Pressure Ulcers: Identifying Poor Care and Resident Harm

Pressure ulcers — also known as pressure injuries or bedsores — are serious wounds and an important indicator of nursing home quality. While not every pressure ulcer is preventable, research indicates that, "[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer formation."[27] According to the Centers for Disease Control and Prevention, "[p]ressure ulcers… are serious medical conditions and **one of the important measures of the quality of clinical care in nursing homes**."[28]

For these reasons, **federal requirements place substantial responsibilities on nursing homes to identify residents at risk, implement appropriate preventive interventions, and provide treatment to heal existing pressure ulcers and prevent infection and additional wounds**. Failure to provide care that comports with these minimum standards is coded as a violation under F686. Importantly, CMS states that a resident need not actually develop a pressure ulcer for noncompliance to exist when a facility fails to implement necessary preventive interventions.

Pressure ulcers therefore provide an especially useful lens through which to assess nursing home oversight. We can compare an independently reported measure of the problem — the number of residents reported through the Minimum Data Set (MDS) as having an unhealed pressure ulcer — with the frequency with which state survey agencies identify violations of the federal pressure-ulcer standard and, when they do, whether they identify the extent to which residents suffered harm.

Important Note: Both quantitative research and direct reports from families over the years indicate that, too often, facilities fail to identify – much less treat – pressure ulcers. Thus, the **public data on pressure ulcer rates understate the true breadth of the problem**. According to a national study using hospital data, nursing homes only reported 67.7% of stage 3 or 4 pressure ulcers.[29]

FINDING: PRESSURE ULCERS ARE A SERIOUS AND PERSISTENT PROBLEM

Even with under-reporting, pressure ulcers were a remarkably significant and persistent problem throughout the period studied. In the fourth quarter of 2022, nursing homes reported **93,770 residents with an unhealed pressure ulcer, or 8.18% of residents**. The number increased to **95,240 residents (8.09%) in 2023** and stood at **94,724 residents (7.92%) in 2024**.

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[27] Edsberg, L., Langemo, D., Baharestani, M., Posthauer, M., & Goldberg, M., "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy & Continence Nursing*, 2014; 41(4), 313–334. https://doi.org/10.1097/WON.0000000000000050.

[28] Park-Lee, E. and Caffrey, C., *Pressure Ulcers Among Nursing Home Residents: United States*, *2004*. Available at www.cdc.gov/nchs/data/databriefs/db14.pdf.

[29] Sanghavi P, Chen Z., "Underreporting of Quality Measures and Associated Facility Characteristics and Racial Disparities in US Nursing Home Ratings," *JAMA Netw Open.* 2023; 6(5):e2314822. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805170.

Finding: Citations for Inadequate Pressure-Ulcer Care are Rare

Given the fact that pressure ulcers are widely acknowledged as a serious concern in nursing homes and are unambiguously (clinically speaking) a harmful event, citation data provide a valuable context for evaluating the effectiveness of state oversight of nursing home quality.

State survey agencies issued **3,052 F686 citations in 2022, 2,895 in 2023, and 2,916 in 2024**. Relative to the number of residents reported with unhealed pressure ulcers, this equated nationally to approximately **3.25 citations for every 100 residents with a reported pressure ulcer in 2022, 3.04 in 2023, and 3.08 in 2024**.

The national results are similar to those found in our previous report on nursing home oversight, *Broken Promises*, which covered 2018-2020. That study found that survey agencies issued the equivalent of fewer than three F686 citations per 100 residents with reported pressure ulcers during those three years.

Finding: Where a Resident Lives Matters — Identifying Inadequate Care

The national rate obscures enormous differences among states. Across the three study years, **Wisconsin issued approximately 10.5 F686 citations for every 100 residents reported with pressure ulcers**, followed by **Rhode Island (9.4), Illinois (8.9), Kansas (8.5), and Michigan (7.4)**.

At the other end of the distribution, **Alabama issued approximately 0.3 citations per 100 residents reported with pressure ulcers**, followed by **Kentucky (0.34), New York (0.60), Florida (0.73), and Tennessee (0.79)**. Wisconsin's resident-adjusted citation rate was therefore approximately **35 times Alabama's** and more than **17 times New York's** over the study period.

A state's low citation activity cannot simply be assumed to reflect an absence of the underlying resident-care problem.

These findings provide important insight into the extent to which state survey agencies are identifying and responding to inadequate pressure ulcer care. Pressure ulcers are wounds, and clinical evidence indicates that they are generally preventable and, when they occur, responsive to appropriate treatment. The substantial differences between the prevalence of reported pressure ulcers and the frequency with which states cite inadequate pressure ulcer care therefore raise meaningful questions about the effectiveness and consistency of state oversight. The data do not establish that every resident with a pressure ulcer experienced deficient care. However, the persistence of pressure ulcers, comparatively low rates of F686 citations, and substantial variation among states provide important evidence for assessing how effectively survey agencies are identifying failures to meet this critical federal care standard.

Finding: Surveyors Usually Do Not Identify Harm Even When They Find Substandard Pressure Ulcer Care

The extent to which surveyors identify harm when citing substandard care is critical because, unless harm or immediate jeopardy are cited, it is very unlikely that the facility will face any penalty for the violation. Thus, **our findings in respect to surveyors' categorization of the**

severity of pressure ulcer violations raise a separate and significant accountability concern. Of the 3,052 F686 citations issued nationally in 2022, 851 — 27.9% — were classified at G or above, meaning that surveyors identified actual harm or immediate jeopardy.[30] The proportion declined to 25.8% in 2023 and 24.6% in 2024.

In other words, **surveyors persistently classified approximately three-quarters of substantiated violations of pressure ulcer prevention and treatment standards as not resulting in any resident harm**.

This finding warrants particular attention given the nature of pressure ulcers and the requirements of F686. Pressure ulcers are, by definition, injuries involving damage to the skin and underlying tissue, and clinical evidence indicates that they are generally preventable and/or responsive to appropriate treatment. CMS guidance provides explicit examples in which deficient pressure ulcer care constitutes actual harm or immediate jeopardy.

The fact that surveyors classified approximately three-quarters of all pressure ulcer care violations as "no-harm" raises serious questions about whether surveyors are accurately identifying the impact of substandard care and neglect on residents.

A facility could feasibly be cited when it fails to implement necessary preventive interventions even when a pressure ulcer has not developed. But that limited exception should not obscure the significance of the overall finding. Where a facility's failure contributes to the development or worsening of a pressure ulcer, or results in inadequate treatment of an existing wound, a finding below the level of actual harm warrants serious scrutiny**.** Against that backdrop, the fact that surveyors classified approximately three-quarters of all pressure ulcer care violations as "no-harm" raises serious questions about whether surveyors are accurately identifying the impact of substandard care and neglect on residents. **If a pressure ulcer is not a sufficient basis for identifying that a resident has suffered harm, what is?**

The persistence of this finding is also notable. Our previous study, *Broken Promises*, found that surveyors identified harm or immediate jeopardy in approximately **23% of pressure-ulcer citations** during 2018–2020. In the current period, the national G+ rate was slightly higher, but still only about one-quarter of citations.

FINDING: WHERE A RESIDENT LIVES MATTERS — IDENTIFYING RESIDENT HARM

Here again, state differences were substantial. Across the three years, **surveyors classified more than half of F686 citations at G+ in several states, including Idaho, South Dakota, Montana, Colorado, Utah, Kentucky, and Vermont**.[31] By contrast, **Alabama, Alaska, and New Hampshire recorded no G+ F686 citations during the three-year period**. Nevada identified

[30] For more on how surveyors identify and rank violations of minimum care standards, see our *Guide to Nursing Home Oversight & Enforcement*, available at https://nursinghome411.org/reports-studies/guide-oversight/.
[31] Several of these percentages are based on relatively small numbers of citations and should be interpreted accordingly.

harm or immediate jeopardy in only approximately 3% of its F686 citations, Maryland in about 6%, Arkansas in about 7%, and Louisiana in about 8%.

Importantly, these differences should not be interpreted as evidence that states with comparatively high G+ rates are providing strong or effective oversight. Even in states that identified harm more frequently, substantial numbers of violations of the federal pressure-ulcer minimum standard were still classified as no harm. More fundamentally, the federal requirements are resident-centered: facilities are required to provide the care and services necessary to prevent avoidable pressure ulcers and promote healing for every resident they admit and retain, based on that resident's needs. **The relevant benchmark is therefore not whether one state identifies harm more frequently than another, but whether state oversight is effectively ensuring that these protections are realized in the lives of residents 24/7,** as required by federal law and regulation.

The differences among states matter, but they occur within a broader context of very limited identification of deficient care and resident harm.

This distinction is particularly important when considering the longstanding argument made by industry lobbyists that variations in state performance are unfair to nursing homes. **The results provide evidence of a regulatory system that, across every state, identifies deficient pressure ulcer care and resulting resident harm at levels that are difficult to reconcile with the prevalence and seriousness of the underlying problem**. The differences among states matter, but they occur within a broader context of very limited identification of deficient care and resident harm. Industry lobbyists may argue that variation in state agency performance is unfair to providers; the more consequential concern raised by these findings is that residents receive markedly different, and often very limited, regulatory protection depending on where they live.

These findings are also important in the context of the broader enforcement trends identified in this report. Financial penalties declined sharply from 2022 through 2024, while the prevalence of reported pressure ulcers changed little. Thus, the decline in penalties was not accompanied by a comparable improvement in this important measure of resident care, reinforcing concerns about whether deficient care and resulting resident harm are being consistently identified and addressed.

For information on individual state performance, see the file "State Citations Pressure Ulcers 2022 2023 2024" at https://nursinghome411.org/ltccc-enforcement-study-2026/.