and common sense sanitary measures."[130]

Disease exposure. AZA standards state that "[f]or animals used in offsite programs and for

[130] "Policy for Animal Contact with the General Public," Association of Zoos & Aquariums. Available at https://www.aza.org/policy-for-animal-contact-with-the-general-public.

educational purposes, the institution must have adequate written protocols in place to protect the rest of the animals at the institution from exposure to infectious agents."[131]

Disease prevention. According to the AZA, veterinary care programs "must emphasize disease prevention," implementing preventative medicine programs (vaccinations, TB testing, parasite exams, etc.) for all of their animals" under the direction of a qualified veterinarian.

Disease awareness. 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 (ex – Avian Influenza, Eastern Equine Encephalitis Virus, etc.). Plans should be developed that outline steps to be taken to protect the institution's animals in these situations."

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."[132] 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.[133]
- **Most cited**. Failure to provide sufficient infection control and prevention is the number one cited deficiency in the United States.[134]
- **Care staff fail to wash their hands.** Handwashing is the most common issue that "surveyors keep tripping on" when it comes to infection prevention.[135]
- **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.[136]
- **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.[137]

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[131] "The Accreditation Standards & Related Policies," Association of Zoos & Aquariums, 1.5.5 (2020). Available at https://www.speakcdn.com/assets/2332/aza-accreditation-standards.pdf.

[132] 42 C.F.R. § 483.80. User-friendly resources on nursing home infection control and protection can be found at https://nursinghome411.org/ltccc-webinar-focus-on-care-pressure-ulcers-infection-control/.

[133] Mayuko Uchida et al., "Infection Prevention in Long-Term Care: A Systematic Review of Randomized and Non-Randomized Trials," *Journal of the American Geriatrics Society* 61 no. 4 (2013): 602-14. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3627497/.

[134] Marty Stempniak, "'We have to do better' on infection prevention, CMS official tells LTC nurse managers during new survey update," *McKnight's*, June 29, 2018, https://www.mcknights.com/news/we-have-to-do-better-on-infection-prevention-cms-official-tells-ltc-nurse-managers-during-new-survey-update/.

[135] *Id*.

[136] Nicholas Castle et al., "Nursing home deficiency citations for infection control," *American Journal of Infection Control* 39 no. 4 (2011): 263-269. Abstract available at https://www.ncbi.nlm.nih.gov/pubmed/21531271.

[137] Jordan Rau, "Infection Lapses Rampant In Nursing Homes But Punishment Is Rare," *Kaiser Health News*, December 22, 2017, https://khn.org/news/infection-lapses-rampant-in-nursing-homes-but-punishment-is-rare/.

NEWS AND REPORTS

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.[138] The surveyor cited the facility for failing to properly follow the facility assessment requirements, noting the facility "failed to evaluate resident population and identify the resources needed to provide the necessary care and services required for residents during . . . [the] outbreak."[139] The surveyor added that "the failure placed the facility's other residents [those that did not die or not transferred to a hospital] in immediate jeopardy of contracting adenovirus infections, with the likelihood to cause serious harm, impairment, or death." The deadly adenovirus outbreak demonstrates the importance of conducting thorough and frequent assessments of what resources are needed to properly care for residents every day.

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.[140] 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.[141] The surveyor found that the facility did not consistently follow transmission-based precautions related to use of personal protective equipment 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.

South Mountain Restoration Center (PA) failed to ensure that proper infection control practices were followed during an influenza outbreak.[142] Though seven residents were tested positive for flu, the surveyor still cited the violation as no harm.

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[138] "Center Comments on Proposed Rule to Revise Nursing Home Requirements of Participation," LTCCC and Center for Medicare Advocacy, September 15, 2019, https://www.medicareadvocacy.org/center-comments-on-proposed-rule-to-revise-nursing-home-requirements-of-participation/.

[139] "Statement of Deficiencies for Wanaque Center for Nursing & Rehabilitation," Centers for Medicare & Medicaid Services, November 17, 2018, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=315229&SURVEYDATE=11/17/2018&INSPTYPE=STD&profTab=1&Distn=6755.3&state=NJ&lat=0&lng=0&name=WANAQUE%20CENTER%20FOR%20NURSING%20%26%20REHABILITATION%2C%20THE.

[140] Jordan Rau, "Infection Lapses Rampant In Nursing Homes But Punishment Is Rare," *Kaiser Health News*, December 22, 2017, https://khn.org/news/infection-lapses-rampant-in-nursing-homes-but-punishment-is-rare/.

[141] "Statement of Deficiencies for Life Care Center of Auburn," Centers for Medicare & Medicaid Services, February 20, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=225661&SURVEYDATE=02/20/2019&INSPTYPE=STD.

[142] "Statement of Deficiencies for South Mountain Restoration Center," Centers for Medicare & Medicaid Services, February 7, 2019, https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=395583&SURVEYDATE=02/07/2019&INSPTYPE=STD.

Conclusion

For far too many nursing home residents, adequate care, treatment with dignity, and the basic comforts of life are out of reach. Though nursing home standards are strong, the promise of those standards is frequently broken. As discussed in this report, decades of rigorous studies, Congressional hearings, news reports, and the nursing home industry's own self-reported data all indicate that problems are significant, widespread, and persistent. As many distraught family members have said to us over the years, "they wouldn't treat a dog" the way their loved one was treated in their nursing home.

For far too many nursing home residents, adequate care, treatment with dignity, and the basic comforts of life are out of reach.

That grievance served as an impetus for our research and this report. We know that, too often, the resident experience falls far short of the promise that nursing homes make to residents when they enter a facility and the requirements for nursing home care under federal law and regulations. But how do these residents' experiences stack up against the requirements for animal care?

Our findings indicate that, in addition to failing to meet expectations for care of *humans*, nursing home care too often fails to even meet requirements and expectations for *animal* care and handling. In the absence of meaningful enforcement of nursing home standards, facilities are free to flout those standards with impunity. This results in unnecessary resident suffering, family heartbreak, and a waste of untold millions of dollars in taxpayer funds every year.

IT DOES NOT HAVE TO BE THIS WAY

Resident-Centered Advocacy

Throughout this report, we provide links to free resources that residents and their representatives can use to be informed about their rights and advocate for better care and treatment in respect to the specific issue of concern.

Monitoring & Enforcement

We hope that this report will help raise awareness among our state and federal elected officials and agencies that the situation for nursing home residents is increasingly dire. In the face of damning evidence of widespread abuse and neglect, the federal oversight agency, the Centers for Medicare and Medicaid Services (CMS), is reducing – rather than increasing – accountability for quality and safety. In 2017, CMS implemented policies to reduce already low penalties for resident abuse and neglect. In 2019, it proposed to reduce a range of essential care standards. As of this writing (January 2020), the agency's administrator is calling for relaxing the requirement that all facilities are inspected annually. If implemented, this change would likely be catastrophic for residents and families. As the experiences and data presented in this report show, more effective quality assurance and enforcement are needed to ensure that residents do not face inhumane care and conditions.[143]

[143] For more information on these actions, and their impacts on resident safety, please see the Comments and Statements page of our website at https://nursinghome411.org/news-reports/comments-and-statements/.