



# CARELESS:

## How the Pennsylvania Department of Health has Risked the Lives of Elderly and Disabled Nursing Home Residents

### **Executive Summary**

The Pennsylvania Department of Health (DOH) has been failing to protect elderly and disabled nursing home residents. Community Legal Services of Philadelphia (CLS) regularly advocates on behalf of nursing home residents, representing them in matters relating to the preservation and protection of their rights. Over the past several years, under the previous governor's administration, CLS has witnessed DOH significantly decrease its enforcement of nursing home regulations and patient protections. In an analysis of DOH nursing home investigations and inspections that occurred in Philadelphia from 2012-2014, CLS has found that DOH's conduct has put elderly and disabled Pennsylvanians at risk of physical harm or death. During this time period, DOH dismissed an extraordinary number of complaints against nursing homes, failed to properly follow up when a violation was found, mischaracterized harm against patients, and dramatically decreased its penalties against nursing homes. Unfortunately, DOH's failures have not only placed residents at risk, but they have also resulted in inaccurate publicly available information that forces potential residents and their families to make major life decisions without all of the important facts. Pennsylvania must fix this crisis and ensure the safety of elderly and disabled nursing home residents.

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## Overview

The Pennsylvania Department of Health (DOH) has been failing in its job to protect nursing home residents. Over the past several years, DOH has significantly decreased the issuance of sanctions against nursing homes and has adopted and employed an investigatory strategy that dismisses 92% of the complaints against nursing homes. Additionally, when DOH finds that there is harm to patients, it is mischaracterizing and minimizing the severity and the breadth of the harm. As a result, current nursing home residents are at a greater risk of having their rights violated and/or their wellbeing threatened. The lack of enforcement action by DOH also means that prospective nursing home residents will not be accurately informed about problems with nursing homes, and will be forced to make decisions based on incomplete and inadequate information.

Pennsylvania ranks fourth in the United States in the percentage of residents 65 and older.<sup>i</sup> By 2030, Pennsylvania's aging population, residents over 60, will reach 4 million.<sup>ii</sup> Research shows that roughly 70% of individuals over 65 will require some kind of long-term care<sup>iii</sup>. For many Pennsylvanians, this care will be provided in a nursing home. As of 2013, Pennsylvania had 88,000 nursing home beds, with an average occupancy statewide of 80,000.<sup>iv</sup> For individuals entering a nursing home, or for families looking for care for a loved one, deciding on a nursing home is a complicated and often difficult decision.

In Pennsylvania, the Pennsylvania Department of Health is charged with enforcing the various federal and state regulations that are in place to protect residents and their rights. DOH conducts yearly inspections of nursing homes, which the agency calls surveys, and also investigates complaints filed by residents or other individuals. DOH's enforcement powers range from requiring nursing home staff training, to civil monetary penalties, to the closure of a facility.

In an in-depth review of data available from DOH concerning Philadelphia nursing homes, Community Legal Services (CLS) has found that from 2012 through 2014 DOH:

- Dismissed 92% of complaints filed by residents or other individuals as unfounded.
- Routinely mischaracterized the severity and breadth of violations, which, in addition to harming nursing home residents, misinformed members of the general public who were looking for safe nursing homes.
- Conducted 161 follow-up visits after finding a violation, and never once found that a violation persisted, despite the unlikelihood that every violation was remedied immediately.

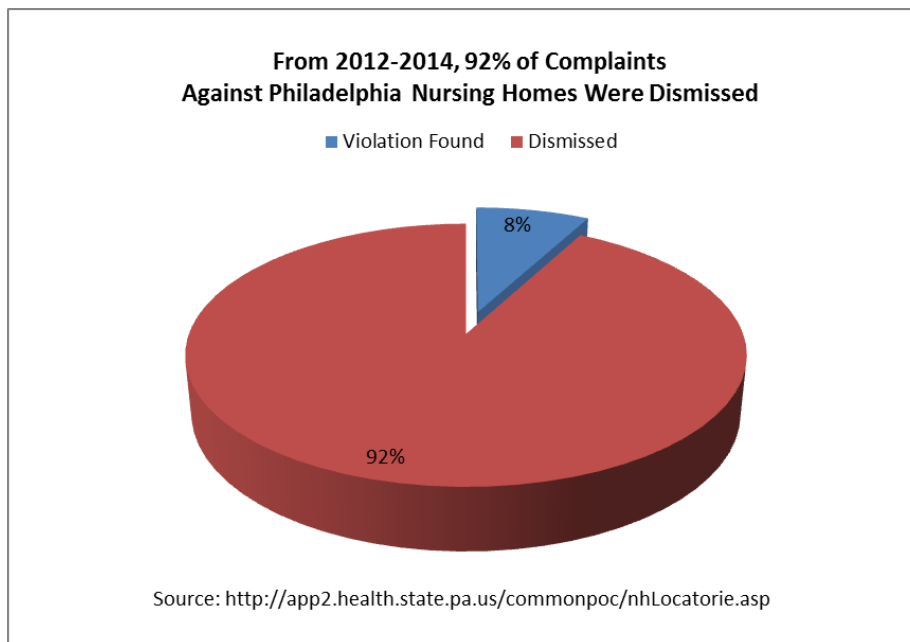
## Background

The Pennsylvania Department of Health is charged with completing routine inspections to certify or recertify nursing homes, investigate complaints, and enforce the various rights afforded to residents by state and federal laws. DOH conducts annual surveys of nursing homes to determine the facilities' compliance with federal and state regulations. In addition, they investigate complaints and reportable events, which are incidents that skilled nursing facilities are required to report to DOH by law. Examples of reportable events include deaths, patient elopements, which is when a patient wanders away from a nursing facility, and falls. Complaints can be filed by anyone, including residents, their families, nursing home staff, or a nursing home ombudsman<sup>v</sup>. All of these events require that an investigation is conducted, which includes a visit to the facility.

A review of the survey data for the 46 nursing homes that operated in Philadelphia from 2012 to 2014 revealed the following:

### **DOH is not properly investigating nursing homes and is failing to enforce regulations.**

DOH received 507 complaints from 2012-2014. Of these complaints, DOH found only 43 to be substantiated. This equals a 92% dismissal rate by DOH. It is certainly to be expected that there will be complaints that are unfounded. However, it stretches belief to suggest that 92% of complaints filed by residents, their families, or the ombudsman were unfounded. Unfortunately, DOH does not provide investigation details where no violation is found.



**DOH conducted 161 follow-up visits in the three year period and never found that a violation persisted.**

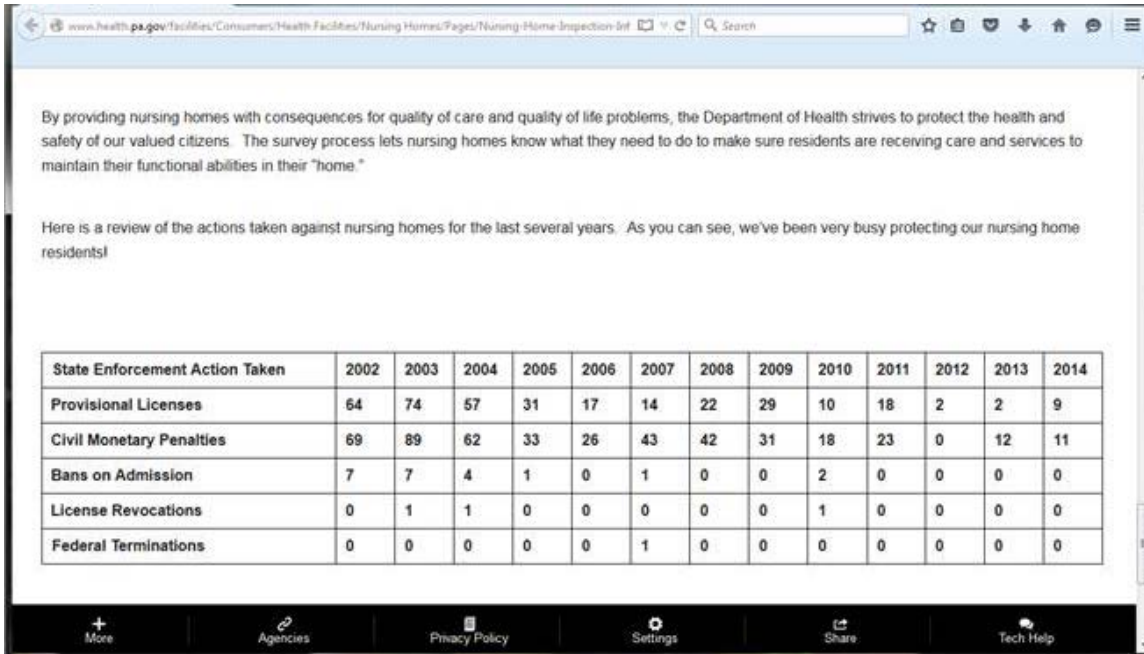
DOH is required by law to return to a facility after a violation is found to determine whether the nursing home has corrected the violation. DOH completed 161 follow-up visits in the three year period and never once determined that a violation persisted. It is highly improbable that in every instance, especially in instances where DOH discovered program-wide deficiencies, that every facility had completely remedied all of the problems.

*In addition to not properly ensuring that violations had been appropriately remedied, enforcement actions against nursing facilities have dropped dramatically in recent years.*

It was also very common that DOH would respond to a complaint or a reportable event and make a finding that no violation occurred, only to return within weeks, sometimes days, to conduct an annual survey in which many serious violations were found.

**DOH has dramatically decreased its monetary penalties against nursing homes.**

In addition to not properly ensuring that violations had been appropriately remedied, enforcement actions against nursing facilities have dropped dramatically in recent years, as illustrated by DOH's own website.



By providing nursing homes with consequences for quality of care and quality of life problems, the Department of Health strives to protect the health and safety of our valued citizens. The survey process lets nursing homes know what they need to do to make sure residents are receiving care and services to maintain their functional abilities in their "home."

Here is a review of the actions taken against nursing homes for the last several years. As you can see, we've been very busy protecting our nursing home residents!

State Enforcement Action Taken	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Provisional Licenses	64	74	57	31	17	14	22	29	10	18	2	2	9
Civil Monetary Penalties	69	89	62	33	26	43	42	31	18	23	0	12	11
Bans on Admission	7	7	4	1	0	1	0	0	2	0	0	0	0
License Revocations	0	1	1	0	0	0	0	0	1	0	0	0	0
Federal Terminations	0	0	0	0	0	1	0	0	0	0	0	0	0

Screen shot of the Department of Health's website. Source: <http://www.health.pa.gov/facilities/Consumers/Health%20Facilities/Nursing%20Homes/Pages/Nursing-Home-Inspection-Information.aspx#.VW9IAqytYSw>

DOH's website shows that civil monetary penalties (fines) decreased from an average of 30 per year from 2005 to 2011 to an average of 8 from 2012 to 2014 (in 2012 no civil monetary penalties were issued at all). Other enforcement actions, including downgrading facilities' licenses to provisional and imposing bans on new admissions, had similarly steep declines.

The decrease in enforcement actions is partly due to DOH sending guidance to nursing home administrators that they will no longer be required to report certain events. Pennsylvania law requires nursing homes to report to DOH certain events which seriously compromise quality of care or patient safety. These occurrences range from patient deaths to elopements.<sup>vi</sup> In a 2012 Long Term Care Provider Bulletin<sup>vii</sup>, DOH informed nursing homes they were no longer required to report certain events, including:

- Falls with Injuries
- Inappropriate Discharge
- Injury or Accident [to] a Resident Other than Falls
- Medication Errors/Adverse Drug Reactions Causing Serious Injury
- Misadventure with Feeding Tube, Catheter, Tracheotomy or Life Sustaining Equipment

DOH claimed that Pennsylvania regulations did not specifically require these events to be reported and that therefore nursing homes would no longer have to report them to DOH. However, the regulations explicitly require that nursing homes inform DOH of medication errors that cause serious injury.<sup>viii</sup> Additionally, although the regulations do not explicitly name the other events listed in the Bulletin, the regulations do not limit the events that a nursing home can be required to report. Why DOH would voluntarily tell nursing homes to stop reporting serious events such as falls with injuries, injuries and accidents, and mishaps with life sustaining equipment is not clear. By allowing nursing homes to stop reporting these serious events, not only do harmed residents continue to be at risk, but the public may never learn of these occurrences.

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**DOH routinely mischaracterized and minimized the severity and breadth of the harm to residents when it did find a violation.**

Violations, which are often referred to as deficiencies by DOH, can be found during surveys or complaint investigations. They can range from substandard care, to

unsanitary conditions, to death. DOH is required to evaluate the level of harm and how many residents the violation had potential to harm. DOH uses the following definitions to assess harm:

- **Potential for minimal harm**

*The severity of a deficiency is defined as potential for minimal harm when the deficiency has the potential for causing no more than a minor negative impact on the resident[s].*

- **Minimal harm**

*A deficiency is determined to have a severity level of minimal harm when it results in minimal discomfort to the resident or has the potential (not yet realized) to negatively affect the resident's ability to achieve his/her highest functional status as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.*

- **Actual harm**

*The actual harm level indicates that the deficiency has resulted in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.*

- **Immediate jeopardy or severe harm**

*This level of severity indicates that the resident is in immediate jeopardy of a situation which has caused, or is likely to cause, serious injury, harm, impairment, or death as a result of the nursing home's noncompliance with one or more regulations.<sup>ix</sup>*

***Violations that DOH classified as minimal harm include a resident setting her head on fire, the death of a patient due to nursing staff failing to provide emergency care after the patient became non-responsive, and a senior citizen who was illegally discharged by herself to an unsafe home, who was later found to have not eaten in days.***

In addition to the severity of harm, DOH is required to assess the number of residents the harm could affect. DOH uses the following definitions:

- **Isolated**

*Scope of a deficiency is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.*

- **Pattern**

*Scope of a deficiency is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice, but the deficient practice is not pervasive throughout the nursing home.*

***Between 2012 and 2014, DOH never classified a resident death due to nursing home negligence as severe harm. In fact, in some instances, deaths were classified as minimal harm.***

- **Widespread**

*Scope of a deficiency is widespread when the problems causing the deficiency are pervasive in the nursing home and/or represents a systemic failure that has affected or has the potential to affect a large portion or all of the nursing home's residents.<sup>x</sup>*

Of the 474 violations DOH found over three years, the vast majority of which were found during annual surveys, only one was characterized as severe harm and widespread. The violation was found when an inspection revealed that hot water in resident showers was too hot<sup>xi</sup>. In that same period of time DOH investigated:

- The illegal discharge of a cognitively impaired senior with serious ambulatory problems to her home by herself. Several days later she was found by a visiting nurse, who said the senior had not eaten in days. The senior required immediate hospitalization. (Classified as minimal harm-March 11, 2014)<sup>xii</sup>
- The death of an unsupervised patient who choked on a mustard packet and died. (Classified as actual harm-March 25, 2013)<sup>xiii</sup>
- A patient that was dropped by staff on his or her head and required hospitalization. (Minimal harm-October 21, 2014)<sup>xiv</sup>
- The death of a patient due to a preventable fall. (Actual harm-September 16, 2014)<sup>xv</sup>
- A resident who set her head on fire. (Minimal harm-January 27, 2012)<sup>xvi</sup>

- A resident suffering from dementia who eloped (left the facility without the nursing home’s knowledge) from the facility and was not found until 11 hours later, having consumed a bottle of vodka (Minimal harm-May 24, 2013)<sup>xvii</sup>
- A nurse who forged a prescription for morphine, stole the medication from a patient, and administered the morphine to another patient, who then required hospitalization. (Minimal Harm-March 18, 2013)<sup>xviii</sup>
- A resident who was served solid food despite doctor’s orders, choked on it, and then died. (Actual Harm-August 30, 2013)<sup>xix</sup>
- Nursing home staff who failed to provide emergency care to a non-responsive patient, who then died. (Minimal harm-January 20, 2012)<sup>xx</sup>

Between 2012 and 2014, DOH never classified a resident death due to nursing home negligence as severe harm. In fact, in some instances, deaths were classified as minimal harm. DOH routinely classified the elopement of patients suffering from dementia as minimal harm only affecting a few, despite that fact that the neglect that led to one patient elopement could have caused other patients to wander from the nursing facility. DOH also classified preventable patient falls resulting in hospitalizations as minimal harm.

The failure of DOH to correctly classify patient deaths, elopements, or injuries violates guidance from the Centers for Medicare and Medicaid Services (CMS)<sup>xxi</sup>. The CMS operations manual, to which links are provided on DOH’s website, instructs state inspectors on how to classify harm and the scope of violations.<sup>xxii</sup> Many of the illustrations the manual provides to define severe harm are elopements, deaths, and negligent care.

DOH routinely mischaracterized the scope of violations. For instance, elopements of demented patients often revealed that facility had no monitoring system in place. Many times, after a violation was found, DOH required nursing homes to implement new systems to ensure patients were safely monitored. Yet, DOH always characterized elopements as only affecting a few residents, despite the systemic failures these events uncovered.

DOH characterized failures of facilities to complete routine tasks such as medication management, supervision of residents, and fall monitoring as only affecting a few, while at the same time requiring the facilities to adopt program-wide protocol changes.

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Not only do these mischaracterizations of harm impact the nursing home residents, they also cause harm to the general public because they result in incomplete and inaccurate data being used by the CMS Nursing Home Compare website, as discussed below.

**DOH’s failures result in potential residents and their families making major life decisions based on incorrect information.**

DOH is required to report violations and complaints to CMS. CMS then compiles this data and shares it with public via its Nursing Home Compare tool (<http://www.medicare.gov/nursinghomecompare/search.html>). CMS advertises this as a tool that the public may use to investigate and compare nursing homes. CMS assigns scores to nursing homes based on substantiated complaints and violations reported by DOH; the severity of violations is considered when CMS is rating nursing facilities. If DOH is not properly investigating complaints or characterizing violations, the public is forced to make decisions based on inadequate and incomplete information.

For example, Care Pavilion, a facility in Philadelphia, had the most complaints filed against it in the three year period of any nursing facility in the city. 38 complaints were filed against Care Pavilion, all but one of which were dismissed by DOH. During that period, the facility also had two reportable events that resulted in violations: a resident died due to a preventable choking accident, and another patient suffering from dementia wandered out of the facility and was returned by the police hours later. A visit to the CMS nursing home comparison website shows that Care Pavilion has an average overall rating and an above average rating for quality measures. Only three violations are listed on the Medicare website, even though 38 complaints were filed against Care Pavilion, because CMS only lists complaints which have been substantiated by the state licensing agency (in this case, DOH). Because DOH rated even the few complaints which it did substantiate as isolated incidents which did not cause severe harm, someone viewing CMS’ website would likely never know that a resident died after the facility failed to supervise him properly, that a patient with dementia wandered away from the facility, or that this facility has more complaints than any other in Philadelphia. Although incident reports are provided on the CMS website, they are extremely difficult to locate, and unlikely to be viewed as the harm is mischaracterized.

***DOH’s failures resulted in families placing their loved ones in homes that they think are safe, when in fact those nursing homes may be subject to high rates of quality of care complaints, severe violations resulting in death, patients going missing, and severe physical harm.***

DOH's failures result in misinformation not only being passed to CMS, but to other entities, as well, including the media. Take for instance, *Pro Publica's* Nursing Home Inspect Tool.<sup>xxiii</sup> In an effort to give consumers an accurate depiction of nursing home violations and safety across the United States, *Pro Publica* relied on data from CMS to rank frequency and severity of violations both by state and by individual nursing home. *Pro Publica's* website ranks Pennsylvania as first in the country for having the smallest rate of severe deficiencies per nursing home. The data *Pro Publica* used to make this finding was taken directly from CMS. Because DOH consistently mischaracterized the severity and breadth of harm, *Pro Publica* is informing the public that Pennsylvania has had few if any severe harm violations, when a closer look at the data compiled by DOH shows this not to be true.

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### **Conclusion and Recommendations**

It is clear from the data analyzed that over the past several years the Pennsylvania Department of Health has failed in its duty to nursing home residents and the public. Its failure to rigorously enforce state and federal regulations has created an environment in Pennsylvania where nursing home residents are at risk of serious health problems and even death. The broad impact of this failure is felt across the state and impacts all residents and their families. In order to protect Pennsylvania nursing home residents, the new administration should:

- Conduct a thorough investigation into why the Department of Health has failed to properly investigate nursing homes and enforce regulations.
- Implement system-wide changes within the Department of Health to ensure it is enforcing federal and state regulations designed to protect nursing home residents.
- Require that all Department of Health nursing home investigators be retrained on an ongoing basis to ensure patient safety.
- Require the Department of Health to provide better transparency to the public regarding investigations and characterization of harm.
- Provide better information to the public about nursing homes so prospective nursing home residents and their families can make informed decisions about care.

This is an important issue that must be addressed quickly in order to protect the elderly and people with disabilities from harm. The new administration and the Department of Health must work together to enforce regulations and ensure patient safety in nursing homes.

<sup>i</sup> US Census Bureau: Census 2010.

<sup>ii</sup> Id.

<sup>iii</sup> Kemper P, Komisar HI, Alecxih L. "Long-term Care Over an Uncertain Future: What Can Current Retirees Expect?" Inquiry. Winter 2005/2006. 42(4): 335-350

<sup>iv</sup> PA Department of Health 2013 Long Term Care Questionnaire

<sup>v</sup> Pennsylvania has a nursing home ombudsman program. An ombudsman is charged with acting as an advocate for nursing home residents. There is an ombudsman assigned to every nursing home. A resident may contact the ombudsman at any time for a variety of issues, including abuse, rights violations, and substandard care. The nursing home must provide the ombudsman access to the facility, the patient, and the patient's record. Ombudsmen often report what they think our violations to DOH. DOH is then required to conduct an investigation.

<sup>vi</sup> The Pennsylvania health code lists 14 examples of reportable events, but does not limit it to those events only. See 28PaCode§51.3

<sup>vii</sup>

<http://app2.health.state.pa.us/commonpoc/content/FacilityWeb/attachment.asp?messageid=2813&filename=Provider+Bulletin+2012-11-13-ERS+November+2012.pdf&attachmentnumber=11>

<sup>viii</sup> 28 Pa. Code § 51.3(g)(3).

<sup>ix</sup><http://app2.health.state.pa.us/commonpoc/content/publicweb/definitions.htm>

<sup>x</sup>Id.

<sup>xi</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=131302&PAGE=1&NAME=MARWOOD+REST+HOME%2C+INC.&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xii</sup><http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=455502&PAGE=1&NAME=WESLEY+ENHANCED+LIVING+AT+STAPELEY&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xiii</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=292002&PAGE=1&NAME=CARE+PAVILION+NURSING+AND+REHABILITATION+CENTER&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xiv</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=020202&PAGE=1&NAME=DEER+MEADOWS+REHABILITATION+CENTER&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xv</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=311202&PAGE=1&NAME=EVANGELICAL+MANOR&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xvi</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=090202&PAGE=1&NAME=INGLIS+HOUSE&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xvii</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=033002&PAGE=1&NAME=MAPLEWOOD+NURSING+AND+REHABILITATION+CENTER&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xviii</sup><http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=011402&PAGE=1&NAME=OAKWOOD+HEALTHCARE+%26+REHABILITATION+CENTER&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xix</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=127502&PAGE=1&NAME=SPRINGS+AT+THE+WATERMARK%2C+THE&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xx</sup> <http://app2.health.state.pa.us/commonpoc/content/publicweb/ltc-survey.asp?Facid=369402&PAGE=1&NAME=TUCKER+HOUSE+NURSING+AND+REHABILITATION+CENTER&SurveyType=H&COUNTY=PHILADELPHIA>

<sup>xxi</sup> CMS is a federal agency which is charged with making sure states are enforcing federal nursing home regulations. Because nursing homes in Pennsylvania take Medicare and Medicaid patients, which are programs funded by the federal government, they are required to comply with federal laws and regulations.

<sup>xxii</sup>

<http://www.health.pa.gov/facilities/Consumers/Health%20Facilities/Nursing%20Homes/Nursing%20Homes/Pages/Long-Term-Care-Licensure-Regulations.aspx#.VWiDx6ytYSw>

<sup>xxiii</sup> <http://projects.propublica.org/nursing-homes/>