

BROKEN PROMISES

**An Interim Assessment of the District of Columbia's Initiatives
to Improve Quality of Care in Nursing Facilities
2002 - 2003**

Prepared by

**The District of Columbia Long-Term Care
Ombudsman Program**

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BACKGROUND

In 2001, at the urging of the D.C. Long-Term Care Ombudsman Program and AARP's D.C. Office, Congresswoman Eleanor Holmes Norton requested the Special Investigations Division of the Committee on Government Reform of the U.S. House of Representatives to prepare a report on nursing home care in the District of Columbia. The Ombudsman Program, other advocacy groups, and the AARP members were concerned about the quality of care in the District's nursing homes, the lack of enforcement of federal regulations, the lax investigation of Ombudsman Program complaints by the Health Regulation Administration of the D.C. Department of Health, and the failure of the Department of Health to issue the D.C. nursing home regulations that had been in development, with the input of advocates and providers, since 1999.

A draft of the Congressional Report, Nursing Home Conditions in the District of Columbia: Many Homes Fail to Meet Federal Standards for Adequate Care, was issued November 26, 2001, and provided to the Mayor and the D.C. Department of Health prior to its release to enable the District government to prepare a response. That response was presented at a press conference held on January 7, 2002, at which Congresswoman Norton officially released the report.

As part of their response to the Congressional report, Mayor Williams and representatives of the Department of Health announced that the long-delayed nursing home regulations would finally be issued. In referring to the District's status as the only jurisdiction in the country without regulations, Mayor Williams stated: "This has got to be unacceptable to me, because it is certainly unacceptable to families of seniors." The Mayor went on to declare: "It's a sin and a crime not to have regulations."

In addition to promising to finalize the regulations, the Department of Health distributed a document at the press conference, entitled "Initiatives to Improve Quality of Care in District of Columbia Nursing Facilities." In this document, the Department of Health promised, among other things, to:

- create "an enforcement mechanism to compel compliance" through "the use of citations for deficiencies and accompanying civil fines";
- "triple its surveyor staff to meet the need for increased monitoring of nursing facilities";

- further increase the nursing facility survey staff to form “an investigative/complaint unit”;
- develop a Disability and Aging Resource Center to “serve the dual function of empowering consumers to make informed choices about their long-term care options and creating a mechanism to assist in channeling individuals in need of long-term care to the most cost-effective setting”;
- establish a “case-mix system” for nursing facility reimbursement by “October 2002”; and
- establish “a unit within MAA/ODA that will focus on continuous quality improvement,” by “organizing and supplying training to providers and staff to improve the quality of care.”

CURRENT SITUATION

A. Department of Health Initiatives Have Not Been Implemented

Sadly, almost two years after the District government assured its citizens that it was working to improve nursing home quality, the Department of Health has failed to follow through on its promises:

- No implementation or enforcement of the January 2002 nursing home regulations has occurred.¹
- No increases in survey staff sufficient to properly monitor nursing homes and investigate complaints have occurred.
- Not one deficiency has been cited and not one penalty has been imposed against a nursing home on the basis of the January 2002 regulations.
- No case-mix system has been implemented.
- No Disability and Aging Resource Center has been developed.

B. Inadequate Nursing Home Care and Enforcement Continues

The Ombudsman Program is unaware of any progress made by the Department of Health to improve nursing home care since the inception of the January 7, 2002 regulations. It has also been observed by the Ombudsman Program that the overall quality of care and services in the District’s nursing homes has continued to decline since

¹ Refer to page 4 for clarification of federal nursing home survey process.

the last Congressional report. As the following pages illustrate, serious problems in D.C. nursing homes have been documented in surveys conducted by the Department of Health's Health Regulation Administration in 2002 and 2003, but **no deficiencies have been cited or penalties or sanctions imposed under the D.C. nursing home regulations.** In addition, complaints to the Ombudsman Program grew to over 2,040 in 2002, a 10.5% increase over 2001, and to approximately 2200 so far in 2003. In 2002, 1,810 of those complaints concerned nursing home care. In 2003, 1,988 so far have concerned nursing home care. In 2002, 191 nursing home complaints were serious enough to be referred to the Department of Health and/or other agencies for regulatory action. To date in 2003, 103 nursing home complaints were serious enough to be referred to the Department of Health and/or other agencies for regulatory action. However, **not one of these complaints resulted in a citation against a nursing home or any fine or sanction under the D.C. nursing home regulations.**

At the same time that the District has not enforced its own nursing home regulations, the Department of Health has also provided only weak enforcement of federal nursing home regulations. Under the federal nursing home regulatory system, every state and the District of Columbia has a contract with the Centers for Medicaid and Medicare Services (CMS), U.S. Department of Health and Human Services, to survey all nursing homes in the state that receive Medicaid or Medicare funding to ensure compliance with minimal standards of care set by the Omnibus Reconciliation Act of 1987 (generally known as OBRA'87) and by the Nursing Home Reform Amendments of 1990. In the District, the Health Regulation Administration (HRA) of the D.C. Department of Health is the agency funded by CMS to conduct surveys of District nursing homes to determine whether or not they meet federal standards of care. Surveyors use the following scope and severity grid developed by CMS to rate deficiencies:

Severity of Deficiency	Scope of Deficiency		
CMS Enforcement Grid			
Immediate Jeopardy	J	K	L
Actual Harm	G	H	I
Potential for More than Minimal Harm	D	E	F
No Actual Harm	A	B	C
	Isolated Incident	Pattern of Harm	Widespread Harm

Under CMS Guidelines, "A" violations are simply mentioned in the survey report with no response required from the nursing home. Violations rated from "B" to "F"

require the nursing home to do nothing more than submit a plan of correction, although in certain cases (but so far not in the District), a civil penalty may be imposed for “D.” Whether or not that plan of correction is actually implemented and actually corrects the violation is rarely addressed in the District. It should also be noted that a facility is considered “in substantial compliance” with federal standards if it receives no deficiencies above a “C,” regardless of how many “A,” “B,” and “C” deficiencies are cited. Any violation rated a “G” or above may be recommended by the HRA for a civil monetary penalty in addition to a plan of correction. Other remedies are possible for deficiencies rated “G” and above, including (for “J” to “L” violations) denial of payment for new admissions, disqualification from Medicare and/or Medicaid payments, and placement of a receiver or temporary manager in the nursing home. In the District, surveyors very infrequently rate a deficiency at “G” or above.

Because HRA surveyors generally rate nursing home violations of care standards under the federal system at only “B” through “F,” District nursing home deficiencies rarely lead to federal penalties or sanctions. In fact, on the basis of the surveys conducted for CMS by HRA, only \$42, 732.50 in civil monetary penalties has been imposed on District nursing homes since January 2002. In addition, no other remedies or sanctions, other than plans of correction, have been required. However, as the following pages of examples demonstrate, the seriousness of the violations that have actually occurred in District nursing homes is not reflected by the small number, and minimal amount, of fines collected under federal guidelines.

The disparity between the seriousness of nursing home deficiencies and the small number and amount of fines imposed is a direct result of HRA surveyors under-rating the scope and severity of deficiencies in District nursing homes. Another result is that the same violations are repeated year after year in the same facilities without correction, because District nursing homes suffer **few consequences under federal law** for poor care and **no consequences under District law**. It is not surprising, then, that the District was rated, in June 2002, as having the second least effective nursing home enforcement system in the United States.²

1. Examples of Inadequate Care

The following are just some examples of deficient care that were identified in the 2002 and 2003 nursing home surveys completed by the Health Regulation Administration for the Centers for Medicaid and Medicare Services. As noted above, **no deficiencies were cited or fines imposed for these violations of care standards under the D.C. nursing home regulations**. The complete surveys are available to the public from CMS, the D.C. Department of Health, and individual nursing homes in the District of Columbia.³

² See, Charlene Harrington, “Nursing Home Quality: State Agency Survey Funding and Performance,” a Kaiser Commission Issue Paper, Kaiser Family Foundation, 2002.

³ The D.C. Long-Term Care Ombudsman Program has not received or completed review and analysis of all of the 2002 and 2003 survey reports, and intends to issue a full report at a later date.

- The facility failed to provide care and services in accordance with acceptable standards of practice in six out of ten sampled cases, as evidenced by failure to schedule a diagnostic study until two weeks after the doctor ordered one, failure to perform treatments ordered for a resident with multiple pressure sores, failure to follow an order to replace a catheter and an order to discontinue contact isolation for a resident, failure to ensure that an order for an appetite stimulant was followed through, failure to follow up on abnormal protein and albumin blood levels for a resident with a weight loss of over 10 pounds (from 92.5 to 81.8 pounds) in less than three months, and failure to obtain blood levels as required for a resident on Coumadin therapy.
 - The facility's physician failed to review the plan of care for six of ten sampled residents by failing to follow up on an elevated PSA level (indication of prostate cancer); changes and continual declines in white blood cell counts; a radiologist's order to repeat an abdominal x-ray; orders to replace a catheter; orders for catheter and colostomy care; orders for blood sugar fingersticks and other lab tests for a resident with a history of diabetes who was taking Coumadin and who received dialysis 3 times per week.
 - The facility failed to provide necessary care and services as evidenced by: the absence of documented evidence that sliding scale insulin coverage for three of thirteen sampled diabetic residents was provided as ordered by physician; the failure to treat a resident's bunion or use a cleansing agent as ordered by a physician; and the failure to administer physician ordered laboratory tests.
 - The facility failed to provide necessary care and services as evidenced by failure of staff to: administer correct pressure sore treatment for one resident; maintain a clean barrier between a soiled draw sheet and an uncovered sacral pressure sore during cleaning; and prevent the spread of infection by not cleaning shower chairs, wall surfaces, handrails, and floor surfaces in bathing areas covered with human excrement.
 - The facility failed to maintain residents' right to be free from physical restraints by failing to use alternative strategies prior to implementing restraints for four of thirty sampled residents, failure to re-evaluate restraints for possible restraint reduction for the residents, and failure to obtain a physician's order for restraints, as required, for one resident.
 - The facility failed to provide, and to have adequate licensed nursing staff to provide, necessary care and services for eighteen of thirty sampled residents and five of twenty supplemental residents by failing to: follow up on medical consults, administer medications ordered by physician, administer insulin and/or fingersticks as ordered by physician, follow up on lab results, change
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connectors for feeding tubes as ordered by physician, follow up on a resident's fall, follow up on an abnormal chest x-ray, inquire about continued use of a splint for a resident returning from the hospital, follow up on weight loss as ordered, implement dietary orders, perform speech and swallow screenings, schedule follow-up clinical appointments for residents, and correctly transcribe and consistently administer anti-coagulants.

- The facility failed to develop or revise care plans for twelve of thirty sampled residents with foley catheters, mood and behavior problems, anticoagulation therapy needs, orthotic devices and physical therapy target dates that required updating, elopement problems, dialysis, restraints, pain management needs, pressure sores, and gastrostomy tubes.
- Facility had a medication error rate of 8% in observed medication administrations, including two significant errors.
- Facility's physician failed to review complete plans of care for six of thirty sampled residents as evidenced by failure to follow up on lab reports, order medications previously prescribed, accurately fill out medical histories, order supplements for residents with weight loss, and follow up on chest x-ray.
- Physician visits to four of thirty sampled residents did not occur within required time limits: at least once every 30 days for first 90 days after admission and at least once every 60 days thereafter, including failure of physician to visit for 60 days a resident who returned from the hospital with a diagnosis of cancer, to review her discharge summary, and to arrange for follow-up treatment within 10-14 days as ordered by the hospital oncologist.
- Facility failed to provide five sampled residents with medications prescribed by their physicians.
- Facility staff failed to provide necessary care and services as evidenced by failure to consistently administer insulin and eye drops, do ordered fingersticks for blood glucose for diabetic residents, and ensure that a resident with a weight loss of nine pounds in three months received the correct diet.
- Facility staff failed to provide care and services in accordance with acceptable standards of practice for three of eighteen sampled residents as evidenced by failure to: administer insulin within the parameters of sliding scale coverage to diabetic residents; follow up on a Dilantin level for a resident whose prior level was toxic; and administer medications as ordered by the physician for a resident on dialysis whose medication was frequently omitted on dialysis days.

- The facility failed to ensure that hot water temperatures were safe in resident baths and showers: one hundred percent of the water temperatures tested in residents rooms were above the 95 to 110 degree Fahrenheit standard.
- Facility staff failed to provide care and services in accordance with acceptable standards of practice for eight of twenty eight sampled residents by failing to administer eye drops as ordered, perform weekly weight checks as ordered, document behavior symptoms for resident on antipsychotic medication, follow up on two orders requesting speech evaluations for diet change, follow up on a hearing evaluation, provide insulin coverage for residents' elevated blood sugar levels, follow up with a psychiatric consult after a resident exhibited aggressive behavior towards another resident, administer B12 injections as ordered, accurately assess a resident's pupils after a head injury, and administer oral care to a tracheostomy resident as outlined in the care plan.
- The facility discontinued physician ordered medicine for one resident without consulting a physician and failed to seek a physician's order to discontinue another resident's medication.
- Dietary staff failed to follow proper procedures to ensure that foods are prepared, served, and stored in a sanitary manner as evidenced by: equipment not functioning properly on the tray line; an upright freezer in the main kitchen failing to maintain cold food temperature below zero degrees Fahrenheit; soiled products on the interior of the ice machine; soiled serving plates, plastic coffee cups, soiled juice glasses; soiled tray on the clean side of the dishwasher tray; soiled sheet pans; soiled counter in the salad preparation area; cold and hot foods served above and or below acceptable ranges; staff transporting food in the hallway without covering.
- Facility staff failed to provide care and services in accordance with acceptable standards of practice for six of 27 sampled residents and 1 supplemental resident by failing to follow up on a Dilantin level that was subsequently toxic, failing to administer ordered medications to a resident receiving dialysis, failing to complete pacemaker checks every three months as ordered, failing to obtain weight checks and administer medications as ordered, failing to obtain a blood specimen as ordered, and failing to implement ordered dietary interventions.
- The facility failed to provide housekeeping and maintenance services adequate to ensure the facility was maintained in a safe and sanitary manner as evidenced by soiled top surfaces of residents' closets; clogged sinks in residents' rooms; soiled surfaces of HVAC Units, filters, and smoking room vents; bedframe surfaces soiled with dust; wall protector guards not secured to walls; interior surfaces of vents soiled with dust; marred residents' bathroom and entrance doors; soiled draperies not secured to hooks; unsecured door knobs and handles; soiled floor surfaces, wheelchairs, and a linen transport cart; worn, torn, and damaged mattresses; dusty overbed lamp surfaces; improper storage of supplies

under sinks; missing lamp covers in showers and tub rooms; damaged wheelchair and gerichair armrests; damaged walls in soiled utility rooms and common areas; soiled janitorial closet floors and sinks; soiled baseboards in residents' rooms and common areas; soiled janitorial closet floors and sinks; soiled baseboards in residents' rooms and common areas; soiled ceiling tiles; soiled and damaged privacy curtains in residents' rooms; cleaning equipment stored on closet floors; and wallpaper separated at the seams in hallways.

- Facility failed to comply with Life Safety Code Standard by failing to ensure doors in corridors and smoke barriers met fire resistant standards and sprinkler system and fire protection equipment were in proper operating condition.
- Facility failed to provide the necessary care and services for seven of twenty eight sampled residents as evidenced by: failure to monitor a resident on restricted fluid intake orders; submission of a referral to the pain clinic over one month after it was ordered; failure to ensure a physician ordered test was administered; use of a syringe to administer medicine to a gastrostomy tube; failure to provide a physician ordered diet; failure to promptly obtain physician ordered x-rays; and failure to promptly obtain an ordered stool culture.
- Facility failed to ensure that residents were free of any significant medication errors by allowing a resident to be given the wrong dosage for twelve days.
- The facility failed to maintain a call system at the nurse's station to receive calls from resident rooms.
- Facility staff failed to provide necessary care and services as evidenced by: failure to administer 14 doses of morphine, failure to document the reason for not giving 6 of the doses, and failure to follow the care plans for 3 of 27 sampled residents.
- Facility staff failed to provide care and services in accordance with acceptable standards of practice for 5 of 30 sampled residents by failing to: obtain the results of a CT scan; follow physician's orders to increase Lasix dosage; discontinue an antithrombotic medication; transcribe a discontinued order for an antihypertensive resulting in resident receiving the medication for an extra 30 days; and provide prescribed antithrombolytic stockings.
- Facility failed to provide 1 of 3 sampled residents with adequate supervision by failing to provide care and services to prevent the fall and hospitalization of a resident having a history of seizures and unsteady gait.
- Physician failed to review 4 of 30 sampled plans of care by: failing to include a diagnosis of diabetes mellitus on one medical history; documenting inaccurate

findings for the extremities of a resident who had gangrene and a stage 4 ulcer on one foot; signing 60 day orders for a prior discontinued medication; and failing to follow up on an abnormal screening test for prostate cancer.

- Facility staff failed to maintain professional standards by failing to: follow through on ordered labs for residents; follow facility policy for insulin administration and notification to physician of abnormal lab results; follow through on order for psychiatric evaluation; obtain ordered blood test; obtain pacemaker checks for a resident with “potential for cardiac distress related to pacemaker placement;” and obtain stool for ordered occult blood test.
- Facility staff failed to identify a pattern of repeated falls or to implement measures to prevent injury to resident who sustained six falls between 11/6/2002 and 1/22/2003.
- Facility failed to provide care and services in accordance with acceptable standards of practice for 10 of 30 sampled residents by failing to: pre-medicate a resident before a dressing change; obtain an order for foley catheter care and to change the catheter; obtain an order for pacemaker checks every 3 months as ordered and to check the pacemaker; notify physician after identifying pressure sores and treat them; schedule an ordered dental exam; obtain stool samples and urinalyses as ordered; transcribe a diet order correctly; apply a splint as ordered; and obtain orders to perform pressure sore treatments.
- Facility failed to provide adequate supervision to prevent accidents to resident who sustained 3 fall related injuries in five months that required hospitalization.
- Facility failed to follow correct infection control procedures to prevent contamination during treatment for 2 of 4 residents with pressure sores and one resident when drawing blood.
- Facility staff failed to provide the necessary care and services to 7 of 42 residents as evidenced by failure to: interpret a blood glucose reading before treating for hypoglycemia resulting in the resident’s hospitalization; clarify a blood specimen as ordered by the physician; provide adequate water to resident as ordered by the physician; implement interventions as recommended to manage aggressive behaviors; and administer prescribed medication as ordered by the physician to 3 of 10 sampled residents.

2. Examples of Inadequate Enforcement:

The following are simply a few examples of the ratings given by the D.C. Department of Health to the deficiencies described above and identified in District nursing homes surveys between January 2002 and the present.⁴ The comment section provides the Ombudsman Program’s assessment of the ratings given by the Health Regulation Administration (HRA) to the deficiencies described. The comments focus on the under-rating of deficiencies, the improper scope and severity ratings issued, and the inconsistencies in the rating process. These enforcement weaknesses continue to result in different nursing homes receiving different ratings for the same violations and in the inability of CMS to assess fines or other sanctions against nursing homes delivering substandard care.

Violation: Facility staff failed to develop and revise care plans for 3 of 10 residents to address daily pain, marked swelling of extremities, pacemaker monitoring, and anti-thrombotic therapy.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for an isolated incident. Three out of 10 residents indicates a pattern of harm and the rating should be at least an **E**. Moreover, failure to address daily pain results in actual pain, and a rating of **H** should have been given to indicate “actual harm.”

Violation: Facility staff failed to develop care plans for one resident with chronic urinary tract infections and one resident with an indwelling foley catheter.

Rating: **B** (pattern; no actual harm; facility in substantial compliance)

Comment: **B** is given for a violation resulting in no actual harm. Failure to have care plans for residents with chronic infections and indwelling catheters has at least the potential for minimal harm and may have resulted in actual harm (recurrent infections). The rating should be at least an **E** and possibly an **H**. In addition, the same violation (failure to develop care plans) in a different nursing home (see previous example) was rated **E** rather than **B**.

Violation: Facility failed to take appropriate action to prevent potential for accidental injury to staff and residents from unsecured compressed oxygen tank.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for an isolated incident. Potential injury “to staff and residents” suggests potential widespread harm and the rating should be an **F**.

Violation: Facility failed to prevent the spread of infection by not cleaning shower chairs, wall surfaces, handrails, and floor surfaces in bathing areas covered with human excrement.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for an isolated incident. Failure to prevent the spread of infection by not cleaning bathing areas suggests potential harm to all residents, and the rating should be an **F**.

⁴ See the “CMS Enforcement Grid” on p.4 of this report.

Violation: Facility failed to maintain residents' right to be free from physical restraints by failing to use alternative strategies prior to implementing restraints for 4 of 30 residents, to re-evaluate restraints for possible restraint reduction for 4 residents, and to obtain a physician's order for restraints, as required, for one resident.

Rating: **C** (widespread; no actual harm; facility in substantial compliance)

Comment: **C** is given for widespread practices resulting in "no actual harm." Physically restraining residents results not only in the potential for more than minimal physical harm, but also in actual psychological and emotional harm. No assessment was made of the possible actual physical harm to the residents, nor was psychological harm addressed. The rating should have been at least an **F**, and further assessment should have been done to determine whether or not **I** was warranted.

Violation: The facility failed to provide necessary care and services for 18 of 30 sampled residents and 5 of 20 supplemental residents as evidenced by failing to follow up on medical consults (6 residents), administer medications ordered by physician (7 residents), administer insulin and/or fingersticks as ordered by physician (7 residents), follow up on lab results (3 residents), change connectors for G-tubes as ordered by physician (2 residents), follow up on a fall, follow up on an x-ray, check on continued use of a splint for resident returning from the hospital, follow up on weight loss as ordered (3 residents), implement dietary orders (2 residents), perform speech screenings (3 residents), schedule follow-up clinical appointments (2 residents), correctly transcribe and consistently administer anti-coagulant.

Rating: **G** (isolated; actual harm to health/safety)

Comment: **G** is given for isolated incidents. In this case, 18 out of 30 residents lacked necessary care and services, so the rating should be at least an **H**. In addition, when more than half of the residents are not receiving basic health care services, "immediate jeopardy to the residents' health" exists, and a rating of **K** is appropriate.

Violation: The facility failed to provide care and services in accordance with acceptable standards of practice in six out of 10 cases as evidenced by failure to follow up on abnormal lab values (including an elevated PSA, which indicates the possibility of prostate cancer) for 3 residents and on a radiologist's order to repeat an x-ray; schedule a diagnostic study until 2 weeks after doctor ordered it; perform treatments ordered for resident with multiple pressure sores; follow orders to replace a catheter; follow an order to discontinue contact isolation for a resident, ensure that order for appetite stimulant was followed through, follow up on abnormal protein and albumin blood levels for resident with weight loss of over 10 pounds (92.5 to 81.8) in less than 3 months, obtain blood levels as ordered for resident on Coumadin therapy.

Rating: **E** (pattern; potential for more than minimal harm)

Comment: **E** is given for violations having the potential for more than minimal harm. Actual harm may have occurred in all of these cases and certainly in cases of residents with pressure sores and weight loss. Consequently, the rating should have been at least an **H** to reflect actual harm, especially since the same violations in a different nursing home (as in the previous example) were rated as causing actual harm, although the violations were erroneously rated as **G** (isolated incident) rather than **H** (pattern of harm). In addition, when more than half of the residents are not receiving basic health care

services, “immediate jeopardy to the residents’ health” exists, and a rating of **K** is appropriate.

Violation: The facility staff failed to provide care and services in accordance with acceptable standards of practice for eight out of twenty eight residents by failing to : administer eye drops as ordered; perform weekly weights as ordered; document behavior symptoms; follow up on two orders requesting speech evaluations for diet change; follow up on a hearing evaluation; provide insulin coverage for elevated blood sugar levels; follow up with a psychiatric consult after the resident exhibited behavior concerns towards another resident; administer B12 injections as ordered; accurately assess a resident's pupils after a head injury; and administer oral care to a tracheostomy resident as outlined in the care plan.

Rating: **C** (widespread; no actual harm; facility in substantial compliance)

Comment: **C** is given for violations causing no harm and having no potential for more than minimal harm. All of these failures of care and services had the potential for more than minimal harm and possibly caused actual harm. Consequently, the rating should be at least **E** and probably **H**. In addition, the same kinds of violations in different nursing homes (as shown in the previous two examples) received severity ratings of **E** (“potential for more than minimal harm”) and **G** (“actual harm”). The problems with the surveys are further evident in the fact that the scope, as well as severity, ratings are inconsistent and under-rated: in this nursing home, where 8 out of 28 residents failed to receive necessary care and services, the scope of the problem was identified as “widespread harm,” whereas in the two previous examples, 18 out of 30 resident care failures was considered an “isolated incident,” and 6 out of 10 resident care failures was considered a “pattern of harm.”

Violation: For three residents the facility failed to document: an initial resident admission and elopement; interventions for frequent urinary tract infections caused by Escherichia Coli; and assessments and interventions for an abnormal laboratory finding.

Rating: None. (An **A**-rated deficiency is so isolated and so minor that not even a plan of correction is required, so it appears on the survey as having no rating.)

Comment: The 3 documentation failures described are not “an isolated incident” and have “potential for more than minimal harm,” since failure to document results in failure to treat. The rating should have been at least **E**.

Violation: The facility failed to provide adequate supervision for a resident known to fall repeatedly.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for deficiencies that have potential for more than minimal harm. Falling repeatedly results in actual harm. The rating should be at least **G** and possibly **J**.

Violation: Dietary services were not adequate to ensure that foods are prepared and served in a sanitary manner as evidenced by a malfunctioning dish-washing machine.

Rating: **E** (pattern; potential for more than minimal harm)

Comment: **E** is given for deficiencies that affect a number of residents. A malfunctioning dishwasher affects the safety of the food served to all of the residents and the scope, therefore, is widespread. Thus, the rating should have been **F** rather than **E**.

Violation: Dietary services were not adequate to ensure that foods are prepared and served in a sanitary manner as evidenced by soiled plates and pans.

Rating: **B** (pattern; no actual harm; facility in substantial compliance)

Comment: **B** is given for deficiencies that affect a number of residents. Soiled pots and pans affect the safety of the food served to all of the residents and the scope, therefore, is widespread. Thus, the rating should have been at least **C**. In addition, in the previous example, the same deficiency at a different nursing home received a rating of **E** rather than **B**.

Violation: Dietary services were not adequate to ensure that foods are prepared and served in a sanitary manner.

Rating: **C** (widespread; no actual harm; facility in substantial compliance)

Comment: The same deficiency in the previous two examples were given ratings of **B** and **E**. As stated above, the scope rating for this deficiency should be “widespread,” and the severity rating for this deficiency, inasmuch as it concerns resident health and safety, should be “potential for more than minimal harm.” Thus, the rating for this deficiency in all three cases should have been **F**, rather than **E**, **B**, and **C**.

Violation: The facility failed to provide housekeeping and maintenance services adequate to ensure the facility was maintained in a safe and sanitary manner as evidenced by clogged sinks in residents' rooms; soiled surfaces of HVAC Units, filters, and smoking room vents; soiled bedframe surfaces; unsecured wall protector guards; marred residents' bathroom and entrance doors; soiled and unsecured draperies; unsecured door knobs and handles; soiled floor surfaces, wheelchairs, and linen transport carts; worn, torn and damaged mattresses; soiled/dusty overbed lamp surfaces; improper storage of supplies under sinks; missing lamp covers in showers and tub rooms; damaged wheelchair and geri-chair armrests; damaged and soiled walls in utility rooms and common areas; soiled janitorial closet floors and sinks; soiled baseboards in residents' rooms and common areas; soiled ceiling tiles; soiled and damaged privacy curtains in residents' rooms; etc.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** ratings are given for deficiencies that are isolated incidents. The housekeeping and maintenance problems described were clearly widespread and the rating, therefore, should have been **F**.

Violation: The facility failed to provide housekeeping and maintenance services adequate to ensure the facility was maintained in a safe and sanitary manner as evidenced by soiled floors, baseboards, bedframes, privacy curtains, wheelchairs, sprinkler heads, duct work, and ceiling tiles; marred entrance doors and door jambs; water leaking and accumulated on laundry floor; standing water in resident's bathtub.

Rating: **C** (widespread; no actual harm; facility in substantial compliance)

Comment: The deficiencies received an appropriate scope rating of “widespread” but a severity rating of “no actual harm,” in contrast to the severity rating of “potential for more than minimal harm” in the previous example for the same deficiencies. The rating here, as suggested in the previous example, should have been **F**.

Violation: The facility failed to provide housekeeping and maintenance services adequate to ensure the facility was maintained in a safe and sanitary manner as evidenced by dust and/or debris in the physical therapy rooms, resident rooms, and pantry and laundry areas; soiled pantry closet floor area; unbalanced refrigerator; absence of dishwashing liquid; plaster missing from one wall; crack in one wall; cracked and loose plaster in one-third of the rooms' ceilings; missing ceiling tile in storage room on the first level; damaged baseboards; soiled stretcher in the shower room; soiled portable whirlpool in bathroom which was also filled with debris; debris covering area next to the loading dock which had three compartments storing small to large oxygen tanks and other articles.

Rating: **B** (pattern; no actual harm; facility in substantial compliance)

Comment: In the previous two examples, the same deficiencies at different nursing homes were rated, respectively, **D** and **C**. For the reasons noted above, **B** is inappropriate for both scope and severity. In all three cases, the rating should have been **F**.

Violation: Facility failed to comply with Life Safety Code Standard by failing to ensure that doors in corridors and smoke barriers met fire resistant standards and that sprinkler system and fire protection equipment are in proper operating condition.

Rating: **F** (widespread; potential for more than minimal harm)

Comment: As recent incidents of nursing home fires in other states have demonstrated, the failure of a home to meet proper fire safety standards poses immediate jeopardy to residents and the rating should have been **L**.

Violation: Double swinging doors failed to lock and latch into frames to prevent passage of smoke and protective plates were not installed on conduit boxes as required by Life Safety Code.

Rating: **B** (pattern; no actual harm; facility in substantial compliance)

Comment: The rating should have been at least **F**. The scope is “widespread,” since all staff and residents would potentially be affected by this violation if a fire broke out. Also, smoke inhalation can cause serious harm to the frail elderly, as well as to staff, so the severity rating should have been at least “potential for more than minimal harm.”

Violation: Facility failed to develop a care plan to address the potential fall risk for a resident who had history of falls just prior to admission and who sustained a fall in the facility soon after admission.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: Resident suffered actual harm from the nursing home’s failure, and the rating should have been **G**.

Violation: The facility staff failed to provide care and services in accordance with acceptable standards of practice for 6 of 14 sampled residents as evidenced by failure to perform an ordered Dilantin level check, include the correct diet order on the physician’s

order sheet, follow physician's order for G-tube management; address abnormal glucose levels; follow physician's orders for blood pressure checks after dialysis treatments; schedule an ordered cardiac consult; and follow wound care treatment orders.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for an isolated incident having only "potential for more than minimal harm." Six of 14 resident care failures indicates at least a "pattern of harm." In addition, the care failures documented indicate "actual harm" to the residents' health and safety. The rating should have been at least **H** and possibly **K**.

Violation: Facility staff failed to provide care and services in accordance with acceptable standards of practice for 10 of 30 residents by failing to pre-medicate a resident before a dressing change; obtain an order for foley catheter care and change the catheter; check a pacemaker and obtain an order for pacemaker checks every 3 months as ordered; notify physician of pressure sores; schedule an ordered dental exam; obtain stool samples and urinalyses as ordered; transcribe a diet order; apply a splint as ordered; and obtain an order to perform pressure sore treatments for two residents.

Rating: **G** (isolated incident; actual harm to health/safety)

Comment: **G** is given for an "isolated incident." Ten of 30 resident care failures indicates at least a "pattern of harm," or **H**. In addition, when one third of residents are not receiving basic health care services, "immediate jeopardy to the residents' health" exists, and a rating of **K** is appropriate.

Violation: Physicians failed to review complete plan of care for 6 of 30 sampled residents as evidenced by failure to follow up on lab reports, order medications previously prescribed, accurately fill out medical histories, order supplements for resident with weight loss, follow up on chest x-ray.

Rating: **G** (isolated incident; actual harm to health/safety)

Comment: **G** is given for isolated incidents. When 6 out of 30 residents lack necessary care and services, the rating should be at least **H**.

Violation: Physician failed to review plan of care for 6 of 10 residents by failing to follow up on abnormal lab values for 3 residents, on a radiologist's order to repeat an x-ray, and on orders to replace a catheter; failing to ensure that orders were placed for catheter and colostomy care and for blood sugar fingersticks, PT, and INR levels for resident with history of diabetes who was taking Coumadin and who received dialysis 3 times a week.

Rating: **E** (pattern; potential for more than minimal harm)

Comment: **E** is given for violations having the "potential for more than minimal harm." Actual harm may have occurred in all of these cases and, as in the previous example, involving a different nursing home, these violations should have been rated as causing "actual harm." Consequently, the rating should have been at least **H**.

Violation: Facility failed to reassess resident with change in behavior and vital signs, to consistently and accurately document and monitor unusual bleeding or bruising for resident on antiplatelet therapy with history of frequent falls, and to monitor resident at risk of falls.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for violations having the “potential for more than minimal harm.” Actual harm seems to have occurred since resident had “history of frequent falls.” Consequently, the rating should have been at least **G**. Even more disturbing, in the previous year’s survey, this nursing home was given a **G** rating for the following deficiency: “Facility failed to provide adequate monitoring and supervision for resident who sustained a fall that resulted in injury, to note changes in vital signs, and to document incidents of weakness.” Instead of increasing the deficiency rating for the failure of the nursing home to correct the problem, the surveyors **downgraded** the deficiency from **G** in 2002 to **D** in 2003.

Violation: The facility failed to ensure that two residents were protected from physical harm from one resident on four occasions.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for violations having the “potential for more than minimal harm.” In this case, two residents experienced actual physical harm on four occasions and the rating should have been at least **G**, and possibly **J**, since the facility had taken no steps to prevent the resident from continuing to jeopardize the safety of other residents.

Violation: The facility failed to prevent one resident from having an accident due to a malfunctioning bedside rail.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for violations having the “potential for more than minimal harm.” In this case, resident experienced actual physical harm so the rating should have been **G**.

Violation: Facility failed to provide necessary treatment to prevent resident from further decreases in range of motion to her left hand.

Rating: **D** (isolated incident; potential for more than minimal harm)

Comment: **D** is given for violations having the “potential for more than minimal harm.” In this case, resident experienced actual physical harm so the rating should have been **G**.

3. Examples of Inadequate Complaint Investigation

The investigation of Ombudsman Program complaints by HRA mirrors the problems described above in the nursing home surveys. Complaints are often not investigated in a timely manner or in depth, and **no deficiencies have been cited against any nursing home under the District’s 2002 nursing home regulations**. In addition, under the federal enforcement system, deficiencies have rarely been cited against a nursing home on the basis of these complaints. In rare cases where a deficiency has been cited, no civil monetary penalties have been imposed on the nursing home. The following are just a few examples of the inadequacy of HRA’s 2003 responses to Ombudsman complaints:

Complaint: Resident was found by nursing staff lying in bed with bruises on her forehead, face, neck and shoulders; swelling to the forehead and face; and vaginal bleeding. Resident was transferred to the hospital.

HRA Response: Review of the hospital record did not identify the cause of the bruising. No deficient practice was noted on the part of the facility.

Comment: The response gives no indication that HRA investigated possible physical and sexual abuse of the resident by facility personnel. It appears that HRA “investigators” simply looked at hospital records.

Complaint: Resident was observed in a restraint without a doctor’s order or reason for the restraint documented in the resident’s medical record.

HRA Response: A level “A” deficiency was cited against the facility.

Comment: An “A” level deficiency results in no penalty and does not even require a plan of correction to prevent the same abuse to other residents.

Complaint: Resident fell out of bed while nursing assistant was changing him with the bed side-rails down, developed acute respiratory distress and irregular pulse. His breathing stopped and heartbeat terminated prior to 911 being called. He subsequently died. A similar incident with this resident had occurred a year earlier.

HRA Response: A deficiency was cited and a plan of correction is expected from the facility.

Comment: Neither the deficiency rating nor the plan of correction, if any, was provided to the Ombudsman Program. Since there was no monetary penalty, the severity rating could not have been more than “potential for more than minimal harm.” The Ombudsman Program does not know whether an appropriate plan of correction was submitted and enforced.

Complaint: Partially paralyzed resident is dependent on staff for range of motion and repositioning assistance. Resident alleged, and Ombudsman observed, that she was not repositioned or provided range of motion as per her care plan. In addition, resident complained about failure of staff to change her soiled diapers for hours at a time and to respond to her call bell or to her subsequent telephone calls to the nurse’s station. The complaint was faxed to HRA on April 23, 2003.

HRA Response: The response, dated September 17, 2003, found all of the complaints to be unsubstantiated.

Comment: There is no indication that investigators interviewed the resident or did anything more than look in her medical chart. No in-depth investigation was done to determine if staff failed to document her complaints and/or if staff documented that treatment was provided, even if it was not – a common occurrence in nursing homes.

Complaint: Ombudsman observed that nine residents on one floor of the nursing home were not turned and repositioned in conformity with physician’s orders or care plan for treatment of pressure ulcers. The complaint was faxed to HRA on April 20, 2003.

HRA Response: The response, dated August 15, 2003, found the complaint to be unsubstantiated. The records for the nine residents identified indicate that they were turned and repositioned regularly.

Comment: Failure to regularly turn and reposition residents with pressure ulcers leads to worsening of those ulcers to the point where they can be life-threatening. Waiting four months to investigate the complaint is too long when the consequences are so potentially

serious. Also, no in-depth investigation was conducted to determine if staff were simply documenting that treatment was given or were actually giving the treatment. It is an all too common practice in nursing homes for staff to engage in weekly “fill-in-the-blank” chart parties documenting the provision of care, whether actually provided or not.

Complaint: Facility discharged resident, who was physically in pain, medically unstable, and emotionally distressed to her former home without providing discharge planning or a supply of medications or ensuring that medical and home care services were in place. She expired 5 hours after arriving home.

HRA Response: Complaint is unsubstantiated. According to the nursing home records, the resident voluntarily agreed to her discharge.

Comment: HRA failed to interview any of resident’s family members or interview staff on duty prior to resident’s discharge. HRA simply took the facility’s word for the fact that resident voluntarily left. However, whether a discharge is voluntary or involuntary, both federal and District law mandate that discharge planning take place to ensure resident a safe and orderly move.

Complaint: Five complaints were filed in 2002 and five in 2003 concerning the illegal procedures used by the same nursing home to discharge residents. In all of the cases, the nursing home intended to discharge residents without proper placements or services in place to ensure their health and safety.

HRA Response: In each case, in which the Ombudsman Program received a response, the nursing home received an “A” level deficiency.⁵

Comment: An “A” level deficiency results in no penalty and does not even require a plan of correction. Consequently, the nursing home continued (and continues) to engage in the same resident rights abuses year after year. At the same time, the Ombudsman Program has to continue going to Court each time to prevent the discharges.

RECOMMENDATIONS

The poor quality of nursing home care in the District of Columbia continues to be a serious problem that will only worsen unless the District government takes immediate action. In order to address this problem, the Ombudsman Program makes the following recommendations:

A. Implementation of the January 2002 Report

The Department of Health must fulfill the promises made in its January 2002 report, “Initiatives to Improve Quality of Care In District of Columbia Nursing Facilities,” by immediately implementing those initiatives:

- compel compliance of the 2002 Nursing Facility Licensure Rules through an effective enforcement mechanism, including the use of citations for deficiencies and accompanying civil fines;

⁵ The Ombudsman Program does not have responses to all of the complaints in its files.

- increase the HRA surveyor staff sufficiently to meet the need for increased monitoring of nursing facilities and to form an investigative/complaint unit;
- develop the long-delayed Disability and Aging Resource Center at the level of funding initially approved and granted by CMS;
- establish a “case-mix system” for nursing facility reimbursement;

B. Implementation of an Effective Enforcement System

In addition, the enforcement mechanism designed to compel compliance with the District’s 2002 nursing home regulations must be something more than simply a schedule of fines. To be effective in improving the quality of nursing home care and services, **the remedy for a nursing home deficiency cannot simply be a civil monetary penalty.** Further, imposing a civil monetary penalty based on a system that connects a fine to violation of a specific regulation without taking into consideration the harm caused by the violation is pointless.

The Ombudsman Program has consistently recommended to the Department of Health that, at the very least, any “schedule of fines” adopted to compel compliance with the District’s 2002 nursing home regulations should classify violations of 22 DCMR 3200 *et seq.* as follows:

- a violation that causes actual physical or emotional/psychological harm to a resident be classified as a Class 1 infraction;
- a violation that poses an imminent danger to a resident’s health, safety, or welfare or that abridges a resident’s right to freedom from neglect, exploitation, or physical, mental, verbal, or sexual abuse be classified as a Class 2 infraction; and
- a violation that impacts a resident’s health, safety, or welfare, but does not pose an imminent risk of harm, be classified as a Class 3 infraction.

The Ombudsman Program has found that actual harm or the risk of harm can stem from failure of a nursing home to comply with almost any provision of the Nursing Facility Licensure Rules – not just from those listed at sections 3243.1 and 3243.2 of Title 16 of the DCMR. The Ombudsman Program believes that the degree of actual harm or potential harm to the resident(s), rather than the section of the regulations in which the violated provision appears, should determine the class of the infraction and the amount of the fine imposed. In addition, the amount of civil penalties and fines in the current schedule of fines for violations of the Nursing Facility Licensure Rules is insufficient. As long as it is cheaper to pay a fine than to correct a problem, quality will never improve.

The Ombudsman Program also strongly opposes an enforcement system that provides a civil monetary penalty alone as a remedy to poor care. Merely imposing a fine is not enough to ensure compliance. A plan of correction, as well as a civil monetary penalty, should be required for infractions of the 2002 District nursing home rules. However, **when a plan of correction is required, it is critical that the facility be given a specific and reasonable date by which to correct the violation and that an inspector be assigned to reinspect, and be held accountable for reinspecting, on the date specified for correction.** If the deficiency is not corrected by the date specified, compound fining of the facility for a repeat offense should immediately commence. Thus, 16 DCMR 3201.2 should also be amended to provide that each day of violation following the day by which the violation is required to be corrected should constitute a separate, repeat infraction and be fined as such. This change is important to ensure the imposition of strict, timely, and appropriate plans of correction on facilities.

Further, the Ombudsman Program believes that, as in some other jurisdictions, additional remedies be included in the enforcement scheme, such as the imposition of staffing ratios, hiring of specialists to train staff, placement of a receiver or new management team, and denial of new admissions. Similarly, as in some other jurisdictions, the Ombudsman Program recommends that the fines collected for infractions be kept in a separate fund designated for hiring and training additional inspectors, hiring receivers/monitors for substandard facilities, making emergency repairs, and hiring additional staff to prevent imminent harm to residents when facilities fail to act -- the cost of which would then be subtracted from the Medicaid and Medicare payments to the facilities from the District. In Maryland, for example, the “Nursing Homes – Quality Assurance” bill, passed in 2000, not only increases fines for nursing home violations, but also provides as follows:

. . . the amount of the penalty imposed, together with any accrued interest, shall be placed in a fund to be established by the Secretary and shall be applied exclusively for the protection of the health or property of residents of nursing homes that have been found to have deficiencies, including payment for the costs of relocation of residents to other homes, maintenance or operation of a nursing homes pending corrections of deficiencies or closure, and reimbursement of residents for personal funds lost.

Similar language establishing a fund for fines paid by District nursing homes should be added to the regulations enforcing the District’s 2002 nursing home rules.

C. Imposition of Effective Nurse Staffing Ratios

Perhaps the major cause of poor quality nursing home care is lack of staff. The staffing studies completed in 2000-2001 for the Centers for Medicare and Medicaid Services (CMS) demonstrated a direct relationship between staffing levels and quality of care. In particular, the studies found that residents must receive at least 4.1 hours of

combined nurse and nursing assistant direct care per day to meet federal standards of care, and that between 2.8 and 3.2 hours per resident per day of nursing assistant care is needed to complete routine personal care.

Currently, the District requires no minimum staffing ratios or hours of nursing care. Under the 2002 Nursing Facility Licensure Rules, the District's nursing homes would be required to provide residents with 3.5 hours of combined nurse and nursing assistant direct care per day **beginning in January 2005**. Even if the Department of Health actually enforces the nursing home regulations by 2005, 3.5 hours per resident per day of direct nursing care is below what experts believe is necessary to meet minimum federal nursing home standards and prevent harm to residents.

Consequently, the regulations must be amended to require at least 4.1 hours of direct resident care per day and to make that provision a priority for nursing homes to meet in 2004, not 2005 or beyond.

D. Increased Home and Community Based Services Options

The D.C. Department of Health's Medical Assistance Administration (MAA) was successful in receiving \$2.1 million dollars in 2002 to develop home and community based services waiver programs and a Resource Center in the District. These programs were designed to provide elderly and disabled persons with options to receive long-term care services at home or in a community-based residence instead of in a nursing home.

Currently, MAA has neither created the Resource Center nor fully implemented the home and community based Medicaid waivers to assist the elderly and disabled. In addition, MAA has not implemented the raises for home care and personal care workers that were promised and that are necessary to attract sufficient numbers of these workers to District agencies that serve elderly and disabled residents who want to avoid institutionalization. Instead MAA has wasted millions of dollars on unnecessary institutional placements, costing the city, and private residents, approximately \$55,000 per individual per year rather than the approximately \$21,000 dollars per individual per year that home and community based services would cost.

Consequently, to provide residents with the choice mandated under federal law to receive long-term care services in their homes and communities, rather than in an institution, and at the same time, to save the city dollars that could be spent providing more and better care, the Resource Center must be fully funded, the waiver programs must be fully funded, and home care and personal care workers must be given the living wage that will keep them from going to Maryland and Virginia for work while District residents languish in institutions for lack of home care services.

CONCLUSION

The quality of nursing home care in the District is, in too many instances, a “sin and crime.”⁶ Unfortunately, the responsibility for this situation lies not just with the nursing home industry but with the failure of the District to take its promises seriously and provide the leadership and funding necessary to fulfill them. The promises made and initiatives for quality nursing home care announced in January 2002 must be fulfilled if the District’s most vulnerable citizens, its elderly and disabled nursing home residents, are to experience even a minimum standard of care -- one that at least keeps them from actual harm -- during the final months and years of their lives.

CONTACT INFORMATION:

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⁶ Reference to the Mayor Anthony Williams’ comments, please see page 1.