



Abuse of Residents Is a Major Problem in U.S. Nursing Homes

Prepared for Rep. Henry A. Waxman

**Minority Staff
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives**

July 30, 2001

Table of Contents

Executive Summary	i
I. Introduction	1
II. Methodology	2
A. Analysis of the OSCAR and Nursing Home Complaint Databases	2
B. Analysis of State Inspection Reports and Citations	3
C. Interpretation of Results	4
III. Findings	4
A. Thousands of Nursing Homes Have Recently Been Cited for Abuse Violations ..	4
B. Many of the Abuse Violations Caused Harm to Residents	5
C. Many Cases of Abuse Are Uncovered Only After a Formal Complaint	5
D. Many Nursing Homes Have Multiple Abuse Violations	6
E. The Incidence of Abuse Violations Has Risen Dramatically	6
F. Potential for Underreporting Violations	8
IV. Documentation of Violations in the Inspection Reports	8
A. Violations Involving Physical Abuse	9
B. Violations Involving Sexual Abuse	12
C. Violations Involving Verbal or Other Abuse	14
V. Conclusion	15

EXECUTIVE SUMMARY

This report, which was prepared at the request of Rep. Henry A. Waxman, investigates the incidence of physical, sexual, and verbal abuse in nursing homes in the United States. It finds that 5,283 nursing homes -- almost one out of every three U.S. nursing homes -- were cited for an abuse violation in the two-year period from January 1, 1999, through January 1, 2001. All of these violations had at least the potential to harm nursing home residents. In over 1,600 of these nursing homes, the abuse violations were serious enough to cause actual harm to residents or to place the residents in immediate jeopardy of death or serious injury.

Federal health and safety standards protect the vulnerable residents of nursing homes from physical, sexual, and verbal abuse. To enforce these standards, the U.S. Department of Health and Human Services contracts with the states to conduct annual inspections of nursing homes. These inspections assess whether nursing homes are meeting federal standards of care, including the prohibitions on abuse of residents. In addition, when an individual files an abuse complaint, state inspectors are required to investigate these allegations and assess whether federal standards of care were violated by the nursing home.

This report is the first investigation to assess the incidence of abuse in nursing homes by comprehensively evaluating the results of these state inspections. It is based on an analysis of the results of all annual nursing home inspections or complaint investigations conducted in the two-year period from January 1, 1999, through January 1, 2001. The report also reviews a sample of state inspection reports and citations to assess the severity of the abuse violations.

The report does not estimate the number of nursing home residents who have been victims of abuse. In some of the abuse violations reviewed for this report, only one resident in the nursing home was victimized; in other instances, a single abuse violation affected numerous residents. It is likely, however, that the findings in this analysis underestimate the incidence of abuse in nursing homes since researchers have reported that abuse cases are especially likely to go undetected or unreported.

Major Findings

Thousands of nursing homes have been cited for abuse violations. Over thirty percent of the nursing homes in the United States -- 5,283 nursing homes -- were cited for an abuse violation that had the potential to cause harm between January 1999 and January 2001. These nursing homes were cited for almost 9,000 abuse violations during this two-year period.

Many of these abuse violations caused harm to residents. Over 2,500 of the abuse violations in the last two years were serious enough to cause actual harm to residents or to place residents in immediate jeopardy of death or serious injury. In total, nearly 10% of the nursing homes in the United States -- 1,601 nursing homes -- were cited for abuse violations that caused actual harm to residents or worse.

Many of these abuse violations are discovered only after the filing of a formal complaint. State inspectors can find evidence of abuse either during annual inspections or during an inspection after a formal complaint is filed. The data indicate that over 40% of the abuse violations -- over 3,800 in the two-year period -- were discovered only after the filing of a formal complaint. In over one-third of these cases, the violation was determined to have caused actual harm to the resident.

The percentage of nursing homes with abuse violations is increasing. The percentage of nursing homes cited for abuse violations has increased every year since 1996. In 2000, over twice as many nursing homes were cited for abuse violations during annual inspections than were cited in 1996. The reasons for this increase are unclear.

The state inspection reports and citations reviewed in this investigation describe many instances of appalling physical, sexual, and verbal abuse of residents. In some cases, the nursing homes were cited because a member of the nursing staff committed acts of physical or sexual abuse against the residents under his or her care. In other cases, nursing homes were cited because they failed to protect vulnerable residents from violent residents who beat or sexually assaulted them. Examples of incidents reviewed in this report include:

- Numerous instances of physical abuse, such as the case where a nursing home attendant walked into a female resident's room, shouted "I'm tired of your ass," hit the resident in the face, and broke her nose. In another case, nursing home attendants used cigarettes to bribe a brain-damaged resident to attack another resident, then watched as the two residents fought each other.
- The failure of many nursing homes to adequately protect residents from other abusive residents. In one case, a resident with a history of over 50 instances of abusive behavior killed another resident when he picked her up and slammed her into a wall.
- Many instances of sexual abuse, including a case where a male nurse aide molested two elderly residents, putting his finger in their vaginas while bathing them, and a case where a male aide was found attacking a resident with senile dementia. The aide was found on top of the resident with his pants down and the resident's legs spread.
- Cases where nursing homes ignored signs of serious abuse. In one instance, state inspectors asked about a female resident who appeared to have been sexually abused. The director of nursing replied, "maybe she fell on a broomstick."
- Numerous instances of verbal abuse, including cases where staff told residents, "If you hadn't sh*t all over yourself, I wouldn't have to clean your ass" and "I . . . am sorry you were born," and called residents "a blob," "stupid," and "bitch."

I. INTRODUCTION

Abuse violations are among the most serious violations that can occur in nursing homes. The elderly and disabled residents of nursing homes cannot protect themselves from physical attack or sexual assault. Sometimes they cannot even communicate to family members that they have suffered from abuse. Residents and their families are almost entirely dependent upon nursing homes to ensure the safety of residents.

Previous reports have indicated that abuse can and does occur in nursing homes. A recent report by the Inspector General of the Department of Health and Human Services, for example, found that there were thousands of reported complaints of abuse and neglect of nursing home residents in just one year in 11 states.¹

This report analyzes two databases maintained by HCFA² to assess the incidence of abuse in nursing homes. The first database contains the results of annual inspection reports filed by state inspectors. The second database contains the results of complaint investigations conducted by state investigators. While many abuse cases may not be reported or detected by state inspectors, these annual inspection and complaint investigation reports provide the only national databases for determining the frequency and severity of abuse violations in nursing homes. This is the first report to analyze these databases for abuse violations.

This report on abuse in nursing homes is an outgrowth of a series of recent investigative reports on nursing home conditions prepared by the Special Investigations Division of the minority staff of the Government Reform Committee for individual members of Congress. The first of these reports, which was released by Rep. Henry A. Waxman in November 1999, assessed nursing home conditions in Los Angeles.³ Approximately fifteen additional reports for members have investigated nursing home conditions in Chicago, the San Francisco Bay Area, Long Island, Texas, Oklahoma, and other areas. Another series of reports has investigated staffing levels in nursing homes, finding that many nursing homes are severely understaffed, impeding their ability to effectively care for patients.⁴

¹Office of Inspector General, Department of Health and Human Services, *Abuse Complaints of Nursing Home Patients* (OEI-06-98-00340) (May 1999).

²The Health Care Finance Administration was recently renamed the Center for Medicare and Medicaid Services.

³Minority Staff Report of the House Committee on Government Reform, *Nursing Home Conditions in Los Angeles County: Many Homes Fail to Meet Federal Standards for Adequate Care* (Nov. 22, 1999).

⁴See Minority Staff Report of the House Committee on Government Reform, *Nursing Home Staffing Levels Are Inadequate in Chicago* (Jan. 16, 2001). Many of the nursing home studies prepared by the Special Investigations Division can be obtained online at www.house.gov/reform/min/nursinghomes.html.

These reports for members of Congress documented many instances where nursing homes were cited for serious abuse violations. They suggested that the problem of abuse in nursing homes may be far more prevalent than the public generally recognizes. Because of the seriousness of this problem, Rep. Waxman requested this report to assess the extent of abuse in U.S. nursing homes.

II. METHODOLOGY

To assess the incidence of abuse in nursing homes in the United States, this report analyzes two sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by the U.S. Department of Health and Human Services (HHS), which compiles the results of state nursing home inspections; and (2) the nursing home complaint database, also maintained by HHS, which compiles the results of state investigations of nursing home complaints. In addition, the report examines actual state inspection reports and citations for a sample of nursing homes cited for abuse violations that caused actual harm to residents.

A. Analysis of the OSCAR and Nursing Home Complaint Databases

Operating through the Health Care Financing Administration (HCFA), which administers the federal Medicaid and Medicare programs, HHS contracts with states to conduct annual inspections of nursing homes. During these inspections, the inspection team interviews a sample of residents, staff members, and family members. The inspection team also reviews a sample of clinical records. Violations of federal health and safety standards observed by the inspectors are cited by the inspection team, reported by the states to HCFA, and compiled in the OSCAR database.

State inspectors also investigate nursing homes when state or federal agencies receive complaints about conditions in the homes. If a complaint is substantiated and state investigators determine that federal health and safety standards were violated by the nursing home, these violations are reported by the state to HCFA and compiled in the nursing home complaint database.

During annual inspections and complaint investigations, the state inspectors use numerical codes to classify the type of violation. Four of these codes relate to requirements that protect residents from abuse. Inspectors use code 223 to cite nursing homes that have not complied with the federal requirement to protect each resident from sexual, physical, or verbal abuse, corporal punishment, or involuntary seclusion. Inspectors use codes 224 and 226 to cite nursing homes that have failed to develop and implement written policies to prohibit abuse, mistreatment, and neglect of residents and misappropriation of residents' property.⁵ And

⁵Prior to May 1999, inspectors used only code number 224 for the failure to develop and implement written policies to prohibit abuse, mistreatment, and neglect of residents and misappropriation of residents' property. After May 1999, code number 224 was split into two codes, with code number 224 indicating the failure to develop these policies and code number 226 indicating the failure to implement these policies.

inspectors use code 225 to cite nursing homes that have failed to properly investigate and report allegations of abuse, neglect, or mistreatment, or to ensure that staff do not have a documented history of abuse, neglect, or mistreatment of residents.⁶

The state inspectors also use an alphabetical code to rank the violations. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. Each violation is given a letter rank, A to L, with A being the least serious (an isolated violation that poses minimal risks to residents) and L being the most serious (a widespread violation that causes or places residents in immediate jeopardy of death or serious injury). Violations categorized as A, B, or C present a risk of only minimal harm to residents. Violations categorized as D, E, or F present the potential for more than minimal harm to residents. Violations categorized as G, H, or I cause “actual harm” to residents. Violations categorized as J, K, or L are those that cause death or serious injury to residents or place them in immediate jeopardy of death or serious injury.

This report analyzes the results, as reported in the OSCAR and nursing home complaint databases, of all nursing home inspections and investigations conducted in the two-year period between January 1, 1999, and January 1, 2001. The report considers violations in codes 223, 224, 225, and 226 to be abuse violations. The report determines the total number of nursing homes cited for these abuse violations; the number of nursing homes cited for multiple abuse violations; and the types and severity of these abuse violations. In order to ensure that all abuse violations included in this report were for violations that caused or had the potential to cause more than minimal harm to residents, this analysis only included violations categorized as D or higher on the scope and severity scale.

In addition, to assess trends in the incidence of abuse violations, the report examines changes in the percentage of nursing homes cited for abuse violations during annual inspections in each calendar year from 1996 to 2000.

B. Analysis of State Inspection Reports and Citations

In addition to analyzing the data in the OSCAR and nursing home complaint databases, the report analyzes in detail a sample of the actual inspection reports prepared by state nursing home inspectors. These inspection reports, prepared on a HCFA form known as “Form 2567,” contain the inspectors’ documentation of the conditions at the nursing home.

The minority staff randomly selected for review the inspection reports of 50 nursing

⁶Federal law requires that states maintain a registry that includes documented findings of resident abuse by nursing assistants. 42 U.S.C. § 1396r(e)(2). In 1996, however, the Institute of Medicine, a branch of the National Academy of Sciences, found that the registries have had a “limited effect” because of difficulties in verifying information in the registries and delays in entering information. Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes*, 183 (1996)

homes in ten states that were cited for abuse violations that caused actual harm.⁷ In addition, the minority staff also reviewed over 20 HCFA Form 2567s that had been previously obtained in the course of investigating nursing home conditions for individual members, citations for abuse issued by the State of California, and a few cases of abuse that were brought to the attention of the Special Investigations Division by family members.

C. Interpretation of Results

The results presented in this report are representative of the conditions in U.S. nursing homes at the times they were inspected. In the case of any individual home, however, current conditions may differ from those documented in the annual inspection or complaint investigation reports. Nursing home conditions can change over time. New management or enforcement activities can rapidly improve conditions; other changes can lead to sudden deterioration. According to GAO, many nursing homes with serious deficiencies exhibit a “yo-yo pattern” of noncompliance and compliance: after a home is cited for deficiencies, it briefly comes into compliance to avoid fines or other sanctions, only to slip into noncompliance after the threat of sanctions is removed.⁸

For this reason, this report should be considered representative of nursing home abuse in the United States from January 1999 through January 2001. It is not intended to be -- and should not be interpreted as -- an analysis of current conditions in any individual nursing home.

The report is also not an estimate of the number of nursing homes residents who have been victimized by abuse. There is no data available that quantifies how many residents have suffered abuse. Some of the abuse violations reviewed in this report involved only one resident in the nursing home; other violations involved numerous residents.

III. FINDINGS

There are approximately 17,000 nursing homes in the United States with approximately 1.5 million residents. An analysis of the results of two years of state inspection and complaint investigation reports for these facilities reveals that abuse of nursing homes residents is a widespread and serious problem.

A. Thousands of Nursing Homes Have Recently Been Cited for Abuse Violations

Over thirty percent of the nursing homes in the United States -- 5,283 nursing homes --

⁷The ten states were California, Florida, Illinois, Indiana, Michigan, Missouri, New York, Ohio, Oregon, and Texas.

⁸GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 12-14 (Mar. 1999). (“This yo-yo pattern of compliance and noncompliance could be found even among homes that were terminated from Medicare, Medicaid, or both”).

were cited for an abuse violation between January 1, 1999, and January 1, 2001.⁹ All of these violations had at least the potential to cause more than minimal harm to nursing home residents. During the two-year period examined in this report, these nursing homes were cited for 8,972 abuse violations.

The most frequent abuse violation was the failure to properly investigate and report allegations of resident abuse, neglect, or mistreatment or to ensure that nursing home staff do not have a documented history of abusing, neglecting, or mistreating residents. In total, 3,797 nursing homes were cited by state inspectors for this abuse violation.

The second most common abuse violation was the failure to develop and implement written policies that prohibit abuse, mistreatment, and neglect of residents and the misappropriation of residents' property. In total, 2,314 homes were cited by state inspectors for this abuse violation.

The third most common abuse violation was the failure to protect residents from sexual, physical, or verbal abuse, corporal punishment, or involuntary seclusion. In total, 1,009 nursing homes -- almost 20% of all homes cited for an abuse violation -- were cited for this violation.

B. Many of the Abuse Violations Caused Harm to Residents

Many of the abuse violations cited by state inspectors were for serious violations that caused actual harm to residents. In total, 1,345 nursing homes were cited for an abuse violation that actually harmed residents. An additional 256 homes were cited for abuse violations that resulted in death or serious injury or placed residents in immediate jeopardy of death or serious injury. Overall, 1,601 nursing homes -- over 9% of all U.S. nursing homes -- were cited for abuse violations that caused actual harm or placed residents in immediate jeopardy (Table 1).

Table 1: Many Nursing Homes Have Been Cited for Abuse Violations That Caused Actual Harm to Residents or Worse During Recent Inspections (1999 - 2000).

Severity of Abuse Violation Cited by Inspectors	Number of Homes	Percent of Homes
Potential for More than Minimal Harm	3,682	21.3%
Actual Harm to Residents	1,345	7.8%
Actual or Potential Death/Serious Injury	256	1.5%
All Violations	5,283	30.5%

C. Many Cases of Abuse Are Uncovered Only After a Formal Complaint

Nursing homes are inspected for two reasons. First, states are required to inspect the quality of care in all Medicare or Medicaid certified nursing homes at least once each year. Second, if a resident, a resident's family, or another member of the community files a complaint

⁹In addition, 834 homes were cited for 1,364 abuse violations that presented only a risk of minimal harm.

about substandard care in a nursing home, the state must investigate that complaint. The data obtained from HCFA indicates that many abuse cases are uncovered only during these complaint investigations.

Overall, over 40% of all abuse violations were discovered during complaint investigations. Between January 1999 and January 2001, 2,450 nursing homes were cited for 3,835 abuse violations after a complaint was received by the state. Abuse violations stemming from complaints were more likely to be serious violations that caused actual harm to residents. Overall, 36% of abuse violations discovered during complaint investigations caused actual harm to residents. In comparison, 23% of abuse violations uncovered during annual inspections caused actual harm to residents.

D. Many Nursing Homes Have Multiple Abuse Violations

Many nursing homes have a history of abuse violations or have had multiple abuse violations since January 1999. Overall, 1,327 homes were cited for more than one abuse violation between January 1999 and January 2001. A total of 305 homes were cited for three or more abuse violations, and 192 nursing homes were cited for five or more abuse violations in the two-year period between January 1999 and January 2001. Moreover, 541 nursing homes were cited for at least two abuse violations that caused actual harm to residents during this period.

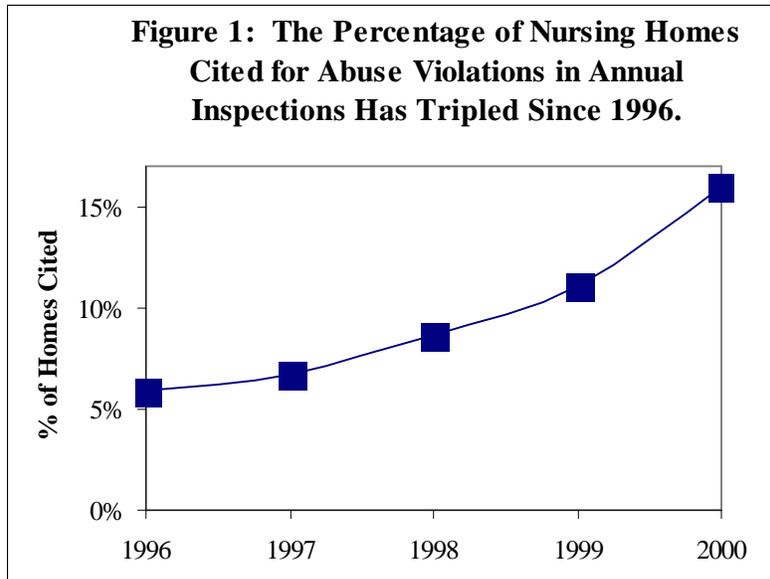
E. The Incidence of Abuse Violations Has Risen Dramatically

The percentage of nursing homes cited for abuse violations during annual state inspections has almost tripled since 1996. In 1996, 5.9% of all nursing homes were cited for an abuse violation during their annual inspections. The percentage of homes cited for abuse violations has risen in each successive year. In 2000, 16.0% of nursing homes were cited for an abuse violation during their annual inspections. Figure 1 illustrates the trends in abuse violations during annual inspections since 1996.¹⁰

The reason for this increase is not clear. Some of the increase in abuse violations is likely due to increased enforcement efforts by state inspectors and better reporting of abuse violations. In July 1998, the Clinton Administration introduced an initiative to increase the quality of care in nursing homes. One goal of this initiative was to reduce the incidence of abuse and neglect. Other goals were to reduce pressure sore violations and the improper use of restraints. As part of the initiative, survey protocols were redesigned to focus on serious patient threats such as abuse. The initiative also required states to conduct a certain number of surveys at night or during weekend hours, and not during the same week every year. This was an effort to ensure that

¹⁰This trends analysis is based on the annual state inspections, not the complaint investigations. According to HCFA, prior to 1999 states had different methods for reporting complaint data to HCFA and there was no comprehensive, consistent national database of complaint investigation results.

inspectors could get an accurate picture of what was going on in the facility on a typical day.¹¹ Because of the focus on abuse and other significant violations, as well as other changes in the survey protocol, HHS stated that it “expected an initial increase in the number and severity of deficiencies as states focused increased attention on the survey process.”¹²



It is also possible, however, that some of the increase in abuse violations represents an increase in the incidence of abuse. One factor that could account for such an increase is the 1997 repeal by Congress of a provision of nursing home law known as the “Boren Amendment.” This provision guaranteed that nursing homes would receive “reasonable and adequate” Medicaid reimbursements to provide quality care. Since the repeal of the Boren Amendment, there is evidence suggesting that Medicaid reimbursement rates have not kept pace with the rising costs of providing nursing home care.¹³ Nursing homes have argued that lower Medicaid reimbursement rates have made it more difficult for them to recruit and retain quality staff.¹⁴

¹¹In addition to the changes made in the annual survey process, the Clinton Administration also established new procedures for complaint investigations. Under these procedures, states were required to complete complaint investigations for violations that put residents in immediate jeopardy within 48 hours, and complete all complaint investigations within ten days of receiving the complaint.

¹²Letter from Department of Health and Human Services to Senator Charles E. Grassley (Apr. 17, 2000).

¹³Department of Health and Human Services, *Report to Congress: Appropriateness of Minimum Nursing Staffing Ratios in Nursing Homes*, 2-12, 2-13 (Spring 2000).

¹⁴American Health Care Association, Press Release, *National Health Care Group Questions HHS Study Criticizing Staffing Levels in Skilled Nursing Facilities* (July 25, 2000)

F. Potential for Underreporting Violations

The report's analysis of the incidence of nursing homes cited for abuse violations was based on the data reported to HCFA in the OSCAR database. However, according to the U.S. General Accounting Office (GAO), even though this database is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."¹⁵ One problem, according to GAO, is that "homes could generally predict when their annual on-site reviews would occur and, if inclined, could take steps to mask problems otherwise observable during normal operations."¹⁶ A second problem is that state inspectors frequently miss many important violations.¹⁷ And in some cases, nursing homes are not regulated by the federal government at all. Nursing homes that do not accept Medicaid or Medicare funds are not subject to federal inspection and quality of care requirements. Even where there are egregious cases of abuse in these homes, federal inspectors cannot inspect these home or cite them for violations.¹⁸

In addition to the general problems of underreporting identified by GAO, researchers have reported that abuse cases are especially likely to go undetected or unreported.¹⁹ Almost 40% of the abuse violations identified in this report were discovered after the filing of a formal complaint. Because formal complaints are not filed for many cases where residents are abused, it is likely that the incidence of abuse is even higher than indicated in this study.

IV. DOCUMENTATION OF VIOLATIONS IN THE INSPECTION REPORTS

To assess the severity of the abuse violations at nursing homes in the United States, the minority staff examined the state inspection reports, citations or other documentation for over 70

(online at www.ahca.org/brief/nr000725c.htm).

¹⁵GAO, *Nursing Homes: Additional Steps Needed*, *supra* note 8, at 30.

¹⁶GAO, *California Nursing Homes: Care Problems Persist Despite Federal and State Oversight*, 4 (July 1998).

¹⁷*Id.* at 18-19. Federal inspectors independently inspect a select number of nursing homes after the states have completed their inspections. A recent GAO report found that in 69% of the instances in which this follow-up federal inspection was conducted, federal inspectors found more serious deficiencies than the state inspectors had found. GAO, *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality*, 9 (Nov. 1999).

¹⁸According to the Social Security Act, a nursing home is defined as an institution or a "distinct part" of an institution. Nursing homes can designate a "distinct part" of the home for Medicare and/or Medicaid patients. Other parts of the home with no Medicare or Medicaid patients are not subject to federal nursing home requirements. See HCFA, *State Operations Manual*, § 3202. *re: Requirements for "Distinct Part" Certification* (May 2000).

¹⁹Pillemer and Moore, *Highlights from a Study of Abuse of Patients in Nursing Homes*, *Journal of Elder Abuse and Neglect*, 2, 5-30 (1990).

nursing homes with incidents of abuse. This review indicates that many of the abuse violations involve serious incidents, often resulting in substantial harm to residents.

A. Violations Involving Physical Abuse

The state inspection reports and citations documented that many residents were subjected to serious physical abuse by nursing home staff. This physical abuse caused numerous injuries, including a fractured femur,²⁰ a fractured hip,²¹ a fractured elbow,²² severe bruises,²³ lacerations of the head, neck, and hands,²⁴ bruises to the eye and bruises to the thigh,²⁵ a fractured wrist,²⁶ a fractured thumb,²⁷ and a variety of other injuries.

In an Illinois nursing home, a staff member cursed at a resident and then hit her in the face, breaking her nose and bloodying her mouth. The resident was in respiratory distress after the incident and required oxygen and continued suctioning as she was coughing up bright red blood. According to interviews with state inspectors, the abusive aide had walked into the resident's room stating to her, "You're going to help me this time. I'm tired of your ass." Despite the fact that this staff member had a history of abusive behavior towards residents, no investigation of the incident was conducted by administrators on site and the incident was not resolved until intervention by the local police department six days later.²⁸

²⁰HCFA Form 2567 for Nursing Home in Winchester, Ohio (K-level violation) (June 18, 1999).

²¹HCFA Form 2567 for Nursing Home in Roseville, Illinois (Jan. 21, 2000) (H-level violation).

²²HCFA Form 2567 for Nursing Home in Roseville, Illinois (Jan. 21, 2000) (H-level violation).

²³HCFA Form 2567 for Nursing Home in Winchester, Ohio (K-level violation) (June 18, 1999).

²⁴HCFA Form 2567 for Nursing Home in Dayton, Ohio (G-level violation) (May 28, 1999).

²⁵HCFA Form 2567 for Nursing Home in Indianapolis, Indiana (G-level violation) (May 28, 1999).

²⁶HCFA Form 2567 for Nursing Home in Winter Springs, Florida (G-level violation) (June 18, 1999).

²⁷HCFA Form 2567 for Nursing Home in Fort Worth, Texas (J-level violation) (Jan. 7, 2000).

²⁸HCFA Form 2567 for Nursing Home in Oak Lawn, Illinois (J-level violation) (Mar. 17, 2000)

In a Missouri nursing home, an 80-year old stroke victim suffering from dementia and impaired short- and long-term memory was violently abused on repeated occasions. This resident was locked in a bathroom, hit with a belt, dragged on his knees, and hit in the head with a book by nursing home employees. Nursing home employees also used cigarettes to bribe a brain-damaged 50-year old resident to attack the 80-year old resident. Because of the resident's impaired memory, family members did not learn of the abuse until another staff member at the facility reported the incident.²⁹

In a case involving an Ohio nursing home, a resident was abused by a staff member who "yanked" him out of bed, "slammed" him into a chair, closed off the resident's nose with his hand to cut off his airway, pried back the resident's thumb, verbally abused him, and let him fall to the floor. The staff person was not disciplined and continued to work at the facility.³⁰ In another case involving an Ohio nursing home, a resident was observed with severe lacerations on the ear, skin tears, and bruising on his neck and hands. When asked by two staff members who had hurt him, the resident replied, "He'll beat me up again if I tell you." Later, the resident identified a male aide, who confessed to abusing the resident.³¹

In another case, a Michigan nursing home resident was attacked by an aide who hit him in the eye. This resident stated that the staff member was in a "rage." The resident's roommate also complained about the rough treatment by this staff member, stating, "He's sadistic. It seems he likes to hurt people." Upon review of the nursing home's personnel files, state inspectors found that this aide had been alleged to have also sexually molested a female resident and had numerous disciplinary and work-related complaints. The sexual abuse allegation had not been investigated or reported to the state.³²

In a California nursing home, a resident was pushed to the ground by a staff member, who was observed "kicking the resident on the sides of her body and her face."³³

In many other cases, the instances of physical abuse involved nursing homes that failed to protect residents from assaults by other residents. For example:

²⁹Missouri Department of Social Services, Police, and Court Records (1999). In this case, because the resident was a private pay patient in a section of the nursing home that did not accept Medicare or Medicaid patients, federal authorities declined to review the case, citing a lack of authority.

³⁰HCFA Form 2567 for Nursing Home in Utica, Ohio (J-level violation) (July 17, 1999).

³¹HCFA Form 2567 for Nursing Home in Dayton, Ohio (K-level violation) (May 28, 1999).

³²HCFA Form 2567 for Nursing Home in Montrose, Michigan (G, H-level violations) (June 4, 1999)

³³State Citation Issued to Nursing Home in Pomona, California (Feb. 17, 2000).

- In an Indiana nursing home, a resident was killed by another resident. The abusive resident had a long history of exhibiting explosive physical and verbal aggression towards residents and staff. His records contained over 50 instances of abusive behavior; he had a criminal record; and he was described by a psychiatrist as “an accident looking for a place to happen.” But the nursing home did not intervene to protect vulnerable residents from the abusive resident. The resident who was killed was standing in a hallway when the attacker approached her, called her a “f***ing b****,” grabbed her by her arms, lifted her off the floor, and slammed her against a wall. The resident was knocked unconscious and suffered a cerebral contusion. Three weeks later the resident died, and her death was ruled a homicide by the County Coroner.³⁴
- In a Colorado nursing home, the facility failed to protect residents from an abusive resident with an 11-month history of attacking other residents. During this period, the resident was involved in 39 reported incidents of physical and verbal aggression, including throwing water pitchers at other residents, punching a female resident in the face, and spitting on and threatening to kill other residents. In the most extreme instance, the abusive resident attacked a female resident, who suffered “hematomas to both eyes, [her] lip was black and blue, [and] both forearms had skin torn to the tendons.”³⁵
- In a similar instance in a Long Island nursing home, the facility failed to protect residents from an abusive resident despite at least 25 reported incidents of abuse over a four-month period. These incidents included hitting, kicking, slapping, and biting other residents, throwing chairs at other residents, and squeezing the breasts of female residents.³⁶
- In another Long Island nursing home, the facility failed to protect residents from an abusive resident who fought with other residents and took their belongings. At one point, the abusive resident smothered his roommate’s face with a pillow.³⁷
- In an Illinois nursing home, the facility failed to protect a resident who was assaulted in three separate physical altercations with other residents, including one in which the resident fractured his hip. A resident of the same nursing home suffered a fractured

³⁴HCFA Form 2567 for Nursing Home in Evansville, Indiana (Feb. 8, 2000) (H-level violation); Vanderburgh County Coroner, *Report of Autopsy, Case or Autopsy No. 99JC-140* (Nov. 11, 1999).

³⁵HCFA Form 2567 for Nursing Home in Northglenn, Colorado (Apr. 10, 2000) (G-level violation).

³⁶HCFA Form 2567 for Nursing Home in Great Neck, New York (Sept. 3, 2000) (G-level violation).

³⁷HCFA Form 2567 for Nursing Home in Island Park, New York (Oct. 8, 1999) (D-level violation).

elbow when assaulted by another resident.³⁸

- In an Oklahoma nursing home, there were seven instances of residents being physically abused by other residents during a one-month period. In one incident, the abuse fractured a resident's hip, requiring hospitalization. In another incident at the facility, a resident was hit in the head with dishware. According to inspectors, the facility also failed to control aggressive behavior by a resident who hit another resident seven times in the face.³⁹

B. Violations Involving Sexual Abuse

The state inspection reports also documented numerous instances where residents of nursing homes were subjected to sexual abuse by nursing home personnel or other residents.

For example, in one California nursing home, a male nurse aide molested two elderly female residents by putting his finger in their vaginas while bathing them. Inspectors found that the facility had failed to perform a complete background check of the staff member.⁴⁰

In another California nursing home, a nurse aide entered the room of a female resident suffering from senile dementia and found a male staff member on top of the resident with his pants down and the resident's legs spread. The aide was later arrested.⁴¹

In a third California nursing home, a 90-year old female resident was approached by a male employee who "exposed his penis and asked the resident to put it in her mouth."⁴²

In another incident, a female resident in one home in New Jersey said that a male aide had made vulgar, sexual remarks to her while assisting her in the shower. She also stated that "he would come into her room while she was in bed, kiss her cheek and feel her breasts. On one occasion, he exposed his genitals to her." Although the resident reported the incident to the staff, state inspectors found that the facility neither investigated the allegations nor reported the allegations to the proper authorities.⁴³

³⁸HCFA Form 2567 for Nursing Home in Roseville, Illinois (Jan. 21, 2000) (H-level violation).

³⁹HCFA Form 2567 for Nursing Home in Jones, Oklahoma (Mar. 2, 2000) (E-level violation).

⁴⁰State Citation Issued to Nursing Home in Walnut Creek, California (May 3, 1999).

⁴¹State Citation Issued to Nursing Home in Alameda, California (Oct. 27, 1999).

⁴²State Citation Issued to Nursing Home in Santa Monica, California (Aug. 8, 2000).

⁴³HCFA Form 2567 for Nursing Home in Long Branch, New Jersey (H-level violation) (Aug. 18, 1998).

In other cases, nursing homes failed to protect residents from sexual abuse by other residents. For example:

- In one Texas nursing home, a male resident was discovered by facility staff laying on top of a female resident with his pants and underwear off, attempting to pry her legs apart. The male resident had an extensive history of inappropriate sexual contact, fondling, and propositioning of female staff and residents. Facility staff were aware of this resident's sexually aggressive behavior, but failed to take protective measures to prevent abuse.⁴⁴
- In another Texas nursing home, an abusive male resident repeatedly sexually harassed and abused female residents, touching their breasts and genital areas and trying to "get under their clothes."⁴⁵
- In a California nursing home, the facility failed to properly monitor and control a male resident who exhibited sexual aggressiveness towards female residents. The resident was observed kissing and touching the breasts of one female resident, and was found lying on top of another resident whose gown had been removed.⁴⁶
- In an Ohio nursing home, a resident with dementia abused 13 other residents over a ten month period, including sexually assaulting a female resident, punching and slapping numerous residents in the face, and striking another resident in the head with a coffee mug.⁴⁷

In other cases, nursing homes simply failed to investigate instances of apparent sexual abuse. For example, in one Oregon nursing home, state inspectors found that a female resident with dementia had a "bruised area and a small abrasion inside the labia" that was indicative of abuse. Upon investigating her condition, the inspectors learned that the nursing home had conducted no inquiry into this apparent sexual abuse. The director of nursing explained to the inspectors that "maybe she fell on a broomstick."⁴⁸

In another Oregon nursing home, residents were repeatedly subject to sexual abuse by another resident, including fondling that "occurred daily at breakfast." No action was taken by

⁴⁴HCFA Form 2567 for Nursing Home in Deport, Texas (G-level violation) (May 2, 2000)

⁴⁵HCFA Form 2567 for Nursing Home in Littlefield, Texas (H-level violation) (Nov. 2, 1999).

⁴⁶State Citation Issued to Nursing Home in Placerville, California (Mar. 23, 2000).

⁴⁷HCFA Form 2567 for Nursing Home in Winchester, Ohio (K-level violation) (June 18, 1999).

⁴⁸HCFA Form 2567 for Nursing Home in Sheridan, Oregon (Aug. 17, 1999) (G-level violation).

the nursing home, and no appropriate plan was developed to prevent this abuse.⁴⁹

C. Violations Involving Verbal or Other Abuse

The review of the state inspection reports reveals that, in addition to sexual and physical abuse, nursing home residents were subjected to verbal and other forms of abuse. For example, the state inspection reports documented instances where nursing staff told residents “If you hadn’t sh*t all over yourself, I wouldn’t have to clean your ass,”⁵⁰ and “I . . . am sorry you were born,”⁵¹ told residents that “they ate like a pig,”⁵² told residents to “shut the f*** up,”⁵³ and called residents “a blob,”⁵⁴ “stupid,”⁵⁵ and “bitch.”⁵⁶

In an Oklahoma nursing home, residents were subject to repeated instances of verbal abuse from staff. When a resident asked for her medications, a nurse aide told her that “she hoped the resident choked on them.” In the same nursing home, a staff member was overheard saying that “the residents they didn’t want to die did, and those they wanted to die didn’t.”⁵⁷

This verbal abuse can have serious effects. In one Texas nursing home, two residents were subjected to repeated instances of verbal abuse and intimidation at the hands of an aide.⁵⁸ One of the residents stated that a staff member would yell at him for using his call light and that the staff member would “tell him she didn’t have time to be bothered with him.” At other times when the resident used his call light, the same aide would come to the resident’s room and yell at

⁴⁹HCFA Form 2567 for Nursing Home in Newberg, Oregon (G-level violation) (Feb. 21, 1999).

⁵⁰HCFA Form 2567 for Nursing Home in Sullivan, Illinois (G-level violation) (Oct. 19, 1999).

⁵¹HCFA Form 2567 for Nursing Home in Poway, California (G-level violation) (Jan. 26, 2000).

⁵²State Citation Issued to Nursing Home in El Monte, California (Nov. 2, 2000).

⁵³State Citation Issued to Nursing Home in Castro Valley, California (Apr. 5, 2000).

⁵⁴State Citation Issued to Nursing Home in Moss Beach, California (Oct. 31, 2000).

⁵⁵HCFA Form 2567 for Nursing Home in Danbury, Connecticut (D-level violation) (Aug. 5, 1999).

⁵⁶HCFA Form 2567 for Nursing Home in Fort Worth, Texas (J-level violation) (Jan. 7, 2000).

⁵⁷HCFA Form 2567 for Nursing Home in Pauls Valley, Oklahoma (Nov. 23, 1999) (complaint investigation).

⁵⁸HCFA Form 2567 for Nursing Home in Dallas, Texas (G-level violation) (Mar. 1, 2000)

him, “What do you want now, you’re always wanting something.” The resident’s roommate confirmed his fear of the staff member, and noted that he tried to transfer himself to avoid contact with the aide. The resident was so afraid of the abusive staffer that he did not seek any assistance even after he fell twice from his bed and fractured his hip. Only after intervention by state inspectors and a social worker from the Texas Department of Human Services was this employee forced to resign.

In some cases, nursing homes were also cited for abuse violations for intentionally denying basic care to residents. For example, in one Florida nursing home, a staff person forced a call light from a resident’s hand, placed it out of reach, and refused to comply with the resident’s requests for assistance on numerous occasions. When the resident required a bedpan at night, the staff person did not provide it, forcing the resident to urinate in bed and wait until morning for their diaper to be changed.⁵⁹

V. CONCLUSION

This report finds that abuse of nursing home residents is a widespread and significant problem. In the last two years, nearly one out of every three nursing homes in the United States has been cited for violating federal standards established to prevent abuse of nursing home residents. In over 1,600 of the nursing homes cited for abuse violations, the violations caused actual harm to residents or placed residents in immediate jeopardy of death or serious injury. The review of a sample of state inspection reports and citations in this report indicates that these violations often involve serious abuses that cause significant damage to the health and well-being of nursing home residents.

⁵⁹ HCFA Form 2567 for Nursing Home in St. Augustine, Florida (G-level violation) (Aug. 6, 1999).