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MEDICAL LIABILITY IN LONG TERM CARE: IS ESCALATING LITIGATION A THREAT TO QUALITY AND ACCESS?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

WASHINGTON, DC

July 15, 2004

Serial No. 108–39

Printed for the use of the Special Committee on Aging

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MEDICAL LIABILITY IN LONG TERM CARE: IS ESCALATING LITIGATION A THREAT TO QUALITY AND ACCESS?

THURSDAY, JULY 15, 2004

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2 p.m., in room SD–628, Dirksen Senate Office Building, Hon. Larry E. Craig (chairman of the committee) presiding.

Present: Senators Craig, Shelby, Dole, Kohl, Lincoln, and Carper.

OPENING STATEMENT OF SENATOR LARRY E. CRAIG, CHAIRMAN

The CHAIRMAN. Good afternoon, everyone. The U.S. Senate Special Committee on Aging will be convened. I welcome all of you.

Over this committee's history, we have explored numerous issues related to the future of long term care. It is well-known that as our Nation ages, the pressure on the long term care system will be enormous in the coming years. Clearly, nursing homes are a valid and essential component of the long term care system. When we receive care at home or in other community settings, there are options. But as we grow more frail, sometimes our elderly have no option, but to have stays in the nursing home setting.

Recently released studies now show that escalating medical liability is beginning to present challenges to access and quality of care for nursing home residents. Tort claims against long term care providers nationwide are the fastest-growing area of health care litigation. The cost of claims over the last 3 years is estimated at over $2 billion, and the average medical insurance premium cost is over 200-percent higher than it was in 2001. These rapidly escalating costs are a massive challenge, especially for smaller providers serving the elderly in rural communities.

Our investigation is based on the latest-available data on the effects of liability costs on quality care and access for our most vulnerable seniors. It is therefore important to remain objective, ask difficult questions and explore solutions to this emerging problem.

The effects of unprecedented increases in long term care litigation costs are twofold:

First, excessive litigation is forcing many doctors to quit serving patients in nursing homes.

Second, the situation is draining resources that should be used to provide quality patient care to nursing home residents. These

trends cannot be allowed to continue. We must ensure that quality long term care services are available to the vulnerable elderly when they are in their greatest need and require their greatest care.

In a recent survey, one out of every five doctors in nursing homes said that they had problems obtaining or renewing their medical liability insurance in this past year. Ten percent said they have already stopped caring for the elderly in these facilities. In addition, medical doctors are leaving the industry due to rising liability costs. This is having a negative impact on people who need the care most.

Before we proceed with today's hearings, I want to make one point clear. Those people who abuse or neglect or intentionally cause harm to our seniors must be held accountable and should be prosecuted to the fullest extent of the law. This hearing is not about that. This hearing is making sure that elderly receive quality care and that resources are not drained unintentionally by the cost of insurance.

We have our colleagues joining at this moment. So, before I introduce our panel of witnesses, let me turn to Senator Shelby, who is here today. One of his constituents is with us. He may want to visit about him and make any opening comments you would wish to make.

Richard?

STATEMENT SENATOR RICHARD SHELBY

Senator SHELBY. Mr. Chairman, thank you very much. First of all, thank you for calling this hearing. I appreciate the work that you are doing as far as leading this committee. I have been tied up all day on Banking. I have got to go right back to another hearing.

So, if you would bear with me just a minute, I do not have this opportunity every day here, but, Mr. Chairman, I am honored to have the opportunity to just tell you a little bit about one of the panelists here, and that is Mr. Norman Estes, who will provide testimony today. Norman Estes is president and CEO of Northport Health Services, Inc., and a representative of the American Health Care Association, and as such will be able to speak directly to the issues being discussed today.

As a fellow native of Tuscaloosa County, AL, I have known Norman and his family for many, many years. He is a friend. I have the highest regard for his intellect, his integrity and his business ability. Norman is a veteran of the long term care industry and has been associated with nursing facilities all of his life. In fact, the company he owns today is a continuation of a tradition of service to the elderly that began more than 40 years ago by his grandmother who cared for residents in her own home.

Later, Norman's father expanded this commitment to caring through a series of nursing facilities throughout Alabama. Upon his father's retirement, Norman purchased three of his facilities and formed what is now known as Northport Health Services, Inc.

Building upon his successes here, Mr. Chairman, Norman Estes has grown Northport Health Services from three nursing facilities in Alabama, my State and his, to 39 nursing facilities throughout

the Southeast. He is also involved with other long term care-related ventures, including pharmacies, therapy companies and a medical supply company. He has been a leader in numerous trade associations throughout the Southeast, including the Alabama Nursing Home Association, the Missouri Health Care Association, the Florida Health Care Association and the Arkansas Health Care Association.

He has also been an active member of the American Health Care Association, in whose capacity, as I said, he appears today. He served on its Regional Multi-Facility CEO Committee, the Policy Council and the Steering Committee to Save Long term Care, where he was chairman of the Tort Reform Subcommittee.

Mr. Chairman, I want to thank you again for holding this timely committee hearing, and I hope you will excuse me because I have got to chair another committee.

Thank you very much.

The CHAIRMAN. Richard, thank you very much for coming by to introduce one of your constituents, and certainly a very valuable spokesman for the American Health Care Association.

Now, let me turn to our colleague on the committee, Senator Herb Kohl. Herb, do you have any opening comments you would like to make?

STATEMENT OF SENATOR HERB KOHL

Senator KOHL. I do, Mr. Chairman. I appreciate your holding this hearing today, at which we will consider the important issue of medical liability reform and how it affects long term care providers and, in particular, nursing homes.

Those of who serve on the Judiciary Committee have some experience with this issue, as we held a hearing on the broader topic of medical malpractice reform last year. We heard then, and we will surely hear today, that we are experiencing a medical malpractice crisis. The number of nursing home beds is declining and doctors are quitting. Unfortunately, legislation we have considered in this Congress that simply cap damage awards, in my judgment, is the wrong approach in addressing this issue. Therefore, I have opposed those bills, and I will continue to do so until we address liability reform with some fresh ideas that I believe would enjoy broad, bipartisan support.

Perhaps we could look to those States that have responded successfully to the pressure of high insurance premiums. Wisconsin is one of those States, and it has a system in place that works well for doctors and patients alike. As a result, we do not have a crisis of insurance premiums or doctors closing their practices or moving out of my State.

Although Wisconsin enacted damage cap awards, in 1995, it also maintains a Patients Compensation Fund and backs a risk-sharing plan for those physicians in nursing homes who cannot obtain insurance in the private market. Not surprisingly, Wisconsin's medical malpractice insurance premiums are below the Nation's average.

Unfortunately, Wisconsin's success is not universal. A so-called reform based on arbitrarily capping pain and suffering awards, in my opinion, is not the answer. Studies show that passing a Federal

medical malpractice law, with damage caps, might have no impact at all on runaway insurance premiums.

Further, there is no promise that any savings insurance companies realize from such a law would be passed on to doctors and ultimately to patients. We would expect the same uncertainty when it comes to caps for long term care.

A full and fair debate on the issue of medical malpractice must look at all facets of this issue. For example, some argue that many of the most serious cases, cases of serious injury or death, are brought against a handful of facilities. Perhaps we should focus more of our attention on cleaning up these bad actors if we want to decrease the litigation faced by the nursing home industry.

As a member of the Appropriations Committee, I have worked for several years to increase funding for State survey agencies so that they can better inspect nursing homes, respond to complaints and help to improve the quality of care. Focusing on improving care at the front end, rather than flatly denying legal rights to people who have been harmed is a far more productive effort.

Finally, it is worth mentioning that while we spend a few hours today focusing on the costs of litigation, we need to remember that this committee has spent countless hours focusing on abuse and neglect in nursing homes. While a vast majority of nursing homes work hard to provide good care to their residents, all of us on this committee know that there are serious problems in nursing homes today.

Over the years, we have heard stories of people with bed sores that go to the bone, people left in their own waste, and people with severe malnutrition and dehydration. We have also heard stories of people who have been beaten and sexually assaulted. So, as we hear today about so-called frivolous lawsuits, let us not forget that there are real people who are being abused, starved and neglected, and the safety of those vulnerable residents must, and I am sure always will be, Mr. Chairman, our top priority.

Thank you.

The CHAIRMAN. Herb, thank you very much for that opening statement.

Now, let me turn to our colleague from North Carolina, Senator Elizabeth Dole. I believe you have a constituent on the panel today that you might like to introduce in your opening comments.

STATEMENT OF SENATOR ELIZABETH DOLE

Senator DOLE. Thank you.

Dr. Larry Cutchin, from North Carolina. Dr. Cutchin, I am very pleased to have you here today. Thank you so much. Mr. Chairman, thank you for holding this hearing today.

Few issues are as important to Americans right now as the rising cost of health care. While the ever-increasing costs concern millions of Americans, there is a way to address the crisis. Passage of real, responsible medical liability reform is one effective answer to the dilemma of growing health care expenses. The broken medical liability system drives up costs for patients and for taxpayers, at least $28 billion each year for the Federal Government alone. According to a 2003 Joint Economic Committee report, meaningful medical liability reform could lower health care costs significantly

and enable an estimated 3.9 million Americans to afford health insurance.

A recent survey found that 8 out of 10 doctors say they have ordered more tests than they need as a defensive measure to avoid litigation. I can remember hearing that from many doctors as I have traveled North Carolina. Three out of 4 refer patients to specialists more often than they believe is medically necessary.

America is in the midst of a crisis. Those who need health care, the most vulnerable and sickest among us, are the real victims. We have all heard their stories. Too many of our patients cannot get doctors, cannot get specialists, cannot get health care.

In my home State of North Carolina, rural residents have been among the hardest hit. In fact, North Carolina is included on a list of 20 States that the American Medical Association says are suffering from a medical liability crisis. According to the AMA, some North Carolina hospitals have seen their liability insurance premiums rise 3 to 5 times in the last few years. Specialists, like our obstetricians, emergency doctors and anesthesiologists, are seeing even higher increases. The level 3 trauma center in Cabarrus County, NC, which is right down the road from my hometown of Salisbury, serves more than 68,000 patients per year, and it is facing the possibility of closure because a 17-member emergency medical group experienced increased premiums of 88 percent with reduced coverage.

I have heard from many doctors, as I have said, in my State, and this crisis is having a detrimental effect on our medical providers. Too many of them cannot afford rising malpractice insurance rates. They have had to curb their medical practices, stop taking some patients, move to another State, perhaps the most painful, leave the profession altogether.

Dr. Jack Schmidt, of Raleigh, NC, says his insurance premiums went from $18,000 a year to $45,000 a year. I talked to him recently here in Washington. He eventually decided to leave his practice in Raleigh, and he is teaching at the University of Virginia Medical School.

Dr. Mary-Emma Beres, of Sparta, NC, had to stop delivering babies altogether after facing a 300-percent increase in her malpractice premiums. Now, there is only one obstetrician in the town of Sparta, which is a person capable of handling high-risk cases, and that is forcing some women who need C-sections to endure a 40-minute ambulance ride to another hospital. It is wrong to deny access to adequate health care. Let me be clear, there are many cases where going to court over a medical mistake is certainly legitimate.

What we are talking about today, however, are frivolous lawsuits and an abused system. This hearing is about the need to pass responsible medical liability reform to curb the trend of multi-million-dollar payouts, 40 percent of which go directly to the patient's attorney.

During a visit to North Carolina in 2002, President Bush spoke in High Point, home of a regional health care system that, like so many others in our country, is feeling the strain of medical liability concerns. While in town, he spoke about why Congress must play a role in this battle. He said the Federal Government uses tax-

payers' money to fund health care programs—Medicare, Medicaid, Children's Health Care, veterans' health care, military health care and long term care. Any time a frivolous lawsuit drives up the cost of health care, it affects the taxpayers. It is a Federal issue.

I believe the President is right, Mr. Chairman. This is not an issue where the Senate can afford to sit idly by. The House has passed a bill. It is time for the Senate to do the same.

I appreciate the presence of every witness here today, and I look forward to a candid discussion on how best to prevent our health care system from spiraling downward. We owe it to our doctors, we owe it to the patients, and we owe it to our country.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Dole.

I think, as all of you panelists know, the Special Committee on Aging is not an authorizing committee. We are an information-gathering, spotlight-pointing committee to build a record for the whole of the Congress to analyze these critical issues from and ultimately to make decisions. So your input today is going to be extremely valuable, as we continue to struggle with the issue of liability and class action-type lawsuits.

So let me introduce the balance of our panelists, and we will start then with you all.

David Stevenson, assistant professor, Harvard University; Theresa Bourdon, managing director and actuarial, Aon Risk Consultants, Columbia, MD. Mr. Estes has already been introduced by Richard Shelby—president and CEO of NHS Management in Tuscaloosa, AL; and representing the national organizations, Marshall Kapp, distinguished professor of law and medicine, Southern Illinois University, School of Law in Carbondale, IL; Lawrence Cutchin, Dr. Cutchin has already been introduced—president, North Carolina Medical Association, Raleigh; and James Lett, immediate past president, American Medical Directors Association, Carmel, CA.

David? Panelists, all thank you. David, we will start with you.

STATEMENT OF DAVID STEVENSON, PH.D., ASSISTANT PROFESSOR, HARVARD UNIVERSITY, CAMBRIDGE, MA

Mr. STEVENSON. Thank you very much.

Chairman Craig, committee members, thank you for the opportunity to speak at the hearing today. It is my pleasure to be here to discuss this important topic. My remarks today are from the perspective of the long term care researcher and someone who has done recent work in the area of nursing home litigation, in particular.

Today, I will focus on three key questions:

First, what is known about the nature and impact of nursing home litigation?

Second, what factors have contributed to recent litigation trends?

Third, what traits of this litigation are important to consider in crafting a policy response?

As will be described by this panel, nursing home claims and liability insurance premiums have soared in recent years, especially in States such as Florida and Texas, yet few details are known about these lawsuits. To address this gap, we conducted a national

survey of plaintiff and defense attorneys who litigate in this area. The empirical evidence I present today is from this study.

We found that nursing home litigation is a new and growing industry that is heavily concentrated in a handful of States. Our data suggests that attorneys mobilized into this area in the mid 1990's and that claims and the size of recoveries have grown substantially in recent years. More than half of the 8,000 claims identified in our survey were in Florida and Texas alone.

Claimants look like your typical nursing home resident, often elderly Medicaid recipients, often with dementia or Alzheimer's disease. The claims themselves typically involve serious allegations. More than half involved deaths and allegations of pressure sores, malnutrition and emotional distress featured prominently.

While few nursing home claims went to trial, almost 9 in 10 recovered some damages for the plaintiff. This is almost 3 times the payout rate for medical malpractice claims. With average payments of almost $400,000 per claim, these data imply total compensation to plaintiffs of $2.3 billion nationwide.

The factors driving recent trends in nursing home litigation are unclear. The bottom line is that we do not currently know how accurate nursing home claims are. In particular, we do not know the extent to which nursing home litigation, (A) reliably tracks negligence; (B) deters poor quality care; or, (C) compensates residents with meritorious claims. One can speculate about each of these points. To the best of my knowledge, though, no studies have addressed these questions in a convincing way.

Still, the overall scale of the litigation is cause for concern. Total compensation payments in Florida were around 20 percent of the State's total nursing home spending. In Texas, this proportion was 15 percent. In addition, failures in the liability insurance market can make it difficult for nursing homes to protect themselves against the risk of large settlements, leaving them, and ultimately residents, exposed to this risk.

Some have argued that the recent litigation trends bolster the case for relying on conventional tort reforms. Several States have recently passed legislation treating nursing home and medical malpractice claims with the same broad brush. I would caution against such an approach. Compared to medical malpractice, nursing home claims have distinctive features that raise questions about using generic reforms across the care continuum. I will focus on three:

First, nursing home awards are disproportionately made up of noneconomic damages. Our results indicate that noneconomic damages accounted for 80 percent of nursing home awards, roughly double the proportion in medical malpractice. The implication of this is that caps on noneconomic damages, one of the more prominent tort reform strategies, would have a more severe impact in the nursing home sector, raising potential questions of equity.

Second, punitive damages are relatively common in nursing home litigation. While punitive damages play a very small role in medical malpractice, they figure in almost 20 percent of nursing home payments. For policymakers seeking to control high-end verdicts, punitive damages are a potentially effective target in the nursing home sector. In addition, limiting punitive, rather than

noneconomic damages, is less restrictive of residents' ability to be compensated for their losses.

Finally, a third distinct feature of nursing home claims is their injury profile. In nursing homes, the usual focus of malpractice suits, like missed diagnoses and surgical errors, give way to allegations of neglected bed sores and emotional abuse. More than half of nursing home claims involve deaths compared to 1 in 5 medical malpractice claims. For policymakers who feel exceptions should be made in egregious cases, the nature of alleged nursing home injuries may provide a ready supply of such cases, potentially undercutting the effectiveness of reforms.

In conclusion, lawsuits against nursing homes have grown substantially in the past several years. At this point, it is unclear whether nursing home litigation has reliably tracked negligent care, deterred substandard care or compensated residents with worthy claims.

As policymakers seek to address the recent liability crisis, distinct features of nursing home litigation should be recognized and their implications treated seriously. If they are not, reforms face the danger of being unfair and ineffective.

Thanks very much.

[The prepared statement of Mr. Stevenson follows:]

Stevenson Testimony

Statement of David G. Stevenson, Ph.D.
Assistant Professor, Department of Health Care Policy
Harvard Medical School

Testimony before the U.S. Senate Special Committee on Aging
Hearing Titled: Liability in Long-Term Care
July 15, 2004

Chairman Craig, Senator Breaux, distinguished Committee members, thank you for inviting me to discuss recent trends in long-term care liability. I have been asked to describe the characteristics and general impact of liability in the long-term care sector, to outline potential implications for policy, and to highlight important questions not yet answered by research studies. I will draw primarily on my own research with colleagues in this area, which has focused on nursing home litigation.

In particular, my remarks will focus on three key questions:

1. What is known about the nature and impact of nursing home litigation?
2. What factors have contributed to recent litigation trends?
3. What characteristics of this litigation are important for policymakers to consider as they seek to address concerns in this area?

Nursing Home Litigation Trends

Lawsuits against nursing homes are a relatively new feature on the health law landscape. Until recently, conventional wisdom was that older people were not attractive clients to plaintiffs' attorneys. The lack of economic losses typically associated with their injuries made recoverable damages (and fees) relatively small.[1] For reasons that are not

clear, this situation began to change dramatically through the 1990s.[2] Nursing home litigation is now widely recognized as one of the fastest growing areas of health care litigation. In several states, most notably Florida and Texas, claims rates and nursing homes' liability insurance premiums have soared.[3] State residents' rights statutes appear to have provided a legal basis for many of these claims.[4]

Despite a growing sense of alarm among policy-makers, little is known about lawsuits against nursing homes. To address this knowledge gap, we surveyed a national sample of plaintiff and defense attorneys who practice in this area about details of the claims they steward, including litigant characteristics and the volume, type, and outcomes of claims. The empirical evidence presented below is from this study.[5] One caveat that is important to interpreting these data is that respondents were asked to characterize their litigation experience for calendar year 2001.

Based on responses from 278 attorneys, we found that nursing home litigation is a new and growing industry that is, at this time, heavily concentrated in a handful of states. Our data suggest that attorneys mobilized into this area in the mid-1990s and that the number of claims and the size of recoveries grew substantially over the period 1996-2001. The attorneys we surveyed were personally involved in litigating nearly 4,700 claims in the 12 months prior to the survey, and their firms handled approximately 8,300 claims. More than half of these claims were in Florida and Texas alone.

Claimants were commonly elderly Medicaid recipients, often with dementia or Alzheimer's disease. Claims often involved serious injuries and were typically initiated by parties other than the residents themselves. More than half of claims nationwide involved deaths, while allegations of pressure sores, dehydration/malnutrition, and emotional

distress featured prominently. The prime initiators of nursing home claims were residents' children (64%) and spouses (22%), a logical result given the portion of claims involving death and the prevalence of cognitive impairment among nursing home residents.

Although fewer than one in ten nursing home claims went to trial (8%), almost nine out of ten recovered some damages for the plaintiff. This is around three times the payout rate for medical malpractice claims. Plaintiff and defense attorneys alike estimated these payments to average around $400,000 per claim. Considered as a whole, these data imply total compensation payments of $2.3 billion to plaintiffs nationwide.[a] Florida and Texas again account for a very significant proportion—three-quarters of the total compensation payments identified in our survey.

Factors Driving Nursing Home Litigation

The factors driving the recent trends in nursing home litigation are unclear. Public discussion often centers on two competing drivers: trial attorneys seeking to maximize their incomes; and consumers responding to unacceptable care in nursing homes and potential failures of regulatory oversight in this sector. Such polarized explanations must be situated in the context of the broader, ongoing debate about the relationship between litigation and quality.[6]

Consumer advocates and the plaintiffs' bar have long argued that lawsuits are essential to ensuring high quality care. Proponents of litigation can point to plentiful reports of substandard care as substantiating the need for the deterrent influence of tort

[a] These figures should be interpreted as a type of "unfunded liability," rather than as strictly annualized estimates of litigation costs. Because of the time lag associated with resolution of claims, a portion of the reported claims would have closed in 2001; the rest will close in future years (and, of course, be joined along the way by new claims).

law.[7] Yet, providers and defense attorneys counter that lawsuits are haphazard and do little to improve quality. Moreover, critics argue that litigation imposes significant financial burdens on providers and diverts scarce resources away from resident care.

The bottom line, however, is that we don't know how accurate nursing home claims are. In particular, we do not know the extent to which nursing home litigation: (1) reliably tracks negligence; (2) deters poor quality care; and (3) compensates residents with meritorious claims (as opposed to non-meritorious or "nuisance" claims). One can theorize about the impact of increased litigation on nursing home quality, and one can also speculate about the responsiveness of litigation to poor quality care. To the best of my knowledge, however, no studies have addressed these questions in a convincing way.[8] Further research is ultimately needed to study these questions at the level of the individual nursing home and at the level of the individual claim.

Still, the overall scale of the litigation is cause for concern. The diversion of substantial resources to defend and pay nursing home lawsuits could have a negative impact on quality of care, especially in high volume litigation states. For example, total compensation payments in Florida represented around 20% of the state's total nursing home spending for 2001; in Texas, the proportion was 15%. In addition, failures in liability insurance markets can make it difficult for nursing homes to protect themselves against the risk of large settlements, leaving them—and ultimately residents—exposed to unpredictable financial losses.

The Policy Response

One response to these concerns is to enact tort reform of the kind recently attempted in Florida, Texas, and other states. The goal of such reforms is to stabilize the nursing home and liability insurance markets without eliminating incentives that litigation may provide to deliver high quality care. Yet, as this Committee knows, fiercely competing political interests make these reforms difficult to advance. The main stakeholders in tort reform debates often disagree about the wisdom of caps on damages awards and on attorney fees, the two most prominent reform measures.

An alternate approach to curbing litigation is to rely on redoubled quality improvement and quality assurance efforts. In theory, quality-oriented efforts could remove the presumed basis of lawsuits—poor quality nursing home care. Yet, the impact of this approach is uncertain. Its effectiveness hinges on (1) the extent to which quality gains can be realized and (2) the extent to which litigation rates will then respond to such gains. There are considerable uncertainties—not to mention potentially large expenditures—associated with these elements.[9]

Some have argued that recent litigation trends bolster the case for relying on conventional tort reforms in the nursing home sector.[10, 11] I would caution against this conclusion. Compared to medical malpractice, nursing home claims have several distinctive features that raise questions about implementing generic reforms across the care continuum. I will focus on three areas of difference in particular—noneconomic damages, punitive damages, and the nature of injuries.

Noneconomic damages. Critiques of excessive medical malpractice verdicts distil largely into concerns about noneconomic damages. The inherent subjectivity of

noneconomic damages, the fact that juries are given little or no guidance in determining them, and their significant contribution to awards feed perceptions that this part of the system is out of control. [12] More than any other tort reform measure, caps on noneconomic damages have emerged as the favored policy strategy for "containing" the malpractice crisis.

In the context of nursing home litigation, this type of cap can be expected to have a disproportionately large impact on plaintiffs' awards because of the distinctive nature of the plaintiffs and the losses involved. Few elderly have ongoing sources of income that would be diminished by physical injury. Consequently, the balance between economic and noneconomic damages is quite different from other types of medical malpractice litigation: economic damages tend to constitute a relatively small portion of nursing home awards, and noneconomic damages constitute a relatively large portion. Our survey results indicate that noneconomic damages account for approximately 80% of residents' awards nationwide—roughly double the proportion in medical malpractice awards.

Punitive Damages. Another distinctive feature of nursing home litigation is the role of punitive damages in awards. While punitive damages play a negligible role in medical malpractice litigation (fewer than 1% of awards include them), they appear to be quite common in nursing home litigation, figuring in nearly one in five payments nationally. One plausible explanation for the difference relates to the defendants involved—typically large, for-profit corporations in the case of nursing homes compared to individuals clinicians in the medical malpractice setting. The latter tend to strike juries as more sympathetic defendants.

For policymakers interested in controlling high-end verdicts, punitive damages present a potentially attractive and effective target in the nursing home sector that does not exist for medical malpractice claims. Placing limits on this component of awards instead of noneconomic damages would ward off the charge that the cap is interfering with plaintiffs' ability to be made "whole" for their losses. At the same time, the prevalence of punitive damages in nursing home litigation means that such limits could still have a meaningful impact on the overall costs of litigation.

Nature of Injuries. The injury profile of nursing home claims reflects the peculiarities of the long-term care environment and the vulnerabilities of residents. The amount of *medical* care received by most residents is quite low; support of personal needs and the maintenance of functioning are the core services. In this relatively "low-tech" environment, the usual stimuli for malpractice lawsuits, such as missed diagnoses and surgical errors, give way to allegations of neglected bedsores, malnutrition, and emotional abuse. More than half of claims against nursing homes involve deaths, compared to less than one fifth of malpractice claims.[13]

Lawmakers and the courts might be reluctant to enforce conventional tort reforms when confronted with the types of harms that befall nursing home residents. For instance, during the recent U.S. Congressional debate over HR 5, even some of the bill's chief proponents joined legislators who declared the importance of establishing exceptions for egregious cases. [14] The nature of alleged injuries in the nursing home setting may produce a ready supply of such exceptions.

Conclusions

In sum, nursing home litigation has quickly assumed an important place in the medical liability debate. Lawsuits against nursing homes have increased substantially over the past decade and now absorb a significant portion of total nursing home expenditures in some states. Visible consequences of these trends include rising liability premiums, provider difficulties in obtaining liability coverage, and concerns among policymakers about threats to quality and access for consumers. Although various factors—such as state residents' rights statutes—have contributed to the ability of residents and their families to seek legal recourse for poor nursing home care, it is unclear whether the rise in nursing home litigation has reliably tracked negligent care, deterred substandard care, and compensated residents with worthy claims. Further information on each of these points is necessary before it is possible to conclude that litigation has been "good" or "bad" for quality of services in nursing homes.

Nonetheless, pushed in part by providers seeking legislative relief, policymakers have sought ways to address the recent liability crisis, focusing primarily on tort reforms. As these reforms are pursued, the distinct features of nursing home litigation should be recognized, and their implications treated seriously. The distinct composition of nursing home residents' damages awards and the distinctive nature of injuries in the long-term care setting deserve attention in the design of a policy response. Insufficient sensitivity to these distinctions is likely to stress *both* of the major stakeholders in nursing home litigation—the negligently-injured residents and their families, whose ability to obtain reasonable compensation for worthy claims would be inappropriately blocked, and nursing homes themselves, for whom ineffective reforms would fail to alleviate the burden of litigation.

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The CHAIRMAN. David, thank you very much for that testimony. Now, we will go to Theresa Bourdon.
Theresa?

STATEMENT OF THERESA BOURDON, FCAS, MAAA, MANAGING DIRECTOR AND ACTUARY, AON RISK CONSULTANTS, INC., COLUMBIA, MD

Ms. BOURDON. Good afternoon, Chairman Craig, Senator Dole.

My name is Theresa Bourdon, and I am a fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries. In addition, I am the managing director of Aon Corporation's Property and Casualty Actuarial Consulting Practice. Aon is the leading actuarial consultant to the long term care industry with respect to the evaluation of the cost of patient care liability claims.

I would like to thank the Senate's Special Committee on Aging for giving me the opportunity to testify today. I feel that it is important for members of this committee to understand that I do not work for an insurance company. I provide consulting services to entities, including nursing homes, to assist them in financing their exposure to liability.

Most of my clients are self-insured. In this context, my testimony is largely focused on the litigation activity of nursing homes, as opposed to the insurance availability and affordability. Because, regardless of whether a nursing home buys insurance or self-insures, it is an increase in litigation that is the driving cause of the above-average increases in the cost of risk per bed occurring in a multitude of States throughout this country.

Legislative changes that will reduce the cost of risk and provide greater predictability in the number and size of claims will directly impact the litigation trends. By reducing the litigation trends, you will also be responding to the issue of insurance availability and affordability. The correlation between the two is not 1-to–1 due to a number of other variables that influence insurance pricing. However, it is very high.

To help you understand the magnitude of the litigation trends, let me share some statistics with you. Aon has recently completed its fifth annual study of the rising cost of professional and general liability claims asserted against long term care operators. In the study, which includes 24 percent of the beds in the United States, which is approximately 470,000 nursing home beds, costs are projected to reach almost 2,300 per occupied nursing home bed for incidents alleged to have occurred in calendar year 2003. Nationally, these costs are now 7 times higher than they were in the early 1990's.

On a cost-of-care basis, this means that $6.27 per day needs to be set aside per long term care resident just to cover the cost of litigation. This is equal to 5 percent of the countrywide average per diem reimbursement rate for Medicaid, the Government source of funding for approximately two-thirds of all nursing home residents.

The providers represented in our study are expected to incur $1 billion in liability claims in 2004 alone. Extrapolated to a national basis, this exposure is a multi-billion-dollar-a-year cost to the nursing home industry, and almost half of the total cost is going directly to attorneys.

The number of claims against nursing home operators is increasing by approximately 13 percent annually, with a current rate of 15 claims per thousand nursing home beds per year. If you consider that the size of a typical nursing home is about 100 beds, that is roughly 1.5 claims per facility per year. The rate of increase in the number of claims in the long term care industry is unprecedented, both in terms of this industry's history and the rate of increase in the number of liability claims incurred by other health care providers.

In addition to the growth in the number or frequency of claims, there has been a significant increase in the size or severity of the average award. The average size of long term care liability claims, which includes indemnification paid to the plaintiff and all related attorney fees has almost tripled from 65,000 per claim in the early 1990's to between 150,000 and 200,000 in more recent years.

Florida and Texas were leaders in driving forward the increase in long term care liability costs. Our 2003 projected loss cost is $8,200 in Florida and $5,500 for Texas. Numerous other States across the country are now experiencing increasing cost trends and appear to be headed toward loss costs per bed similar to those in Florida and Texas. Most notable on this chart is Arkansas.

These rising litigation costs are already beginning to impact the industry in the following ways:

First, there is a lack of expansion in the nursing home sector of elder care services. In fact, the number of available nursing home beds is on the decline. Between December 2001 and December 2003, the number of certified nursing home beds in the United States dropped 20,000 according to CMS OSCAR Data surveys. Large multi-state providers are choosing to leave the States like Florida and Texas, where the cost of care has exceeded the funding available to pay for it. In addition, there is very little expansion into other States.

Second, smaller providers and those that have not diversified into multiple geographic regions are, in many cases, choosing to go uninsured or underinsured. Additionally, the organizations that are buying the facilities being divested by larger multi-state operators are often doing so with materially reduced limits of liability from the levels traditionally available from divesting operators. All of this has the effect of reducing the average compensation for patients who truly have suffered a patient care violation.

Last, lending institutions are restricting capital investments by more strictly underwriting this industry. Where loans are available, the cost of borrowing has gone up due to the litigation risk, further adding to the cost of delivering health care to the elderly.

The long term outlook, if reforms are not implemented, is a continued contraction of available nursing home beds, particularly for those Americans who depend on Medicaid funding to provide these services. One does not have to be an actuary to figure out the ramifications of such a contraction as the baby boom generation approaches retirement age.

Thank you for the opportunity to provide this testimony, and I would be pleased to answer any questions you may have.

[The prepared statement of Ms. Bourdon follows:]

AON
Actuarial and Analytics Practice

The Honorable Larry Craig
Chairman
U.S. Senate Special Committee on Aging
U.S. Senate
Washington D.C.

RE: U.S. Senate Special Committee on Aging Hearing on Long Term Care Liability

Date: July 15, 2004

Dear Mr. Chairman and Members of the Committee:

My name is Theresa Bourdon, and I am a Fellow of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. In addition, I am Managing Director of Aon Corporation's property and casualty actuarial consulting practice. Aon Corporation, through its subsidiary companies, is a leading provider of risk management services, insurance brokerage, human resource consulting, and specialty insurance underwriting. Aon is the leading actuarial consultant to the long term care industry with respect to the evaluation of the cost of patient care liability claims.

I would like to thank the Senate Special Committee on Aging for giving me the opportunity to provide an actuarial perspective on the patient care liability crisis affecting long term care providers in the U.S. This is a very complex issue, yet critically important to the future of the delivery of healthcare to the elderly. It is my hope today, by sharing with you the unique knowledge I have of the liability claims the industry is incurring, to help the committee develop a greater understanding of the issues in order that you may effect policy changes that are in the best interest of the American public.

I feel it is important for members of this committee to understand that I do not work for an insurance company. I provide consulting services to entities, including nursing homes, to assist them in financing their exposure to liability. Most of my clients are self-insured. In this context my testimony is largely focused on the litigation activity of nursing homes as opposed to insurance availability and affordability. Because, regardless of whether a nursing home buys insurance or self-insures, it is an increase in litigation that is the driving cause of the above average increases in the cost of risk per bed occurring in multitudes of states throughout this country. Legislative changes that will reduce the cost of risk and provide greater predictability in the number and size of claims will directly impact the litigation trends. By reducing the litigation trends, you will also be responding to the issue of insurance availability and affordability. The correlation between the two is not one to one due to a number of other variables that influence insurance pricing. However, it is very high.

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To help you understand the magnitude of the litigation trends, let me share some statistics with you. Aon has recently completed its fifth annual study of the rising cost of professional and general liability claims asserted against long term care operators. In this study, which includes 24% (approximately 470,000) of the beds in the U.S., costs are projected to reach almost $2,300 per occupied nursing home bed for incidents alleged to have occurred in calendar year 2003 (see Attachment I). Nationally these costs are now seven times higher than they were in the early 1990's.

On a cost of care basis this means that $6.27 per day needs to be set aside per long term care resident just to cover the cost of litigation. This is equal to 5% of the countrywide average per diem reimbursement rate for Medicaid, the government source of funding for approximately two thirds of all nursing home residents.

The providers represented in our study are expected to incur $1 billion in liability claims in 2004 alone. Extrapolated to a national basis this exposure is a multi-billion dollar a year cost to the nursing home industry. And, almost half of the total cost is going directly to attorneys (see Attachment II).

The number of claims against nursing home operators is increasing by approximately 13% annually, with a current rate of 15 claims per year per 1,000 nursing home beds (see Attachment III). If you consider that the size of a typical nursing home is about 100 beds, that's roughly 1.5 claims per facility per year. The rate of increase in the number claims against the long term care industry is unprecedented both in terms of this industry's history and the rate of increase in the number of liability claims incurred by other healthcare providers.

In addition to the growth in the number or frequency of claims, there has been a significant increase in the size or severity of the average award (see Attachment IV). The average size of long term care liability claims, which includes indemnification paid to the plaintiff and all related attorneys fees, has almost tripled from $65,000 in the early 1990's to between $150,000 and $200,000 in more recent years.

Florida and Texas were leaders in driving forward the increase in long term care liability costs. Our 2003 projected loss cost is $8,200 for Florida and $5,500 for Texas. Numerous other states across the country are now experiencing increasing cost trends and appear to be headed towards loss costs per bed similar to those in Florida and Texas (see Attachment V). Most notable are Arkansas (at $5,760), Mississippi (at $4,070), Alabama (at $3,310), Tennessee (at $2,980), and California (at $2,790).

These rising litigation costs are already beginning to impact the industry in the following ways:

- There is a lack of expansion in the nursing home sector of elder care services. In fact, the number of available nursing home beds is on the decline. Between December 2001 and December 2003, the number of certified nursing home beds in the U.S. dropped from 1,802,722 to 1,780,899, according to CMS OSCAR Data surveys. Large multi-state

providers are choosing to leave the states like Florida and Texas, where the cost of care has exceeded the funding available to pay for it. In addition, there is very little expansion into other states.

- Smaller providers and those that have not diversified into multiple geographic regions are in many cases choosing to go uninsured or underinsured. Additionally, the organizations that are buying the facilities being divested by larger multi-state operators are often doing so with materially reduced limits of liability from levels traditionally available from divesting operators. All of this has the effect of reducing the available compensation for patients who truly have suffered a patient care violation.

- Lending institutions are restricting capital investments by more strictly underwriting this industry. Where loans are available, the cost of borrowing has gone up due to the litigation risk, further adding to the cost of delivering healthcare to the elderly.

The longer-term outlook, if reforms are not implemented, is a continued contraction of available nursing home beds, particularly for those Americans who depend on Medicaid funding to provide these services. One doesn't have to be an actuary to figure out the ramifications of such a contraction as the baby boom generation approaches retirement age.

Thank you for the opportunity to provide this testimony. I would be pleased to answer any questions you may have.

Sincerely,

Theresa W. Bourdon

Theresa Bourdon, FCAS, MAAA
Managing Director & Actuary
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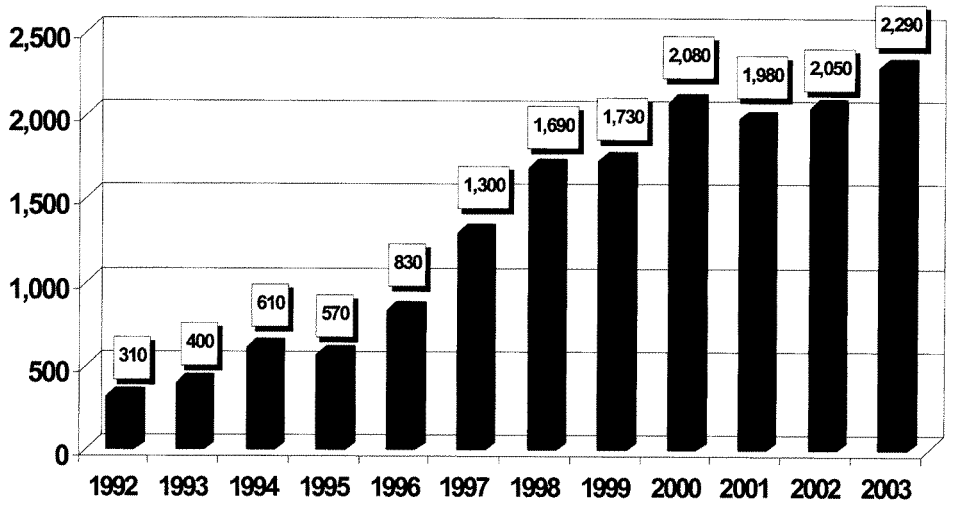
Long Term Care
Professional and General Liability

Attachment I - Countrywide Loss Cost Per Occupied Bed



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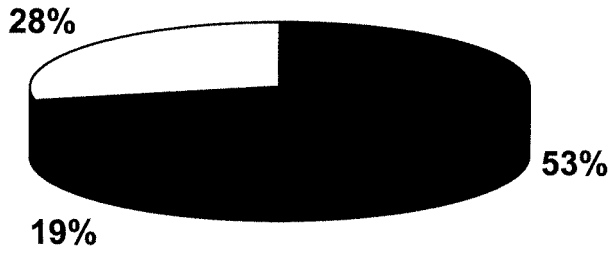
Long Term Care
Professional and General Liability

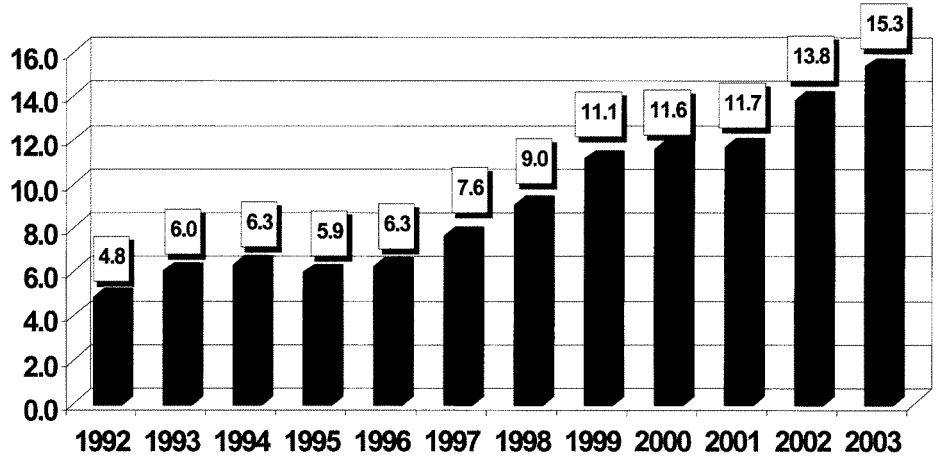
Attachment II - Distribution of Compensation



- ■ Patient and/or Family Compensation
- ■ Defense Costs (Defense Attorneys & Investigation)
- □ Plaintiff Attorney Fees

Long Term Care
Professional and General Liability

Attachment III - Countrywide Annual Number of Claims per 1,000 Occupied Beds



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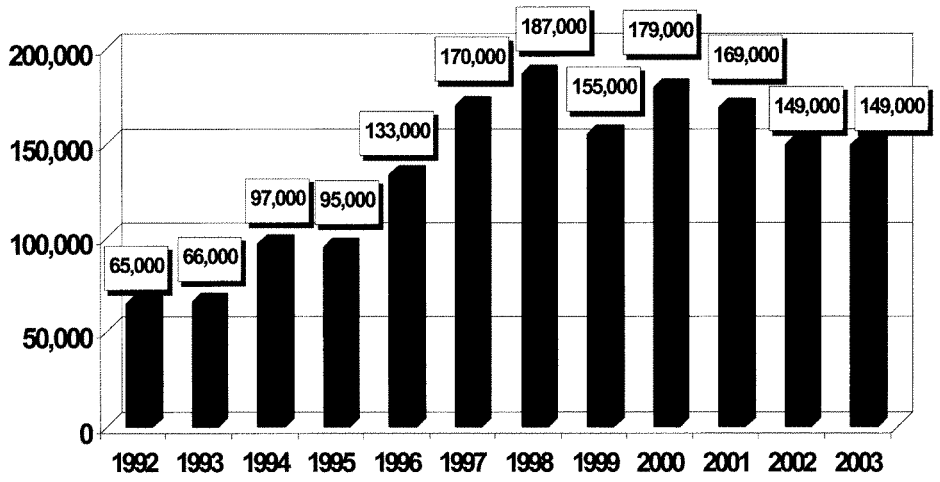
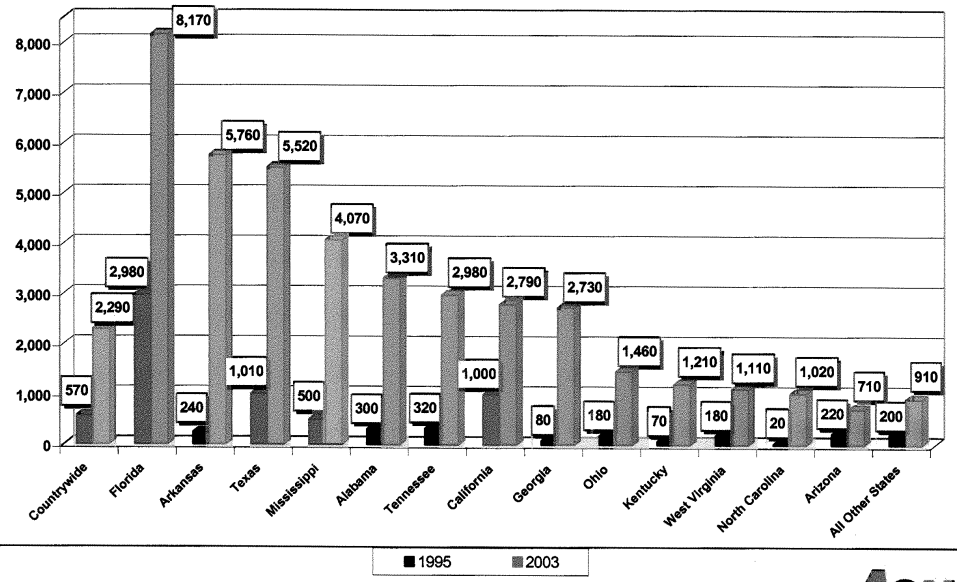
Long Term Care
Professional and General Liability

Attachment IV - Countrywide Severity per Claim



Long Term Care
Professional & General Liability

Attachment V - 2004 Long Term Care Loss Cost Comparison 1995 vs. 2003



Aon Risk Consultants, Inc.

The CHAIRMAN. Theresa, thank you for that testimony. Those are startling statistics.

Before we move to Mr. Estes, we have been joined by our colleague, Senator Blanche Lincoln. Blanche, do you have any opening comments you would like to make?

Senator LINCOLN. No.

The CHAIRMAN. Well, we appreciate your presence with the committee today.

Now, let me turn to Norm Estes, president and CEO of NHS Management. He has already been introduced at length by Senator Shelby, and we do appreciate that.

Norm, welcome before the committee.

STATEMENT OF J. NORMAN ESTES, PRESIDENT AND CHIEF EXECUTIVE OFFICER, NHS MANAGEMENT, TUSCALOOSA, AL

Mr. ESTES. Good afternoon, Chairman Craig and members of the committee. My name is Norman Estes, and I am the president and CEO of NHS Management, LLC.

The CHAIRMAN. Is your microphone on?

Mr. ESTES. I do not know. I think so.

The CHAIRMAN. Is there a button to be pushed on that one?

Mr. ESTES. Maybe it needs to be a little closer. I was trying to keep from being too loud, which is my tendency. Is that better?

The CHAIRMAN. That is better. Thank you.

Mr. ESTES. Good.

The CHAIRMAN. I am also 58 years of age. [Laughter.]

Mr. ESTES. Thank you. As I was saying, I am the CEO of NHS Management, LLC, and affiliated companies. Our companies operate, manage and provide services to 39 nursing facilities throughout the Southeast. The Southeast, by the way, is one of the hardest-hit regions of the country from the standpoint of today's topic.

Today, Mr. Chairman, I speak on behalf of the American Health Care Association. We are a national organization representing more than 10,000 providers of long term care who serve, on average, 1.5 million elderly and disabled people per year and employing more than 1 million caregivers nationally.

I have worked in and around nursing homes all my life and am proud to continue a family tradition started three generations ago. I care deeply about this profession and care deeply for the frail, elderly and disabled who trust us to provide quality care that they can depend on.

I would like to use my time today to discuss the following three items:

One, the budgetary challenges that we currently face and you face today as legislators here in Washington;

Two, the demographic challenges that we all face and how that affects our need to attract capital to our profession;

Third, how elderly patients are being victimized by the crowding out or the diversion of funds away from our ability to improve patient care so that we can allocate those funds to the higher cost of lawsuits.

Every way you look at it, Mr. Chairman, the litigation status quo, as we have it today, benefits the few at the expense of our elderly, our taxpayers and our Nation's future and strikes directly at

the credibility of our system of justice, fairness, and our basic sense of right and wrong. With so many competing demands on the Federal budget, we must ensure Federal dollars are used efficiently to serve the specific intended purposes. Unfortunately, because of this problem today, that is not always the case with our Medicaid program.

In a stark and statistically undeniable manner, the Nation's plaintiff lawyer community has targeted the Medicaid program and the dollars meant to pay for seniors' long term care services. Research shows that in the last 3 years more than $2 billion have been diverted away from Medicaid to pay for the cost of lawsuits.

In many States, like Texas, Florida and Arkansas, nearly half of the Medicaid rate increases from 1995 until 2003 have not even reached the elderly Medicaid residents they intended to benefit because of this diversion issue that I raised today. While the Nation's health care system is serving greater numbers of seniors under mounting Federal and State budgetary pressures, failure to bring more accountability to the way these Medicaid expenditures are made, through common-sense legal reforms, is a disservice to every senior and taxpayer in America.

The very funds necessary to help improve care are being systematically removed from the health care system. The number of Americans requiring long term care will double to 7 million by the year 2020 and double again to 14 million by the year 2040. In the face of growing demand for facility care, the number of available nursing home beds is on the decline. To the detriment of patients, some of the larger multi-state providers are choosing to simply leave States because they can no longer afford liability insurance.

Access to capital continues to be a critical problem for our sector, and while there are a variety of causes, the litigation crisis has exacerbated the situation. Bank loans, bonds and other forms of capital that fund day-to-day operations for most nursing facilities are an absolute necessity to maintaining and improving quality care.

With much of the current discussion about the Federal health care policy centered upon the need to improve quality care in our hospitals, nursing homes and other settings, it is significant and timely that Government and professionwide initiatives to improve the quality of nursing home care are beginning to receive a great deal of national attention. Those of us in long term care are enormously excited about the Federal Government's National Home Quality Initiative or what we call, NHQI, and our profession has started its own quality initiative that we call Quality First.

There is no question that an honest and reliable performance measurement system, coupled with a system of public disclosure, provides consumers with the best-possible information for comparing quality and basing their long term care choices and decisions.

But while we move forward on the quality front, we are once again confronted by the fact that resources that could be utilized to help improve care are being crowded out or diverted to pay for non-productive legal expenditures. Every dollar spent on defense attorneys and legal settlements is a dollar directed away from staffing needs, therapies, and programs that make a real difference

in quality care for seniors and for the very quality of life that they have in our facilities.

Today, Mr. Chairman, we can say that there has never been a broader recognition by Government and the provider community about the importance of quality care nor a broader commitment to work cooperatively to improve it.

We look forward to working with this committee, this Congress and this administration to help restore balance to the legal system and where Federal resources designated to care for the frail, vulnerable and disabled Americans is utilized for this noble purpose.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Estes follows:]

TESTIMONY OF J. NORMAN ESTES

PRESIDENT AND CEO, NHS MANAGEMENT, LLC

BEFORE

THE SENATE SPECIAL COMMITTEE ON AGING

JULY 15, 2004

"MEDICAL LIABILITY IN LONG TERM CARE: IS ESCALATING LITIGATION A THREAT TO QUALITY AND ACCESS?"

Good afternoon Chairman Craig, Ranking Member Breaux, and members of the Committee. I appreciate the opportunity to be with you here today, and to provide you with perspective on the medical malpractice insurance crisis and how it is wreaking havoc upon America's long term care system.

My name is Norman Estes, and I am President and CEO of NHS Management, LLC and affiliate companies, some of which own, operate, manage, and provide services to 39 nursing facilities throughout the Southeast—one of the hardest hit regions of the country from the standpoint of today's topic.

I have also served in various capacities in the trade associations for the states in which NHS operates, including the Alabama Nursing Home Association, the Missouri Health Care Association, the Florida Health Care Association and the Arkansas Health Care Association.

Today, Mr. Chairman, I speak on behalf of the American Health Care Association (AHCA). We are a national organization representing more than 10,000 providers of long term care, who serve more than 1.5 million elderly and disabled people annually, employing more than 1 million caregivers.

I have worked in and around nursing facilities all of my life, and am proud to continue a family tradition started three generations ago. I care deeply about this profession I love, and care deeply for the frail, elderly and disabled who trust us to provide quality care they can depend upon.

I'd like to thank the Chairman for calling this important hearing—and for providing a valuable forum to discuss how the malpractice insurance crisis negatively impacts not just seniors and providers, but also America's taxpayers, and the public at large.

During the course of the broader debate on necessary common sense legal reforms, it has been somewhat frustrating to those of us in long term care as we see a majority of the news media and legislative focus centered upon hospitals and physicians.

In fact, the challenges facing long term care providers mirror, and in some areas, are more acute than those facing physicians and hospitals. We believe it is both necessary and appropriate that our federal officials appreciate that key legislative and policy changes must consider long term care providers if we hope to craft a workable health care system for today's and tomorrow's retirees.

Theresa Bourdon of Aon Risk Consultants will paint in her testimony a grim picture of the problems confronted by patients, providers, and government as we strive to deliver high quality care.

I would like to use my time to discuss the troubling statistics and trends we've now seen in three important, pertinent contexts:

First, to the budgetary challenges you as legislators face here in Washington;

Second, to the demographic challenges we confront as the provider community attempts to invest in the additional long term care capacity and infrastructure America will inevitably require;

Third, how elderly patients are being victimized by the crowding-out and diversion of funds away from improved patient care to pay for the higher costs of lawsuits.

Every way you look at it, Mr. Chairman, the litigation status quo benefits the very, very few at the expense of our elderly, our taxpayers, and our nation's future—and strikes directly at the credibility of our system of justice, fairness and basic sense of right and wrong.

Today's Budgetary Realities and the Diversion of Funds from Seniors ' Care Needs

With so many competing demands on the federal budget, and because we no longer enjoy the benefits of the budget surplus we enjoyed just a few years ago, it is more important than ever to ensure federal tax dollars are used efficiently to serve their specific, intended purpose.

Unfortunately, this is not the case with the nation's Medicaid program.

Those of us here today see Medicaid as the key federal program that funds the care of approximately two-thirds of our nation's nursing home patients. It is an essential lifeline to America's most vulnerable population of seniors and persons with disabilities.

However, in a stark and statistically undeniable manner, the nation's plaintiff lawyer community has targeted Medicaid dollars meant for seniors' long term care. The Aon analysis sheds light on a situation that should be troubling to every taxpayer, federal official and senior citizen reliant upon Medicaid.

Consider this disturbing fact that places this problem into perspective: Between 1995 and 2003, according to the Aon analysis, more than $5 billion in Medicaid resources were diverted away from patient care to pay for the cumulative costs associated with the increasing volume of nursing home litigation. Approximately half of this total has gone directly to litigation costs.

And in many states like Texas, Florida and Arkansas, **nearly half** of the per diem Medicaid rate increases from 1995-2003 have not even reached elderly Medicaid patients because of this diversion of funds.

While the nation's health care system is serving greater numbers of seniors under mounting federal and state budgetary pressure, failure to bring more accountability to Medicaid spending through common sense legal reforms is a disservice to every senior and taxpayer in America.

And the cruelest Catch-22 irony of all is also the most absurd: the rationale for most lawsuits is the allegation of inadequate care—yet the very funds necessary to help improve care are being systematically removed from the health care system.

Contrary to what some may believe, the litigation crisis is very much a problem for the federal government. Although some states have been moderately successful in establishing reforms, plaintiff's attorneys and others who see the long term care profession as a source of income are moving to states without reforms and are wreaking havoc on providers' abilities to maintain access to quality care. A federal remedy would create a national standard that would protect providers from frivolous lawsuits, regardless of geography.

The Demographic Challenge and the Capital Crunch

The number of Americans requiring long-term care is growing rapidly: In 2010, the number of individuals 85 and older will be 3.5 million. Their numbers will double to seven million by 2020 and will double again to 14 million by 2040.

Yet another troubling aspect of the Aon report is that in the face of necessary capacity increases to accommodate certain, growing demand for facility care, the number of available nursing home beds is on the decline.

To the detriment of patients, some of the larger multi-state providers are choosing to leave states because they can no longer afford liability insurance. Beverly Enterprises, for example, has pulled out of Florida completely and has divested facilities in Mississippi, Alabama, Tennessee, and Georgia.

Genesis Health Ventures departed Florida because it cost $7,000 per bed to insure while, comparatively, it cost $700 per bed in the other 12 states in which it operates.

Kindred Healthcare has sold all of its Florida and Texas facilities, and Extendicare Inc. also has divested its Florida facilities and 17 Texas facilities because of the company's need to "eliminate its exposure to litigation." Likewise, Atlanta-based Mariner Health Care Inc. has sold its Florida facilities and its three holdings in Louisiana.

Decisions of this nature are unfortunate for provider and patient alike—and we must keep in mind the human costs associated with patient uncertainty and the other sad aspects of these developments.

Access to capital continues to be a critical problem for our sector, and while this has a variety of causes, the litigation crisis has exacerbated the situation tremendously. Bank loans, bonds and other forms of capital fund the day-to-day operations of most nursing facilities, and are an absolute necessity to maintaining and improving quality of care.

According to a recent Lewin Group analysis of capital formation, nursing homes' capital ratios and other statistics evaluated by lenders have deteriorated to the point that the credit profile of nearly the entire sector is viewed as poor.

Furthermore, a Legg-Mason equity research analysis stated the problem very succinctly by specifying the need for predictability in funding over the long term if our profession is to regain investor confidence, and attract the capital needed to meet the future long term care needs of the Baby-Boomers.

The cash squeeze caused in part by the malpractice insurance crisis has been affecting the capital availability needed to modernize and replenish physical plants and equipment, acquire new technologies, and meet changing community health care needs.

This comes at a time when an aging population will, increasingly, require complex medical services within the nursing facility setting.

As Ms. Bourdon will assert in her testimony, "The longer-term outlook, if reforms are not implemented, is a continued contraction of available nursing home beds, particularly for those Americans who depend on Medicaid funding to provide these services."

Reform Necessary to Advance Government, Profession-wide Quality Initiatives

With much of the current discussion about federal health care policy centered upon the need to improve care quality in our hospitals, nursing homes and other settings, it is significant and timely that government and profession-wide initiatives to improve the quality of nursing home care are beginning to receive a great deal of national attention.

Those of us in long term care are enormously excited about the federal government's Nursing Home Quality Initiative (NHQI), and our profession's Quality First program. There's no question that an honest and reliable performance measurement system, coupled with a system of public disclosure, provides consumers with the best possible information for comparing quality, and basing their long term care choices and decisions.

But while we move forward on the quality front, we are once again confronted by the fact resources that could be utilized to help improve care are being crowded-out and diverted to pay for unproductive legal expenditures.

It is basic common sense to understand the correlation between improved care quality for our seniors and the extent to which our federal and state governments implement the legal reforms needed to create a more stable environment in which to care for patients.

Every dollar spent on defense attorneys and legal settlements is a dollar directed away from staffing needs, therapies and programs that make qualitative differences not just in care quality, but in seniors' quality of life itself.

Quality long term care also is at risk when facilities are unable to purchase liability insurance. This means that in unfortunate instances there is no means of recourse for the patient or for his or her family. In many Aon states, such as Florida, liability insurance is commercially unavailable. In Arkansas and Texas, half of the facilities are without insurance.

Today, Mr. Chairman, we can say there has never been a broader recognition by government and the provider community about the importance of quality care, nor a broader commitment to work cooperatively to improve it.

We look forward to working with this Committee, this Congress and this Administration to help restore balance to a legal system run amok—and where federal resources designated to care for frail, vulnerable and disabled Americans is utilized for this noble, necessary purpose.

Thank You.

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The CHAIRMAN. Thank you very much.

Now, let us turn to Marshall Kapp, a distinguished professor of law and medicine, Southern Illinois University.

STATEMENT OF MARSHALL B. KAPP, J.D., M.P.H., FCLM, DISTINGUISHED PROFESSOR OF LAW AND MEDICINE, SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF LAW, CARBONDALE, IL

Mr. KAPP. Thank you. Good afternoon and thank you for the opportunity to address the committee today. I come at today's subject from the perspective of a health law academic.

You have heard from others the results of several quantitative studies. I have done extensive qualitative research, including conducting numerous extensive discussions with physicians and other health care providers, particularly in geriatrics and long term care, regarding providers' perceptions of the legal climate in which they live and the ways in which those perceptions affect providers' behavior, with consequences for the quality of care and quality of life of older consumers of long term care.

Based on my research, I would like to share several conclusions regarding the impact of the current litigation and liability climate on long term care providers and their behavior and the consequences of that behavior for older consumers.

First, long term care providers' anxieties about functioning in what is perceived to be a perpetual, pervasive, highly adversarial legal environment are, whether factually based or sometimes exaggerated, real, sincere and powerful. As one provider explained to me, the fear is everywhere. It is in the ether.

Providers' legal apprehensions emanate from the cumulative effect of a variety of sources, including not just civil litigation brought against providers by or on behalf of long term care consumers, but also enormous increases in professional liability insurance premiums, when such insurance even is available in one's geographic locale; the energetic and relentless media attack on long term care providers; a combination of Federal and State governmental quality assurance and fiscal integrity mechanisms that several providers have described to me as, in their perception, virtually a "regulatory jihad," including most notably Medicare and Medicaid certification requirements and surveys, State licensure inspections and potential criminal prosecutions or civil penalties for elder abuse and neglect or other clinical crimes and for program fraud and abuse; the growing role of private accreditation agencies and third-party payers in overseeing long term care activities; and the proliferation and enlarged presence of private organizations purporting to advocate for older long term care consumers against long term care providers.

In many respects, apprehension about potential litigation and liability has exerted the expected, desired, positive effect on providers' behavior and the resulting quality of care. We have to acknowledge that sometimes tort law actually does work as intended. Areas in which long term care quality has improved in the past decade, at least in part because of the deterrent impact of the tort system, include a drastic reduction in the use of physical and chemical restraints, more vigorous attempts and efforts to protect

against medication errors and enhanced respect for residents' rights.

However, to a significant extent, the constant, virtually universally perceived frightening legal environment acts on the provider community to incentivize behavior carrying the risk of negative, counterproductive effects on consumers' quality of care and quality of life. Just a few specific examples of the negative impact of excessively defensive long term care practice would include:

A reluctance to openly identify, disclose, discuss, and remedy treatment errors because of fear that such error-addressing activity will harm providers in subsequent litigation;

The devastating impact on staff morale at all levels that makes it much more difficult to attract and retain adequate people, let alone the best and the brightest who are desperately needed to work in long term care, thereby jeopardizing quality and continuity of care for consumers;

Overtreatment, for example, excessive infliction of life-prolonging medical technology, premature or unnecessary transfer to acute care hospitals, reluctance to honor consumer and/or family wishes to limit treatment, and undertreatment—mainly inadequate administration of pain medications—in many end-of-life situations that unfold in long term care facilities; Efforts by long term care providers to avoid entering into professional relationships with individuals who are anticipated or whose families are anticipated to be potential "litigation magnets," to use the term that I have heard frequently, thereby impairing access to needed services for some older persons.

Certainly, forms of external oversight and possible intervention, including legal oversight and intervention, have, and should continue to have, an important salutary role to play on behalf of the interests of long term care consumers. At the same time, it is not in anyone's best interests for long term care providers to continuously live and work in fear that legal sanctions will be imposed against them for providing care that they honestly and conscientiously believe is clinically sound and ethically correct. The challenge is to review and revise the long term care system in ways that optimize the positive role of external oversight and possible intervention, while encouraging more open, honest and nonadversarial relationships among all of the involved parties.

Thank you.

[The prepared statement of Mr. Kapp follows:]

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Testimony before the U.S. Senate Special Committee on Aging, Washington, DC, July 15, 2004

Good afternoon and thank you for the opportunity to address the Committee today. I am interested in the subject of long term care malpractice litigation from the perspective of a former nursing home regulator who has taught and written* full time about health law and health care ethics for the past 24 years in both medical and law schools and in various continuing professional education settings, with a particular focus on issues affecting older persons. I have done extensive qualitative research, including conducting numerous extensive discussions with physicians and other health care providers (particularly in geriatrics and long term care) regarding providers' perceptions of the legal climate in which they live and the ways in which those perceptions affect providers' behavior with consequences for the quality of care and quality of life of older consumers of long term care. Based on my empirical research, observations in the field, and review of the pertinent literature, I have formed several conclusions regarding the impact of the current litigation and liability climate on long term care providers and their behavior and the consequences for older consumers.

- Long term care providers' anxieties about functioning in a perpetual, pervasive, highly adversarial legal environment are (whether factually based or sometimes exaggerated) real, sincere, and powerful. As one provider explained to me, "The fear is in the ether."
- Providers' legal apprehensions emanate from the cumulative effect of a variety of sources, including: civil litigation brought against providers by or on behalf of consumers; enormous increases in professional liability insurance premiums, when such insurance even is available in one's geographical locale; the energetic and relentless media attack on long term care providers; a combination of federal and state

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*See attached Bibliography.

governmental quality assurance and fiscal integrity mechanisms that several providers have described to me as a "regulatory jihad," including most notably Medicare/Medicaid certification requirements and surveys, state licensure inspections, and potential criminal prosecutions or civil penalties for elder abuse and neglect or other "clinical crimes" and for program fraud and abuse; the growing role of private accreditation agencies and third-party payers in overseeing long term care activities; and the proliferation and enlarged political presence of private organizations purporting to advocate for older long term care consumers against long term care providers.

In many respects, apprehension about potential litigation and liability has exerted the expected, desired positive effect on providers' behavior and the resulting quality of care. Areas in which long term care quality has improved over the past two decades at least in part because of the deterrent impact of the tort system include a drastic reduction in the use of physical and chemical restraints, more vigorous efforts to protect against medication errors, and enhanced respect for residents' rights.

However, to a significant extent, the constant, virtually universally perceived frightening legal environment acts on the provider community to incentivize behavior carrying the risk of negative, counterproductive effects on consumers' quality of care and quality of life. A few specific examples of the negative impact of excessively defensive long term care practice include:

- Reluctance to openly identify, disclose, discuss, and remedy errors because of fear that such activity will harm providers in litigation
- The devastating impact on staff morale at all levels that makes it much more

difficult to attract and retain adequate people (let alone the "Best and the Brightest" who are desperately needed) to work in long term care, thereby jeopardizing quality and continuity of care for consumers

- Overtreatment (excessive infliction of life-prolonging medical technology, premature or unnecessary transfer to acute care hospitals, reluctance to honor consumer and/or family wishes to limit treatment) and undertreatment (inadequate administration of pain medications) in many end-of-life situations that unfold in long term care facilities.
- Efforts by long term care providers to avoid entering into professional relationships with individuals who are anticipated (or whose families are anticipated) to be potential "litigation magnets," thereby impairing access to needed services for some older persons

Certainly, forms of external oversight and possible intervention (including legal oversight and intervention) have, and should continue to have, an important salutary role to play on behalf of the interests of long term care consumers. At the same time, it is not in anyone's best interests for long term care providers to continuously live and work in fear that legal sanctions will be imposed against them for providing care that they honestly and conscientiously believe is clinically sound and ethically correct. The challenge is to review and revise the current long term care system in ways that optimize the positive role of external oversight and possible intervention while encouraging more open, honest, and non-adversarial relationships among all of the involved parties.

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The CHAIRMAN. Professor, thank you very much.

Now, let us turn to Dr. Lawrence Cutchin, president of the North Carolina Medical Association in Raleigh.

Doctor, welcome before the committee.

STATEMENT OF LAWRENCE M. CUTCHIN, M.D., PRESIDENT, NORTH CAROLINA MEDICAL SOCIETY, RALEIGH, NC

Dr. CUTCHIN. Good afternoon, Chairman Craig, Senator Dole, Senator Lincoln. I am Lawrence Cutchin, M.D., president of the North Carolina Medical Society and an internist from Tarboro.

On behalf of the physicians of the North Carolina Medical Society, I would like to extend to you my appreciation, and to the members of the committee, for allowing me to be here this afternoon before you to comment on the ways that our Nation's medical liability crisis is seriously threatening access to health care for all of us, and in particular the medical care for patients in long term care facilities.

Long term care is an indispensable part of our health care system. The continued productivity of our work force and quality of life for their families depends, in many ways, on the availability of long term care. In the past, we have perhaps taken for granted that liability insurance would be available and affordable so that patients could be compensated in legitimate cases of negligent care. Today, however, the status of medical liability in North Carolina's long term care facilities has reached crisis proportions.

Insurance costs, as you have already heard, have skyrocketed. This has been well-documented by private actuaries whose work has been made available to the members of this committee. North Carolina has not escaped these problems. Premiums for some North Carolina nursing homes have skyrocketed by as much as 1,800 percent since 1995.

North Carolina Medical Mutual Insurance Company, which is the largest insurer of physicians in North Carolina, has determined that many long term care facilities have taken drastic steps to compensate for this escalating cost. Among the steps is a negotiation of contracts with their part-time medical directors to shift liability to them for purely administrative functions of the nursing home; that is, liability that is totally unrelated to the actual medical care the doctors are providing.

Most professional liability policies, and in particular policies by North Carolina Medical Mutual, do not cover this contractually assumed liability. Additionally, some large nursing home chains now share one single annual limit of liability insurance of a million dollars or so and other much smaller companies just do not have insurance at all. They cannot afford it.

The physicians serving as medical director for one of these nursing homes faces extraordinary additional risk exposure in the event of a lawsuit, where the underinsured or uninsured nursing home is a codefendant. To address this problem, some insurance companies have canceled, not renewed or refused to cover physicians who spend a significant portion, for example, 15 percent or more, of their professional time serving as medical director for nursing homes.

In North Carolina, we have four malpractice insurance companies still active. Two of those are not actively pursuing new insureds, as a matter of fact. One had significant loss on payouts last year, with resulting decrease in its surplus. It is still solvent.

Medical Mutual Insurance Company, which I said again is the largest in the State, will no longer insure any physician, either a new policy or renew an old policy on a physician who has at least 15 percent of his practice involved with nursing home care.

The resulting lack of doctors to fill these roles has left some nursing homes without a medical director, placing them in violation of Federal certification standards. This is an untenable situation, to say the least, that can lead to problems with access and quality of medical care for long term patients.

Other nursing home responses to the liability crisis include reduction in staff hours, freezing wages and reducing residents' activities. These adaptations, together with the loss of available medical directors, escalates the professional risk associated with the medical care of nursing home residents, making already reluctant physicians think twice about taking on the care of nursing home patients as part of their practice.

In North Carolina, nursing homes, physicians and hospitals formed a coalition in late 2002 to address the medical liability crisis. Among the reforms that we sought together, through this coalition at the State level, were the establishment peer-review privilege to protect proceedings, records, and materials produced by or considered by a Quality Assurance or Medical Review Committee from discovery or use in a civil action against a nursing home; and, two, liability limitations for nursing home medical directors who might otherwise be named as a defendant in an action against a nursing home.

We believe there are solutions to this crisis, and we believe the long term care system is worth saving. It has to be. We believe the U.S. Senate should act to reduce the excessive burden of our broken liability system on our Nation's long term care providers.

Thank you for the opportunity to be with you, and I will be glad to answer any questions.

[The prepared statement of Dr. Cutchin follows:]

Testimony

of the

North Carolina Medical Society

to the

Special Committee on Aging
U.S. Senate

Re: Medical Liability in Long-Term Care: Is Escalating Litigation a Threat to Quality and Access?

Presented by: Lawrence M. Cutchin, MD

July 15, 2004

Good afternoon Chairman Craig, Senator Breaux, and Members of the Committee.

I'm Lawrence Cutchin, MD, president of the North Carolina Medical Society and an internist from Tarboro, North Carolina.

On behalf of the physicians of the North Carolina Medical Society, I want to extend our appreciation to this committee for allowing me the opportunity to discuss how our nation's medical liability crisis is seriously threatening access to quality health care, including medical care for patients in long term care facilities.

Long term care is an indispensable part of our health system. The continued productivity of our workers and quality of life for their families depends on the availability of long term care. Perhaps we have taken for granted that liability insurance would be available and affordable so that patients could be compensated in legitimate cases of negligent care. Today, however, the status of medical liability in North Carolina's long term care facilities has reached a crisis.

Insurance costs have skyrocketed. This has been well-documented by private actuaries whose work has been made available to the committee. North Carolina has not escaped

these problems. Premiums for some North Carolina nursing homes have skyrocketed by as much as 1800% since 1995.

Medical Mutual Insurance Company, which is the largest insurer of physicians in North Carolina, has determined that many long term care facilities have taken drastic steps to compensate for the escalating costs. Among them, negotiating contracts with their part-time medical directors shifting liability to them for purely administrative functions of the nursing home. That is, liability unrelated to the actual medical care the doctors are providing. Most professional liability policies, certainly all of the policies sold by Medical Mutual, do not cover this contractually-assumed liability. Additionally, some large nursing home chains were "sharing" one single annual limit of liability insurance of $1 million. A physician serving as medical director for one of these nursing homes faced extraordinary additional risk exposure in the event of a lawsuit where the underinsured or uninsured nursing home is a co-defendant. To address this problem, some companies have cancelled, not renewed, or refused to cover physicians who spend a significant portion (e.g., 15%) of their professional time serving as the medical director for a nursing home. The resulting lack of doctors to fill these rolls has left some nursing homes without a medical director, placing them in violation of federal certification standards. This is an untenable situation, to say the least, that can lead to problems with access and quality of medical care to long term care patients.

Other responses to the liability crisis include reductions in staff hours, freezing wages, and reducing residents' activities. These adaptations, together with the loss of available medical directors, certainly tend to escalate the professional risk associated with the medical care of nursing home residents, making already-reluctant physicians think twice about taking on the care of nursing home patients.

The nursing homes, physicians, and hospitals formed a coalition in late 2002 to address the medical liability crisis. Among the reforms sought by the coalition at the state level: 1) establishment of a peer review privilege to protect proceedings, records, and materials produced or considered by a quality assurance or medical review committee from discovery or use in a civil action against a nursing home; and 2) liability limitations for nursing home medical directors who might otherwise be named as a defendant in an action against a nursing home.

We believe there are solutions to this crisis. We believe the long term care system is worth saving. And we believe the United States Senate should act to reduce the excessive burden of our broken liability system on our nation's long term care providers.

Thank you for this opportunity. I would be glad to answer any questions.

The CHAIRMAN. Doctor, thank you for that testimony.

Now, let us turn to James Lett, immediate past president, American Medical Directors Association. I said "Carmel." That is Carmichael.

Dr. LETT. Carmichael, yes, sir.

The CHAIRMAN. California.

Dr. LETT. Correct.

The CHAIRMAN. Excuse me.

Thank you.

STATEMENT OF JAMES E. LETT, II, M.D., C.M.D., IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL DIRECTORS ASSOCIATION, CARMICHAEL, CA

Dr. LETT. Good afternoon, Mr. Chairman, esteemed panel members. Thank you for this opportunity.

I am Dr. James Lett. I am the immediate past president of the American Medical Directors Asian or AMDA. It is a greater than 7,000-member organization dedicated to the care of frail elders and others who inhabit America's long term care facilities. More importantly, I am a full-time geriatric physician in Sacramento, CA, spending my days in nursing facilities in the care of those frail elders. I have learned one thing; that the best way to provide excellent care to this vulnerable population is having available, committed, knowledgeable physicians who compete to provide that care. The winners are our patients.

Thank goodness, due to efforts by dedicated groups like AMDA, the body of knowledge about this unique population has greatly expanded. Even better news is that the pool of physicians who can apply this information and meet those needs has greatly expanded, that is, until recently.

At a stunningly increasing pace, physicians are leaving long term care not of their choice, but because they cannot afford or, in many cases, cannot attain professional liability insurance at any price. I am seeing the effects. Locally, I am assuming care of residents for a physician who cannot obtain professional liability insurance and one who is retiring for a similar reason.

Statewide in California, I have one colleague who is a professor of geriatrics at UCLA. After 13 years, his coverage was canceled. What was his sin? He marked "yes" in the box, "Do you see nursing home patients?"

For another colleague, an acknowledged statewide leader in long term care whose group sees 8,000 visits a month in nursing homes in Southern California, the only professional liability insurance she can obtain for her group is a month-to-month policy. So, on July 31 of this month, Chris will sit by her fax machine hoping to receive the letter of renewal from her insurance company so she can see patients August 1, as she does each month. Helpfully, her insurance broker suggested that she fire the four most experienced physicians in her group to "reduce their liability exposure." So not only would she lose physicians who want to practice, but those residents lose experienced physicians who want to see them.

Nationally, AMDA was stunned by calls around the country from members about the magnitude and widespread nature of the crisis.

In order to learn more, we conducted some surveys, which are to my left on the easel.

In 2002, we found about 1 out of 5 of those respondents had difficulty obtaining or renewing their liability coverage. More importantly and worrisome, 27 percent of the respondents said they modified their practices because of liability concerns.

Just over 5 percent of them resigned their roles at one or more, I should point out, nursing facilities in this country, which is, as has been described by Dr. Cutchin, a federally prescribed role to oversee quality of care in long term care facilities.

Nearly 9 percent reduced patient care hours. They began turning complex cases over to others.

We asked the question whether this was a bad year, a bad survey or an impending crisis. We got our answer the next year. About the same number of respondents reported they could not get medical liability coverage or had difficulty renewing it, but the number that jumped out at us is now over a third of them directly were told they could not renew or get insurance because they work in nursing facilities. The number that reported that insurance companies pulled out of the market doubled over the course of that survey.

Even more importantly, again, nearly 1 in 5 physicians said they significantly modified their practices due to liability concerns. What concerned us even more was that it was double the number this year—10 percent who stopped being medical directors, and the 10 percent stopped providing care in nursing homes, 3 times as many reduced patient care hours in nursing homes, and 3 times as many began referring complex cases.

Another terrible number not up there: 10 percent of the respondents in this group simply locked their doors and turned out the lights in their offices, on their medical practices. While this trend continues to decimate the pool of available physicians, the same barriers that forced the current exodus limit potential physician entrants into long term care, even though they wish to enter.

Ultimately, access to care will simply be overwhelmed, as the shrinking pool of long term care physicians collides with the need for access, as some 76-million baby boomers explode upon our Nation.

The dedicated long term care physicians of America, specialists in the care of frail elders, implore you to ensure a pipeline of committed, knowledgeable and, above all, available physicians to the frail elders of long term care. Please enable, not disable, access, for only access will assure quality to the vulnerable elders in America's nursing homes.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Lett follows:]

STATEMENT OF
JAMES E. LETT II, MD, CMD

AMERICAN MEDICAL DIRECTORS ASSOCIATION

TO THE SENATE SPECIAL COMMITTEE ON AGING

JULY 15, 2004

Mr. Chairman and Committee Members,

I am James E. Lett II, MD, CMD, Immediate Past President of the American Medical Directors Association (AMDA). AMDA represents more than 7,000 medical directors, long term care physicians and others who practice in nursing homes, as well as other venues in the long term care continuum (LTCC), which includes home health care, assisted living settings, hospice and other sites of care for the frail elderly.

AMDA focuses its work on clinical practice guidelines and best practices to improve the care for frail elders in Long Term Care (LTC). Once the right method to care for our elders is established, our mission then moves to educating long term care physicians on the unique needs of frail elders who require LTC and how to meet those needs. We are pleased that the body of physicians with specialized training and experience in long term care has been growing in recent years, but we fear that threats posed by the current liability crisis will stop that trend dead in its tracks. We now see experienced LTC physicians who are unable to renew liability coverage despite their claims history. Equaling alarming, we are now finding that physicians who wish to embark upon a nursing home practice, full time or part time, cannot obtain insurance coverage, even if they have completed advanced training programs in geriatrics. In states such as California, a further barrier is in place. Physicians treating geriatric patients, particularly those in nursing homes, are more likely to be involved in lawsuits.

To fully understand the crisis, it is necessary to describe the dual roles fulfilled by physicians in LTC. Many AMDA members perform both an administrative position as medical director within nursing facilities, which is mandated by federal law, and act as attending doctors providing direct clinical care to nursing home patients. Both activities are essential to quality care for the nation's frail elders, and both are threatened by the current legal quagmire.

Under federal statute (specifically the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, or OBRA '87), each nursing facility must have a licensed physician to act as medical director. The medical director is charged with a wide range of clinical oversight and duties to protect the frail elders, vulnerable adults and children in long term care facilities. Those responsibilities include:

- Implementation of resident care policies.
  This portion of the job includes involvement in such wide-ranging clinical policies as how residents are admitted to and discharged from the facility; how infections are addressed and prevented; the use of medications; and determination of requirements for physician and non-physicians to practice in the nursing home, among many others. The medical director is the clinical watchdog for the manner in which policies are applied to promote overall quality of care for residents; and

- Coordination of medical care in the facility.
  This includes assuring that the facility is providing appropriate care to residents. It also includes clinical oversight and supervision of physician, non-physician and ancillary (laboratory, radiology, pharmacy, etc.) services and the medical care provided for residents by all providers.

AMDA members see the issue of medical liability as a direct threat to quality of care and access to care for frail elders. Liability issues impacts AMDA physicians in two distinct, but intertwined sectors: both as a medical director of a nursing facility and as a practicing physician.

Impact on AMDA Nursing Facility Medical Directors

Medical directors must be covered for errors and omissions which may be alleged while acting in their administrative acts for the nursing facility. This type of policy is over and above the required separate professional liability coverage for their clinical work. Since most medical directors also serve as attending physicians to patients in their facilities, and maintain private practices or practice in other settings, they need two distinct policies. Typically, the nursing facility will offer coverage for the *administrative* actions only of the medical director.

We are seeing increasing numbers of nursing homes that are losing their liability insurance or are simply no longer able to afford it, leaving them —and their medical directors—"bare"; that is, without any liability insurance for themselves and for the medical director's administrative acts. This increasingly common circumstance leaves medical directors with three unpleasant choices: 1) find a personal administrative acts policy – now expensive ***if*** available; 2) risk personal financial ruin by maintaining no insurance: or, 3) leave the medical specialty and patients they love.

Catastrophically, more and more experienced, dedicated physician medical directors are choosing the third option. A 2002 AMDA membership survey on the liability crisis showed that 5.1% of respondents simply left their medical director role due to liability cost and access. Alarmingly, a follow up survey mailed in late 2003 revealed a continued loss of medical directors. There is no evidence that this trend is slowing, much less stopping. Since all nursing facilities who accept federal payments must have a physician medical director, there will soon be facilities forced to hire medical directors with little knowledge of LTC and frail elders, or even facing unlikely, but potential closure due to their inability to acquire any medical director, especially in rural and inner city areas.

Impact on AMDA Long-Term Care Practicing Physicians

The second major problem being encountered is the adverse impact of medical liability on coverage for the physicians' clinical work.

In the 2002 AMDA physician member survey:

- 20.5% of respondents reported problems renewing or obtaining professional liability insurance (PLI);
  - 4.6% were told this was related to working in LTC

The 2003 AMDA follow up survey then revealed:

- 21.5% or respondents reported problems renewing or obtaining PLI, but now
  - 34.2 % were now refused PLI because they work in nursing homes.

The inevitable result by many physicians was a decision to reduce or quit LTC involvement entirely.

- In 2002, 8.7% reduced LTC patient hours.
- In 2003, 18.4% of respondents reported changing their practices. Of those, 25% reported reducing LTC patient hours, 28% began referring complex cases to other physicians, and another 10% completely left LTC.

The numbers above were current as of January, 2004. Ongoing communications to AMDA from around the country since then indicate the situation is worsening. Each reduction in patient contact hours and departure from LTC further denies quality and access to frail elders in ever growing numbers. Given the fact that AMDA membership represents the physicians most dedicated to LTC, we expect that the exodus of less LTC-focused doctors far exceeds the percentages noted above.

The threat to quality and patient access, combined with higher costs, is the inevitable price of the liability crisis, borne out by the actions of AMDA members. This is a pattern we believe is present throughout the medical community, based upon observations and conversations.

The current long term care patient population is not just unique; medicine and society have never encountered such a challenge. These patients are older, have greater numbers of co-existing illnesses and take more medications than any we have ever treated. By the time they have reached nursing facilities, these elders are no longer sustainable at home despite every new surgery, new medical innovation and community-based support that science and society can boast. And the numbers in this group are growing rapidly. This population needs an expanding group of equally unique and committed physicians to care for them. While some medical training programs are incorporating focused geriatric skills, no medical school, no residency, no fellowship focuses on the frail long term care elder alone. Instead, physicians more often learn about the special needs of long term care patients through training such as AMDA offers, and through experience. Once they are gone, such physicians cannot be replaced. The average age of the AMDA physician is 51 years of age. As frustrated,

experienced LTC doctors leave the scene due to liability concerns, the supply of younger physicians willing to enter the long term care continuum has abruptly declined. We are seeing that more and more often, physicians feel that the costs, liability and hassle of practice in this environment have overwhelmed their desire to see this increasingly fragile population.

Expansion of capacity of the remaining doctors and the use of mid-level practitioners can only extend the time before the numbers of LTC elders completely overwhelm available care resources. The drain of talent from long term care highlighted above can only result in a decline in the quality of care for patients, and inevitably to access problems. Well-trained and dedicated physicians continue to leave long term care because they cannot obtain or afford liability coverage for their actions as medical directors and physicians. Furthermore, the intimidation of the specter of years of hassle and financial exhaustion to prove oneself innocent in such a litigious climate hasten the exodus of current doctors and inhibit any desire the enter the arena.

Recommendations

Emergency action is needed now to remedy liability problems in long term care. AMDA would like to recommend some short-term and long-term steps to solve this problem.

- The hemorrhage of experienced physicians and resources from LTC must be halted. The best single remedy available now is the Help Efficient, Low-Cost, Timely Health Care (HEALTH) Act of 2004 ((HR 4280). Although not the ultimate answer, this bill would go a long way to control wasteful liability costs by limiting non-economic (pain and suffering) damages and limiting attorney fees until more permanent answers are in place. This will again allow patient access to more physician services where they live.

- We need more careful examination of, and acceptance of, the credentials of "experts" in litigation. Each trial is a series of allegations by "experts". Based upon the jury verdict, each trial creates a new, and possibly contradictory, "standard of practice." One trial of a nursing facility in which I participated included a prosecution "expert" who expounded upon the quality of care in a nursing facility. He was a retired plastic surgeon who, under cross-examination, admitted he had never been in a long term care facility.

- Furthermore, there is a dearth of evidence-based outcome data in the care of frail elders. Development of and adherence to evidence-based standards of care is necessary. Once uniformly accepted, they can allow care to be judged objectively. AMDA has taken the lead in developing such a series of evidence-based clinical practice guidelines for long-term care. A partial list includes guidelines for osteoporosis; pain management;

depression; falls and fall risk; medication management; chronic obstructive pulmonary disease; and acute change of condition. Much more is necessary.

- Finally we also must recognize that in long term care, untoward outcomes are not necessarily the result of bad care. They may also be the inevitable result of the natural progression of degenerative diseases suffered by many patients.

Thank you for your consideration of this serious problem. The optimal pathway to quality care for frail elders is access to committed, knowledgeable, available physicians who compete to provide the best care. I urge your immediate action to maintain access to quality physician medical direction and physician services for nursing home patients. AMDA is ready to work with you in any way possible to deal with this crisis before it becomes a catastrophe.

The CHAIRMAN. Well, Doctor, thank you very much. I guess my first reaction to most all of the information you have provided this afternoon is the reaction of being alarmed that the care that our seniors need may, in many ways, be diminished dramatically by the information that you have provided to us.

Let me, in prefacing that, say that this really is about providers and doctors and not about attorneys. It is about the vulnerable, frail elderly who are in need of nursing home care. And it is in that context that I will begin my questioning starting with you, David.

As an academician—academic, I should say—looking at the statistics and the facts and gathering that information that you have supplied to us in part, in your view, what information or more information is needed to better understand the relationship between quality care and litigation?

Mr. STEVENSON. Thanks for the question. This is an important question and one whose answer affects the appropriate policy response.

Professor Kapp talked about the positive and the negative influences of the tort system on quality of care. As I said in my remarks, we do not yet know what the relationship between quality and litigation is. We do not know if the net effect has been bad or good, despite the alarming trends we have heard about and despite the alarming stories.

Ultimately, what is needed in this area is more research that is done at the level of the nursing facility and also at the level of the individual nursing home litigation claim.

Now, if I could just clarify for one moment why this is such an important question. If the relationship between litigation and quality were essentially random, if it were not there, that would imply one sort of situation that might emphasize tort reforms aimed at reducing the nonmeritorious claims. However, if it were shown that litigation was tapping into a reservoir of substandard care, you might take another approach to the problem, and in fact you might look outside of the litigation and the legal system more generally.

So I should say that it is an important question, but a very important question.

The CHAIRMAN. Is there any study that has been done that links quality indicators with survey deficiencies to the likelihood of a facility being sued?

Mr. STEVENSON. I know of four studies that have looked at this question, all of which have focused on State-specific data. Three of these have been done in the State of Florida, and one of them has been done in the State of California. The three in Florida were done by academics. The one in California was done by an advocacy group. These studies have reached mixed results.

I should also point out that they face limitations in their interpretation not only because they are State-specific studies, but also because there is a challenge in obtaining data on all litigation claims. It is simply hard to get access to those data, so it is hard to do national studies, on this question.

The CHAIRMAN. The GAO found that one-fourth of the nursing homes studied had deficiencies causing harm to residents, replacing them at risk of injury. Forty percent of these facilities were re-

peat offenders. Could liability cost issues be effectively addressed by simply cracking down on the 40 percent to improve safety?

Mr. STEVENSON. If the litigation claims were concentrated among the worst facilities, which I would say is an open question, but if they were, one could imagine that having some major impact.

Perhaps Professor Kapp can speak to the relationship between tort law and regulation, between which there are different but complementary purposes. But if one were to magically remove the repeat offenders from the universe of nursing homes, perhaps this would help mitigate the problem, but there still could be serious problems that could come up in the other nursing homes, I would argue.

The CHAIRMAN. Now, as I ask these questions, and as we move down the line, if you wish to respond in part to a question already asked or believe you can offer additional information to it, please feel free to do so as we visit with you this afternoon.

Theresa, you mention in your testimony factors that affect insurance availability and cost of premiums other than litigation. What are those factors?

Ms. BOURDON. There has been a very thorough discussion of these factors provided by the American Academy of Actuaries, last March 2003 to the Senate Committee on Appropriations when they conducted a hearing on the medical malpractice liability crisis.

In summary, the key factors:

One is the lag effect in recognizing changes in trends.

Another is investment yields, as premium dollars can be invested between the time they are collected and the time they are needed to pay for claims.

A third is reinsurance capacity—the insurance insurers buy to help them spread the risk of the risks they are insuring.

Fourth would be competitive pricing, particularly during periods of expansion into new markets. The mismatch between premium increases and current loss cost trends that may be occurring now in the nursing home industry is really the result of a period back in the late 1980's, early 1990's of unexpected low trend, very favorable investment yields, extensive reinsurance capacity and aggressive expansion into new markets because at that time health care was considered a profitable line of business to be in.

This period was then followed by a period of worsening trends, lower investment returns and increased insurance costs, creating the "Perfect Storm" that is resulting in the huge premium increases now.

There was a great quote from the American Academy's statement that said, "While one can debate whether companies were prudent in their actions, today's rate increases reflect a reconciliation of rates and current loss levels given available interest yields. There is no added cost for past mispricing. Thus, although there was some delay in reconciling rates and loss levels, the current problem reflects current data."

The CHAIRMAN. How does the rate of increase and the size of the claims in nursing home care compare with the liability claims incurred by other health care providers?

Ms. BOURDON. Based on research that we have done at Aon, both on the nursing home industry and hospital and physician liability

claims, we see a material difference in the overall trend in total losses. Hospitals have been trending, based on research we have been doing for the last 4 years or so, at about 10 percent per year.

We look back 10 years every time we do our study, and the trends have been fairly consistent for the last decade in our research. Nursing homes in total, as reported in the study that we have made available to this committee, are incurring an average annual trend of about 17 percent over the last 9 years. It was greater in the earlier years of that period of study, and it has tapered off a little due to Florida and Texas and effects there that we expand on in our study.

If you exclude Florida and Texas, the rest of the country is incurring about a 27-percent year-over-year trend, compared to hospital and physician data that we have analyzed. If you break it down between the number of claims and the size of awards, our research on hospitals and physicians indicates that frequency really is not an issue. There is maybe a 3-percent year-over-year increase in the number of claims against physicians and hospitals. The growth is in the size of the awards, which are growing at about 6.5 percent year-over-year.

Contrary to that, on the nursing home side, if we ignore the effect of Florida and Texas and the corresponding withdrawal of much of the industry from those States, and look at the rest of the country, claims are increasing at about 15 percent year-over year, and the size of the awards are increasing 10 percent. So you have the double effect of claims increasing in number and the size of the awards growing.

The CHAIRMAN. As I turn to my colleague for her time for questioning, you used the phrase once or twice, if you ignore Florida and Texas. How do you ignore them? Are they not lead indicators in the public pool?

Ms. BOURDON. They are lead indicators, but there have been a lot of factors that have occurred in the industry in the last few years that are causing some distortion in the actual trendlines. One of the largest factors is that many of the nursing home providers, particularly the multistate providers, are leaving Texas. They have left. Let us put it in the past tense. They have left Florida, they have left Texas. They cannot do business there. When you leave a State with an average cost per bed of $8,000 or $5,000, you lower the average. So when you looked at the first graph we put up, the trendline appears to be tapering off, but there are other factors that are causing that besides just getting this issue litigation under control.

In addition, in those States Florida and Texas it is very hard to buy insurance. So a lot of providers do not even have insurance, and therefore, the claims are not coming in any more, or they are coming in with very low limit claims because providers are purchasing a minimal amount of coverage, $25,000 per claim, for example, whereas the larger providers used to provide unlimited amounts of recovery for plaintiffs.

The CHAIRMAN. When you were talking about 8,000 or 10,000 per bed annually, you were talking about that against the average figure that you gave us of 2,000; is that correct?

Ms. BOURDON. Exactly. So when you take out the 8's and the 10's and the 5's it drops the average.

The CHAIRMAN. That would drop averages, you bet it would.

Let me turn to my colleague, Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman, for certainly bringing up this hearing on a very important topic of liability concern in the long term care setting. It is certainly clear to many of us this country is at a crossroads in regards to the process by which a patient seeks the compensation for harm occurring in the medical setting, and at this crossroads we have to make some decisions, because clearly, I think, to many of us, it has become quite an issue of patient access. Skyrocketing insurance costs are driving our physicians from the practice of medicine. They are closing the doors of our long term care facilities, and affecting the overall access to affordable and available health care.

It is especially true in some of our more rural areas of the country, such as my State in Arkansas which you have mentioned a couple of times, and something has to be done. States like Arkansas, we are a snapshot of where the rest of the country is going to be in the next 15 years. We rank No. 6 in this country as a percentage of our population that is over 65. So we rank up there with California, Florida, Pennsylvania, Arizona and other States, and unfortunately, our population of elderly tend to be more disproportionately low-income and disproportionately in those rural areas, so they are more difficult to serve.

But being that snapshot, we also recognize that the rest of the country is soon to follow where we are in the circumstances, and we really have got to work at solving this problem and cannot become locked into one solution. Oftentimes that is our problem here in Washington, becoming locked into one solution to the detriment of others, and I am afraid that some of what has happened in the Senate, while our constituents are driving long distances just to find a physician that will treat them or visit their parents in a long term care facility, the Senate has been debating the same solution in different forms with the same results, and that is why we are glad you are here today to help us look from many perspectives of what the solution must be in order to eliminate that detriment to the access of care.

We have seen in most of these proposals a $250,000 cap on the non-economic damages, which really has not politically been a viable solution in Congress, and I am not sure that it will be in the near future. Our hope is, is that we can look at multiple areas of places where we can bring together a consensus. Certainly our constituents do not need to suffer because of what we do up here, treading water, instead of getting something done. My hope is, is that we will look at some alternative forms and approaches to tort reform.

One of the ones in one of my working groups—and, Dr. Cutchin, my husband did his residency in North Carolina, so I come from it from all perspectives—but really looking at some of the alternative forms. One of those has been medical review boards, which can lower some of the liability costs for providers and help maintain I think some of the current levels of access to care, or increase that level of access if we can bring down some of those liability

costs, and would like to certainly hear any of your thoughts on the panel about that solution to tort reform or at least as being a part of that overall solution that we need, in bringing together hopefully a comprehensive package of tort reform that is going to help make more availability of liability insurance, but more importantly, bring down those costs that are detrimental to our physicians and to our medical facilities, our hospitals and everything else.

Without a doubt, we cannot delay much longer on this matter, certainly not indefinitely and I hope that we will not. So I thank the Chairman for bringing this up.

Dr. Stevenson, you mentioned in your testimony that the caps on non-economic damages could have a disproportionate and unfair effect on the plaintiffs in long term care malpractice actions. To some degree that seems to be one of our biggest sticking points in the Senate. Do you have any other solutions, or maybe others on the panel may out there, that we could address in terms of the rising liability costs other than those caps or maybe looking at how we redistribute those caps on non-economic damages or at least take a different perspective?

Mr. STEVENSON. I should start off by saying I am not a health lawyer, and so I am treading on thin ice with some of these points. I should also point out by way of clarification that in detailing the differences and talking about the large role of non-economic damages for claims that nursing home residents tend to be involved in, I am not arguing one way or another about tort reform more generally. What I am arguing is if tort reforms move forward they should pay attention to the distinct characteristics of nursing home claims, rather than assuming these differences away by imposing generic reforms. But I would cede the floor to other people who know a great deal more about health law and tort reform.

Senator LINCOLN. I think we too want to cover all the bases. We do not want to just focus on one area of tort reform that is going to only help one section of the medical community. Anybody else? Dr. Kapp?

Mr. KAPP. Tort reform encompasses several things. It could encompass things like damage caps which essentially take the existing system and try to make it work better. Essentially damage caps, when one advocates damage caps, one is saying we have a good basic tort system. We need to tinker with it. We need to make some changes in it to make it work better.

The other approach, of course, is to say that resolving claims of substandard medical care that injure a patient ought to be dealt with in a different kind of system, that the tort system, as it currently exists in its adversarial environment, is not the best way to accomplish the two goals of compensating injured victims and improving the quality of care, and that perhaps administrative systems, and you mentioned one, that would substitute for the existing mechanism of resolving disputes about quality of care would be a more viable and positive way to address the issue. My own view is that discussions about damage caps and other tinkering mechanisms with the existing system are mistaken in taking as viable the existing system that can be made better by tinkering at the edges.

Senator LINCOLN. So explain that. You are saying that you do not think tinkering is the way to go, that we need a complete overhaul, or are you saying that the current system through some modifications is still a viable system?

Mr. KAPP. I would argue for the former, for the replacement of the existing system or some administrative mechanisms. I understand the problems of political viability, but I would argue in favor of the more radical approach, the more systemic approach.

Senator LINCOLN. You do not mean in terms of the due process that individuals have, your feeling that that can be done with every confidence that people's right to due process can be preserved?

Mr. KAPP. I think it can be. Obviously, the devil is in the details——

Senator LINCOLN. It usually is around here.

Mr. KAPP. I do believe that that is the approach that ought to be pursued.

The CHAIRMAN. Could I follow up on that? Are you suggesting that in certain instances a review board or a board that can make a determination of findings and therefore a potential of a reward for damages, versus, if you will, the threat of a lawsuit that would take one to a trial setting, and therefore settling out of court, and all of those kinds of things that hold down expenses, if you will, and do not argue the issue may be in detail, to lessen the potential impact of a deep pocket jury finding? Is that part of what you are suggesting? I am putting words in your mouth to a degree to explain what I am trying to say, but is that the kind of significant reform you are talking about?

Mr. KAPP. Correctly so, and certainly there are problems with that. The total cost of an administrative system may be more because the current tort system, for all its problems, filters out many potential claims where an individual cannot prove negligence or cannot prove causation, and in an administrative system, particularly a no-fault kind of administrative system, you would have many more claims being filed and paid at lower rates than the current system often compensates victims, but the total cost might be more, but I would suggest that the results certainly might be more efficient and might be fairer, likely would be fairer, and certainly in terms of perceptions of providers of fairness. I think there would be some valuable benefits that would then improve their behavior with ramifications for quality of care.

The CHAIRMAN. Senator Lincoln, I interrupted you. Please proceed.

Senator LINCOLN. Thank you, sir. I appreciate it.

Just a couple of more questions to follow up. I do not know if any of you all have had any experience with medical review boards, but it is something certainly that I have encouraged some of my colleagues for us to look into the States that do have medical review boards in conjunction with their medical malpractice and their tort system there in the States. There are a lot of different unanswered questions there in terms of the admission of a verdict from a panel that is not bound by the rules of evidence. I am not a lawyer, but I learn to talk it occasionally up here. But certainly looking at all of those.

I would certainly be interested to hear any of your comments about that if any of you all have come in contact with that. Mr. Estes?

Mr. ESTES. I have spent some time studying the States' medical review panels. I do not have data with me, did not come prepared to discuss the data. But the trends in the States that have utilized medical review panels have been positive, and they have found to be effective, in my view. I want to say, as you did, I am not an attorney. I operate nursing homes. That is the limit of my involvement here. But I would answer your question by saying that some combination of medical review panels or some other administrative process. We have got the Federal Tort Claims Act that is an effort to take an existing process and deal with similar problems that involve the Government as an option.

In some States we have tried to deal with these things through the actual rules of evidence. Punitive damages, according to David, are a big problem in nursing homes. There is a lot of evidence that comes in against nursing homes because we are nursing home. The regulatory record that we have is three miles long. A good nursing home has a lengthy, lengthy, regulatory record, that when you bring it into court and use it to put the nursing home on trial, sometimes it results in the jury getting aggressive in their desire to punish this nursing home, and we end up I think, with some of the punitive damage awards because of the amount of regulatory history and the amount of things that come in against us.

So there are a variety of things out there that are options, and it may very well be that some combination of some of those fixes with different caps than those who have been unsuccessful thus far that are being debated here could be a viable fix, and I wanted to give you my thoughts.

Senator LINCOLN. I am glad you brought that up, because it is important I think for us to look at all of the options of how we can comprehensively craft something that will provide the kind of relief that you need, and obviously be consistent with the important things that we enjoy in this country. So I appreciate. We would love to have any more of your comments on those that you find.

I would just like to ask Ms. Bourdon, in your loss cost per bed, I am assuming that that has only to do with litigation costs. Does that have anything to do with regulatory liability? I mean I hear these horror stories from my nursing homes, and I am sure Mr. Estes can concur, but I mean getting written up for a $10,000 fine for a dent in the can, or some of these crazy rules that are out there that——

Ms. BOURDON. No, this is just the cost for the professional liability and the general liability claims against nursing homes. It is the amount paid in compensation to the plaintiff, their attorney's fees, and the defense costs that the provider incurs.

Senator LINCOLN. It is not any kind of regulatory liability or regulatory fee liability?

Ms. BOURDON. Does not include those costs.

Senator LINCOLN. I am glad the Chairman has had the foresight to draw you together, and I hope that we can continue to call on you for good suggestions, and certainly your input as we tangle with this issue.

I visited with a nursing home owner, a multi-state nursing home owner not too long ago, who indicated that they had sold, not sold, but closed down eight of their nursing homes, and every one of those nursing homes was operating at 85 to 90 percent capacity. They are not closing their doors because they are not needed. They are closing their doors because they cannot keep them open. That is a real problem when we realize that in the next 15 to 20 years we are going to double the number of seniors in this country, and we are just not making sure that as a Nation we are prepared. The geriatricians is an issue that I am enormously involved in. We are training less and less, unfortunately, geriatricians to deal with that problem. I am hoping that through the Aging Committee and the great leadership of our chairman, we will face many of these issues on behalf of our constituents.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Lincoln, thank you for your presence here today and your knowledge and contribution. That is greatly appreciated.

Professor Kapp, what can be done to improve long term care providers' perception about the legal environment in a way that would change their behavior to improve quality of care and quality of life for our long term consumers?

Mr. KAPP. I think it is important for the Congress and for the State legislatures to do something that sends a signal, that sends a symbol to long term care providers that their work is valued and important and supported. Data is important, but symbols are important as well, and I think providers are looking for symbols that those in positions of authority and influence value their contributions.

The biggest complaint that I have heard from providers is a perception, which I think is in many cases well grounded, of inconsistency, unpredictability and arbitrariness in the enforcement of standards to which they are going to be held by regulators, juries and prosecutors, mixed signals.

There was discussion before about the regulation litigation synergy, and providers tell me that a great deal of their frustration is that the signals they get from regulators and from the legal system are often mixed and inconsistent and unpredictable. To the extent that providers can be better convinced that they will be held in a fair and consistent way to specific, knowable standards of care, that would go far in improving their perceptions of the legal environment and the behavior that is driven by those perceptions.

The CHAIRMAN. Thank you.

Dr. Cutchin, what would be the consequence if steps are not taken to correct the liability problem that is impacting nursing homes and long term care facilities in North Carolina?

Dr. CUTCHIN. I think just some clarity on what we had said a moment ago. First of all, if nursing homes cannot secure medical directors, they have to close by Federal law. If nursing homes cannot——

The CHAIRMAN. Repeat that.

Dr. CUTCHIN. If they cannot secure medical directors, they have to close.

The CHAIRMAN. In other words, the Federal law says you have——

Dr. CUTCHIN. By regulations they have to have a medical director available. By the same token, if they cannot pay for a PLI or professional liability insurance, they probably have to close, not necessarily, but they are at great risk.

The CHAIRMAN. Because they cannot get the medical director.

Dr. CUTCHIN. They cannot get the medical director, correct.

The CHAIRMAN. So you are suggesting one creates the other problem or vice versa.

Dr. CUTCHIN. Makes it more difficult to get the medical director, of course. If primary care physicians cannot get professional liability insurance because of their relationship with nursing homes, they will cease to care for those patients in nursing homes, they will cease to serve as medical directors, and again, you cannot operate nursing homes without them. So we think all of those things together will happen if the process continues in the direction that it is moving.

The CHAIRMAN. The ultimate Catch-22, in essence.

Dr. Lett, what does long term care seem to be—why does long term care seem to be a focal point for this litigation? We have heard a variety of reactions. Is there a problem with care in these settings, or are we simply catching up after it being ignored for a time?

Dr. LETT. Senator, certainly long-term care is administered by humans, and humans most certainly are capable of errors. That we freely have to understand and admit, but there certainly are special circumstances around long term care. It is a very highly emotional transition in life, and I can speak to it very directly, having put my mother in a nursing home some 5 months ago.

Memories of the patients clouded by illness and medicines, anger over the loss of independence, anger over being placed by your family and the family feeling very guilty about that as well, leads to a great number of unmet expectations which often leads to anger which appears to be, in my understanding, one of the chief causes of lawsuits.

Second, we are dealing with a very elderly, vulnerable, fragile population with a high probability for decline, and in fact, the reason they are in a nursing facility is they have recently had a decline and no longer could care for themselves, so it becomes very difficult to differentiate between an expected decline and an inappropriate decline, even among the best of experts.

Certainly, I think there are some assumptions in our culture at this point in time that nursing homes are not good. One of the things I hear most from our patients is my family promised me they would never put me in a nursing home. There is kind of a perception that it is a negative environment to begin with, which is added to in the media. I have to tell you that upon checking into my hotel room yesterday, I turned on the TV and the first commercial I saw was from a plaintiff attorney advertising, has your loved one been abused or neglected in the nursing home? Free consultation.

I think there is a negative media barrage, and an assumption that, yes, there may be a problem and we should look into it.

Last but not least, there are States, and California is one of them, that has laws in place that not only make it easy to sue physicians and other nursing facilities, other entities around the care of elders, it actually is a very good business decision to do so.

The CHAIRMAN. Like Senator Lincoln, I represent a rural State with a good many small nursing homes in smaller communities. What effect does these kinds of costs have on a one or two-home operator, or a single home operator, versus a multi-home, multi-state operator?

Dr. LETT. I think it is going to be horrendous for smaller markets. The availability of——

The CHAIRMAN. The costs are the same, are they not, in many instances, the liability costs?

Dr. LETT. Theresa can probably speak to this more directly than I can, but, yes, the costs are high relatively speaking especially in a small market. That is, even if costs are lower in Idaho for the premiums than they are in California, the cost of living is different, the income is different, et cetera. So the economic pressures for not entering into the long term care market by a physician are the same in rural markets, since you start out with fewer physicians, you probably will have just statistically fewer physicians who have been trained in long term care and elder care by a responsible organization such as AMDA, so you have a very small pool to begin with that gets drained very quickly when you add in the high cost of trying to be involved either as a medical director, at an administrative level, or as a practicing physician in long term care.

The CHAIRMAN. Ms. Bourdon, you wish to make additional comment on that?

Ms. BOURDON. Yes. I would just add to that that in our study we separately analyzed 13 States and we selected those States based upon two criteria. One was that there was enough data, there was a credible sample of claims data in order to get a sense of the trends. Second, we did consider these to be some of the States with the higher trends, and wanted to take a look at them.

But we took the remainder of the States, which would include the rural States, that independently by themselves, if there is less than 5,000 beds in the data, could not give us a statistically significant indicator, and we aggregated them all together and put them in what we call "the all other States" category. That category, I would say, represents a lot of the rural States. That category, while it has a lower relative cost per bed—and it was on one of the charts we threw up—still indicates and annual double digit increase, double digit at 20 percent a year, year over year in the costs in those other States.

In addition, in our study there is a section in which we specifically address the insurance premium and coverage changes that some of the smaller providers are reporting, because again, independently, if they are only operating one or two facilities, their own data is not statistically significant, and we tracked the premium increases that they were incurring, and then they are highlighted in the report, and it is what indicates 200 percent, 300 percent increases over the last 3 to 4 years.

The CHAIRMAN. Thank you.

We have just been joined by another one of our colleagues, Senator Carper. Tom, would you wish to make any comment and/or question of these panelists?

Senator CARPER. Thanks, Mr. Chairman. I sort of joined you in mid-flight.

The CHAIRMAN. Well, we appreciate the touchdown.

Senator CARPER. It is my pleasure. We just had a sort of losing battle last week in the Senate on the issue of class action litigation reform, and the concern there, as you may recall, has been the emergence of something called magnet courts, where oftentimes county courts with locally elected judges who end up hearing a national class action litigation that really in many cases belongs in a Federal court. You have a defendant from one State, plaintiffs from many other places.

I literally have not read your testimony, and I really do sort of join you in mid flight. If you could use as a basis of reference we have been working on that, we are working on asbestos litigation reform, to try to ensure that people who are sick and dying from mesothelioma or asbestosis actually get money soon that they need for their pain and suffering, for their families, and to make sure that people who maybe have an exposure but do not have the symptoms, that they do not get anything, at least for now, until they ultimately become impaired, and to reduce the amount of money that goes in transactions costs on the legal side from 40, 50 percent, where it is now, to something far less than that. Those are two that we actually are debating on.

Just discussed with one of our leaders the next steps on asbestos, so those are issues I think that are alive and well, despite what happened last week on class action.

The issue that is before us now, my mom lives in a nursing home, lives in a wonderful nursing home in Ashland, KY just across the line from Huntington, WV, lives not far from her sister, not far from my sister, and so we are very mindful of the kind of care that she gets, and want to make sure she gets the very best care.

By virtue of having said all of that and my personal involvement with my mom and our family, my involvement on class action litigation and legislation and asbestos legislation, if you would each take a little bit of time and tell me what I should know about the issue that you bring to the table? These are issues that I care about, have a personal interest in, and have a professional interest in. Dr. Lett?

Dr. LETT. I am smiling because I was raised in Ashland, KY, and my grandparents were both in a nursing facility in my hometown there for many years, so I certainly can relate.

Senator CARPER. No kidding. I do not remember where I was, but I stopped someplace. Maybe it was, happened to be at—there is a YMCA there, and I try to work out every day, and I went there to work out. I remember seeing like inscribed on one of the lockers there, "For a good time call James Lett." I remember wondering, who is—— [Laughter.]

Dr. LETT. I was certainly glad you erased all those, sir.

Senator CARPER. Who is this guy? [Laughter.]

Dr. LETT. I am sorry. I could not help the personal note, hearing about my hometown.

Senator CARPER. I still visit it every month. I am going to be there this coming weekend to see my mom.

Dr. LETT. My thumbnail is that at this point in time liability insurance problems are no longer a threat. They are a fact in terms of limiting access to frail elders of the physicians who are most experienced and best positioned to care for them, and it is getting worse, and we must do something immediately.

Senator CARPER. Mr. Cutchin?

Dr. CUTCHIN. Dr. Cutchin, yes, Larry Cutchin. At the risk of being repetitive, what we——

Senator CARPER. You grew up in Ashland, KY too? [Laughter.]

Dr. CUTCHIN. No, I live in North Carolina.

Senator CARPER. Where?

Dr. CUTCHIN. Tarboro.

Senator CARPER. My wife is from Boone up in the mountains.

Dr. CUTCHIN. That is the other end of the State, but we like both of them, sir. Nice place to be.

The issue of course that we are concerned with is the fact that nursing homes are under stress because of the liability insurance costs, and the issue I brought to the table and Dr. Lett brought to the table as well is the fact that they are having problems securing and maintaining medical directors, and other physicians to see patients in the nursing homes because of the fact that those physicians cannot get liability insurance if they have a certain percentage, a large portion of their practice is in nursing home care. That is a big issue.

I can give you a personal example. A friend of mine in Greensboro, NC, a retired physician, who is the board chairman for a nursing home organization in that county, that is a nonprofit organization that takes care of about 500 elderly people in the nursing home. He was notified out of the blue the first of March that the 10-physician group, they had provided medical director services as well as patient care services in that home would no longer be able to do it because they could not get malpractice insurance or medical liability insurance.

They negotiated over a month and finally did get a policy, but it was with a 120 percent increase in the premium from before. They do not know what it is going to be next year. That is the example of what we are dealing with.

Senator CARPER. Thank you.

Mr. Kapp?

Mr. KAPP. In a sentence my message was that health care providers, long term care providers today have a strong pervasive anxiety, or apprehension about the scary adversarial legal climate in which they function, and that perception, those apprehensions or anxieties, often translate into behavior that has negative consequences for the care of consumers.

Senator CARPER. Thank you, sir.

Mr. Estes?

Mr. ESTES. In direct response to your questions of the relationship between the situation we are talking about here today and the other issues that you raised, I would respond that it is different but

yet similar to both, and that from a State perspective, we are seeing certain States have a much more significant problem with liability costs than we are other States. We do not know exactly why. We know from a data standpoint that it is a fact and we believe it to be related to the State laws and the way the courts work in the individual States, and that is one of the reasons, quite frankly, we think that there needs to be some Federal method to address this problem.

The second thing I would say to you relates to the asbestos situation that you raised. We are already starting to see, because nursing homes can no longer buy insurance in certain markets, we are starting to see what I consider to be the ultimate bad circumstance for our residents, and that is when one of our employees makes a mistake or when one of our employees does something bad, there are legitimate claims that are not going to be compensated because there is simply no insurance available to compensate these victims.

So I would tell you that those are the two things that come to my mind that would kind of get you up to speed on how what we are talking about relates to the things that you discussed.

Senator CARPER. Thank you.

Ms. Bourdon?

Ms. BOURDON. As an actuary to the nursing home industry, I have been tracking these lawsuits for the last 6 to 7 years, and we do an annual survey every year of the industry, which represents about a quarter of the industry. From the response to our survey, we have watched this issue grow from a $50 million a year cost to a $1 billion a year cost in a 10-year timeframe.

Senator CARPER. The cost of what? I am sorry.

Ms. BOURDON. Cost of lawsuits against nursing homes alleging patient care violations.

As this has occurred, I have watched our clients go into bankruptcy, get out of nursing home facilities in certain States, and completely contract their operations. I have not seen any growth, per se, other than those acquiring the homes being sold off, but not new licenses being established in States.

This is probably the main reason why the number of beds in this country is down from 3 years ago, which is a serious issue when you consider the baby-boom generation aging and approaching retirement age.

Senator CARPER. Thank you.

Mr. Stevenson?

Mr. STEVENSON. I come to this issue as an academic health policy researcher, and the reason I am here in particular is that I and a colleague did a national survey of defense and plaintiff attorneys who see these types of claims.

In brief, what I said today was that first there is a large number of claims, and there has been a substantial increase in the number and the size of the compensation over the past several years.

Second, I said that there is an unclear relationship between litigation and quality, it is simply unclear how accurate the tort system is in compensating and deterring poor quality care at this point.

Then the last thing that I said was that there are a number of distinct features about nursing home litigation claims that might

give one pause if they were to think about using conventional tort reforms such as limiting non-economic damages to control the cost of these claims.

In direct relation to the point you made at the outset about class action suits and the magnet courts, I should just add from our study that the vast majority, 92 percent, of nursing home litigation claims are settled out of court. Only about 7 or 8 percent actually go to trial. Then, 9 out of 10 result in some dollars going to the plaintiff, and we found that is a large amount of total dollars. In large part the high settlement rate has been out of concern, we would posit, of going to court.

Senator CARPER. Thank you. Could I ask one more?

The CHAIRMAN. Sure. Please do. Tom.

Senator CARPER. Thanks, Mr. Chairman.

When Senator Craig and I, and some of our other colleagues, who support class action reform and also asbestos litigation reform, when we approach those issues I always say I do not know that the States have the ability to fix those problems, and my view is it takes some intervention by the Federal Government, by the Congress and by the executive branch. I used to be a Governor for 8 years, and I am mindful of the prerogatives of the States and respectful of the prerogatives of the States. There is a question I would ask you. The States cannot fix action. States cannot fix asbestos, at least not in my view. I am not so sure, I just do not know, do States have the ability, whether it is Delaware or Idaho or any other State, if they have the problem, malpractice costs or whatever revolving around long term care, do States have the ability to fix those problems? Are there some examples of States who are?

Mr. ESTES. Yes, sir. I am stepping forward because nobody else did. There are some examples of State reforms that have been passed. It is my view that some of those reforms will be successful, although it is still very early to say that they are successful.

Senator CARPER. Do you recall any States that have done so?

Mr. ESTES. The State of Texas has passed medical malpractice tort reform in the last year. The State of Mississippi has passed tort reform. There are two or three others that have done things to a lesser degree, and I believe they will be effective.

The reason that I am not sure we can leave it to the States to figure out is two thing. No. 1, it is the Federal Government's money that is being spent in this process, and the diversion of Federal money, whether it be from Medicare or Medicaid, into this process is wasteful to the taxpayers and needs to be addressed from a Federal standpoint.

The other problem I would tell you is that as we have been able to successfully pass measures that we think will curb the lawsuit abuse problem in these States, the problem just crops up in another State, literally. So those two reasons are the reason we think that there needs to be a Federal fix, rather than it be left up to the States.

Senator CARPER. Dr. Lett?

Dr. LETT. Thank you, sir. After having been raised in Kentucky, I took Horace Greeley's advice and went West, and I am now practicing in California. California has a very successful tort reform act

called MICRA, Medical Injury Compensation Reform Act, passed in the mid 1970's. It has without a question held down insurance premiums for physicians. They have risen only about 170 percent, while in other States——

Senator CARPER. Since the 1970's?

Dr. LETT. I believe it is since the 1970's, while in other States like Florida they have gone up 2,300 percent in that same period of time. However, as well as MICRA works, one reason why I would think—if you will forgive me for putting this in—that a Federal solution is better, is that in California, what has happened is there is a specific law, the Elder Abuse Statutes, under which MICRA can be circumvented. This is why even a State with a marvelous, marvelous tort reform system in place still is on the endangered list for long term care and the care of elders, is because it can be circumvented through this legal loophole. Certainly a Federal fix of that would be greatly appreciated by the long term care geriatric physicians of California and the frail elders we serve.

Senator CARPER. Thank you.

Dr. CUTCHIN. I would agree with that, that there is evidence that States can fix that, fix it, but a Federal effort would certainly be a big improvement, and we would not then have a patchwork across the country on this.

Senator CARPER. Thanks.

Mr. Chairman, thanks for being so generous with your time.

To our witnesses today, thanks for your testimony and for letting a guy come in mid flight and asking a couple of questions. Thank you.

The CHAIRMAN. Tom, thank you.

Let me thank you all very much for the time you have spent with the committee today, and the record you have helped us shape, and I think that will be valuable to our colleagues as we again continue to work at this issue. Tom has spelled it out well, and has certainly been a leader in the area of tort reform here and class action. We worked mightily on the floor last week to try to make that happen, and it did not quite make the hurdle. We are going to get there. We have to get there.

I do believe, Mr. Estes, that in the end—you said something that sometimes is misunderstood or not remembered, that a fair amount of Federal tax dollars goes into the care of a good many of these elderly patients. I believe nearly 80 percent of them in the nursing homes across America receive some direct Federal tax and State tax dollar benefit through Medicaid. If in fact, and it appears there is growing evidence that there is a diversion of funds, if you will, to keep these homes open by paying these very high premiums.

The average cost, Tom, is now nearly $2,000 per bed per year, that is $6.27 a day. That is a significant cost, and there appears to also be growing evidence that it impacts care. If that is certainly the case, then that is all the more reason for us to look at some approach toward beginning to shape and control this issue. Clearly, this industry cannot sustain, nor can the health care profession sustain the hundreds of percent per year increases in these kinds of premium costs. Of course, the great tragedy is that, and as you said it or you said others have said it, we are not seeing any new nursing homes. Bed numbers are dropping at a time when we are

coming upon an age of citizens in our country where by all evidence bed numbers ought to be going up or preparing to go up, and that, based on what I hear from you and other materials I read, will not be a fact unless we resolve some of these problems or stabilize some of the environments in which these numbers are now declining.

We thank you very much for your time and your presence here today, and rest assured your time here was valuable to us, and that you have helped us establish an important record. Thank you.

The committee will stand adjourned.

[Whereupon, at 3:44 p.m., the committee was adjourned.]

APPENDIX

THE PREPARED STATEMENT OF SENATOR JOHN BREAUX

Thank you Mr. Chairman. Today's hearing allows us to examine how the long-term care industry—specifically the nursing home industry—is affected by rising costs of liability insurance and litigation.

Clearly, there will always be a demand for nursing home care because there are elders who require around the clock care. With the pending age wave of 77 million baby boomers that demand will only increase. Today's hearing is an opportunity to examine how rising medical liability insurance costs and increased litigation is affecting this industry. Will seniors have access to quality care? Are nursing homes really going out of business due to rising medical liability costs?

While we examine these important questions today we must also do so within the context of two points. First, as the author of the Elder Justice Bill, I must point out that elder abuse and neglect are serious problems in our society that have not been adequately addressed. While most nursing homes work hard to provide quality care for residents, there are some "bad apples" out there. Some of the litigation in this area is a result of family members who bring lawsuits against nursing homes who have abused or neglected their family members. Nursing home residents and family members should have legal recourse when they have been harmed.

Second, there is a growing demand in this country for more home and community based long-term care options. When asked, seniors and baby boomers want to remain independent and live at home for as long as possible. I believe that nursing home executives who hope to prosper and flourish in the coming decades as baby boomers age should act quickly to diversify into home and community based services.

The bottom line is that as we look at tort reform and long-term care we want to ensure that people have choices. I look forward to hearing from today's witnesses. Thank you Mr. Chairman.

MEDICAL LIABILITY IN LONG-TERM CARE: IS ESCALATING LITIGATION A THREAT TO QUALITY AND ACCESS?

Senate Special Committee on Aging
July 15, 2004

STUDY BY CENTER FOR MEDICARE ADVOCACY DISPELS MYTHS ABOUT TORT REFORM AND NURSING HOMES

The Center for Medicare Advocacy's study *Tort Reform and Nursing Homes* (Apr. 2003) dispels the myths that pervade the nursing home industry's discussion of tort litigation. The civil justice system compensates victims of grossly inadequate care or gross failures of care. When nursing home care kills or injures vulnerable elderly nursing home residents, tort litigation is necessary to hold facilities accountable. The civil justice system also complements the public regulatory system in its efforts to improve the quality of care for all residents, current and future. Tort litigation has led to significant changes in facilities' care practices and removed providers that refuse and consistently fail to give residents good care.

Myths about Civil Litigation against Nursing Homes Are Deflated by the Study's Findings

- *Cases are not frivolous*

First and foremost, the cases are not frivolous. Cases represent situations where residents have been seriously injured and died. They involve deaths by strangulation on bedrails or other physical restraints, pressure sores, malnutrition, and dehydration.

- *There is no explosion of litigation*

  While the number of cases has increased, there has not been an explosion in tort litigation, as the industry contends. The Center's evaluation of litigation in Maryland found few filings statewide and no reported decisions at all at the appellate level.

  Moreover, while a handful of facilities have many cases filed against them, most have few or none. The *Orlando Sun* found that litigation is generally concentrated in relatively few facilities.

Compared to the amount of abuse, neglect, and grossly poor care suffered by residents each day, as documented by the General Accounting Office and others, the number of cases filed against nursing homes in fact remains small.

- *Recoveries are not astronomical*

  While cases involving hundred million dollar jury verdicts receive attention in the media, these verdicts are publicized because they are in fact both large and unusual. The study finds that actual settlements and pay-outs are considerably lower than these multi-million dollar verdicts. Judges may reduce large verdicts in post-trial motions and cases are often settled for lower amounts during appeal. As a consequence, one insurer reported that its average claim payment increased nationally from $25,599 in 1995 to $59,370 in 2000, considerably less than the multi-million dollar verdicts publicly reported in the press.

- *Litigation supplements the public regulatory system*

  The distribution of cases against facilities is not random. Facilities with large numbers of verdicts and settlements recorded against them are the same facilities that have been the subject of significant public enforcement activity. Frequently-sued facilities have usually been cited with large numbers of deficiencies by state survey agencies. Civil litigation may also bring about quasi-regulatory results in specific facilities and permanent changes to facility practices, benefiting future residents.

  Viewed in this light, civil litigation is an important adjunct of the public regulatory system. Like the public enforcement system, it serves an important public function of improving care for all residents.

- *Civil litigation is not the cause of rising liability insurance premiums*

  Finally, the Center's study demonstrates that tort litigation is not the cause of rising liability insurance premiums. Various analyses identify multiple causes for increased rates that include, but go far beyond, tort litigation:

  - The profit-motivated insurance industry, which has minimal experience with nursing homes and little competition for business;
  - The insurance industry's unregulated status with respect to pricing nursing home liability policies;
  - The insurance industry's not finding in nursing homes the types of risk management programs that are standard in other health care settings;
  - Poor quality nursing home care;
  - Insurance companies' raising premiums based on national, rather than state-specific, nursing home pay-out experience (so that facilities in states without significant tort litigation nevertheless experience significant rate increases);
  - Rising commercial insurance rates, as a general matter; and

- The cyclical pattern in the insurance industry, so that insurance companies raise premiums based on financial matters unrelated to claims (i.e., (1) insurance industry invests premiums in the stock market to generate revenues; declining stock prices affect insurance companies' profitability; (2) insurance companies had substantial payouts as a result of September 11, 2001).

Study Consistent with Other Findings

The Center's findings about the serious failures of care reflected in tort litigation are consistent with findings of others who have looked specifically at civil justice litigation against nursing homes. As the Florida Task Force on the Availability and Affordability of Long-Term Care reported in December 2000, "the lawsuits are fundamentally about pressure sores, falls, dehydration, and malnutrition or weight loss." Cases described in the Appendix amply supported the finding. For example, the Florida Task Force described a May 20, 1999 settlement for $1.5 million in Leon County:

> Admitted 3/95; good condition. By spring 1995, contractures resulting in fetal position; falls, traumas, multiple bedsores (1/96); 3/96 gross mismanagement of feeding tube; weight loss of 43 pounds over the next 67 days. Died 10/11/96. Fraudulent and inconsistent charting entries included entries showing care during hospitalizations and day after death.

The Florida Task Force's findings were echoed by the Harvard study reported in *Health Affairs* (March 2003), which recently documented that more than half the cases in civil justice litigation against nursing homes involved residents' deaths.

Copies of the Study Available from the Center for Medicare Advocacy

The Center's report on tort litigation and nursing homes is available from the Center for Medicare Advocacy.

The Center for Medicare Advocacy is a private, non-profit organization founded in 1986 to provide education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain necessary healthcare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and healthcare rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Toby S. Edelman
July 15, 2004

TORT REFORM AND NURSING HOMES

INTRODUCTION

Enacting tort reform is a major public policy priority of the nursing home industry at both the state and federal levels. Arguing that rising liability premiums, caused by tort litigation, are consuming scarce financial resources intended for care and forcing good providers into bankruptcy, the industry calls for a variety of stringent limitations on tort litigation. This paper explores these issues as it presents and evaluates the discussion about tort reform in nursing home litigation.

Four appendices to this report describe (1) examples of recent verdicts and settlements in tort cases against nursing homes, (2) a methodology for identifying tort litigation in a state and implementation of that methodology in Maryland, (3) the major components of tort reform that are proposed and enacted at the state level, and (4) legal theories used by residents' advocates to complement or replace tort theories and strategies used by the nursing home industry to avoid tort litigation.

BACKGROUND

Limiting tort litigation on behalf of nursing home residents is a key legislative priority for the nursing home industry in many states.[1] The public debate has also moved to Congress[2] in recent months as nursing home providers have joined the healthcare industry's broader call for national tort reform for all healthcare providers.[3] Media reports of large verdicts against nursing facilities,[4] exponentially

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[1] *See* American Health Care Association's Issue Brief, "Civil Justice Reform" (Mar. 2002).

[2] The House Subcommittee on Commercial and Administrative Law held an oversight hearing on June 12, 2002, "Health Care Litigation Reform: Does Limitless Litigation Restrict Access to Health Care?;" the House Energy and Commerce Committee held a hearing on July 17, 2002, "Harming Patient Access to Care: The Impact of Excessive Litigation."

Ten Members of Congress have requested that the General Accounting Office evaluate "the extent to which current market conditions and insurance company practices are contributing to an increase in medical malpractice premiums." Letter from Congressman John Conyers, Jr. and nine other Members of Congress to Comptroller General of the United States David M. Walker (Jul. 2, 2002).

[3] In the summer 2002, the American Medical Association began one of its "most aggressive, ambitious lobbying efforts in recent years – a proposed $15 million campaign to persuade Congress to enact federal tort reform measures." Michael Romano, "AMA's call to arms: $15 million campaign aims to enact tort reform," *Modern Healthcare* (Jul. 15, 2002), http://www.modernhealthcare.com/currentissue/pastpost.php3?rfid=8938.

[4] *The National Law Journal* reported in April 2001 that in the previous 12 months, juries had awarded verdicts of $312 million and $82 million in Texas. Margaret Cronin Fisk, "Juries Treat Nursing Home Industry with Multimillion Dollar Verdicts," *The National Law Journal* (Apr. 30, 2001). Michael Moss, "Nursing Homes Get Punished by Irate Jurors," *The Wall Street Journal* (Mar. 6, 1998) (reporting then-record $95.1 million verdict in California against Beverly Enterprises).

rising liability premiums for nursing facilities[5] and other healthcare providers,[6] well-publicized reports of healthcare providers leaving their professions or moving to states with lower insurance rates,[7] and the Bush Administration's strong support for tort reform[8] have all made tort reform a national issue as never before.

The definition of tort

A tort is a civil wrong that is not a breach of contract or trust. A tort occurs when there is intentional or negligent injury to an individual or to an individual's property or reputation. The individual who is harmed may be compensated with two types of money damages.[9] *Economic damages* include such monetary losses as past and future medical expenses, past and future earnings, and use of property. *Non-economic damages* compensate individuals for non-tangible losses, such as pain and suffering, emotional distress, and loss of enjoyment of life. A third type of money damages, *punitive, or exemplary, damages*, does not compensate individuals, but is intended to deter and punish outrageous or malicious conduct.

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[5] Diane Levick, "Liability Headaches For Caregivers," *The Hartford Courant* (Aug. 31, 2001); Phill Trewyn, "Nursing home liability insurance on the rise," *The Business Journal of Milwaukee* (Jul. 13, 2001), http://milwaukee.bccentral.com/milwaukee/stories/2001/07/16/focus2.html?t=printable;

[6] Insurance premiums for physicians in the New York area increased by 20-40% in 2002. Joseph B. Treaster, "New York Doctors Facing Big Jump in Insurance Rates: Coverage Is Among Most Expensive in U.S.," *The New York Times* A25 (Mar. 22, 2002); Joseph B. Treaster, "Malpractice Rates Are Rising Sharply; Health Costs Follow," *The New York Times* (Sep. 10, 2001).

[7] Joseph B. Treaster, "Rise in Insurance Forces Hospitals to Shutter Wards," *The New York Times* A1 (Aug. 25, 2002) (reporting closures of obstetric wards, reduced trauma services, and closure of rural clinics "as a result of soaring costs for medical malpractice insurance."); Marilyn Werber Serafini, "Risky Business," *National Journal* (May 18, 2002); Karla Dooley, "Doctors Seek Cure for Skyrocketing Insurance; Malpractice Rates Take Toll on Medical Care," *The Lexington Herald Leader* (KY) (Feb. 24, 2002); Carol Ann Campbell, "Jersey physicians run for coverage – Malpractice insurers vanishing," *The Star-Ledger* (Newark, NJ) (Feb. 18, 2002); Roger F. Mecum, "Medical liability crisis threatens quality health care," *York Daily Record* (PA) (Jan. 20, 2002); Patricia V. Rivera, "Malpractice rates take feverish leap: Texas doctors hit hard by increases which insurers say are needed," *The Dallas Morning News* (Jan. 20, 2002) (reporting increases of 30-200%); Rafael Gerena-Morales, "Rising Malpractice Premiums Hit Florida Doctors Hardest," *The Tampa Tribune* (Dec. 19, 2001); John Porretto, "Costs Lead Rural Doctors to Drop Obstetrics," *The Washington Post* (Nov. 23, 2001);

[8] "President Proposes Major Reforms to Address Medical Liability Crisis" (Speech by President George W. Bush at High Point University, Greensboro, NC, Jul. 25, 2002); Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs By Fixing Our Medical Liability System* (Jul. 24, 2002); and Council of Economic Advisors, *Who Pays for Tort Liability Claims? An Economic Analysis of the U.S. Tort Liability System* (Apr. 2002).

[9] *The American College Dictionary* (1970).

Tort reform defined

"Tort reform" is the term used to describe legislative proposals and legislation to change how lawsuits about torts are brought and pursued in court. Tort reform legislation usually includes a number of similar provisions that restrict the ability of an individual to sue a nursing home that caused harm, limit the type of evidence that the individual can present in court, and limit the financial recovery, including attorneys' fees, that a court can award.[10]

Tort reform may involve healthcare, broadly defined, or it may be focused specifically on nursing home care. Some nursing home-specific tort reform proposals seek to include nursing home litigation within medical malpractice, although there are differences between the two. While medical malpractice often involves a single instance of negligence by a healthcare professional, nursing home torts typically involve a larger number of workers, most of whom are not healthcare professionals, and poor care occurring over a longer period of time.

Tort reform provisions typically require individuals to take certain actions before filing a lawsuit. Individuals may be required to mediate complaints before filing a lawsuit. They may be required to file the lawsuit within a short period of time and to submit a sworn declaration from a healthcare professional in the same discipline as the defendant confirming that malpractice has occurred.

Tort reform provisions often limit the evidence that individuals can submit. Nursing home-specific tort reform legislation restricts or eliminates the right of a plaintiff to introduce state survey reports and statements of deficiencies as evidence. Such evidence demonstrates a facility's prior knowledge of deficiencies and may be presented in court to support an award of punitive damages.

Tort reform provisions also limit the money damages that individuals can recover, particularly non-economic compensatory damages. Limiting non-economic damages is especially significant for nursing home residents. Since residents generally do not have lost wages or long life expectancies, traditional measures of economic damages, and since their medical costs may be small or non-existent, economic damages are usually not a significant part of recoveries for residents. Punitive damages are also rare. Consequently, non-economic damages are the primary damages that residents and their families recover in tort litigation against nursing homes.

Participants in the discussion about tort reform

The nursing home industry is the leading supporter of nursing home tort reform. State and national nursing home trade associations, representing both for-profit and not-for-profit providers, are the primary advocates for nursing home tort reform legislation. They join other health care providers in seeking broad tort reform on a national level. An additional nursing home trade group has taken an active role in tort reform legislation. The Alliance for Quality Nursing Home Care, an association formed in 1999 by 12 investor-owned multi-state nursing home corporations, has added tort reform

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[10] A fuller discussion of typical features of tort reform legislation appears in Appendix III.

to its original mission of increasing Medicare reimbursement.[11]

Healthcare providers from a variety of disciplines have formed several coalitions to advance tort reform both at the state level and nationally: the Health Care Liability Alliance,[12] the Tort Reform Institute, and the American Tort Reform Association. Most recently, Common Good has been formed and joined the debate, supporting even broader reform of the entire civil justice system.[13]

Opponents of tort reform are not as organized as its supporters. While the American Trial Lawyers Association is concerned with tort reform and medical malpractice reform as a general matter,[14] older people's advocates and nursing home advocacy groups have typically become involved in the issue only when nursing home litigation is threatened in the legislature. AARP has taken a strong position in opposition to tort reform in a number of states.

METHODOLOGY

The project compiled and analyzed articles and reports on tort reform, interviewed participants in the nursing home tort reform debate, and developed a methodology to collect and analyze tort litigation in a state. The project then tested this methodology in the state of Maryland in the summer 2001.

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[11] "Fighting Back: Long-Term Care Industry Pursues Solutions to Funding Crisis," *Repertoire* (Jul. 2001), at http://www.medicaldistribution.com/rep/Rep_2001_July_629012562090.htm.

There is some irony in the Alliance's interest in tort reform. "The large national chains are, for the most part, self-insured" and do not purchase liability insurance on the commercial market. Aon Risk Consultants, Inc., *Long Term Care General Liability and Professional Liability; Actuarial Analysis* 34 (Feb. 28, 2002). As a consequence, rising insurance premiums, the primary factor identified in support of tort reform legislation, do not directly affect Alliance members.

A second irony is that the largest tort verdicts and judgments are typically imposed against the large chain providers. To the extent that insurance premiums are based on insurers' experiences with the nursing home industry as a whole, these verdicts are driving up premiums for the rest of the nursing home industry.

[12] The Health Care Liability Alliance describes itself as "a group of medical organizations dedicated to rescuing the nation's health care system from an out-of-control legal system that is severely damaging the delivery of health care and hurting patients." http://www.hcla.org/html/contacts.htm. Its mission statement describes its "strong belief that federal health liability laws are needed to bring greater fairness, timeliness and cost-effectiveness to our system of civil justice. We also believe legal reform is the best way to protect medical progress and to ensure that affordable health care is accessible to all Americans."

[13] The Common Good was formed in April 2002 "to call for a radical overhaul of America's lawsuit culture." Common Good: Why We Have Come Together, http://www.ourcommongood.com/. *See also*, George McGovern and Alan K. Simpson, "We're Reaping What We Sue," *The Wall Street Journal* (Apr. 17, 2002) (announcing formation of Common Good and calling for "a basic overhaul of our legal system.").

[14] ATLA's website, http:/www.atla.org, includes materials about tort reform. *See, e.g.*, "Critical Questions about Medical Malpractice 'Reforms,'" http://www.atla.org/CJFacts/medmal/critical.ht#anchor335382.

THE DISCUSSION ABOUT TORT REFORM

Supporters of tort reform argue that there is an explosion in tort litigation, that the cases are frivolous, that recoveries are astronomical, that the tort system does not efficiently compensate individuals who are harmed or injured, and that, because of tort litigation, insurance premiums are rising dramatically to unaffordable amounts, leading to facilities' bankruptcies and creating financial drains on resources that should go to resident care.

MYTH 1: There Is an Explosion in Tort Litigation

Supporters of nursing home tort reform argue that the number of lawsuits filed against nursing facilities has escalated dramatically. A survey by Aon Risk Consultants, Inc., commissioned by the American Health Care Association, described "an explosion in litigation that started in a handful of states and is spreading to a multitude of regions throughout the country."[15] In March 2002, AHCA reported that "the massive increase of litigation that has spread to quality facilities" and the "proliferation of lawsuits" threaten the future of long-term care.[16]

While cases alleging appalling failures in care and/or large verdicts are reported in the media with increasing frequency,[17] there is no evidence that tort cases against nursing homes are in fact flooding the courts. Now, as before, many families are told by lawyers whom they consult for advice and representation that cases involving their family members have little legal merit and are not worth filing, when the resident was frail and sick and would have died soon anyway, regardless of whatever the facility did or did not do.[18] These arguments also remain common defenses to cases that are filed.

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[15] Aon Risk Consultants, Inc., *Long Term Care: General Liability and Professional Liability; Actuarial Analysis*, Executive Summary 3 (Feb. 28, 2002).

[16] American Health Care Association, *Issue Brief: Civil Justice Reform* (Mar. 2002), http://www.ahca.org/brief/ib-tort.htm.

[17] *The National Law Journal* reported in April 2001 that in the previous 12 months, juries have awarded verdicts of $312 million and $82 million in Texas. Margaret Cronin Fisk, "Juries Treat Nursing Home Industry with Multimillion Dollar Verdicts," *The National Law Journal* (Apr. 30, 2001); Trebor Banstetter, "Nursing their wounds: Homes seek award limit, but activists balk," *Star-Telegram* (Mar. 26, 2001) (reporting $313 million judgment against Horizon/CMS Healthcare Corp. to the family of a resident who died, having suffered from severe bedsores and malnutrition; a $250 million judgment against HEB Nursing Center when a resident died from malnutrition; and a $54 million judgment against Beverly Enterprises when a resident died of malnutrition.)

[18] A woman who went to a Central Florida facility to recuperate from hip surgery was not bathed once during her two-week stay. When she complained, a nurse gave her a bucket of water and told her to bathe herself. She also reported that the incision on her hip broke open when she was left on a toilet for three hours. When she contact several law firms about filing a lawsuit, she was told that her injuries were not sufficiently extensive to merit litigation. Greg Groeller, "Elderly care put to test," *Orlando Sentinel* (Mar. 4, 2001).

Those who complain about large numbers of cases point to increased numbers of claims,[19] but only a relatively small number of cases with significant recoveries.[20]

In addition, litigation is generally concentrated in relatively few facilities. A review of nursing home lawsuits filed between 1996 and 2000 in Central and South Florida found that 115 of the 231 facilities had been sued not at all (29 facilities), once (57 facilities), or twice (29 facilities).[21] While the total number of lawsuits tripled, from 90 lawsuits in 1996 to 270 in 1999, with 231 lawsuits filed in 2000,[22] a small number of facilities accounted for a large proportion of lawsuits. Of the 143 facilities in South Florida, ten facilities had 15 or more lawsuits each, a total of 174 of the 924 lawsuits filed in South Florida in the five-year period.

This project's study of litigation in Maryland found a small number of cases at all stages. There were few filings statewide and no reported decisions at all at the appellate level.[23]

MYTH 2: Cases Are Frivolous

The American Health Care Association's Charles H. Roadman II has said that "'a significant number

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[19] Aon's survey, accounting for 26% of the industry nationwide, reported "11 claims per year for every 1000 occupied skilled nursing care beds," an increase from the 3.6 claims per 1000 beds reported in 1990. Aon Risk Consultants, Inc., *Long Term Care: General Liability and Professional Liability; Actuarial Analysis*, Executive Summary 3 (Feb. 28, 2002). Most claims do not result in verdicts or judgments for residents or their families. *See* notes 31 and 32 and accompanying text.

Not all *claims* are the result of civil judgments. The Texas House Committee on Human Services has pointed out that closed claims can also include claims of fraud against the federal government, which it described as "an issue with some of the larger chains nationwide." Committee on Human Services, Texas House of Representatives, *A Report to the House of Representatives, 77th Texas Legislature* 32 (Interim Report, Dec. 5, 2000).

[20] In an April 1999 article in *Provider*, the American Health Care Association reported that St. Paul Fire and Marine Insurance Co., a Florida-based insurer, reported that between 1988 and 1992, it closed 2500 claims against nursing homes and that between 1993 and 1997, it closed more than 4200 claims against nursing homes. In the early period, one claim cost more than $500,000; in the later period, the company paid 32 claims over $500,000, including six claims that exceeded $1 million. Markian Hawryluk, "Navigating Through A Legal Storm Wave of litigation catches up to long term care," *Provider* (Apr. 1999) (cover story).

The House Committee on Human Services of the Texas House of Representatives quoted an article in the *Austin Statesman* that civil judgment claims increased from 86 (worth $10.4 million) in 1997 to 92 claims (worth $26.1 million) in 1999. Committee on Human Services, Texas House of Representatives, *A Report to the House of Representatives, 77th Texas Legislature* 34 (Interim Report, Dec. 5, 2000).

[21] Diane C. Lade, "Some well-kept nursing homes have never been sued," *Sun-Sentinel* (Mar. 5, 2001).

[22] Greg Groeller (*Orlando Sentinel*) and Bob Lamendola (*Sun-Sentinel*), "Skyrocketing suits spur crisis in care," *Sun-Sentinel* (Mar. 3, 2001).

[23] *See* Appendix II.

of lawsuits are frivolous.'"[24] A Florida defense attorney described cases as "frivolous" when they do not compensate anyone who suffered but simply punish a corporation. Punishment is the role of the regulatory system, he argued.[25] Another industry representative found it difficult to categorize cases, when so few go to trial, but pointed out that accidents that cannot be prevented may be treated the same as neglect and abuse, which are appropriately litigated.[26]

Those who have independently reviewed the litigation have reported otherwise. The Florida Task Force on the Availability and Affordability of Long-Term Care, which was commissioned to study long-term care issues in Florida, described the tort litigation that it identified and reviewed in Hillsborough County, Florida as both significant and serious:

> All of the complaints list one or more serious allegations pertaining to the resident's physical condition and cite the violation of the statutory right to adequate and appropriate health care as the cause of action. These lawsuits are fundamentally about pressure sores, falls, dehydration, and malnutrition or weight loss among nursing home residents, and none of these conditions or incidents is a minor matter in this population, or any other.
> * * *
> If a Chapter 400 case has been filed in circuit court, . . ., it is most unlikely to be a frivolous lawsuit.[27]

Other analyses have produced similar findings. In March 2001, the *Sun-Sentinel* and the *Orlando Sentinel* reported the results of their joint four-month investigation of tort litigation in Florida. Reviewing 924 lawsuits filed during the previous five years against facilities in eight counties of South and Central Florida (one-third of the state's facilities), the newspapers found that the

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[24] "Nursing homes bow to power of lawsuits," *The Atlanta Journal Constitution* (Sep. 26, 2000), http://www.accessatlanta.com/partners/ajc/epaper/editions.../news_93da42a6310alf2007c.htm.

[25] Telephone interview with Andy McCumber (nursing facility defense attorney), Quintairos McCumber Prieto & Wood, Tampa, FL, (813) 875-1100, Sep. 5, 2002.

[26] Telephone interview with Suzanne M. Weiss, Senior Vice-President, American Association of Homes and Services for the Aging, Washington, DC, (202) 783-2242, Sep. 6, 2002.

[27] Florida Task Force on the Availability and Affordability of Long-Term Care 357 (Dec. 16, 2000, Second Draft Report). Cases described in the Task Force report's Appendix amply support the finding. For example, the report describes a May 20, 1999 settlement for $1.5 million in Leon County:

> Admitted 3/95; good condition. By spring 1995, contractures resulting in fetal position; falls, traumas, multiple bedsores (1/96); 3/96 gross mismanagement of feeding tube; weight loss of 43 pounds over the next 67 days. Died 10/11/96. Fraudulent and inconsistent charting entries included entries showing care during hospitalizations and day after death.

Id. 396.

allegations in the lawsuits were "anything but frivolous."[28] Allegations included "rape, physically abusive staff, poor medical decisions and outright neglect, "festering bedsores that led to infections and amputations," multiple falls, and malnutrition and dehydration, with nearly half the lawsuits claiming that the poor care led to the resident's death.

The facts in nursing home cases with large verdicts can be appalling. Sadie McIntosh, an 80–year old woman, went to Pompano Rehabilitation and Nursing Center to recover from hip replacement surgery. *The National Journal*'s Verdict Search described what happened to Ms. McIntosh at the Kindred facility:

> Her estate alleged that an aide accidentally ripped open a surgical incision on her right hip with a bedpan, while at the same time dumping urine and stool into the wound. The aide then allegedly left her lying in her own waste until she was discovered later that evening. The wound deteriorated into a stage 4 decubitus ulcer, which became infected, requiring two operations. McIntosh was sent to a hospice and subsequently died.[29]

After trial, the jury found for the plaintiff on June 6, 2002 and awarded $97,617 in medical expenses and $2 million in pain and suffering. Post-trial motions are pending.[30]

MYTH 3: The Tort System Does Not Efficiently Compensate Individuals Who Are Harmed or Injured

Those who support tort reform argue that the existing civil justice system is an inefficient mechanism to compensate victims of poor care. The American Medical Association argued before Congress in June 2002 that the medical liability litigation system "is neither fair nor cost effective in making a patient whole" and does not assure "prompt and fair compensation," but instead, "has become an increasingly irrational 'lottery driven by open-ended non-economic damage awards."[31] The American Hospital Association agreed, calling the medical liability system "a costly and ineffective

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[28] Greg Groeller (*Orlando Sentinel*) and Bob Lamendola (*Sun-Sentinel*), "Skyrocketing suits spur crisis in care," *Sun-Sentinel* (Mar. 3, 2001), http://www.sun-sentinel.com/news/daily/detail/0,1136,37500000000119584,00.html (site visited Mar. 5, 2001).

[29] *McIntosh v. Persana Care of Pompano West, Inc.*, No. 01-373421 (Fla. Cir. Ct., Broward Co. Jun. 6, 2002) (jury verdict). The case was described in *The National Journal*'s "Verdict Search" (Aug. 19, 2002), at http://www.verdictsearch.com/news/verdicts/.

[30] Appendix I contains additional examples of recent verdicts and settlements.

[31] Testimony of Donald J. Palmisano, MD, JD, testifying on behalf of the American Medical Association before the House Judiciary Committee's Subcommittee on Commercial and Administrative Law, Oversight Hearing on Health Care Litigation Reform: *Does Limitless Litigation Restrict Access to Health Care?* 7 (Jun. 12, 2002).

way of resolving health care liability claims and compensating injured parties."[32]

Although the civil justice system may be flawed, there is no other system that compensates individuals who are harmed in nursing homes. The public regulatory system does not compensate individuals who are harmed or injured. Instead, it is intended to assure that facilities comply with federal standards of care and provide high quality care and high quality of life to their residents. Although the system reviews the care of individuals in deciding whether a facility meets public standards of care, it is not designed to compensate the specific individuals who are harmed when the facility fails.[33] Even when the regulatory system identifies failures in care for particular residents, any enforcement action is imposed by the state in its own name and on its own behalf. As a result, facilities pay financial penalties to the regulatory agency, not to the victims who were harmed by the poor care. Tort litigation compensates residents and families for harm they suffer and encourages nursing facilities to make necessary changes and improve the care they provide to all residents.[34]

Moreover, the relatively small amounts of financial penalties typically imposed against facilities under the federal regulatory system[35] – and the even smaller amounts paid by facilities after appeal[36] – lead families to look for another way to express their concerns about the poor care their family members received. Many family members who file suits report that they sue in order to assure that another family will not have to suffer as their family did.

MYTH 4: Recoveries Are Astronomical

The nursing home industry and its supporters point to a handful of enormous verdicts against nursing homes to support the argument that verdicts are astronomical.

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[32] Testimony of Stuart H. Fine, testifying on behalf of the American Hospital Association before the House Energy and Commerce Committee's Subcommittee on Health, *Harming Patient Access to Care: The Impact of Excessive Litigation* 7 (Jul. 17, 2002), http://energycommerce.house.gov/107/hearings/07172002Hearing648/Fine1113.htm.

[33] Mark Englehart, "Nursing Home Litigation in the 90's: Not Just 'Old Folks in a Home,'" No Nonsense Seminar sponsored by the Alabama Trial Lawyers Association (Aug. 21-23, 1997).

[34] Interview with Steven Levin, Chicago, IL (Apr. 10, 2002). Those who support the current civil justice system argue that tort litigation leads to improvements in products, health care providers' procedures, workplaces, and the environment. *See* Center for Justice & Democracy, *Lifesavers: CJ&D's Guide To Lawsuits That Protect Us All* (2002).

[35] The maximum civil money penalty imposed per day is $10,000, regardless of the amount of harm suffered by residents and regardless of the number of residents who are harmed. 42 C.F.R.§488.438(a)(1). The federal rules also authorize a 35% reduction in the amount of a civil money penalty if the facility foregoes an appeal. *Id.* §488.436(b).

[36] Fines are often further reduced by settlement during appeal or are reduced by Administrative Law Judges following an administrative hearing.

While cases involving hundred million dollar jury verdicts receive attention in the media, these verdicts are publicized because they are in fact both so large and so unusual.[37] Large verdicts may also differ considerably from the amounts actually paid by defendants. Judges frequently reduce large verdicts in post-trial motions and cases are often settled for lower amounts during the appeal.

In 2001, two juries in Fort Worth, Texas awarded multi-million dollar verdicts against the same facility owned by Horizon/CMS Health Care Corp.: a $312.8 million verdict (including $310 million in punitive damages) and a $82 million verdict (including $75 million in punitive damages).[38] These jury awards received considerable national attention,[39] but both awards were significantly reduced. The $312.8 million verdict was settled for $20 million and the $82 million verdict was also reduced to $20 million based on a "high/low agreement."[40] Both cases involved residents who died of malnutrition and bedsores.[41]

Studies of actual settlements and pay-outs also reflect smaller amounts than reports of jury verdicts. A joint report by the *Sun-Sentinel* and the *Orlando Sentinel*, published in March 2001, found that although most of the 440 settlements were confidential, the 56 settlements that were publicly disclosed had an average payout of $304,000.[42]

CNA HealthPro, "a leading insurer of nursing homes" nationwide, reported that its average claim payment increased nationally from $25,599 in 1995 to $59,370 in 2000,[43] once again, considerably less than the multi-million verdicts reported in the press.

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[37] Large verdicts are reported because of their novelty. "Juries Treat Nursing Home Industry With Multimillion Dollar Verdicts," *National Law Journal* (Apr. 23, 2001) (reporting verdicts in the previous 12 months, $312 million and $82 million in Texas, $5 million in California, $20 million in Florida, and $3 million in Arkansas); Gail Diane Cox, "End of Life Valued; Suits alleging abuse or wrongful death of nursing home patients draw big settlements and awards," *National Law Journal* (Mar. 2, 1998) (reporting on a $6.3 million jury award when a resident wandered away from a nursing home, fell in a nearby pond, and drowned, *Hamilton v. First Healthcare Corp.* (Florida, Feb. 11, 1998)).

[38] "Texas juries award 2 of 2001's largest verdicts," *Dallas Business Journal* (Jan. 9, 2002).

[39] *See, e.g.*, "Texas juries award 2 of 2001's largest verdicts," *Dallas Business Journal* (Jan. 9, 2002); Trebor Banstetter, "Nursing their wounds: Homes seek award limit, but activists balk," *Star-Telegram* (Mar. 26, 2001); Margaret Cronin Risk, "Juries Treat Nursing Home Industry with Multimillion Dollar Verdicts," *The National Law Journal* (Apr. 30, 2001); Mary Alice Robbins, "No Defense: Its pleadings struck because of alleged delay tactics, nursing home owner gets hit with $312.8 million verdict," *Texas Lawyer* (Feb. 20, 2001).

[40] "Texas juries award 2 of 2001's largest verdicts," *Dallas Business Journal* (Jan. 9, 2002).

[41] *Id.*

[42] Greg Groeller (*Orlando Sentinel*) and Bob Lamendola (*Sun-Sentinel*), "Skyrocketing suits spur crisis in care," *Sun-Sentinel* (Mar. 3, 2001).

[43] Diane Levick, "Liability Headaches For Caregivers," *The Hartford Courant* (Aug. 31, 2001).

Finally, a recent survey of providers, conducted by Aon Risk Consultants, Inc. for the American Health Care Association, reported 211 claims equaling or greater than $1 million, including ten claims in excess of $5 million. More than two-thirds of the reported claims (67.8%), however, were between zero and $50,000.[44]

In the broad area of medical malpractice, payouts have remained "virtually unchanged for the past decade."[45]

Verdicts and settlements reflect the facts of the cases. Large verdicts and punitive damages reflect the community's voice and values and indicate jurors' outrage about poor care that harms residents.[46] Punitive damages, by definition, are intended to deter and punish outrageous or malicious conduct.

MYTH 5: Large Proportions of the Recoveries Go to Litigation Costs and Attorneys' Fees

Supporters of tort reform argue that large proportions of recoveries are paid as litigation costs, including amounts paid to attorneys, rather than as payments to residents who were allegedly harmed. Aon Risk Consultants, Inc. reported that approximately 47% of total claim dollars go to litigation costs.[47] Representatives of nursing homes contend that lawyers take money that should be spent on resident care.[48]

The amounts they count as attorneys' fees frequently include amounts paid to *defense* counsel. Aon

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[44] Aon Risk Consultants, Inc., *Long Term Care General Liability and Professional Liability; Actuarial Analysis* 8 (Feb. 28, 2002), http://www.ahca.org/brief/aon_ltcanalysis.pdf.

Malpractice jury verdicts exceeding $1 million increased from less than 1% of paid claims in 1985 to almost 6% in 2000. Marilyn Werber Serafini, "Risky Business," *National Journal* (May 18, 2002). These data mean that nearly 95% of claims paid in 2000 were lower than $1 million.

Industry complaints about the size of verdicts may reflect confusion about the difference between median (the mid-point number) and mean (average). A few extremely large verdicts or settlements inflate the average verdict or settlement, which remains relatively low.

[45] "[T]he current average medical malpractice insurance payout is about $30,000 and has been virtually unchanged for the past decade." Joanne Doroshow, Executive Director, Center for Justice & Democracy, Testimony before the House Judiciary Committee's Subcommittee on Commercial and Administrative Law, Oversight Hearing on Health Care Litigation Reform: *Does Limitless Litigation Restrict Access to Health Care?* 2 (Jun. 12, 2002).

[46] Mark Curriden, "Power of 12: How jury decisions are impacting public policy," *ABA Journal* 36 (Aug. 2001).

[47] Aon Risk Consultants, Inc., *Long Term Care General Liability and Professional Liability; Actuarial Analysis* 9 (Feb. 28, 2002), http://www.ahca.org/brief/aon_ltcanalysis.pdf.

[48] Telephone interview with Andy McCumber (nursing facility defense attorney), Quintairos McCumber Prieto & Wood, Tampa, FL, (813) 875-1100, Sep. 5, 2002.

Risk Consultants, Inc. reported that "19% of total losses are allocated loss adjustment expenses, which represent defense costs such as investigation and attorney fees."[49] The Florida Task Force also reported that the costs of legal *defense* to a tort case range from $100,000 to $200,000.[50] Defense attorneys' fees are a significant part of the overall costs of tort litigation.[51]

MYTH 6: As a Result of Tort Litigation, Liability Insurance Premiums Are Rapidly Rising and Becoming Unaffordable

The primary argument made by proponents of tort reform today is that tort litigation is the cause of escalating liability insurance premiums that are leading the industry to bankruptcy or, at the very least, consuming large portions of Medicare and Medicaid rates that are intended for nursing home care.[52] The American Health Care Association described the "landslide of lawsuits and the associated insurance affordability and availability crisis" as endangering "patient access to quality care."[53] The American Association of Homes and Services for the Aging agreed, calling the cost of liability insurance "the single biggest threat to the financial viability of our country's nursing homes."[54]

Arguments about liability insurance, while compelling, are overstated. Although it is indisputable that insurance premiums are rising rapidly in many states,[55] the multiple causes of increased rates

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[49] *Id.*

[50] Florida Task Force on the Availability and Affordability of Long-Term Care 360 (Dec. 16, 2000, Second Draft Report).

[51] Plaintiffs' counsel are generally paid on a contingency basis, receiving payment only if they win or favorably settle a case. In addition, their payment is typically a proportion of the amount recovered for the plaintiff. These factors mean that attorneys agree to take cases only where they believe a large recovery is likely. In contrast, defendants' attorneys are paid regardless of outcome. If defense counsel are paid on an hourly basis, they have little incentive to resolve cases quickly.

[52] Aon Risk Consultants, Inc. reported that large portions of states' Medicaid rate increases between 1995 and 2000 went to pay for increased liability premiums: 70% ($18.90) in Florida; 50% ($8.85) in Texas; 39% ($4.36) in Arkansas; 23% ($4.85) in Alabama; 28% ($4.11) in Mississippi; 30% ($5.21) in Georgia; $17% ($2.41) in California; and 8% ($2.68) in West Virginia. Aon Risk Consultants, Inc., *Long Term Care General Liability and Professional Liability; Actuarial Analysis,* 15, 18, 20, 22, 24, 26, 28, 30, respectively (Feb. 28, 2002).

[53] "AHCA Backs Introduction of New Medical Liability Report Bill; Passage of 'The Health Bill' Would Safeguard Patient Access to Quality Care: Additional Safeguards for Long Term Care, Assisted Living Recommended" (News Release, Apr. 25, 2002), http://www.ahca.org/brief/nr020425.htm (supporting the HEALTH Act of 2002).

[54] News Release supporting the HEALTH Act of 2002, which would establish tort reform on a national level (Apr. 25, 2002), http://www.aahsa.org/public/press_release/PR234.htm.

[55] A Woodland, California facility's premiums went from $8000 to $170,000 in 2001. Kathy Robertson, "Without a net: With liability-insurance premiums skyrocketing, nursing homes across the state are going without

include, but go far beyond, tort litigation.

A. A case study in Florida

The most sustained analysis of tort litigation occurred in Florida in 2000-2001, when the state was considering comprehensive tort reform legislation that it later enacted.

1) Florida Task Force on the Availability and Affordability of Long-Term Care rejected industry myths about insurance

The Florida Task Force on the Availability and Affordability of Long-Term Care identified a variety of factors that led to increased insurance premiums.

> "First and foremost, insurance companies are in business to make money."[56]
>
> "The long-term care industry is poorly understood by most insurers, and relatively few have been active in this market at any point in time. Developing sophistication in individualized risk assessment is hampered by a lack of sufficient interest, as the total long-term care market is very small relative to other markets (homeowners or car insurance, for example), lack of data and limited experience overall. Many insurers have entered this market and quickly exited, after sustaining losses. Very few companies have a long track record writing policies for the long-term care industry to contribute to an information base for underwriting."[57]
>
> "Further, insurers familiar with the broader health care market find it vexing that few long-term care providers have facility-based risk management programs that are standard in the acute care setting. There is consensus of opinion that the implementation of comprehensive risk management programs would be an extremely important component of an effort to resuscitate the long-term care insurance market in Florida. Risk management programs are successful in loss prevention and serve to improve quality of care, as issues are continually identified and addressed. Aggressive risk management programs are expensive to implement, but it's difficult to imagine how the long-term care industry can afford to be

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coverage and living dangerously," *Sacramento Bee* (Feb. 1, 2002), http://sacramento.bcentral.com/sacramento/stories/2002/02/04/focus1.html; Arkansas: "Solutions sought to lack of insurance coverage for nursing homes," Little Rock AR, AP Wire (Sep 20, 2001), http://www.thecabin.net/stories/092001/sta_0920010043.shtml; "Commissioner says nursing home insurance not reasonably available," Little Rock, AR, AP Wire (Oct. 2, 2001), http://www.thecabin.net/stories/100201/sta_1002010057.shtml. South Carolina: "Higher insurance rates raise nursing home costs," Charleston, SC, AP Wire (Sep. 16, 2001), http://www.jacksonville.com/tu-online/apnews/stories/091601/D7EIKK401.html;

[56] Florida Task Force on the Availability and Affordability of Long-Term Care 369 (Dec. 16, 2000, Second Draft Report).

[57] *Id.* 369.

without them any longer."[58]

> "Finally, premiums are likely to remain prohibitively high as long as insurers are operating in a non-competitive market. With only a handful of E & S companies writing policies, there is no incentive to lower rates and no regulatory authority to review pricing practices."[59]

The Task Force found that the profit-motivated insurance industry has minimal experience with nursing homes and little competition for business. The insurance industry is unregulated with respect to pricing nursing home liability policies. When it looks at the nursing home industry, it does not find the types of risk management programs that are standard in other healthcare settings. These factors, in addition to increases in tort litigation, led the liability insurance industry to raise its premiums for Florida's long-term care providers. These findings of the Task Force also support a conclusion that problems in the nursing home industry (poor care outcomes for residents and absence of risk management programs) and financial incentives in the insurance industry contributed to the increased liability insurance premiums that the nursing home industry in Florida experienced. Tort litigation has been a factor in rising premium rates, but not the sole cause.

2) Florida insurance commissioner identified poor nursing home care as a cause of high premiums

When the Florida Task Force was considering tort reform legislation, the state Department of Insurance conducted research to determine the status of the liability insurance market in the state. The Department's September 2000 report to the Task Force indicated that the insurance market for long-term care facilities had shrunk considerably in Florida. For example, of the 17 insurers reporting that they currently wrote policies in Florida, six actually wrote no policies, five wrote one policy, and two wrote only two policies in 2000.[60] The Deputy Commissioner also acknowledged that nursing homes claims "are growing in both frequency and severity."[61] Nevertheless, a summary of the survey results indicated that companies that were withdrawing from the insurance market in Florida were doing so as part of a *national* strategy: all 14 companies that said they were

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[58] *Id.* 369-70.

[59] *Id.* 370. The Texas House Committee on Human Services reported in December 2000 that the state regulates insurance rates for only a small portion of the insurance market that insures not-for-profit facilities. All for-profit facilities, and many not-for-profit facilities as well, purchase insurance from the "surplus market," which the state does not regulate. "[O]nly about five to ten percent of the Texas nursing home market purchases coverage from the regulated market which, since subject to rate controls, must submit rates to TDI [Texas Department of Insurance]." Texas House Committee on Human Services, Interim Report 2000, 30 (Dec. 2000).

[60] Letter From Susanne K. Murphy, Deputy Insurance Commissioner, Department of Insurance, The Treasurer of the State of Florida, to The Honorable Frank Brogran, Lieutenant Governor of Florida and Chairman of the Task Force on the Availability and Affordability of Long-Term Care 2 (Sep. 20, 2000).

[61] *Id.*

withdrawing from the Florida nursing home market said that the reason was a national decision.[62] The Deputy Insurance Commissioner concluded her letter to the Task Force with the statement: "We believe that any solution [to the insurance problem] must include risk management controls and mechanisms to ensure a high degree of quality of care."[63]

B. Insurance companies raise premiums based on national, rather than state-specific, nursing home pay-out experience

Insurance companies raise premiums for facilities that have had no claims filed against them[64] and some insurance companies increase premiums in states despite the absence of any claims whatsoever in the state or despite only limited tort litigation. In Ohio, the threat of tort litigation that had not materialized was sufficient to lead to tort reform legislation.[65]

The director of rates and forms at the South Carolina Department of Insurance explained this apparent anomaly with the observation that since insurance carriers write policies nationally, increased claims in one state can affect other states.[66] A similar view was expressed by the managing director of the insurance company CNA HealthPro, who acknowledged that rate increases in Connecticut reflected both Connecticut and national claims experience. As the article recounted, "the company has too little data for Connecticut alone to be statistically credible."[67] Large rate increases in Wisconsin also represent claims filed elsewhere, since Wisconsin has one of the lowest rates of liability claims nationwide.[68] Consequently, increased numbers of cases in Florida affect insurance premiums nationwide, even in states having no tort litigation at all or only limited tort litigation.

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[62] *Id.* An update of the information, obtained during an informal telephone survey in February 2001, indicated that another insurance company had left Florida for the same reason.

[63] *Id.*

[64] Diane Levick, "Liability Headaches For Caregivers," *The Hartford Courant* (Aug. 31, 2001). *See also* House Committee on Human Services, Texas House of Representatives, Interim Report 2000, 32 (Dec. 2000) (reporting premium increases for facilities with "no judgments against them and a clean operating history").

[65] "Editorial: Putting limits on lawsuits," *The Cincinnati Post* (Mar. 8, 2002), http://www.cincypost.com/2002/mar/08/edita030802.html.

[66] South Carolina: "Higher insurance rates raise nursing home costs," Charleston, SC, AP Wire (Sep. 16, 2001), http://www.jacksonville.com/tu-online/apnews/stories/091601/D7EIKK401.html.

[67] Diane Levick, "Liability Headaches For Caregivers," *The Hartford Courant* (Aug. 31, 2001).

[68] Phill Trewyn, "Nursing home liability insurance on the rise," *The Business Journal of Milwaukee* (Jul. 13, 2001), http://milwaukee.bcentral.com/milwaukee/stories/2001/07/16/focus2.html.

C. Insurance companies are raising premiums for healthcare providers in addition to nursing facilities; commercial rates in general are rising

Liability insurance premiums are rising for many categories of health care providers. Medical malpractice insurance premiums have risen dramatically in many parts of the country.[69] The second largest malpractice insurer for physicians raised rates an average of 24% in 25 states, by 65% in Ohio and Mississippi, and by 30 - 50% in a dozen states, including Florida and Texas.[70] St. Paul Companies, the nation's fourth largest business insurer, announced on December 12, 2001 that it would exit the medical malpractice insurance business entirely, "ending coverage for 750 hospitals, 42,000 physician and 73,000 other health care workers nationwide."[71] The ramifications of this decision are still being felt.

Public Citizen reports that insurance rates have also risen in areas totally unrelated to healthcare, including automobiles, property/casualty, homeowners, and commercial and workers' compensation.[72] The Consumer Federation of America testified before the House Committee on Energy and Commerce in July 2002 about rising commercial insurance rates in areas unrelated to healthcare.[73]

D. The insurance industry is cyclical and insurance companies raise premiums based on financial matters unrelated to claims

While some insurance industry blames tort litigation as the sole cause of rising premiums, other analysts identify other causes as more significant. A critical factor is insurance companies' use of the stock market to generate revenues. Insurance companies invest the premiums they receive in the market. In the 1990s, many insurers "kept prices artificially low while competing for market share

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[69] Joseph B. Treaster, "Doctors Face a Big Jump in Insurance," *The New York Times* (Mar. 22, 2002); Joseph B. Treaster, "Insurers Raise Doctors' Rates At Rapid Pace: Malpractice Coverage Jumps 10% or More," *The New York Times*, A1 (Sep. 10, 2001).

[70] *Id.*

[71] Milt Freudenheim, "St. Paul Cos. Exits Medical Malpractice Insurance," *The New York Times* (Dec. 13, 2001).

[72] Public Citizen, Congress Watch, *Equal Opportunity Rate Hikes: Rising State Insurance Premiums Not Unique to Medical Malpractice* 4-12 (Jul. 2002) (state-by-state analysis of insurance increases and discontinuance of policies in areas unrelated to healthcare; for example, State Farm Insurance announced in June 2002 that it would stop writing new homeowner policies in 17 states).

[73] Testimony of Travis Plunkett, Legislative Director, Consumer Federation of America, before the Subcommittee on Health of the House Committee on Energy and Commerce (Jul. 17, 2002), http://energycommerce.house.gov/107/hearings/07172002Hearing648/Plunkett121.htm.

and new revenue to invest in a booming stock market."[74] When the stock market stopped "booming," insurance companies reported, in 2001, a 30% decline from 1998 in realized capital gains[75] and became more selective in the companies and industries they would insure.[76] This pattern of the interplay between insurance premiums and the stock market is cyclical.[77]

The Consumer Federation of America described this cyclical pattern in Congressional testimony in July 2002:

> [T]he practices of the insurance industry itself are to [sic] largely to blame for the wildly gyrating business cycle of the last thirty years. Each time the cycle turns from a soft to a hard market the response by insurers is predictable: they shift from inadequate under-pricing to unconscionable over pricing, cut back on coverage and blame large jury verdicts for the problem. It is particularly appalling to see a crisis caused by insurer action being blamed, by the very insurers that caused the problem, on others. Insurers seem to expect legislators and the American public to swallow the dubious line that trial lawyers have managed to time their million-dollar jury verdicts to coincide precisely with the bottom of the insurance cycle three times in the last thirty years. Medical malpractice insurance rates are now rising fast. Insurers tell the doctors it is the fault of the legal system and urge them to go to state legislatures or to Congress and seek restrictions on the rights of their patients. Physician associations, unfortunately, are only too willing to accept this faulty logic.[78]

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[74] Joseph B. Treaster, "Insurers Raise Doctors' Rates At Rapid Pace: Malpractice Coverage Jumps 10% or More," *The New York Times*, A20 (Sep. 10, 2001).

[75] *Id.* The *Memphis Business Journal* made similar findings in July 2001: "Carriers can still turn a profit even when their loss ratios exceed 90%, provided investments they make with premium dollars continue to perform. The high-tech bust and a chronically soft stock market have wiped out that revenue stream." Scott Shepard, "Insurance rates soar as fear of litigation mounts," *The Memphis Business Journal* (Jul. 13, 2001). *See also* Phill Trewyn, "Nursing home liability insurance on the rise," *The Business Journal of Milwaukee* (Jul. 13, 2001), http://milwaukee.bcentral.com/milwaukee/stories/2001/07/16/focus2.html.

[76] Reed Branson, "Tort reform faces tough Miss. fight," GoMemphis, http://www.gomemphis.com/cr/cda/article_print/1,1250,MCA_437_951563,00.html ("As the stock market began retreating last year, insurance companies – whose profits are closed tied to investments – have clearly become more selective in their coverage, both here and around the nation.")

[77] Andy Gotlieb, "Insurance crisis widens," *Philadelphia Business Journal* (Mar. 4, 2002), http://philadelphia.bizjournals.com/philadelphia/stories/2002/03/04/story1.html?t=printable. Insurers who in the 1990s paid out $1.12 in claims and expenses for every $1.00 they collected in premiums are raising premiums now to "catch up." *Id.*

[78] Testimony of Travis Plunkett, Legislative Director, Consumer Federation of America, before the Subcommittee on Health of the House Committee on Energy and Commerce (Jul. 17, 2002), http://energycommerce.house.gov/107/hearings/07172002Hearing648/Plunket1121.htm.

See also Testimony of Joanne Doroshow, Executive Director, Center for Justice & Democracy, Testimony before the House Judiciary Committee's Subcommittee on Commercial and Administrative Law, Oversight Hearing on Health

CFA's Plunkett testified that an actuarial analysis conducted by CFA's Director of Insurance, J. Robert Hunter, found that:

1. inflation-adjusted medical malpractice premiums have declined by one-third in the last decade;
2. Medical malpractice as a percentage of national health care expenditures are a fraction of the cost of health care in this nation. Over the last decade, for every $100 of national health care costs in the United States, medical malpractice insurance cost 66 cents. In the latest year (2000) the cost is 56 cents, the second lowest rate of the decade.
3. There is no "explosion" in the severity of medical malpractice claims.
4. Medical malpractice insurance losses have risen very slowly.
5. Medical Malpractice profitability over the last decade has been excellent [12.3%].[79]

The healthcare industry monthly business journal *Modern Healthcare* published an editorial on July 15, 2002, "Back on the tort reform merry-go-round," that made this exact point:

Care Litigation Reform: *Does Limitless Litigation Restrict Access to Health Care?* 3 (Jun. 12, 2002) (describing previous "volcanic eruptions in insurance premiums for doctors" and the insurance crisis of the mid-1980s that led to tort reform but no impact on insurance rates).

[79] Testimony of Travis Plunkett, Legislative Director, Consumer Federation of America, before the Subcommittee on Health of the House Committee on Energy and Commerce, 6-7 (Jul. 17, 2002), http://energycommerce.house.gov/107/hearings/07172002Hearing648/Plunket1121.htm.

Similar findings and conclusions were made when the last "liability insurance crisis" occurred in the mid 1980s. After studying the earlier crisis, the Ad Hoc Insurance Committee of the National Association of Attorneys General concluded:

> The facts do not bear out the allegations of an "explosion" in litigation or in claim size, nor do they bear out the allegations of a financial disaster suffered by property/casualty insurers today. They finally do not support any correlation between the current crisis in availability and affordability of insurance and such a litigation "explosion." Instead, the available data indicate that the causes of and therefore solutions to, the current crisis lie with the insurance industry itself.

Francis X. Bellotti, Attorney General of Massachusetts, et al., *Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance* (Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986), *as quoted in* Center for Justice & Democracy, *Premium Deceit: The Failure of "Tort Reform" to Cut Insurance Prices* 4 (1999).

Business Week agreed in a January 1987 editorial:

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry has slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.

Id.

> Those of us who have been around a while are used to the cyclical nature of medical malpractice insurance. Every 10 years or so there's a huge jump in premium costs, always accompanied by a clamor for limiting plaintiffs' right to sue and collect for pain and suffering. And each time around, providers have joined in pursuit of the wrong culprit.
> * * *
> In truth, the medical liability insurance crisis has very little to do with jury awards and everything to do with an out-of-control insurance industry.[80]

Beyond their losses in the stock market, however, insurance companies' affected by large pay-outs as a result of the terrorist attacks of September 11 have also sought to remove "high-risk" industries like nursing homes from their books.[81]

Some insurers agree with this analysis:

> "During the soft market," said Moreno, "many carriers jumped into the marketplace, and the premiums were priced competitively——and much too low. The stock market problems of the past few years have added to the profitability problems of the overall insurance market. Thus, those insurance carriers that have been writing coverages for the long-term care marketplace have been hit by losses that have been unexpectedly higher than anticipated. Premiums that are too low, losses that are higher than expected, the reduction of investment income and the increases in the cost of reinsurance as a result of September 11 – all these add to the increase in pricing and the lack of availability for this class of business."[82]

MYTH 7: Tort reform will lead to reduced insurance costs and will keep providers in the state

Supporters of tort reform argue that liability insurance premiums will be reduced and that nursing homes will continue to provide care in the state when tort reform is enacted. They also argue that enacting positive incentives – such as increasing reimbursement – will be more effective than negative incentives, such as tort litigation, in improving care. The promised benefits are not realized, however, when tort reform legislation is enacted.

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[80] Todd Sloane, "Back on the tort reform merry-go-round," *Modern Healthcare* (Jul. 15, 2002), http://www.modernhealthcare.com/currentissue/pastpost.php3?refid=8939.

[81] Kathy Robertson, "Nursing homes priced out of insurance," *East Bay Business Times* (Mar. 18, 2002), http://eastbay.bizjournals.com/eastbay/stories/2002/03/18/focus.html; Andy Gotlieb, "Insurance crisis widens," *Philadelphia Business Journal* (Mar. 4, 2002) (describing the World Trade Center attack as "batter[ing] the reinsurers who assume the risk from insurance companies."), http://philadelphia.bizjournals.com/philadelphia/stories/2002/03/04/story1.html?t=printable.

[82] Maria Moreno, Vice President of Aon/Huntington T. Block (American Association of Homes and Services for the Aging Property/Casualty Program), as quoted in Linda Boyle, "I. Risky Business: A Liability Insurers Roundtable," *Nursing Homes; Long-Term Care Management* (Aug. 2002), http://www.nursinghomesmagazine.com/Current_issue.htm?CD=207&ID=725.

A. Liability insurance premiums are not reduced when tort reform is enacted

The expectation that tort reform will reduce liability insurance premiums is not realized when tort reform is enacted. Reviewing data from every state from 1985 through 1998, the Center for Justice and Democracy categorized states on their "tort reform" efforts and evaluated the relationship with insurance premiums. The Center found that "States with little or no tort law restrictions have experienced the same level of insurance rates as those states that enacted severe restrictions on victims' rights."[83]

To the extent that insurance companies set rates on a national basis, the enactment of tort reform in a particular state will have no effect on premiums.

B. Providers and insurance companies may still abandon states even after tort reform is enacted

After tort reform was enacted in Florida, Beverly Enterprises sold all its Florida facilities.[84] Insurance companies have not returned to the state.

C. Proposals for additional tort reform continue after tort reform is enacted

Tort reform was enacted in Florida in the spring 2001 along with increased reimbursement to facilities to meet (effective January 1, 2002) increased nurse staffing ratios. Supporters of tort reform persuaded the legislature that lawsuits drained funds that could otherwise be spent on staffing. Legislative relief for providers did not deter additional provider demands.

Complaints from the industry that facilities could not find workers to meet the new higher staffing ratios, combined with the state's budget shortfall, led to proposals in the fall 2001 to delay the increased staffing requirements.[85] Industry demands for additional relief from tort litigation also continued in Florida in 2002, with the Alliance for Quality Nursing Home Care asking for strict caps on litigation and arbitration panels, instead of litigation.[86]

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[83] Center for Justice and Democracy, *Premium Deceit: The Failure of 'Tort Reform' to Cut Insurance Rates*," Executive Summary (Jul. 29, 1999).

[84] Nathan Childs, "The Lingering Insurance Question; The cost and availability of liability coverage can sometimes trump even the best demographic profiles," 29 *Provider* 29 (Apr. 2002); Phil Galewitz, "Beverly sells 49 facilities," *Palm Beach Post* (Jul. 17, 2001) (reporting that the Florida facilities accounted for 10% of Beverly's $2.6 billion in revenues in 2000, but about 70% of the corporation's liability costs).

[85] Lloyd Dunkelberger, "Nursing Home care may fall victim to budget woes," *Gainesville Sun* (Oct. 19, 2001).

[86] Mary Ellen Klas, "Nursing home chains ask for liability caps," *Palm Beach Post* (Feb. 20, 2002), http://www.gopbi.com/partners/pbpost/epaper/editions/to.../news_c.337d207e67b703d0054.htm.

MYTH 8: Nursing Homes Are Victims

Ultimately, the fundamental argument in support of tort reform is that facilities are mistreated by the litigation system. The concluding paragraph under the heading "Policy Reasons against the Use of Litigation to Enforce Quality of Care," in a 2002 study by The John C. Stennis Institute of Government at Mississippi State University, states in its entirety:

> The long-term care industry is the target of an unprecedented amount of prosecutorial activity. This activity comes in the form of allegations that long-term care facilities are providing an insufficient quality of care. In Mississippi, the facts contradict these assumptions. Predatory litigation strategies do little to improve the quality of care, rather these practices drain resources and capital from the industry, escalate insurance premiums, increase the cost of providing long-term care, and divert scarce financial resources away from care. Increasing litigation has already begun to drive providers from the market, particularly those who provide services to Medicaid patients and smaller operators. There is a very narrow window of opportunity to prevent a future crisis in long-term care.[87]

The full report concludes:

> Tort reform is needed, in general, because of the inefficiencies, increased transaction costs, and perverse incentives caused by an increasingly litigious society. Tort reform is even more essential in an industry crucial to the care and protection of those least able to protect or care for themselves. This is particularly true with the use of the tort system as a mechanism for destroying an industry and compensating persons other than those who are actually injured, rather than for punishing abuses and compensating losses.[88]

A CONCLUDING ISSUE

An issue that is not thoroughly explored in the public discussion about tort reform is the extent to which tort litigation both complements and supplements the public regulatory system to help assure that residents receive high quality nursing home care. In many industries, tort litigation serves an important public role of identifying dangerous products and practices in ways that lead to changes that benefit the public at large.[89]

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[87] Charles A. Campbell, et al., *An Independent Study of the Long-Term Care Industry in Mississippi*, 25, The John C. Stennis Institute of Government, Mississippi State University (Jan. 2002). Unlike the Florida Task Force report, the 83-page Mississippi report does not analyze any of the tort cases litigated in Mississippi, but cites a survey of 22 Mississippi facilities that reported increased insurance premiums between 2000 and 2001. *Id.* 6.

[88] *Id.* 67.

[89] The Center for Justice and Democracy, *Lifesavers* (Feb. 2001) (compilation of tort cases leading to reform in the areas of aircraft, consumer and household products, crimes, drugs and medical devices, environmental hazards, firearms, hospital and medical procedures, public spaces, toys and recreational products vehicles, and work-related injuries); *see also* American Trial Lawyers Association, *Cases that Made a Difference.*

Tort litigation can serve important public purposes of compensating residents who were injured, holding facilities accountable for the poor care they provide, and improving care for all residents. Consumer advocates describe the liability insurance crisis as a smokescreen to enact tort reform that denies compensation to residents and their families who are harmed by poor care.[90]

Tort Litigation Is an Important Supplement to the Regulatory System

The tort system also supports and complements the regulatory system, both as a general matter and in specific cases.

1. The same facilities often have large numbers of verdicts/settlements and public enforcement actions taken against them

Facilities with the largest number of verdicts/settlements and/or the cases involving the largest dollar values are frequently the same facilities that state survey agencies have identified and cited with large numbers of deficiencies. In other words, poor performing facilities are subject to both tort litigation and public enforcement actions. The two legal systems are separate and have different functions, but complement each other.

The *Sun-Sentinel* and *Orlando Sentinel* in Florida evaluated tort litigation filed in the state between 1996 and 2000 and compared the results with the state agency's survey findings. They reported a "commonality . . . among infrequently sued homes:" "they had few violations on their inspections reports," while facilities with "many violations were three times more likely to be sued."[91] Between 1996 and 2000, the 10 facilities (out of 143 in South Florida) that had 15 or more lawsuits filed against them had an average of 48.7 deficiencies during the period (ranging from 24 to 72). During the same five-year period, the 25 facilities with zero lawsuits had an average of 20 deficiencies (ranging from 1 to 44).

Similar correlations of extensive deficiencies (or other civil and/or criminal litigation) and large tort recoveries are found in other states. A Denver, Colorado facility that had been the subject of two multi-plaintiff tort cases was also the subject of significant deficiencies and state enforcement actions.[92] A former employee of a Missouri facility pleaded guilty to elder abuse, and was sentenced

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http://www.atla.org/CJFacts/cases/casemenu.ht#anchor443498 (describing removal from sale of faulty surgical ventilators and flammable children's pajamas, recall of the Dalkon Shield IUD, among other changes resulting from tort litigation).

[90] California Advocates for Nursing Home Reform, *Liability Crisis: Only an Excuse for Elder Abuse* (Jun. 2001), http://www.canhr.org/LTCPro/LRSpro/NetNews/NN0106.html#LiabilityCrisis.

[91] Diane C. Lade, "Some well-kept nursing homes have never been sued," *Sun-Sentinel* (Mar. 5, 2001), http://www.sun-sentinel.com/news/daily/detail/0,1136,37500000000120653,00.html (site visited Mar. 8, 2001).

[92] Ann Imse, "A question of care: Denver nursing home group runs into repeated problems with regulators," (Nov. 3, 2001), http://www.rockymountainnews.com/cr/cda/article_print/1,1250,DRMN)15_866880,00.html.

to 15 years in prison, the month before the facility settled cases with six families for nearly $2.5 million.[93] A Beverly Enterprises facility in California was sued 15 times by residents' families at the same time the state Department of Justice was opening a criminal investigation.[94] Beverly Enterprises recently pleaded guilty to felony elder abuse in a case that also resolved civil claims against the corporation for its operation of its 60 facilities in California.[95]

2. Tort litigation may bring about quasi-regulatory results in specific facilities

Large tort recoveries can also lead to change of ownership of a facility, a quasi-regulatory result that survey agencies are usually unable to achieve directly on their own.

The Florida Task Force reported that the three facilities in Hillsborough County that had been sued most frequently (more than 20 times each) "have subsequently undergone transformation: two properties have changed ownership and the third has permanently closed."[96] Tort litigation may have helped play an important public role in bringing about critical changes in ownership and/or management of nursing facilities that provided exceptionally poor care to a large number of individuals.

American Healthcare Management of Chesterfield sold 11 of its 12 St. Louis, Missouri facilities, with 1500 beds, following seven lawsuits in three years alleging wrongful death and neglect of 11 residents, settlement with six families for nearly $2.5 million, state regulatory enforcement actions, and the no-contest plea to criminal elder abuse by a former employee.[97]

3. Tort litigation can also result in permanent changes to facility practices that improve care for residents

Although tort litigation has financial compensation for individuals as its primary focus, some attorneys have also used the vehicle of a settlement to bring about permanent changes in facility practices in order to benefit future residents. Tort litigation may change facility practices through

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[93] Michele Munz, "American Healthcare Management sells local nursing homes," *St. Louis Post-Dispatch* (Jul. 11, 2001).

[94] Joshua Molina, "Family's suit: Patient died of neglect," *News-Press* (Jun. 29, 2001).

[95] *California v. Beverly Enterprises, Inc.*, Case No. 01096941 (Cal. Super. Ct., Santa Barbara Co., Jul. 31, 2001); "Attorney General Lockyer, Santa Barbara D.A. Sneddon Announce Major Enforcement Action Against Nation's Largest Nursing Home Chain" (Attorney General Lockyer, News Release, Aug. 1, 2002).

[96] Florida Task Force on the Availability and Affordability of Long-Term Care 350 (Dec. 16, 2000, Second Draft Report).

[97] Michele Munz, "American Healthcare Management sells local nursing homes," *St. Louis Post-Dispatch* (Jul. 11, 2001).

quasi-injunctive relief.

In one case in Texas, a resident died in a nursing facility when she strangled after being pinned between her bed and the bedrail. Settlement of the wrongful death case against the facility included a lengthy written agreement requiring the facility to establish extensive new policies and procedures to reduce its use of physical restraints.[98] The facility reduced its use of restraints by more than 90%. A separate tort action against the parent corporation of the bedrail manufacturer led to payment of $3 million to the family and the corporation's sending a *Safety Alert Concerning Entrapment Hazards with Bed Side Rails* to all of its customers. The *Alert* described proper use of the bedrail and attached a copy of the Food and Drug Administration's 1995 Safety Alert, *Entrapment Hazards with Hospital Bed Side Rails.*[99] Tort litigation serves an important public role of identifying dangerous products and practices in ways that lead to changes that benefit the public at large.[100] This attorney continues to establish similar types of relief in his cases.[101]

CONCLUSION

Tort reform is in the news. Healthcare providers, including the nursing home industry, identify litigation against them as the primary cause of insurance premiums that are escalating to unaffordable levels. They call for state and national tort reform that would restrict access to the courts and limit the damages that individuals could collect. Opponents of tort reform argue that litigation is not the cause of rising insurance premiums, that rising premiums are a cyclical issue unrelated to tort litigation, and that the civil justice system serves important roles of compensating victims of poor care and complementing the regulatory system.

March 2003

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[98] *Trew v. Smith and Davis Manufacturing Co., Inc.*, No. SF 95-354(C) (N.M. Dist. Ct. Jul. 1996).

[99] Telephone conversation with plaintiffs' attorney, Jeff Rusk, Austin, TX, Mar. 12, 1997.

[100] The Center for Justice and Democracy, *Lifesavers* (Feb. 2001) (compilation of tort cases leading to reform in the areas of aircraft, consumer and household products, crimes, drugs and medical devices, environmental hazards, firearms, hospital and medical procedures, public spaces, toys and recreational products vehicles, and work-related injuries).

See also American Trial Lawyers Association, *Cases that Made a Difference,* http://www.atla.org/CJFacts/cases/casemenu.ht#anchor443498 (describing removal from sale of faulty surgical ventilators and flammable children's pajamas, recall of the Dalkon Shield IUD, among other changes resulting from tort litigation).

[101] Telephone conversation with Jeff Rusk, The Rusk Law Firm, Austin, TX, Sep. 4, 2002. *See* http://www.shields-rusk.com/rusk.htm.

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Statement

For the Record

to the

Special Committee on Aging
United States Senate

RE: Medical Liability in Long-Term Care: Is Escalating Litigation a Threat to Quality and Access?

July 15, 2004

Division of Legislative Counsel
202 789-7426

Statement for the Record

of the

American Medical Association

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Special Committee on Aging
U.S. Senate

RE: Medical Liability in Long-Term Care: Is Escalating Litigation a Threat to Quality and Access?

July 15, 2004

On behalf of our physician and student members, the American Medical Association (AMA) appreciates the opportunity to provide our statement for the record regarding an issue that is seriously threatening the availability of and access to quality health care for patients.

THE CRISIS

Escalating jury awards and the high cost of defending against lawsuits, even those without merit, have caused medical liability insurance premiums to reach unprecedented levels. As insurance becomes unaffordable or unavailable, physicians are being forced to relocate, close their practices or drop vital services – all of which seriously impede patient access to care. Emergency departments are losing staff and scaling back certain services, such as trauma units, while some advanced and high-risk procedures (such as neurosurgery) are being postponed because physicians can no longer afford or even find the liability insurance they need to practice. Many young physicians are opting out of high-risk specialties even before their careers begin, while other physicians are choosing to retire from practice altogether.

Throughout 2003 and 2004, the medical liability crisis has not waned. In fact, it is getting worse. Access to health care is now seriously threatened in 20 states, up from 12 states in 2002.[1] In many other states a crisis is looming—a crisis that not only threatens access to quality medical care, but also stifles medical and scientific innovation, inhibits efforts to improve patient safety, discourages new treatments and procedures, heaps billions of dollars in additional costs upon a health care system already strained to the

[1] See attached map of medical liability crisis states.

breaking point, and places lives at risk. Virtually every day for the past three years there has been at least one major media story on the plight of American patients and physicians as the liability crisis reaches across the country. A sample of media reports that illustrate the problem faced by patients and physicians is available at http://www.ama-assn.org/go/crisismap.

The AMA recognizes that injuries due to negligence do occur in a small percentage of health care interactions, and that they can be as, or even more, devastating to patients and their families as an injury due to natural illness or unpreventable accident. When injuries occur and are caused by a breach in the standard of care, the AMA believes that patients are entitled to prompt and fair compensation. This compensation should include, first and foremost, full payment of all out-of-pocket "economic" losses. The AMA also believes that patients should receive reasonable compensation for intangible "non-economic" losses such as pain and suffering and, where appropriate, the right to pursue punitive damages.

Unfortunately, our medical liability litigation system is neither fair nor predictable. Transformed by high-stakes financial incentives, it has become an increasingly irrational "lottery" driven by open-ended damage awards for unquantifiable non-economic damages. Studies have concluded that the only significant predictor of payment to plaintiffs in a medical liability case was disability, and *not* the presence of an adverse event due to negligence.[2] In other words, in our medical liability litigation system, injuries often lead to settlements or jury awards even when there is no negligence.

We must bring common sense back to our courtrooms so that patients have access to their emergency rooms, delivery rooms, operating rooms, and physicians' offices. This is why the AMA has worked so hard to seek passage of S. 11, the "Patients First Act," and why we continue to join with numerous other members of a broad-based coalition known as the Health Coalition on Liability and Access (HCLA) to seek passage of this critical legislation.

THE IMPACT ON PATIENTS

The most troubling aspect of the current medical liability litigation system is its impact on patients. Unbridled lawsuits have turned some regions of our country – and in several cases entire states – into risky areas to be sick, because it is so risky to practice medicine. Due to large jury awards and the burgeoning costs of defending against lawsuits (including claims with no merit), medical liability insurance premiums are skyrocketing. A look at the crisis states provides a grim picture of the future of medicine if effective tort reforms are not enacted.

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[2] Troyen A. Brennan, Colin M. Sox & Helen R. Burstin, *Relation between Negligent Adverse Events and the Outcomes of Medical-Malpractice Litigation*, 335 N. ENG. J. MED. 1963, 1963 (1996).

ARKANSAS

- Several physicians have discontinued their nursing home practice because of increased exposure and/or lack of insurance coverage for the nursing homes. Currently, there are no carriers writing new nursing home coverage. Those that have coverage have seen their premiums go up 1000% or more. Many nursing homes have been forced to "go bare" because of unaffordability or unavailability. (Arkansas Medical Society, March 2003)

- Seventy percent of the medical liability cases filed over a 10-year period were dismissed before they went to court, but not before an average of $10,000-$15,000 was spent defending each one or before the cases were noted on the named physician's permanent record, according to information compiled by the Arkansas Medical Society. (*Arkansas Business*, December 1, 2003)

- For every $1 Arkansas medical liability insurers received in premiums, they paid out $1.61 in jury awards and settlements in 2001. (National Association of Insurance Commissioners)

- Arkansas physicians saw their premiums increase 829% between 1976 and 2000, while California physicians only saw a 167% increase during the same time period. California has had a $250,000 cap on non-economic damages since 1975 (National Association of Insurance Commissioners)

FLORIDA

- In Florida, emergency neurosurgery patients are increasingly being transported from Palm Beach County to hospitals in Broward and Miami-Dade counties, and sometimes as far as Tampa and Gainesville. In March, one of those patients, Mildred McRoy, died six days after being transferred to a hospital in Broward County because no neurosurgeon was available to treat her in Palm Beach County. (*Palm Beach Post*, March 9, 2004)

- Lee Memorial Health System officials announced they were giving the state a required six-month notice to close the trauma center after two neurosurgeons quit, leaving only two to handle 24-hour on-call duty. The center treats more than 1,000 trauma-alert patients a year. Recruitment efforts to bring neurosurgeons to Lee County have been disappointing. "The fact is, three trauma centers in Florida have notified the state that they can't hang on much longer," according to Lee Memorial's government consultant. (*The News-Press*, December 14, 2003)

- 100% of South Florida neurosurgeons have been sued, according to surveys of area physicians. In fact, 31% of physicians also have limited their practice in hospital settings, and physicians in South Florida can expect to be sued 1.44 times in their career. (Floridians for Quality Affordable Healthcare, December 2002)

- At least seven Florida hospitals have closed their obstetrics units due to insurance concerns, and four other hospitals have reduced or limited obstetrics services. In addition, ten hospitals have eliminated, reduced or limited neurological services. (Florida Hospital Association, January 2, 2003)

ILLINOIS

- One physician relocated from Chicago to Centura Parker Adventist Hospital near Denver after her liability insurance premiums more than doubled, from $75,000 to $170,000. In Colorado, she pays only about $25,000. (*Denver Post*, March 4, 2004)

- Dr. Stephanie Skelly, an obstetrician-gynecologist in Belleville, is considering a move to her home state, Louisiana, where liability costs are about half compared to Illinois. The combined premium for Skelly and her partner, Dr. John Hucker, doubled to $200,000 from $100,000. They took out a loan to pay a one-time $250,000 for tail coverage. "We have to work for free this year," Hucker said. (*St. Louis Post-Dispatch*, October 6, 2002)

- In 2002, non-economic damages comprised 91% of the average total monetary value awarded by a jury. In 1997, it was 67%. (Illinois State Medical Society, Feb. 9, 2004)

- When three obstetrician-gynecologists on staff at Advocate Lutheran General Hospital in Park Ridge learned their 2004 liability insurance premiums would climb from $345,000 to $510,470, they decided to take their practice to Kenosha, [Wisconsin], where during their first year their combined insurance will cost $50,018. "This state is like the Titanic," said one of the doctors. "A year ago, we saw the iceberg. Now we've already hit." (*Chicago Tribune*, March 12, 2004)

MASSACHUSETTS

- Cape Cod lost its only board-certified neurosurgeon when Robert Leaver, MD, retired early rather than face insurance premiums that reached $115,000. Dr. Leaver, who said he would have to perform about 100 operations just to pay his insurance bill, had no intention of retiring. (*Cape Cod Times*, October 6, 2003)

- The number of jury awards topping $2 million has quadrupled over five years, according to ProMutual's chairman, Barry M. Manuel, MD, a surgery professor at Boston University. Dr. Manual also said that ProMutual's investments are not behind rising insurance premiums: "In the past 10 years, there's not one year that we've shown a negative return on our investments. It's the severity of awards that's driving this situation." (Associated Press, May 17, 2004)

- A majority of Massachusetts patients believe patients bring too many lawsuits against physicians, and they strongly support reforms advocated by the state

medical society. 85 percent of voters said they supported legislation that would assess liability based on a doctor's or nurse's level of responsibility, and nearly 70 percent favor limiting non-economic damages ("pain and suffering") when economic damages (such as child care costs, lost wages, benefits, etc.) are fully covered. (*Boston Herald*, June 7, 2004)

- Large jury awards and settlements continue to occur in Massachusetts, putting further pressure on the liability system. In 2003, there were jury awards of $3.18 million and $1.8 million. Settlements were reported for $3.75 million and $3.25 million, eight settlements between $2 million and $3 million, and eight settlements between $1 million and $2 million. (*Mass. Lawyers Weekly*, January 19, 2004)

MISSOURI

- St. Anthony's Health Center in Alton will lay off 50 to 75 employees in coming months. William E. Kessler, president and CEO of St. Anthony's, blamed the layoffs on declining revenue associated with increased medical liability insurance premiums and the resulting exodus of doctors from the community. (*St. Louis Post-Dispatch*, June 26, 2004)

- Dr. Al Elbendary, a gynecological oncologist, left a group practice and eliminated a rural outreach clinic because of rising professional liability premiums. "Women with gynecologic cancers in Ste. Genevieve, Carbondale and Chester now have to drive over a hundred miles to see a gynecologic oncologist and receive the care they deserve," said Elbendary. (*St. Louis Post-Dispatch*, October 31, 2002)

- Dr. Scot Pringle, a Cape Girardeau obstetrician, said he has delivered approximately 8,000 babies during his 23 years, and his premiums will likely exceed $85,000 if he continues to practice. "A lot of us have been practicing long enough we are near retirement," Dr. Pringle said. "Frankly, I don't want to put up with this mess anymore." (*Southeast Missourian*, April 26, 2004)

- After obstetrician Jamie Ulbrich's liability insurance carrier stopped doing business in Missouri, the best coverage he and three colleagues at their Marshall clinic could find would have cost them double what they paid in 2003. The four doctors decided they couldn't each afford the $50,000 liability insurance premium, so they decided to stop providing obstetric service and instead work solely as family physicians in 2004. (Associated Press, January 3, 2004)

NEVADA

- The people of Nevada overwhelmingly support comprehensive medical liability reforms. A May 2003 poll conducted by the "Keep Our Doctors In Nevada" initiative found that more than 80 percent of Republicans and Democrats said they would support candidates who supported reforms, including a limit on non-

economic damages and trial-lawyer contingency fees. (BestWire, September 15, 2003)

- "I left Nevada because the litigation climate had driven medical liability premiums to astronomical heights," obstetrician-gynecologist Shelby Wilbourn, MD, testified before a Congressional subcommittee. Dr. Wilbourn, whose premiums increased to $108,000, moved to Maine this year and still receives calls from some of the 8,000 patients he saw during his 12 years in Nevada. "Liability isn't about fault or bad practice-it's about hitting a jackpot. Even the best obstetrician-gynecologists have been sued, many more than once." (Associated Press, February 12, 2003)

- Mary Rasar's father died in Las Vegas after the only Level 1 trauma center was forced to [temporarily] close due to skyrocketing medical liability costs. Jim Lawson was injured July 4 in a traffic accident and rather than being rushed to the Level 1 trauma center at nearby University Medical Center, which had been forced to close, Lawson was taken to a hospital that did not have the resourced necessary to save his life. He died while physicians tried to stabilize him for airlift to Salt Lake City. (PR Newswire, April 21, 2003)

- The ongoing crisis has caused one of the few remaining liability insurers, American Physicians Assurance, to pull out of Nevada, a move that will leave about 125 doctors looking for new coverage to continue their practices. Dr. Fred Redfern, president of the Nevada Orthopedic Society, said the withdrawal of another insurance carrier should alarm Nevadans. He said APA is his third insurance carrier to decide to leave Nevada because of the high cost of fighting medical liability claims. "This is not a good place to practice medicine. That's the message doctors are getting," he said. (*Las Vegas Review-Journal*, January 29, 2004)

NEW YORK

- Dr. John Cafaro, 45, an obstetrician-gynecologist in Garden City, said some doctors are paying $130,000 for only $1 million worth of protection. "But we are getting sued for $85 and $90 million at a time," he said. "You do the math. Every time I walk into an operating room I put my family's life savings on the line." (*New York Times*, May 25, 2003)

- Of the 13 largest medical negligence lawsuits in the United States in 2002, seven were in New York state, according to the National Law Journal, including a $94 million verdict from a Brooklyn jury. (*Albany Business Review*, March 21, 2003)

- Awards greater than $1 million are three times more frequent in New York than in California, a state that has had reforms since 1975, according to the Insurance Information Institute. (*Poughkeepsie Journal*, April 1, 2003)

- Many young doctors won't specialize in obstetrics. They fear the threat of lawsuits and wince at liability insurance costs, which can be as much as $200,000 per year. Last summer, Manhattan's Elizabeth Seton Childbearing Center, which practiced natural childbirth, had to close when its medical liability insurance premiums rocketed to $2 million. (*New York Daily News*, February 12, 2004)

NORTH CAROLINA

- Dr. David Pagnanelli, a neurosurgeon, said he moved to Hendersonville, North Carolina in 2002 because liability costs were too high in Pennsylvania. But they shot up here too - to nearly $190,000 a year - even though there've been no successful claims against him, he said. Following his insurance carrier's advice, Pagnanelli stopped seeing trauma cases. But neurosurgeons are in short supply in Hendersonville, so his decision means patients with life-threatening head injuries have been transferred to other hospitals. (*Charlotte Observer*, February 11, 2004)

- The annual number of settlements greater than $1 million for medical liability cases has more than tripled between 1993 and 2002 from 6 to 19. (*N.C. Lawyer's Weekly*, April 21, 2003)

- Hospitals in North Carolina have had insurance premiums go up 400 percent to 500 percent in the past three years, the North Carolina Medical Society says. Small, rural hospitals were hit hardest. (*Winston-Salem Journal*, March 9, 2004)

- "If we remain in North Carolina we will likely be forced to make the decision to limit procedures which carry high risks (but also are often life-saving)," said K. Stuart Lee, M.D. of Eastern Neurosurgical and Spine Associates Inc. Dr. Lee's practice saw their medical liability premiums increase 116 percent last year. (The News and Observer, January 26, 2003)

OREGON

- Personal injury lawyers have filed 465 open suits against Oregon's doctors with total demands of $1.5 billion. This averages out to $3.4 million per suit, or 800 percent more than the current average claim payment of $401,000. (Oregon Medical Association, April 2004)

- Dr. Katherine Merrill delivered as many as 40 babies a year in Astoria, a job she loved. In August 2003, Merrill stopped delivering babies, a decision prompted by the steeply rising costs of medical liability insurance. Merrill said something needs to be done to keep physicians from leaving the state or quitting high-risk specialties. "Otherwise there will be no doctors in your town to deliver babies or to do brain surgery when you've been in a car accident," she said. (Associated Press, January 24, 2004)

- Rural patients in Oregon are being particularly hard hit. Roseburg Women's Healthcare, which delivered 80% of the babies for the area, closed its doors in

May 2002 because its liability insurance was canceled after a single, $8.5 million lawsuit. The closest other providers are 60-90 minutes away. "We consider this a medical crisis for the community," Mercy Medical CEO Vic Fresolone told the Associated Press. (June 26, 2002)

- An Oregon Health & Science University survey of Oregon's qualified professionals who deliver babies showed that 125 providers stopped delivering babies during the past four years, 22 percent of all those delivering babies in Oregon. The survey also showed that one in three professionals who deliver babies now plan to quit doing so in the next five years. (Oregon Medical Association, April 2004)

PENNSYLVANIA

- In 2000, Philadelphia accounted for 82 percent of the $415 million in medical-liability awards in Pennsylvania, and 14 of the 19 awards that exceeded $5 million, according to the Pennsylvania Trial Lawyers Association. (*The Wall Street Journal*, January 28, 2003)

- More than two out of three medical residents in six medical specialties chose to leave Pennsylvania after completing their training, according to the Philadelphia Daily News, which examined data from the city's major teaching hospitals between 1998-2002. "The resident brain drain is greatest among doctors going into high-risk specialties: ob-gyns, orthopedic surgeons and neurosurgeons. These doctors, not surprisingly, are most likely to be sued for malpractice, and pay some of the highest malpractice insurance premiums." (*Philadelphia Daily News*, May 28, 2003)

- A good example of Pennsylvania's lawsuit culture came in early 2004 when juries returned $15 million and $20 million verdicts on the same day. (Associated Press February 4, 2004)

- According to Grand View Hospital President Stuart Fine, the medical liability crisis is a main reason why patient access problems are occurring throughout the state and "has caused experienced doctors to leave the area, especially neurosurgeons, orthopedic and general surgeons, obstetricians and cardiologists. Few young doctors are coming in to take their place, and the result is a shortage of doctors." (*Morning Call* (Allentown, PA), January 23, 2004)

WYOMING

- Jim Derrisaw, MD, a Riverton anesthesiologist, moved his young family to Ft. Collins, Colorado to practice. Dr. Derrisaw grew up in Cheyenne, graduated from the University of Wyoming, married a native of Encampment, and returned to Wyoming to raise his family and "practice medicine in the state I love." Student loan debt for medical school of more than $100,000, coupled with insurance premiums that had escalated to $52,000 per year, created a burden that his deep

Wyoming roots could not overcome. His insurance coverage in Colorado, a state with caps on non-economic damages and other key liability reform measures, has been quoted at a cost of $8,200. (Wyoming Medical Society)

- Cheyenne urologist Stacy Childs, MD will end his practice in Wyoming on May 31, 2004 and move to Colorado, where his liability insurance premiums will be considerably less. Dr. Childs was an advocate for patients and physicians and served as Chairman of the WMS Liability Reform Task Force in 2003. He also served the people of the state during his tenure on the Wyoming Health Care Commission. (Wyoming Medical Society)

- Emergency and trauma care also is in jeopardy in Jackson Hole and Gillette. Without trauma services in the popular ski town, patients' lives will be compromised by the long distance to the next open center, travel that can take several hours in good weather. (*Jackson Hole News & Guide*, June 11, 2003 and *Buffalo Bulletin*, May 15, 2003)

- The loss of even one physician can have dire consequences for Wyoming patients, yet the liability crisis has forced the loss of obstetricians in Wheatland, Cheyenne and Newcastle. Surgeons have disappeared from Casper and Gillette, and more may leave Jackson. And all remaining Fremont County anesthesiologists have left their practice. (Wyoming Medical Society)

SOLVING THE PROBLEM

Studies and expert opinions confirm that certain types of reforms to the medical liability system lower costs and improve access. In a study on the effect of reforms, Stanford University researchers Kessler and McClellan concluded that direct reforms, including caps on non-economic damages, reduced the likelihood that a physician will be sued by 2.1 percent. Within three years, premiums in direct reform states declined by 8.4 percent.[3] Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping medical liability awards reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. Premiums for general practitioners and obstetrician-gynecologists were impacted similarly.[4]

When liability insurance premiums are lower, more physicians are able to remain in practice, and the access to quality care is improved. A July 3, 2003, study from the Agency for Healthcare Research and Quality (AHRQ) looked at the distribution of physicians across states with and without caps on non-economic damages since 1970. [5]

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[3] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS., 81-106 (1997).
[4] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167-182 (1990).
[5] FRED HELLINGER & WILLIAM ENCINOSA, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (2003).

After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12 percent more physicians per capita than states without damage caps.

In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[6] The study points to California, which under MICRA (the Medical Injury Compensation Reform Act of 1975) has a $250,000 cap on non-economic damages, allows for binding arbitration agreements, collateral source offsets, limits on contingency fees, advance notice of liability claims, statute of limitations, and periodic payment of damages. The Joint Economic Committee praises California as "perhaps the most successful example of reform at the state level," noting its slower rate of growth in medical liability premiums.[7]

MICRA reforms have been proven to stabilize the medical liability insurance market in California—increasing patient access to care and saving more than $1 billion per year in liability premiums—and have reduced the time it takes to settle a claim by 33 percent. MICRA is also saving California from the current medical liability insurance crisis brewing in many states that do not have similar reforms. In fact, the gap between medical liability insurance rates in California and those in the largest states that do not limit non-economic awards is substantial and growing. Data from the National Association of Insurance Commissioners (NAIC) shows that aggregate premiums in California increased by 245% over the 1976 to 2001 period, while premiums in the rest of the United States increased by 750%.

Although some states are attempting to address the medical liability crisis at the state level, it is clear that a uniform federal solution is needed.

Last year, the Senate considered S. 11, the "Patients First Act," which is based on MICRA, and would benefit patients by:

- Awarding injured patients unlimited economic damages (e.g., past and future medical expenses, loss of past and future earnings, cost of domestic services, etc.);

- Awarding injured patients non-economic damages up to $250,000 (e.g., pain and suffering, mental anguish, physical impairment, etc.), with states being given the flexibility to establish or maintain their own laws on damage awards, whether higher or lower than those provided for in this bill;

- Awarding injured patients punitive damages up to two times economic damages or $250,000, whichever is greater;

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[6] JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MED. MALPRACTICE: ISSUES & EVIDENCE 19 (2003).
[7] *Id.*

- Establishing a "fair share" rule that allocates damage awards fairly and in proportion to a party's degree of fault; and

- Establishing a sliding-scale for attorneys' contingent fees, therefore maximizing the recovery for patients.

While it is unfortunate that the Senate has been unable to reach the 60 votes necessary to pass a motion to proceed to debate on S. 11, the AMA strongly urges continued efforts to bring about the reforms in S. 11 that have been proven to stabilize the medical liability insurance market in California. Debate on this important issue must continue in order to improve the situation in crisis states and prevent any more states from slipping into crisis mode.

Furthermore, there is strong support for continued efforts to fix our broken medical liability system. In a recent Wirthlin Worldwide poll, seventy-six percent of those surveyed favored a law that would guarantee an injured patient full payment for lost wages and medical costs and place reasonable limits on awards for "pain and suffering" in medical liability cases.[8] In addition, a March 2004 poll conducted by the Health Coalition on Liability and Access (HCLA) concluded that 72 percent of Americans favor a law that would guarantee an injured patient full payment for lost wages and medical expenses but that reasonably limits awards for "pain and suffering" in medical liability cases.[9] These findings are consistent with the results of a Gallup poll released on February 4, 2003, which show that 72 percent of those polled favor a limit on the amount patients can be awarded for "pain and suffering." Also noteworthy, the attached survey on medical liability reform shows that 99 percent of those AMA physician-members surveyed are very or somewhat concerned with the current medical liability environment, with 87 percent being very concerned.[10]

CONCLUSION

Physicians and patients across the country realize more and more every day that the current medical liability situation is unacceptable. Unless the hemorrhaging costs of the current medical liability system are addressed at a national level, patients will continue to face an erosion in access to care because their physicians can no longer find or afford liability insurance. The reasonable reforms set out in the "Patients First Act" have brought stability in those states that have enacted similar reforms.

By enacting meaningful medical liability reforms, Congress has the opportunity to increase access to medical services, eliminate much of the need for medical treatment

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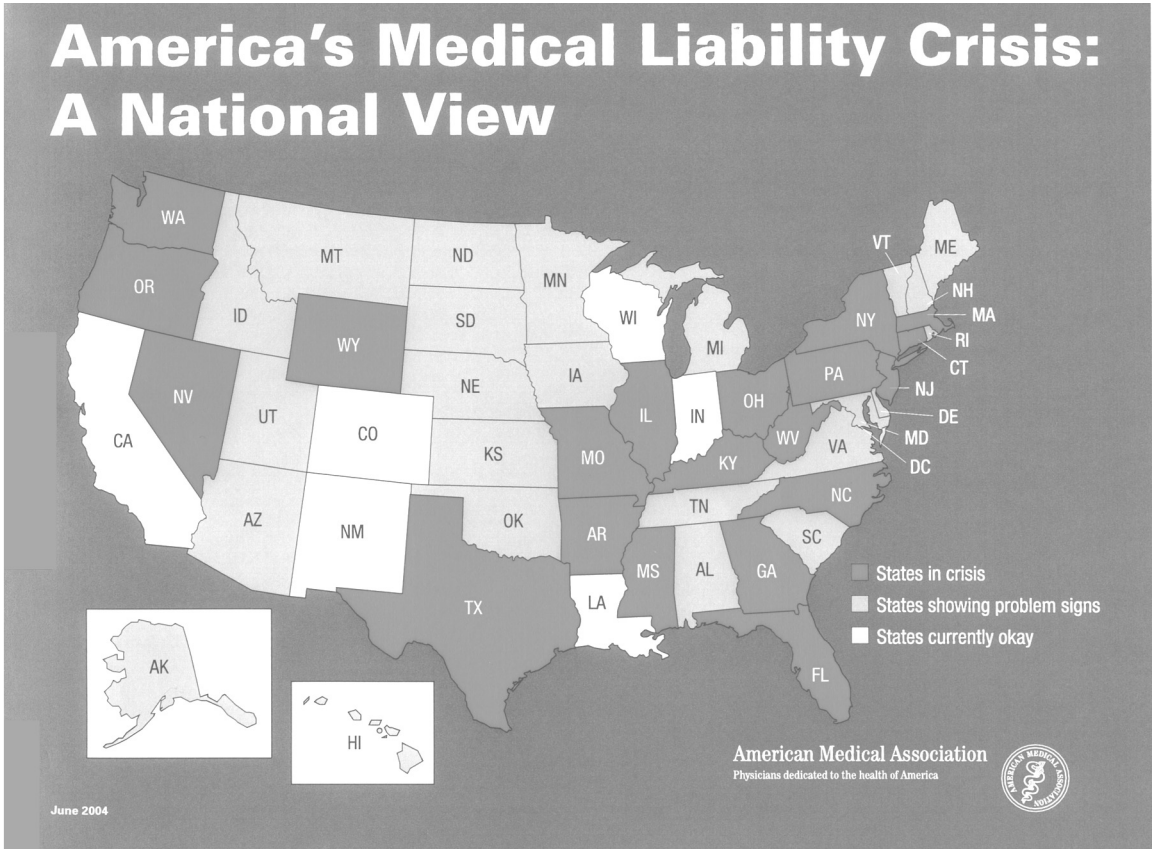
[8] WIRTHLIN WORLDWIDE, AMERICANS BELIEVE ACCESS TO HEALTH CARE THREATENED BY MED. LIABILITY CRISIS (2003), *available at* http://www.hcla.org (last visited Feb. 12, 2004).

[9] Health Coalition on Liability and Access, *More Than Seven-In-Ten (72%) Americans Believe That Health Care Costs Are Rising Because of Medical Liability Lawsuits* (2004), *available at* http://www.hcla.org/polldata/2004-HCLA-Poll.pdf (last visited May 21, 2004).

[10] AMERICAN MEDICAL ASSOCIATION, DIVISION OF MARKET RESEARCH AND ANALYSIS, 2004 MEDICAL LIABILITY REFORM SURVEY (MAY 2004).

motivated primarily as a precaution against lawsuits, improve the patient-physician relationship, help prevent avoidable patient injury, and curb the single most wasteful use of precious health care dollars—the costs, both financial and emotional, of health care liability litigation. The modest proposals in recent reform legislation answer these issues head on and would strengthen our health care system.

The AMA appreciates the opportunity to submit this statement for the record and strongly urges the Senate to move forward in passing meaningful reform legislation.


America's Medical Liability Crisis:
A National View
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States in crisis
States showing problem signs
States currently okay
American Medical Association
Physicians dedicated to the health of America
June 2004

AMA Member Connect Survey: 2004 Medical Liability Reform Survey

Highlights

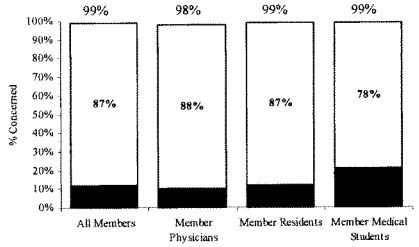
Background

There have been numerous surveys of physicians on the current medical liability environment, including AMA's 2002 National Professional Liability Survey. However, few of these surveys have examined the practice changes physicians are making as a result of medical liability pressures. This survey examined AMA members' concerns related to the current medical liability environment, practice changes resulting from medical liability pressures, opinions of approaches to medical liability reform, and likelihood to vote for an elected official who does not support medical liability reform.

AMA Members Are Concerned

Members were asked about their level of concern with the current medical liability environment. An outstanding 99% of AMA members are very or somewhat concerned with the current medical liability environment, with 87% being very concerned. Physicians (88%) and residents (87%) are more likely than medical students (78%) to be very concerned about the current medical liability environment.

Concern with the Current Medical Liability Environment:
Physicians, Residents and Medical Students



*Significant at p < .0001 level.

■ Somewhat Concerned □ Very Concerned

More than four-fifths of AMA members are concerned about an increase in medical liability insurance premiums (93%), an increase in cost of care (87%), and an increase in unnecessary or excessive care (defensive medicine) (86%) as a result of the current medical liability environment.

Table 1. Concerns Related to the Current Medical Liability Environment: All Members

	% Concerned
Increase in medical liability insurance premiums	93
Increase in cost of care	87
Increase in unnecessary or excessive care (defensive medicine)	86
Deterioration of patient-physician relationship	74
Limiting of patients' access to care	70
Decrease in ability to provide quality care	60

Practice Changes Resulting From Medical Liability Pressures

Members physicians were asked about practice changes made in the last 12 months and the importance of medical liability pressures in their decision to make practice changes. One-third (32%) of member physicians have begun referring complex cases in the last 12 months and 98% of them report that medical liability pressures were important in their decision. More than one-fourth (27%) of member physicians have stopped providing certain services in the last 12 months and 96% of them indicate that medical liability pressure were important in their decision.

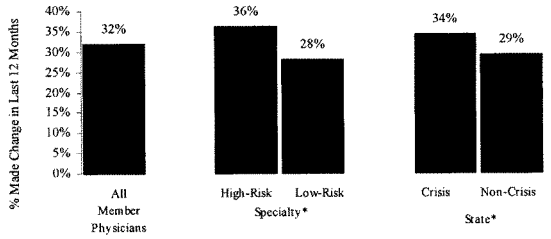
Practice Changes Made in the Last 12 Months: Member Physicians

	% Made Change	% Medical Liability Pressures Important in Decision
Began referring complex cases	32	98
Stopped providing certain services	27	96
Retired from medicine	9	76
Stopped providing patient care	6	90
Closed/sold practice	4	82
Relocated practice to another state	2	65

Physicians Referring Complex Cases

Member physicians in high-risk specialties (36%) are more likely than member physicians in low-risk specialties (28%) to have begun referring complex cases in the last 12 months. Member physicians in crisis states (34%) are more likely than physicians in non-crisis states (29%) to have begun referring complex cases in the last 12 months.

Began Referring Complex Cases



Respondents Indicating that Professional Liability Pressures Were Important in Decision

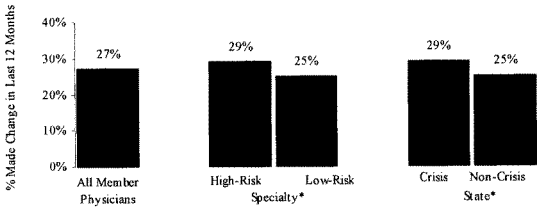
All Member Physicians	Specialty		State	
	High-Risk	Low-Risk	Crisis	Non-Crisis
98%	98%	98%	99%	97%

*Statistically significant at $p < .0001$.

Physicians Have Stopped Providing Certain Services

Member physicians in high-risk specialties (29%) are more likely than member physicians in low-risk specialties (25%) to have stopped providing certain services in the last 12 months. Member physicians in crisis states (29%) are more likely than member physicians in non-crisis states (25%) to have stopped providing certain services in the last 12 months.

Stopped Providing Certain Services



Respondents Indicating that Professional Liability Pressures Were Important in Decision

All Member Physicians	Specialty*		State	
	High-Risk	Low-Risk	Crisis	Non-Crisis
96%	98%	95%	97%	96%

* Statistically significant at $p < .0001$.

Likelihood to Vote for an Elected Official Who Does Not Support Medical Liability Reform

The majority (90%) of AMA members are less likely to vote for an elected official who does not support medical liability reform. More member physicians (92%) and member residents (91%) than member medical students (88%) are less likely to vote for an elected official who does not support medical liability reform. More member physicians in high-risk specialties (92%) than member physicians in low-risk specialties (89%) are less likely to vote for an elected official who does not support medical liability reform.

Opinions of Approaches to Medical Liability Reform
The majority of AMA members favor comprehensive medical liability reforms for all physicians based on California's MICRA law, including a $250,000 cap on non-economic damages for "pain and suffering" (90%, favor; 60%, reform most favor).

Opinions of Approaches to Medical Liability Reform: All Members

	% Favor	% Reform Most Favor
Comprehensive reforms for all physicians based on California's MICRA law, including a $250,000 cap on non-economic damages for "pain and suffering"	90	60
Contingency fee limits for trial lawyers	85	19
Tighter regulation of so-called "expert witnesses"	79	4
Incremental reforms for physicians in the specialties most affected by the current medical liability crisis (e.g., ob/gyns, neurosurgeons)	44	4
State-based medical court demonstration projects	40	3

American Medical Association Division of Market Research and Analysis. May 2004

In March 2004, the American Medical Association (AMA) conducted a survey of all its members on medical liability reform. A total of 172,359 members were sent a five-question survey to complete either by mail or online. The survey was sent to all physician, resident, and medical student members who had joined the AMA for 2004 as of February 23, 2004. A total of 127,483 members were sent the survey by mail and were given the option to either complete the hardcopy of the survey and return it by mail or go online to complete the survey. A total of 45, 910 members were sent an email notifying them of the survey with a link to the survey so that they could complete it online. These members, if they had not completed the survey, also received two reminder emails.

A total of 10,205 AMA members completed the survey, yielding a 6% response rate. 4,158 members returned the survey by mail and 6,047 members completed the survey online. A total of 1,389 medical student members, 527 resident members, and 8,289 physician members competed the survey.

Analysis of the data was conducted to examine statistically significant differences between the following groups:

- Medical students, residents, and physicians,
- Physicians in high-risk specialties and physicians in low-risk specialties, and
- Physicians in crisis states and physicians in non-crisis states.

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for the Aging

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TESTIMONY OF

WILLIAM L. MINNIX, JR., D. MIN.
CEO AND PRESIDENT
THE AMERICAN ASSOCIATION OF HOMES & SERVICES
FOR THE AGING

BEFORE THE
SENATE SPECIAL COMMITTEE ON AGING

MEDICAL LIABILITY IN LONG TERM CARE: IS EXCESS LITIGATION A THREAT TO ACCESS AND QUALITY OF CARE?

JULY 15, 2004

Advancing the Vision of Healthy, Affordable, Ethical Aging Services for America

WILLIAM T. SMITH, Ph.D.
CHAIR

WILLIAM L. MINNIX, JR, D.MIN.
PRESIDENT AND CEO

Thank you for this opportunity to provide testimony to the Senate Special Committee on Aging regarding the important issue of the malpractice crisis in our long term care facilities. The American Association of Homes and Services for the Aging (AAHSA) is the national association of not-for-profit organizations dedicated to providing high-quality health care, housing, and home and community based services primarily to the elderly. AAHSA promotes the vision of healthy, affordable, ethical long term care. Our membership includes more than 5,600 nonprofit nursing homes, continuing care retirement communities, senior housing facilities, assisted living residences, and community service providers.

Introduction

Since the 1990s nursing homes have become one of the fastest growing areas of health care litigation. Extensive and unabated litigation against providers across the continuum of aging services and heavy losses (actual and potential) on liability insurance policies have resulted in skyrocketing insurance premiums. In some states insurers have stopped underwriting coverage. Insurance coverage consequently has become prohibitively expensive and harder to find, and in some states unavailable at all. These lawsuits and the rise in insurance rates have led to the absurd situation where resources are drained away from resident care in facilities with no or little history of claims, and are unavailable to improve care in other facilities with problems.

History

There are a number of factors that contribute to higher premium rates. Prior to the 1990's, nursing homes were not sued often for negligence or malpractice, and rates were low. Beginning in the 1990's, verdicts against nursing homes shot upward astronomically, as did the number of claims and the number of law firms taking these cases. Residents' rights statutes that permit third parties to sue for violations of those rights are the basis for many of these claims, in contrast to the traditional medical malpractice claim. In Florida, 83 percent of claims relied on the nursing home residents' rights statute[1] as the basis of the claim, according to a national survey of attorneys.[2] In response, Florida and other states have passed sweeping reforms in an effort to decrease the volume and cost of nursing home lawsuits.[3] However, these state attempts to address the situation through caps on recovery and other liability reforms have not adequately addressed insurance company concerns nationally.

The Crisis

As a result of the large verdicts and escalating number of claims, insurers rapidly reassessed their interest in the field. The bulk of damages awarded in nursing home case litigation comes in the form of non-economic damages (elderly plaintiffs do not have wage or other similar losses), where there is no generalized or standard method of calculation. These damage claims are impossible to predict. Insurers assess premiums for nursing homes on the basis of industry risk, not individual experience, and look for predictability. Thus, large, unpredictable claims influence not only the insurability of the affected homes, but also have a ripple effect on insurance costs for the rest of the industry, including high quality homes with a history of no, or minor claims.

Large jury verdicts also affect settlements. Insurance companies often settle nursing home and assisted living claims at substantially higher amounts and at greater frequency than medical malpractice claims. Cases are settled not because of the merit of the claim, but because insurers fear uncontrollable jury verdicts. Claims resolved out of court result in compensation payment to the plaintiff at nearly three times the rate of payment seen among medical malpractice claims.[4] The average recovery among claims settled both in and out of court is nearly twice the typical malpractice claim.[5]

A majority of nursing home claims involve chronic, long stay residents with multiple, chronic conditions.[6] Jurors often have unrealistic expectations and award higher amounts to plaintiffs than in other medical malpractice cases, because they mistakenly believe that nursing home residents, like hospital patients, should get better.[7]

Insurance costs for less medically oriented assisted living and retirement communities also are increasing, sometimes to nursing home levels, because of underwriter assumptions based on the common profile of nursing home, assisted living and retirement community residents. The crisis has even hit senior housing with services. Insurers are beginning to require senior housing providers to buy insurance based on assisted living rates because insurers now view the mere existence of such well-established programs as emergency pull-cord services and wellness checks as liability risks, despite years of successful use.

Our members provided us with information about their facilities' recent experiences attempting to obtain professional liability insurance. Their comments, set forth as an appendix to this testimony, reflect both increases in premiums and decreases in coverage, along with the struggle to find insurance. Types of facilities range from stand-alone nursing homes to multi-facility, multi-state providers, and comments came from all parts of the country, from Michigan and Indiana in the mid-west to Georgia and Florida in the South and Texas in the Southwest. Increases ranged from 280% to 1000%. These are facilities with no or very few claims.

Paying for skyrocketing premiums is difficult for providers. Medicare and Medicaid pay for the largest share of nursing home costs, but neither payment system takes adequate account of recent, significant increases in insurance costs. In federally assisted senior housing, the demand on HUD for increased subsidies to cover rising operational costs that include insurance is not able to keep pace with the dramatic shifts in insurance costs that have been seen in the past few years.

Nursing homes, retirement communities, assisted living facilities and federally assisted senior housing simply cannot pass the cost of higher insurance premiums to private-pay residents. As the cost of care and housing becomes far less affordable for these individuals, dependence on government programs will increase. In HUD housing, rent increases are not always feasible due to recent changes in rent adjustment authority and rent caps. Further, rent increases can place a significant out-of-pocket burden on market rate renters in HUD facilities that are only partially subsidized.

Not-for-profit providers face a particularly difficult dilemma. They are community and mission-based charitable institutions that receive contributions because of the benefits they provide to their communities and the reputations they earn through providing quality care and services. They simply cannot ask their contributors to pay for liability insurance – contributors want their dollars to go towards care, not administrative costs.

In summary, huge verdicts and high premiums divert a tremendous amount of money out of long-term care that could, with some tweaking of the legal system, be returned earmarked for improvements in care. Florida and Pennsylvania, for example, have created trust funds financed with a portion of punitive damage awards which are to be used to pay for increased staffing and new quality programs. The United States Attorney for the Eastern District of Pennsylvania in civil settlements under the False Claims Act for failure of care has directed the facility as part of the settlement agreement to establish a "Quality of Care/Quality of Life Fund."[8] The Fund is to be used, in addition to expenditures already budgeted for programs, services, and equipment in the ordinary course of business, for programs, services and equipment to improve the quality of life and care for residents in the facility.[9]

Staffing and Morale Challenges Facing the Long Term Care Field as a Result of the Litigation Explosion

Providers struggle on a daily basis to provide quality care. The greatest challenge they face - the shortage of staff – is a combination of financial, personal and demographic issues. The number of potential caregivers for the elderly requiring long term care will decrease by approximately 40 percent between 2010 and 2030.[10] Meanwhile, the number of people age 65 and older will increase from 13 percent to 20 percent of the population by 2030.[11] The impending crisis is obvious; there will be fewer caregivers for an increasing elderly population who need care. Obviously, we must address this issue by recruiting caregivers into long term care and encourage retention of existing caregivers. However, the litigation crisis has an adverse impact on providers' ability to recruit and retain both front-line and administrative staff.

Fear of being sued is one of the reasons both administrators and frontline staff give for leaving the field and potential candidates give for not entering long term care. This is part of a serious morale problem in a field already dealing with staff shortages, financial challenges and a poor public image. Certified nursing assistants are afraid that if anything goes wrong, they will lose their certificate, or be charged with neglect or abuse, and so they leave.[12] Licensed nursing home administrators are also seeking alternative employment.[13] The number of applicants for the National Association of Boards of Long Term Care (NAB) licensure exam for nursing home administrators has dropped by 40 percent in recent years.[14] Existing administrators are seeking alternative employment, citing aggressive "prosecution" (emphasis added) by plaintiffs' attorneys and rising liability insurance rates as among the reasons for leaving the field.[15] The NAB Executive Committee, as a result of their concern, held a panel discussion with long term care administrators in 2001 to discuss why prospective administrators were not entering the field, and conducted a survey of state administrators in 2002. Reasons for the decline were fear of lawsuits, personal and corporate; and attorneys that advertise for services to promote litigation against nursing homes.[16]

AAHSA's Approach

AAHSA is committed to finding a solution to the liability insurance crisis that includes the ability of persons injured by negligence or malpractice to recover reasonable damages, addresses quality of care and patient safety, and enables providers to obtain liability insurance at reasonable rates related to the quality of care they provide.

AAHSA and its members are committed to achieving excellence in the quality of care and the quality of life provided throughout the long-term care continuum, as evidenced by our signature program developed in 2002 called Quality First: A Covenant to Achieve Healthy, Affordable and Ethical Aging Services. Quality First's goal is to ensure excellence in aging services. Quality First is centered around seven principles intended to cultivate and nourish an environment of continuous quality improvement:: openness and leadership among aging services providers: continuous quality assurance and quality improvement; public disclosure and accountability; patient/resident and family rights; workforce excellence; public input and community involvement; ethical practices; and financial stewardship.

Improving quality alone, however, will not resolve the litigation crisis. The long term care field needs federal legislation to address many of the issues raised in this testimony. The federal government is deeply and necessarily involved in the financing, monitoring and administration of long term care, and needs to play a role in resolving this crisis.

As a beginning, AAHSA urges this Committee and the Congress to consider the following:

- We urge Congress to pass comprehensive legislation that sets reasonable limits on lawsuits brought against health care providers, including the amount that can be recovered for non-economic damages such as pain and suffering and punitive damages. We specifically urge Congress to include long-term care providers in any legislation that addresses the issue of professional liability, including patient safety legislation and legislation to develop alternatives to litigation for medical liability claims.

- In HUD appropriations, include a study of the recent insurance cost increases and options for HUD to self-insure, and assure that adequate funds are available to renew all expiring contracts at levels which reflect the new insurance cost burdens.

- The staffing crisis must be addressed, as baby boomers approach their retirement years, through recruitment and retention initiatives. It is the most pressing, aging related issue facing our nation today. Funding must be increased for recruitment, training, scholarships and to supplement salaries. Support for innovative approaches to the nursing home culture such as Wellspring, the Eden Alternative, and the Greenhouse Project is crucial.

- A system needs to be developed that directs a portion of damage awards to a trust fund or other similar mechanism to be used to improve the quality of life and quality of care in the poor performing facility.

We thank the Committee for your attention to this issue. The litigation crisis has led to an insurance crisis and a tremendous diversion of assets out of long term care even in facilities with excellent records. This crisis is not going away. We welcome working with the Committee to address these issues and find appropriate solutions.

[1] Florida Statutes, secs. 400.022-400.023
[2] Stevenson, David G. and David M. Studdert, *The Rise of Nursing Home Litigation: Findings from a National Survey of Attorneys*, 22, Trends, 219, 221, (2003).
[3] *Id* at 219. Citing Florida Senate Bill 1202, Ohio House Bill 412, and more general malpractice reforms in Mississippi, Nevada and Pennsylvania.
[4] Stevenson at 223.
[5] *Id* at 223.
[6] *Id* at223-224.
[7] *Id.*
[8] *Majestic Oaks v. CMS*, Docket No. C-03-593. Settlement announced June 30, 2004, posted on the Web sit of the U.S. Attorney for the Eastern District of Pennsylvania at http://www.usdoj.gov/usao/pae/News/Pr/2004/jun/jun04.html.
[9] *Id.*
[10] Guagliardo, John, Nation *must prepare for nursing crisis,* 22, McKnight's Long Term Care news,, May 29, 2001.
[11] *Id* at 1.
[12] Bilyeu, Susan, *Spotlight on Annie Bryant, CNA*, Contemporary Long Term Care, January 2002 at 34.
[13] Peck, Richard L., *The Administrator: An Endangered Species,* Nursing Home Long Term Care Management, July 2001 at 4.
[14] National Association of Board of Examiners of Long Term Care Administrators, unpublished NAB State Survey Summary, 2002.
[15] Peck at 4.
[16] McIlwaine, William B., *Why is the Number of Applicants to become NHAs Declining?*, Pennsylvania State Board of Examiners of Nursing Home Administrators Newsletter, Summer 2001a2001at 11.
National Association of Board of Examiners of Long Term Care Administrators, unpublished NAB State Survey, 2002.

APPENDIX
AAHSA MEMBER EXPERIENCES IN THEIR OWN WORDS*

1. Our liability insurance went up 280% in one year with **no** claims.

Retirement Community, Inc.
Georgia

2. We are a Not-For-Profit organization that operates 3 nursing homes and 1 Alzheimer's residential facility. . . . With all of the current financial challenges that have come our way, we have received a "big" hit from the insurance industry. In 2001, [w]e paid $38,478 for the year and had **no** claims. We were notified by this group in November of 2001 that they would no longer be able to cover us and that our current policy would expire on 12/31/01. Panic stricken, we desperately tried to find another company to cover us. We have good experience and could not understand why we continued to be told "we no longer insure nursing homes". ... **During the year of 2002, our organization spent $111,769 for the same coverage we paid $38,478 for the year before!** Our industry continues to receive cuts in our reimbursement, and at the same time suffers from increased costs in our insurance premiums. We are very mission driven and believe in what we do. We will try to continue to operate to meet the healthcare needs of the senior population in our community. We are hopeful that someone in our government will see what is happening to our industry and put policies in place to protect the organizations that someday may be caring for "their" parents.

Multi-facility organization
Indiana

3. [Two life care communities that are part of a larger company]: [Parent] manages over 150 retirement communities across the country, and we have an advantage insurance program with premium discount pricing, because of our aggregate good experience with liability issues.

Both organizations have experienced significant increases in our property and liability insurance coverages over the last two years in particular. These increases have not been as significant as many of our communities, but both communities have needed to increase resident services fees above and beyond what is usual to maintain a solid financial position. [One] passed a fee increase for our residents that was 1.9% higher than our historical averages. With the turn in the economy, this affects our marketing and has the potential to damage the viability of our organizations and the mission of charitable care for our residents. **[We] absorbed nearly 55% of the increase in premiums this last year.** Fortunately, we have a strong cash position. Not all of our communities are so fortunate for a myriad of economic issues.

Our national experience has been even more dramatic. [Parent] bid our insurance package to more than 100 carriers, including international carriers last year, and most of them declined to bid. Fortunately, because of the reputation of [Parent], we were able to secure insurance for our properties with increases "only" in the 65% range. Our properties that choose not to participate

* Examples collected in 2003.

experienced increases in the 300% range this past year, and for our properties located in Florida who do participate, that rate of increase was standard. This equated to **over $100,000 increases in premiums for each property in one year. With revenues generated from resident fees, one can image the detriment this crisis brings.** The market for retirement and nursing home housing can only sustain a certain level of increase: ceilings do exist, yet this fact is overlooked in rate increase experiences. In addition, coverage and premiums were not secured until after the start of the insurance fiscal year.

Moreover, we have assumed management of properties in various states, including Texas, that do not even have property and liability insurance, and yet they have not been able to self restrict funds for self insurance purposes, because the funds are simply not there. It is a frightening prospect to discover senior housing providers of all types without any insurance. In the event of a disaster, these housing providers simply would cease to operate, and hundreds, if not thousands of seniors would be without housing.

I'd say that is a crisis.

Retirement Community
Michigan

4. In 1998 our general and professional liability insurance premium was $179,000 for a long-term care system comprised of seven campuses located in three cities.... Since 1988 we added one additional campus. **Our general and professional liability insurance premium increased by 373% to $846,000 over the 1998 premium**. We have had limited law suits filed against us in the past with only one resulting in a settlement of a small amount.

This increase in the cost of liability insurance is not born by the third party payors such as Medicare and Medicaid as they are being ratcheted down by both the federal government and, in our case, the [state] legislature. **The impact is to pass as much of that cost increase as we prudently can on to our private pay residents, eat into our endowment reserves which are held to support those residents who out live their financial resources, and then trim other operational areas such as staffing in areas away from direct resident care.**

If this increasing spiral of liability insurance doesn't abate, we will be forced to either reduce the number of nursing home beds we operate which will be detrimental to those residents who really need that level of care, reduce the number of staff to the State minimum staffing standards which only provides minimal levels of quality care, reduce our liability coverage and/or go bare which is a scary thought with all the trial attorneys looking for new and different ways to make their over inflated fees and to justify their relative existence.

As a business that serves and cares for our aged population who can no longer care for themselves, we need our members of the House and Senate to lead the charge to provide proper levels of reimbursement for quality care given, limit the ridiculous liability awards that have been made in the recent past to levels that are reasonably related to the alleged offense, and provide insurance companies an incentive to lower premiums in the near future.

Faith-based retirement system
Texas

5. [Faith-based nursing home] has an outstanding history of quality and leadership. We have had minimal claims in our [over 50] year history. Three years ago we were presented with a 1000% increase in premium for liability insurance. We had been insured ... with a "one million/ three million policy" and $1,000 retention. Our cost was $80,000. **With a history of no claims under that policy, the renewal quote was $800,000, a ten-fold increase.** This would have been impossible to absorb.

Our board members said they would rather close or cut back beds than reduce quality of care in order to pay extortionate premiums. Ultimately, we were able to procure offshore coverage with Lloyds of 500k/1500k with 100k retention at a cost of 270k.

We presently maintain this level of coverage, although the cost contributes to the upset of some delicate financial balances regarding Bond covenants and diverts significant resources away from care. Since many providers are going nearly bare, it also makes us a more likely target.

Nursing Home
Florida

6. [Continuing care retirement community] that has **never** been sued, was notified in June of 2001 that the company that provided [it] with liability insurance was no longer going to write in the state of Florida.... After shopping for new insurance and with no admitted insurance carrier in the State of Florida, [retirement community] had to go to a Lloyds of London product. **Our General Liability premium went from $65,602 to $230,840 and the deductible went from $1,000 to $100,000.** Previously we had had a $10 Million umbrella that cost us $16,557. We were now only able to get an umbrella for $1 Million for $107,046. Thus in 2002 [we] saw an increase in our insurance premium just for liability of 311% or $255,700. Also, we had an occurrence policy, and now we have a claims-made policy. Then in 2003 our liability insurance decreased by $16,000 or 6%, however our deductible increased by another $50,000 to $150,000. And [community] was not able to get any excess insurance.

The other shocker that we have had to deal with is property insurance. In the last two years [our] property insurance has increased by $183,600 or 165% in 2002 and then in 2003 in increased $199,900 or 67% above what it increased over the previous year. We have had to pass this cost on to our members.

Additionally, [our] sister community ... opened recently and in its first year, saw a 30% increase in its liability insurance. The insurance cost for liability, property workers compensation and health care are higher than planned for in [new community's] feasibility study by almost $500,000. And this is with the bidding being done by [our management company] which oversees both [communities. As my role of President of [the] Management Co., I can say that these costs have significantly impacted the financial operations of the communities and its members.

Continuing Care Retirement Community
Florida

7. Our story is a very simple one. In the past two years, our professional liability premiums have risen from $373 per bed (per year) to $2,500 per bed, and that is with a reduction in coverage from $5 million to $3 million. Add to that the fact that we have **never** (thank G-d) had a claim in 35 years!

Faith based care system
Texas

8. [Faith-based organization] amended its Articles of Incorporation in 1906 to include offering services to the elderly. So we have been doing this, officially, for nearly a century.

In **1999**, our professional and general liability insurance premium was **$300,000**. In **2002**, the same coverage cost us **$4,500,000**.

In 2002, we closed [a] 120-bed ... nursing center; this decision was closely tied to the litigation/liability insurance crisis in Texas. We also have reduced our nursing bed capacity in Austin by almost 25% because of the same issues.

Faith-based retirement and aging services company
Texas

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For Release July 15, 2004

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Victims of Abuse and Neglect Should Not Be Blamed For Nursing Home Industry's Rising Insurance Rates

For more than 30 years, the Senate Special Committee on Aging has held hearings and issued reports on the negligent treatment of the elderly in nursing homes. Countless men and women have been invited to testify about how their mothers, fathers, spouses, or other loved ones were callously neglected or deliberately abused by those in whose care they had been entrusted. As the Committee's hearings have documented, the maltreatment of the individuals is often compounded by the failure of the state regulatory agency and the federal government to protect residents and penalize the perpetrators. The National Citizens' Coalition for Nursing Home Reform is therefore disappointed that the Committee has called witnesses for today's hearing who blame the victims who seek redress in civil courts for the rising cost of liability insurance, rather than the providers who neglected and abused them.

The recent dedication of the World War II Memorial has resurrected eloquent tributes to our nation's "Greatest Generation." But in truth, many of those men and women reside today in long-term care facilities in which they are treated without dignity and without respect for their decades of sacrifice to make this a great country. Of all adult Americans, the disabled and dependent elderly would be hurt most by the tort reform proposals that have been considered by this Congress. These proposals would permit those who are young and working to sue for unlimited economic damages, but they would severely cap awards for noneconomic damages – the pain and suffering of those whose work lives are over. Tort reform would effectively end the Greatest Generation's access to the courts.

There are no witnesses for the elderly victims of nursing home abuse at this hearing. Therefore, NCCNHR is requesting that the Committee insert in the record a copy of *Faces of Neglect*, a report we published in conjunction with Texas Advocates for Nursing Home Residents in 2003. This report provides graphic case studies of elderly and disabled Texans who suffered serious injury and even death because of the negligence of nursing home personnel who repeatedly violated standard nursing practices and doctors' orders. It also demonstrates the failure of state agencies to take effective action against the operators and individuals who were responsible, and the high cost borne by American taxpayers to treat the victims of neglect.

NCCNHR believes that the treatment of these residents speaks volumes to the nursing home industry's claim that rising insurance rates are taking away from quality care: Quality care was never provided to residents who were victims of abuse and neglect, and *that* is the issue that the Committee should address.

###

NCCNHR is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety, and dignity of America's long-term care residents.

THE FACES OF NEGLECT:

Behind the Closed Doors of Texas Nursing Homes

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The National Citizens' Coalition for Nursing Home Reform (NCCNHR)

Founded in 1975 by Elma Holder and based in Washington, DC, NCCNHR has been the independent voice of nursing home residents for more than 25 years. Our mission is to protect nursing home residents' rights, safety, and dignity. NCCNHR is a membership coalition of residents, family members, resident and family councils, long-term care ombudsmen, citizen advocates, and professionals in the field who seek to enhance residents' rights and improve nursing home care. Its core members are state-level organizations, including in many if not most states consumer advocacy groups that represent the interests of residents and their families and that play at the state level the same role that NCCNHR plays at the national level.

NCCNHR's programs include consumer education, family council development, empowerment of resident advocates, and public policy advocacy. We house the National Long-Term Care Ombudsman Resource Center (established by the Older Americans Act). NCCNHR publications include a quarterly newsletter, the *Quality Care Advocate*; a book, *Nursing Homes: Getting Good Care There*; and consumer guides to such issues as chemical and physical restraints and staffing in nursing homes.

In the public-policy arena, NCCNHR is looked to as the *premier* representative of residents by policymakers in Washington, D.C. We are credited with putting together the coalition that resulted in enactment of the landmark 1987 Nursing Home Reform Act, and continue to monitor its enforcement by the Centers for Medicare & Medicaid Services (CMS) and the states.

Because residents' right to enforce standards of care in civil lawsuits is so crucial for both restitution and deterrence, NCCNHR has been an active voice against tort reform and for strong civil justice remedies.

Texas Advocates for Nursing Home Residents (TANHR)

Texas Advocates for Nursing Home Residents (TANHR) is a statewide nonprofit, volunteer membership advocacy group that started around a kitchen table in 1989. Its four founding members drafted TANHR's bylaws and determined its goals.

TANHR works to inform long-term care consumers about the rules and regulations governing nursing homes and to empower friends and families of nursing home residents to speak out against poor resident care and advocate for quality care.

TANHR supports the friends and families of nursing home residents in their work to improve nursing home conditions. TANHR's recently released Nursing Home Family Council Manual provides information on organizing family councils, regulations, and residents' rights, and offers tips on monitoring resident care.

Members participate in TANHR state meetings targeting nursing home policy and regulatory enforcement, and TANHR Units run educational programs on a wide variety of topics, including Health Care for the Aged and Disabled and Nursing Home Policy and the Texas Legislature.

For more than a decade, TANHR has worked toward strengthening the Texas regulatory enforcement system and its members regularly write and speak to nursing home staff, state surveyors, policy makers and representatives from the Centers for Medicare & Medicaid Services (CMS) in Washington, DC.

TANHR's mission is to improve the quality of care and quality of life for nursing home residents.

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III. *Nursing Home Conditions in Texas: Many Nursing Homes Fail to Meet Federal Standards for Adequate Care*
Report Prepared By:
Special Investigations Division
Committee on Government Reform
U.S. House of Representatives

I Faces of Neglect: Behind the Closed Doors of Texas Nursing Homes

The Scope and Severity of Nursing Home Neglect and Abuse

Today, in Texas and across America, many of our nation's 1.6 million nursing home residents suffer terrible neglect and all-too-frequent abuse in facilities that violate laws designed to protect some of society's most vulnerable citizens. Nursing homes that habitually violate minimum care regulations and cause widespread harm and appalling suffering abound in every public health region of the state. Recent federal reports found more than 90% of nursing homes are understaffed, more than half of them so short of workers that residents are seriously endangered.[1] Physical and sexual abuse of nursing home residents is not being promptly reported and is rarely prosecuted.[2] Residents in more than 5,000 nursing homes were physically, verbally, or sexually abused in 2000 – 2001.

We have worked for almost 30 years to create a federal and state regulatory enforcement system that would ensure nursing homes comply with care and safety standards. However, that system is still woefully inadequate to the task. The ongoing inability of federal, state, and local government to enforce nursing home laws and protect vulnerable elderly residents has been chronicled by government agencies, legislative commissions, and the media for well over three decades. As a result, nursing home residents and their families have been forced, on occasion, to turn to the civil justice system to not only provide meaningful remedies for negligence and abuse, but also meaningful deterrence to future neglect and abuse by those facilities. Indeed, for those of us who have been involved in the struggle for decent and humane care for so many years, tort judgments may well be one of the most effective disincentives to poor nursing home care. Given the scope and severity of abuse and neglect, coupled with the longstanding inability of state and federal government to adequately police the nursing home industry, nursing home residents desperately need every tool of deterrence available.

Today, however, nursing home residents are dangerously close to losing access to this effective deterrent to abuse and neglect — the civil justice system. Congress and state legislatures are scheduled to consider extreme tort reform legislation that would severely limit or eliminate damage awards for the pain and suffering of victims of nursing home neglect and abuse.

[1] *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes,* U.S. Department of Health and Human Services (HHS), January 2002.

[2] *Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse,* U.S. General Accounting Office (GAO) Report to Senator John Breaux and Senator Charles Grassley, March 2002.

Under current tort laws, the recovery of damages for physical pain and suffering forms the core of civil cases brought on behalf of nursing home victims. Rare, indeed, is the nursing home case where economic damages of a meaningful nature can be recovered for future medical expenses or any other financial loss over the remainder of a resident's life. How often could a frail and disabled nursing home resident, perhaps living out his or her last days, recover damages for lost wages or impaired earning capacity? Yet, damages for lost wages and future medical expenses often make up the bulk of a personal injury or medical malpractice damage claim. Practically speaking, these economic damages are not available to a victim of nursing home neglect or abuse. Without the ability to collect for pain and suffering, nursing home residents effectively lose their right to have their cases heard in a court of civil justice, and the law loses its deterrent effect on those who are paid to care for the elderly.

In summary, the legislation that is now being proposed would: 1) effectively erect new barriers to the enforcement of residents' rights to quality care and safety; 2) decrease the price of neglect; and, 3) cripple the impact of the civil justice system.

Texas Nursing Homes: An Epidemic of Abuse and Neglect

Right now, the future is bleak for many of the close to 85,000 elderly and disabled nursing home residents in Texas. A recent Congressional report shows 86% of the state's 1,148 nursing homes violated federal health standards during recent state inspections.[3]

The report, based on an analysis of recent annual inspections, complaint investigations of Texas nursing homes, and staffing data maintained by the U.S. Department of Health and Human Services (HHS), found:

- **"The vast majority of nursing homes in Texas," — 86% — violated federal health and safety standards during recent state inspections.[4]**
- **Many nursing homes in Texas — 39% — had violations that caused *actual harm to residents or placed them at risk of death or serious injury.***
- **The 443 Texas nursing homes with actual harm violations or worse serve 37,417 residents and are estimated to receive more than $440 million each year in federal and state funds.**

[3] *Nursing Home Conditions in Texas, Many Nursing Homes Fail to Meet Federal Standards for Adequate Care,* U.S. House of Representatives, Committee on Government Reform, Special Investigations Division, Minority Office, October 2002. Please see report following page 187.

[4] "Of the 1,148 nursing homes in Texas, only 161 facilities (14%) were found to be in full or substantial compliance with the federal standards. In contrast, 987 nursing homes (86%) had at least one violation with the potential to cause more than minimal harm to residents or worse," *Nursing Home Conditions in Texas, Many Nursing Homes Fail to Meet Federal Standards for Adequate Care,* U.S. House of Representatives, Committee on Government Reform – Minority Office, October 2002. Please see report following page 187.

- **More than 90% of Texas nursing homes did not meet the recommended minimum staffing levels identified by the U.S. Department of Health and Human Services (HHS).**

These statistics attest to the prevalence of poor care and violations of dignity in Texas. However, statistics alone fail to capture the terrible abuse and neglect residents endure in many Texas nursing homes. Perhaps the only way to understand the scope and severity of nursing home neglect and abuse is to examine its real-life occurrence. The case studies included in this legislative briefing book ***are*** the faces of abuse and neglect. Combined with the statistics, these studies complete the picture and document the severity of resident suffering that extends across Texas.

The Link Between Abuse, Neglect, and Understaffing

In January 2002, the U.S. Department of Health and Human Services (HHS), released a report showing nine out of ten nursing homes in the United States lack adequate staff. The report found "strong and compelling" evidence that nursing homes with a high ratio of personnel to residents were more likely to provide substandard care. Residents in these homes were more likely to experience bedsores, malnutrition, weight loss, dehydration, pneumonia, and serious blood-borne infections.

A lead researcher in the field, Charlene Harrington, and her staff at the University of California, San Francisco, released a nursing home staffing study confirming that the "single most important factor related to poor nursing home quality across the country [is] the inadequate numbers and training of registered nurses, licensed practical nurses, and Certified Nursing Assistants in facilities providing care to residents."[5]

Understaffing in Texas Nursing Homes

Most nursing homes in Texas do not provide adequate staffing. During their most recent annual inspections, the vast majority of nursing homes in Texas — 1,060 of the 1,124 facilities for which staffing data was available (94%) — did not meet minimum staffing levels identified as necessary in a recent report to Congress.

Compared to other states, Texas nursing homes rank 43rd in the nation in hours of nursing care provided to residents each day. Texas nursing homes that failed to meet the minimum

[5] U.S. Senate Special Committee on Aging Forum, *Nursing Home Residents: Short-Changed by Staff Shortages,* November 1999, Chair, Senator Charles Grassley, Moderator, Charlene Harrington, Ph.D., R.N., Professor, Department of Social and Behavioral Sciences, University of California, San Francisco, California.

staffing levels were more than three times as likely to have violations that caused actual harm to residents compared to nursing homes that met all minimum staffing levels.[6]

Medical Malpractice Reform and Nursing Home Residents in Texas

The 78th Legislature is currently engaged in a fierce debate over medical malpractice liability limits. Legislation recently introduced by Rep. Joe Nixon (HB 3 and HJR 3) and Sen. Jane Nelson (SB 12) would limit attorneys' fees and cap noneconomic damages at $250,000. ***Nursing home claims will be swept up in this bill.*** These bills would effectively cap damages for a nursing home resident at $250,000, no matter how outrageous or extensive the abuse or neglect.

In an effort to create a "one-size-fits-all" approach to the civil justice system, the authors of these bills: 1) ignore the scope and severity of nursing home abuse and neglect that exists today; and, 2) are insensitive to the horrible suffering of many elderly citizens.

It is our view that these bills constitute a clear and present danger to the dignity and safety of Texas nursing home residents. Severely restricting liability limits would seriously compromise the legal protections now provided to elderly and disabled nursing home residents in Texas.

Specifically, limiting noneconomic damages would eliminate one of the few protections shielding elderly and disabled nursing home residents in Texas. Noneconomic damages are awarded for pain, suffering, mental anguish, and disfigurement. These damages are especially important in nursing home cases in which the victim is a frail elder whose damages for lost wages would be nonexistent. Compensation for the abuse and neglect of Texas seniors would be capped at $250,000 regardless of the suffering of the resident.

This Legislature will determine the fate of the state's nursing home residents. Will the nursing home industry be forced to increase staffing and meet a higher standard of care or will the industry be allowed to write legislation that shields it from accountability, stripping legal protections from the vulnerable elderly?

Nursing Home Residents Need *More* — Not Less — Protections

Who is protected under HB 3, HJR 3 and Senate Bill 12? The ***worst*** nursing home providers — those who commit the most horrific forms of abuse and neglect against some of our most vulnerable citizens — are afforded the greatest protection. These bills not only devalue the life of nursing home residents, they ignore a resident's capacity to experience pain and the devastating effects caused by it. ***Enacting the proposed pain and suffering cap sends***

[6] *Nursing Home Conditions in Texas, Many Nursing Homes Fail to Meet Federal Standards for Adequate Care,* U.S. House of Representatives, Committee on Government Reform – Minority Office, October 2002. Please see report following page 187.

the dangerous message that no matter how egregious or repulsive the neglect or abuse, the actual damage cost to a nursing home can never exceed $250,000.

The shockingly poor quality of care in Texas nursing homes has led the families of nursing home residents to fight to safeguard their rights. But rather than address serious staffing problems and poor care, the proposed legislation strips nursing home residents of their right to protect themselves against abuse, neglect, and exploitation.

These bills threaten to catapult elderly nursing home residents back to the days before nursing home accountability — a time of unspeakable abuse by nursing home operators who knew they would not be held accountable for their treatment of elderly and disabled residents.

Texas Advocates for Nursing Home Residents (TANHR) and the National Citizens' Coalition for Nursing Home Reform (NCCNHR) strongly oppose this legislation, and we urge Texas lawmakers to commit themselves to protecting the dignity and safety of Texas nursing home residents by voting against it.

Conclusion:

We debated whether we should include the graphic material contained in this book. In the end, we chose to include these horrifying images because we believe they are necessary to bear witness to the abuse and neglect of too many Texas nursing home residents.

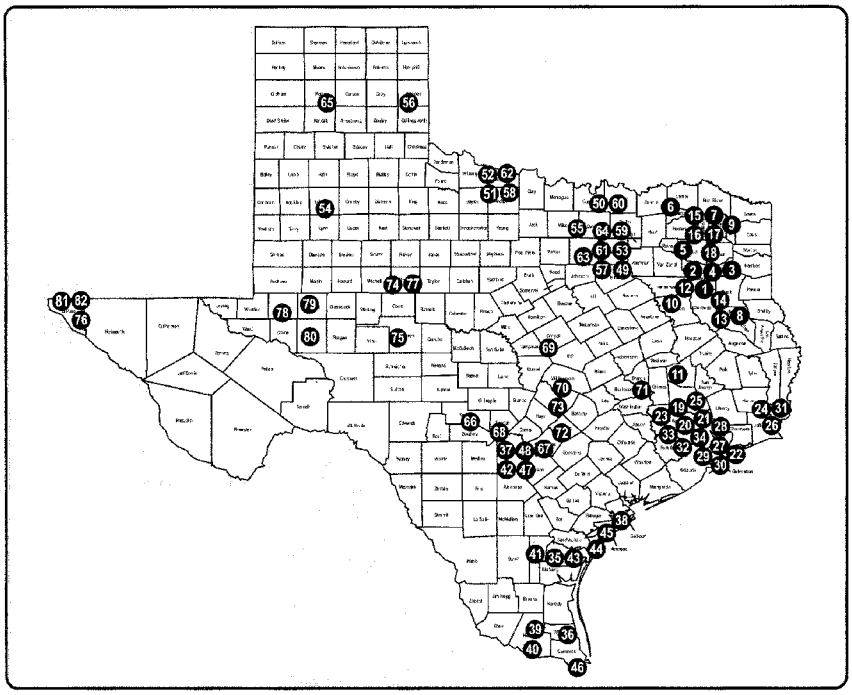
We fear — but also hope — that these images are indelible, that they remain with you because they are the faces of our mothers and fathers, our grandparents, and friends. They are the faces of nursing home abuse and neglect.

II Faces of Neglect: What Does Nursing Home Abuse and Neglect Look Like?

The following pages contain graphic depictions of abuse and neglect. Due to the shocking and medically-explicit nature of this material, they should be viewed with caution.

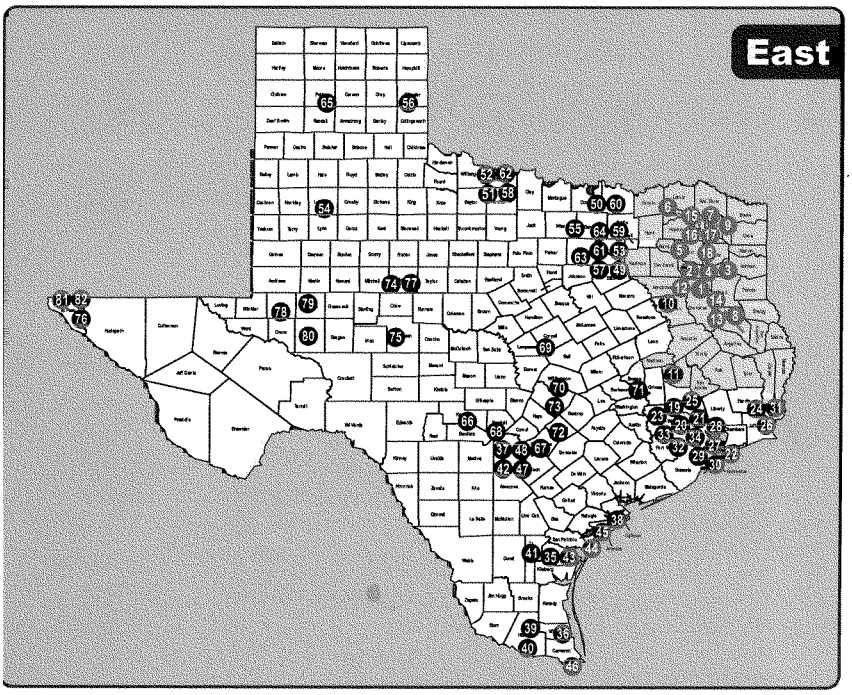
In the following case studies, we report information about the resident's condition when he or she was first admitted to the nursing facility; the treatment at the facility; the injuries that resulted because of the treatment; and, any regulatory consequences to the nursing home for the treatment. *This information is based solely upon reports of official government investigations or court records.* Information from court records, deposition testimony, sworn testimony offered in court, medical records, facility internal reports and records, facility investigations, facility personnel files, and other evidence is quoted or reported in the case studies which follow. With respect to information from government investigations, applicable findings of fact and of law by the government agency are quoted and summarized.

The Continuing Epidemic of Abuse and Neglect



This map identifies selected sites of nursing home abuse and neglect. Each case study has been assigned a unique number, which is referenced on the above map and grouped according to geographic region.

The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
1	Colenia C.	Tyler	Smith	E
2	Kenneth E.	Tyler	Smith	E
3	Lunnie C.	Longview	Gregg	E
4	Gertrude H.	Longview	Gregg	E
5	Myrtle G.	Mineola	Wood	E
6	Charlie D.	Paris	Lamar	E
7	Leatha B.	Mt. Pleasant	Titus	E
8	Payton M.	Nacogdoches	Nacogdoches	E
9	Ruby T.	Linden	Cass	E
10	James S.	Rusk	Anderson	E
11	Wardell F.	Huntsville	Walker	E
12	Dorothy B.	Tyler	Smith	E
13	JoAnn B.	Center	Shelby	E
14	Flossie S.	Kilgore	Rusk	E
15	Mildred S.	Mt. Pleasant	Titus	E
16	Mary W.	Mt. Pleasant	Titus	E
17	Howard C.	Mt. Pleasant	Titus	E
18	Velma C.	Gladewater	Upshur	E

1

Resident: Colenia C.

Nursing Home: Smith County

Location: Tyler, TX

Residency: 6/9/98 - 8/30/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 89;
- Life's Occupation: Homemaker and cook;
- Primary Diagnosis: Alzheimer's, dementia, psychosis, schizophrenia, and congestive heart failure;
- Unable to care for herself or provide food, water and shelter;
- Alert, responds to verbal stimuli.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- Stable condition;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **Specific TDHS Findings of Neglect and Fraud Regarding Colenia:**
  - **"The facility failed to prevent the development of multiple, avoidable pressure sores**...on this resident through inadequate care planning, positioning of the resident, poor preventive measures, and poor nutritional assessment and intervention."
  - **"Treatment records were repeatedly falsified."**
  - "Critical nutritional support was routinely omitted."
- **The Nursing Home:**
  - The Director of Nurses admitted the treatment nurse for Colenia **persistently failed to provide ordered wound care and manufactured fictitious assessments** on a frequent basis;
  - **Routinely falsified wound treatment records of Colenia;**
  - **Violated physician's orders to turn and reposition over 97% of the time;**
  - Destroyed or failed to document nurses notes for 51 days during the critical evolution of Colenia's pressure sores;
  - Repeatedly failed to notify physician of significant changes in Colenia's skin, pressure sores, nutritional status, and continually violated MD orders for nutritional support;
  - **Ignored Colenia's unrelenting pain with continual violations of physician's narcotic orders;**
  - **Violated physician's orders for pain medication 78% of the time.**

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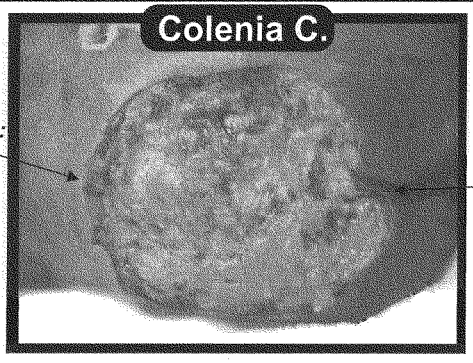
THE AFTER PICTURE: SEVERITY OF INJURIES

Colenia C.

Necrotic, Stage IV Sacral Pressure Sore: 20 cm Diameter, 6 cm Deep to Bone



- **Developed massive, in-house sacral wound (20 cm) to bone** which was infected and draining copious amounts of thick, odorous pus;
- Developed in-house, **Stage IV, left trochanter pressure sore, measuring 10 cm x 7 cm, with bone protruding** from the gaping, festering cavity surrounded by a 15 cm ridge of inflammation and fetid odor (6/24/99 – 8/30/99);
- Developed **9 avoidable in-house pressure sores** due to neglect;
- **Severe and unrelenting pain,** requiring morphine, as a consequence of massive pressure sores (6/11/99 – 12/31/99);
- Severe malnutrition with 50% depletion of visceral protein stores despite the presence of a PEG tube (7/17/98-8/30/99);
- Medical Expenses – $76,164.06.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?... Yes
- LVN Board Action?.....No
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....No
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

15

2

Resident: Kenneth E.

Nursing Home: Smith County

Location: Tyler, TX

Residency: 5/14/96 – 3/25/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 65;
- Life's Occupation: Security guard;
- Primary Diagnosis: Alzheimer's Disease;
- Needs assistance and supervision with activities of daily living;
- Cooperative, friendly.

Nursing Home's Description on Admit: (per MDS)

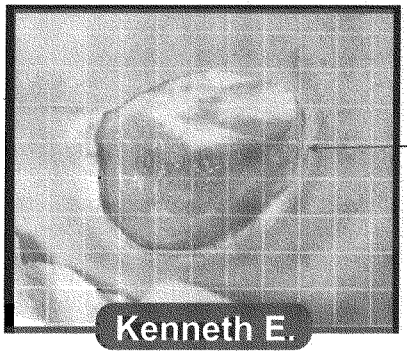
- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- Stable condition;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **The Hospital and Admitting Physician:**
  - **Reported to the State that Kenneth was a victim of nursing home neglect based on his grossly infected wounds and malnourished and dehydrated state on 7/20/97.**
- **TDHS Findings:**
  - **Substantiated the neglect of Kenneth;**
  - The facility was negligent in the areas of preventing hypernatremic dehydration in dependent residents, like Kenneth. TDHS also found that nursing home failed to assess, treat, and prevent pressure sore development in dependent residents such as Kenneth;
  - **The nursing homes practices jeopardized Kenneth's and other resident's health and safety;**
  - Cited facility for insufficient staff to meet the needs of the residents.
- **The Nursing Home:**
  - **Despite causing massive in house pressure sores, failed to medicate Kenneth for pain;**
  - Repeatedly failed to monitor the deterioration and growth of the coccyx pressure sore;
  - **Continuously failed to turn and reposition Kenneth resulting in massive wounds;**
  - **Repeatedly failed to follow the physician's orders for pressure sore treatments;**
  - Routinely violated facility policy regarding the provision of fluids and nutrition;
  - Persistently violated physician's orders to monitor Kenneth's blood sugar, resulting in diabetic crisis.

16 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES



Infected, Stage IV Sacral Pressure Sore: 24 cm x 6.8 cm, 5 Inches Deep to the Bone

- **Developed deadly, infected Stage IV pressure ulcer, measuring 24 cm x 6.8 cm x 5 inches in depth to the bone and spinal cord;**
- **Developed an avoidable Stage IV right hip pressure sore measuring 10 cm x 8.0 cm;**
- **Suffered gram positive septicemia of his spinal fluid and blood;**
- Kenneth suffered two episodes of dehydration, the latter resulting in a diagnosis of **hypernatremia and profound malnutrition;**
- **Physician assessment found 62 pressure areas that needed to be treated on Kenneth's body;**
- **Endured horrible continuous pain;**
- Death due to overwhelming sepsis from infected pressure sores;
- Medicare Expenses – $8,390.91.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....None
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

17

3

Resident: Lunnie C.

Nursing Home: Gregg County

Location: Longview, TX

Residency: 9/6/95 - 5/29/97

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 93;
- Life's Occupation: Housewife;
- Primary Diagnosis: Coronary artery disease, UTI, anemia, congestive heart failure, syncope and peripheral vascular disease;
- At nutritional risk because of swallowing problems.

Nursing Home's Description on Admit:

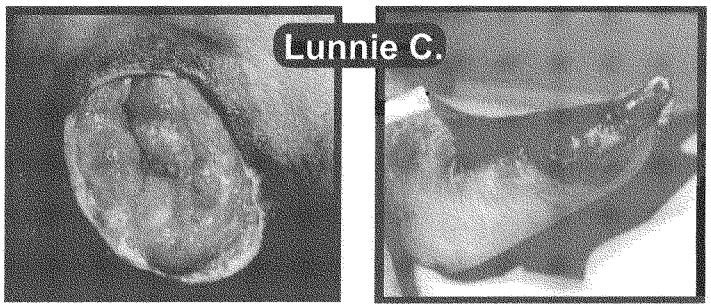
- **No pressure sores;**
- **No pain symptoms;**
- **No malnutrition;**
- **No dehydration;**
- No pain symptoms;
- No terminal illness;
- Within ideal body weight range;
- Dependent on staff for all basic needs.

A PROFILE IN NEGLECT: CORE FACTS

- **Hospital Physician Described Lunnie C. Upon Admittance:**
  - **"In general, Lunnie C. is very wasted, very cachectic. She is in horrible condition, there is a stench in the room, to the point of gagging me as well as the hospital staff that has been present in the room."**
- **TDHS:**
  - Cited the facility for pressure sore violations regarding Lunnie C.;
  - **Found the staff waited too long to turn the resident, to the point that Lunnie became uncomfortable, especially on the day and night shifts; any length of time past two hours is intolerable to the resident.**
- **Nursing Home Caregivers Admitted:**
  - When Lunnie would yell out for help or out of pain, the nurses and aides would just shut her door;
  - The facility was short of staff all the time;
  - They would find Lunnie "soaked from the top of the bed to the bottom";
  - Routine patient care was not being done, but was documented in medical records that it was.

18 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES



Stage IV, Left Hip Pressure Sore: 10 cm x 9 cm x 3 cm

Gangrenous, Left Foot Sore: 6 cm x 2 cm

- On admission to the hospital from the nursing home, the hospital discovered:
  - **Developed multiple Stage IV pressure sores down to the bone with osteomyelitis, abscess;**
  - **Severe malnutrition:** there was no evidence the dietician ever discussed Lunnie's nutritional state with her nurses or physician;
  - **Hypernatremic dehydration despite presence of feeding tube;**
  - Left foot amputation from severe unmanaged gangrene;
  - Sepsis;
  - **Unmanaged pain.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?...No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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4

Resident: Gertrude H.

Nursing Home: Gregg County

Location: Longview, TX

Residency: 8/22/98 – 4/12/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 87;
- Occupation: Homemaker;
- Primary Diagnosis: osteoarthritis, hypertension, congestive heart failure and urinary incontinence;
- Unable to care for herself or provide food, water or shelter;
- Alert, pleasant, aware of surroundings.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- **No end-stage disease;**
- Stable condition;
- Alert and oriented;
- Could ambulate around her room.

A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Stated:**
  - **"This is one of the worst cases of neglect I have ever seen."**
  - "I was shocked by the condition of the pressure sores. I was never informed of the deterioration."
  - "I have no doubt that **Gertrude experienced severe and unrelenting pain from June 27, 2000 to February 6, 2001,** from the deep, eroding pressure sores."
- **TDHS:**
  - **Cited the facility for the neglect of Gertrude;**
  - Repeatedly warned the facility of dangerous care practices.
- **Confessions of Neglect:**
  - **The administrator admitted the facility was in "desperate shape" due to the understaffing;**
  - **The charge nurses and registered dietician admitted Gertrude was grossly neglected.**
- **The Nursing Home:**
  - Engaged in pattern and practice of dangerous understaffing;
  - Destroyed personnel files and timecards to cover up it's practice of understaffing;
  - **Despite dangerous understaffing, the facility sought more heavy care patients;**
  - Falsified care records on a wholesale basis;
  - **Failed to turn and reposition, which led to deterioration to life-threatening pressure sores;**
  - Ignored Gertrude's severe and ongoing pain caused by massive pressure sores (6/27/00 – 2/6/01).

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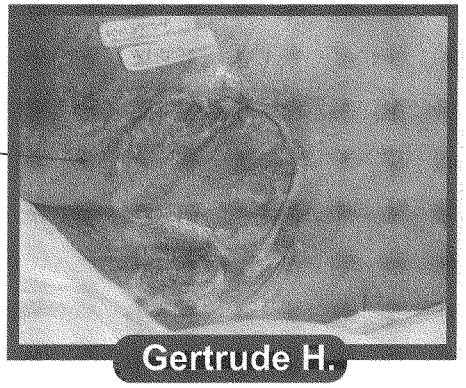
THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Stage IV Coccyx Pressure Sore: 22 cm Diameter, 2 cm Deep



- **Developed a 10" in diameter, 3/4" deep, Stage IV sacral/coccyx pressure sore with sloughing yellow drainage**, with diagnosis of sepsis (by 4/12/01);
- Developed **8 avoidable, in-house pressure sores;**
- Hospitalized at least **4 times for dehydration;**
- **90 lb weight loss** from 4/15/99 to 4/11/01;
- Excruciating, ongoing pain from 6/27/00 to 4/12/01;
- Cause of death: infected pressures and gross neglect (4/12/01);
- Hospital Expenses - $95,765.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?..Yes
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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5

Resident: Myrtle G.

Nursing Home: Wood County

Location: Mineola, TX

Residency: 9/17/97 - 1/21/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 90;
- Life's Occupation: Nursing home dietary employee;
- Primary Diagnosis: Hypertension, left hip fracture and diabetes;
- Dependent on nursing home for all needs.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No nutritional problems or weight loss for last 180 days;**
- **No dehydration;**
- Stable condition;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

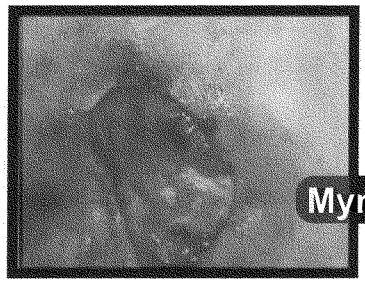
- **The Attending Physician Testified:**
  - **" Myrtle became dehydrated due to the fact that nursing home provided less than one third of her fluid needs."**
  - **"The nursing home never informed me of the deterioration of her wounds."**
  - **"The facility never notified me that Myrtle was septic in appearance."**
- **The Nursing Home:**
  - **Persistently failed to administer Myrtle's tube feeding as ordered;**
  - **Routinely failed to provide required fluids through Myrtle's G–tube;**
  - Routinely violated physician's orders to turn and reposition resulting in massive sores;
  - Repeatedly failed to assess and notify physician of significant changes in Myrtle's skin, weight and hydration status;
  - **Was unaware or indifferent to massive sores developed by Myrtle in the nursing home** (See photos on opposite page, taken at time of hospitalization when wounds were discovered.);
  - Continually failed to provide pain medication.

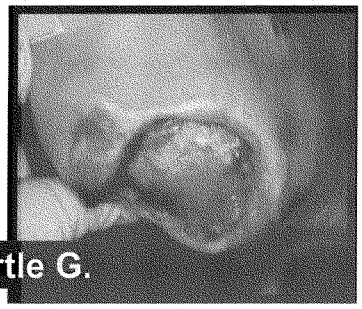
22

Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Stage IV Sacral Pressure Sore: 7.5 cm x 5 cm





Osteomyletic, Stage IV Left Heel Pressure Sore: Entire Heel Eroded

- Developed **in-house Stage IV sacral pressure sore, measuring 7.5 cm x 5 cm**, severely infected and necrotic, with underlying abscesses requiring surgical debridement – hospital discovered;
- Developed **in-house Stage IV, infected, necrotic left heel pressure sore**, to the bone, encompassing the entire heel, creating osteomyelitis;
- **26 lb weight loss in 4 months, despite PEG feeding tube;**
- **Dehydration;**
- **Excruciating pain, requiring morphine as a consequence of pressure sores (3 months);**
- Death due to infected pressure sores (1/21/98);
- Medicare Expenses – $13,058.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?...No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

23

6

Resident: Charlie D.

Nursing Home: Lamar County

Location: Paris, TX

Residency: 10/24/97 - 12/11/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 85;
- Life's Occupation: Farmer;
- Primary Diagnosis: Alzheimer's, probable CVA, hypertension and history of prostate cancer;
- Dependent on staff for basic needs.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No malnutrition;**
- **No dehydration;**
- No terminal illness;
- No end-stage disease;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **The Hospital Social Worker:**
  - **Called this "the worst case of adult neglect I have ever seen".**
- **TDHS:**
  - **Cited the facility on 2 separate occasions for the neglect of Charlie;**
  - Repeatedly cited the facility for neglect.
- **The Facility's Director of Nurses Said:**
  - **Budgetary cuts by the new corporate owner created a staffing and care crisis;**
- **The Attending Physician Stated:**
  - **"The routine violation of my treatment orders was unacceptable, and certainly had adverse consequences for Charlie."**
  - **"I should have been notified by the facility of the resident's significant weight loss. I was not. There was no excuse for Charlie to lose weight after he got the PEG tube."**
- **The Nursing Home:**
  - **Routinely failed to reposition Charlie, causing massive pressure sores;**
  - Repeatedly failed to notify the physician of pressure sore development and deterioration;
  - Repeatedly deprived Charlie of needed fluids;
  - Continually violated physician's orders for pain medication (11/17/97 – 12/11/98);
  - Engaged in pattern and practice of dangerous understaffing.

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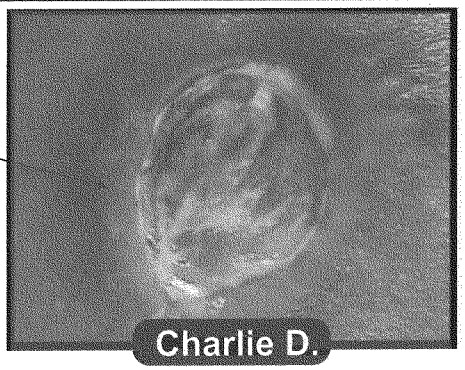
THE AFTER PICTURE: SEVERITY OF INJURIES

Necrotic, Stage IV Right Hip Pressure Sore: 8 cm Diameter



- **Developed necrotic right hip pressure sore, measuring 8 cm, and a left hip pressure sore measuring 7 cm x 5 cm and 6 cm x 4 cm: both were Stage IV, with necrosis and putrid drainage;**
- **The necrotic pressure sores required 36 surgical debridements;**
- **Developed 10 avoidable, in-house pressure sores,** 6 of which became Stage III and Stage IV wounds;
- **37 lb weight loss in less than 2 months** despite the placement of a PEG tube (11/25/97-1/21/98);
- **Hypernatremic dehydration** caused by deprivation of basic fluids;
- Severe and unrelenting pain from massive pressure sores (11/17/97 – 12/11/98);
- Death caused by infected pressure sores (12/11/98);
- Medicare Expenses – $14,535.54.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to the AG?.....No
- Did the AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes, 2 times
- LNFA Board Action?.....Yes,
  1. 20 hrs CE, 2. Dismissed, lack of evidence.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?...Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

25

7

*** Resident: Leatha B. (Resident #12)**

Nursing Home: Titus County

Location: Mt. Pleasant, Texas

Date of Investigation: 4/13/00

File No. 7

THE BEFORE PICTURE

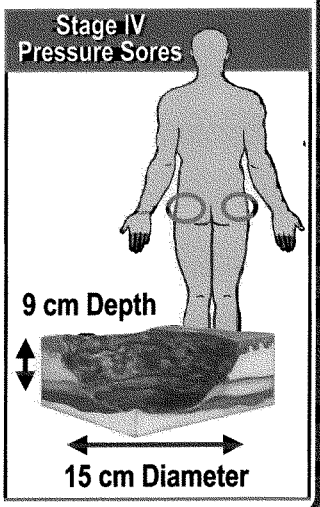
Profile of Resident on Admit to Nursing Home:

- Age: 86;
- Primary diagnosis: Congestive heart failure, arthritis, weight loss with feeding tube insertion;
- This was helpless, totally dependent nursing home resident who required that her total care needs be met by the nursing home staff;
- **No pressure sores noted on admission to the nursing home.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 24th day of March 2000, Leatha B. was admitted to the hospital, where the following conditions were discovered:
  - **Right hip pressure sore, Stage IV, measuring 15 cm x 15 cm with depth and undermining of 9 cm, 100% necrotic tissue, foul odor, and copious drainage.**
  - **Left hip pressure sore, Stage IV, measuring 5 cm x 4 cm, with a depth and undermining of 7.5 cm, 100% necrotic tissue, and very foul odor.**
  - Culture and sensitivity of these pressure sores revealed multiple organism infections with sepsis.
  - Due to the severity of the wounds, **Leatha B. required extensive surgical debridement and a diverting loop colostomy to keep stool out of the massive pressure sores.**
  - **Leatha B. was also found to have severe protein calorie malnutrition, with an albumin level of 1.5, despite the presence of a feeding tube.**
  - **The emergency room described Leatha B. as being hot to touch, with a temperature of 105 degrees, with foul smelling pus oozing from her bilateral hip wounds.**



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*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - TDHS determined that Leatha B.'s pressure sores were an avoidable and preventable occurrence.
- **Evidence of Neglect:**
  - **The hospital complained that Leatha B. was the victim of nursing home neglect.**
  - **TDHS substantiated the hospital complaint of neglect of Leatha B.**
  - **TDHS determined that Leatha B.'s attending physician had not been notified of the resident's worsening pressure sores.**
  - **TDHS found the nursing home failed to provide adequate numbers of licensed nursing staff to meet the needs of residents, placing all residents, including Leatha B., in immediate jeopardy for their health and safety.**
  - TDHS determined the facility failed to ensure that pressure sore treatments were administered as ordered.

TDHS determined that the facility diluted Leatha's tube feedings, resulting in her receiving only half of the ordered calories.

- **Evidence of Neglect (Cont.):**
  - TDHS determined the facility violated M.D. orders for tube feedings.
    - **TDHS determined that the facility diluted Leatha B.'s tube feedings, resulting in her receiving only half of the ordered calories.**
    - **TDHS found that the nursing home had no full-time administrator and no full-time registered nurse.**
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) by failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.1001(1)(A)(i) – the facility failed to maintain sufficient staff to meet the needs of residents.
  - 40 TAC §19.1601(1)(C) and 40 TAC §19.1601(3) and 40 TAC §19.1601(C) – facility failed to maintain an effective infection control program 40 TAC §19.1902(a)(1) – administration. The facility was not administered in a manner that enabled it to use its resources effectively and efficiently.

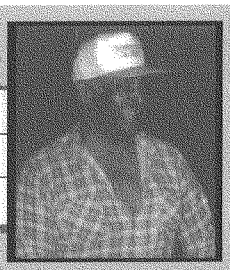
ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....Yes
- Did TDHS recommend denial of payment for new admissions for this neglect?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?....No
- Did TDHS place nursing home on state monitoring status due to this neglect?...Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

27

8

Resident: Payton M.



Nursing Home: Nacogdoches County

Location: Nacogdoches, TX

Residency: 12/16/99 - 5/19/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 75;
- Life's Occupation: Construction;
- Primary Diagnosis: Diabetes mellitus, CVA, dementia and hypertension;
- Totally dependent on nursing staff for all needs;
- Bed-bound but alert.

Nursing Home's Description on Admit: (per MDS)

- **No dehydration;**
- **No malnutrition;**
- **No pain symptoms;**
- No end stage disease;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - Consistently failed to turn and reposition Payton;
  - Failed to perform pressure sore risk assessments and did not complete weekly skin sheets for at-a-glance data about the pressure sore;
  - **Repeatedly violated the physician's orders for hydration, blood glucose monitoring and gastrostomy tube feedings;**
  - Failed to maintain accurate records – pressure sore notes were conflicting;
  - Continuously failed to monitor Payton's fluid intake and output and did not collaborate with the Registered Dietician, resulting in dehydration and malnutrition;
  - Falsified documentation in the clinical record;
  - Failed to keep the physician informed regarding the condition of the pressure sore or deterioration in nutrition/hydration status;

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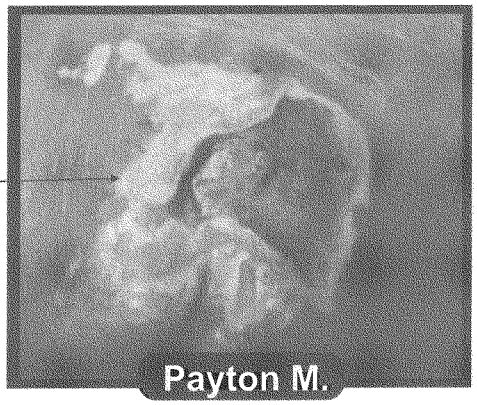
THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Necrotic Coccyx Stage IV Pressure Sore: 10 cm x 9.9 cm, 2.1 cm Deep



- **Developed a Stage IV necrotic, infected coccyx pressure sore, measuring 10 cm x 9.9 cm x 2.1 cm;**
- **Hospitalized 4 times for hypernatremic dehydration;**
- **Suffered dangerously extreme hyperglycemia which required hospitalization;**
- Severe weight loss, despite presence of gastrostomy tube;
- Medical Expenses – $47,921.88.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

29

9

Resident: Ruby T.

Nursing Home: Cass County

Location: Linden, TX

Residency: 4/30/97 - 2/16/02

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 82;
- Life's Occupation: Owned/Managed restaurant;
- Primary Diagnosis: Dementia;
- Wheelchair bound;
- Required assistance and supervision with activities of daily living.

Nursing Home's Description on Admit: (per MDS)

- **No pressures sores;**
- **No dehydration;**
- **No malnutrition;**
- No end-stage disease;
- No terminal illness;
- Medically stable;
- Good rehabilitation candidate.

A PROFILE IN NEGLECT: CORE FACTS

- **Key Direct Care Staff, Including The Director of Nurses, Admitted:**
  - Nursing home was short staffed on a routine basis;
  - **Understaffing at facility posed a threat to the health and safety of residents, including Ruby;**
  - Turning and incontinent care greatly suffered due to lack of staff;
  - ADL sheets, including food intake, were routinely falsified.
- **Specific TDHS Findings:**
  - **Findings of neglect relating to Ruby based on an investigation of complaints given by the former director of nurses;**
  - **Substantiated allegations specific to Ruby of failure to prevent, assess and treat pressure sores.**
- **The Nursing Home:**
  - Failed to implement any pain management program, despite severe pain;
  - Resident was sexually abused, but incident never reported to TDHS by nursing home (3/23/99);
  - **Ongoing violation of nutritional recommendations for 4 months, despite weight loss;**
  - From the time Ruby was identified as being at high risk for developing pressure sores, the facility had a **greater than 60% failure rate of turning and repositioning** (5/24/00-12/31/00);
  - Engaged in chronic and severe understaffing.

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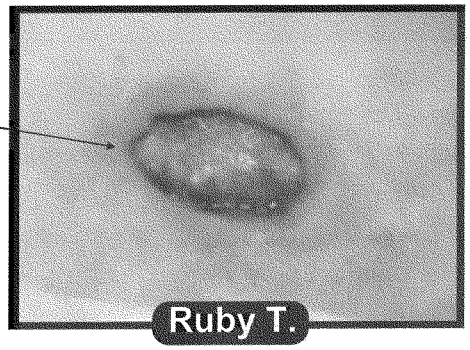
Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Left Hip Pressure Sore: 11 cm x 8 cm, 3.75 cm Tunneling



- Developed life-threatening, necrotic, Stage IV pressure sore of the left hip, measuring 11 cm x 8 cm, tunneling down to a depth of 3.5 cm;
- Left hip wound resulted in 4 hospitalizations;
- Developed at least **10 in-house pressure sores** (2/26/00 - 5/31/01);
- **63 lb weight loss** (6/23/99 - 2/9/01);
- **Hospitalized at least 5 times for dehydration** (4/24/00-7/11/01);
- Became totally bedfast and dependent with contractures (by 7/5/01);
- **Continual, excruciating pain from Stage IV wound for over 8 months (6/5/01 - 2/16/02);**
- Death due to infected wound (2/16/02);
- Hospital Expenses – $67,298.50.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

31

10

*** Resident: James S. (Resident #12)**
Nursing Home: Cherokee County
Location: Rusk, Texas
Date of Investigation: 1-10-00
File No. 5

THE BEFORE PICTURE

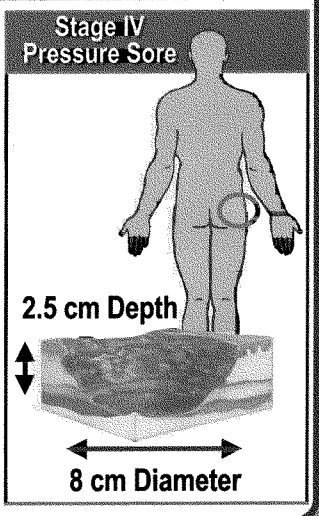
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Urinary retention, chronic schizophrenia, hypertension, history of CVA and Alzheimer's disease;
- Helpless; totally dependent upon nursing home staff for basic care needs;
- **No pressure sores upon admission.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 1/2/00, James S. was hospitalized in the critical care unit where the hospital discovered a Stage IV right hip pressure sore, measuring 8 cm x 6 cm, with a depth of 2.5 cm, with eschar in the center.**
- On admit to the hospital, James S. weighed only 86 pounds, with severe malnutrition, and weight loss of 24 pounds in 2 1/2 months suffered at the nursing home.
- **Severe hypernatremic dehydration was present upon hospital admission, with a 5 liter fluid deficit, complicating wound healing.**
- The physician was not informed of the resident's deterioration until James' blood pressure was down to nearly shock level.
- The attending physician documented "the patient is critically ill" with profound cachexia, malnutrition, Stage IV pressure sores, and profound hypernatremia.



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*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **TDHS found that the facility had not provided treatments for this right hip pressure sore.**
  - The right hip pressure sore was not assessed and documented by the facility with severe deterioration over several weeks.
  - **James S.'s complaints of pain were not assessed or reported to the physician.**
  - The facility failed to assess James when his condition changed, failed to follow up with the attending physician in regards to laboratory reports with abnormal values.
  - No proof the facility monitored James S.'s intake and output.
  - **The infected pressures sores, combined with hypernatremic dehydration, caused life-threatening septic shock.**

TDHS found that the facility had not provided treatments for this right hip pressure sore.

- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - failing to prevent and treat pressure sores
  - 40 TAC §19.901, §19.1010(a) - failing to maintain highest quality of care by failing to assess James S. with regards to his continuing to refuse foods and fluids and complaints of abdominal pain.
  - 40 TAC §19.901(9)(A) - failing to ensure that resident maintains acceptable parameters of nutrition status, avoiding weight loss and malnutrition.
  - 40 TAC §19.901(10) - failing to provide each resident with sufficient fluid intake to maintain proper hydration and health, preventing dehydration.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$40,950
- Amount of fine paid?.....$12,350
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes

  $500 AP & 20 hrs facility mgmt CE.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

33

11

Resident: Wardell F.

Nursing Home: Walker County

Location: Huntsville, TX

Residency: 11/29/95 - 4/9/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 80;
- Occupation: Farmer;
- Primary Diagnosis: Diabetes mellitus with hypertension and arthritis;
- Unable to care for himself or provide food, water and shelter;
- Alert, friendly.

Nursing Home's Description on Admit:

- **No dehydration;**
- **No malnutrition;**
- **No end-stage disease;**
- Stable condition;
- No terminal illness;
- Not able to bear weight and required a geri-chair.

A PROFILE IN NEGLECT: CORE FACTS

- **Emergency Room Physician's Description of Wardell:**
  - **Starvation; dehydration;** azotemia; rule-out sepsis.
- **The Nursing Home:**
  - **Continuous failure to follow physician orders regarding pressure sore preventive measures: (turning, repositioning) resulting in 24 in-house pressure sores;**
  - Routinely failed to assess nutritional status and comply with nutritional orders;
  - **Repeatedly failed to contact physician in a timely manner regarding Wardell's multiple pressure sores;**
  - Failed, on an ongoing basis, to establish a program to assess and alleviate Wardell's pain;
  - Ignored repeated TDHS citations and warnings concerning substandard and negligent patient care;
  - Engaged in a practice of understaffing, which is corroborated by huge gaps in the medical records during critical stages of Wardell's residency.

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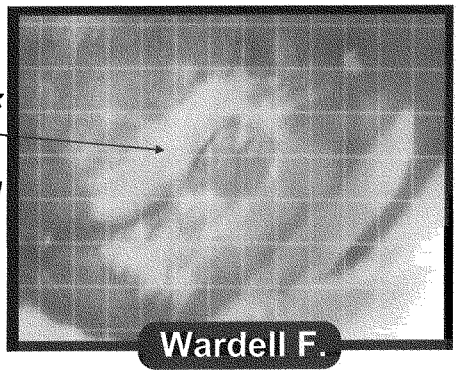
THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Stage IV, Foul-Smelling Coccyx Pressure Sore: 10 cm x 7 cm, 5 cm Deep, Developed in the Nursing Home



- **Developed Stage IV**, foul-smelling, deep, necrotic, infected tunneling pressure sore that was **10 cm x 7 cm with a depth of 5 cm;**
- **Developed 24 in-house pressure sores in the nursing home;**
- **40 lb weight loss** (1/99 – 3/00);
- **Severe dehydration and malnutrition;**
- **Excruciating pain, untreated (1/7/00 – 4/9/00);**
- Death certificate: death due to septicemia from multiple decubitus ulcers (4/9/00);
- Hospital Expenses – $14,730.83.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

35

12

Resident: Dorothy B.

Nursing Home: Smith County

Location: Tyler, TX

Residency: 2/15/00 – 5/26/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Hypertension, gastritis, CVA and urinary tract infection;
- Friendly and cooperative.

Nursing Home's Description on Admit: (per MDS)

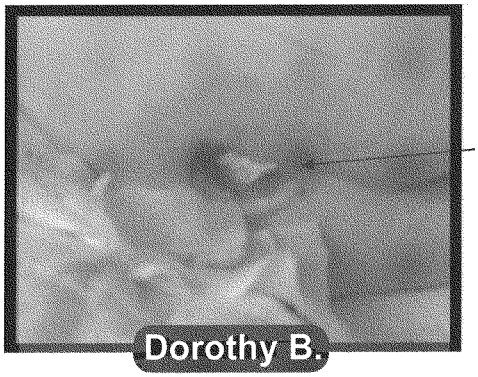
- **No pressure sores;**
- **No pain symptoms;**
- **No malnutrition;**
- No contractures;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **The Facility Charge Nurses Admitted:**
  - "Her pressure sores were rotting flesh. The odor would turn anybody's stomach."
  - "Dorothy's sores were preventable; treatments were not done as ordered."
  - "Residents at this nursing home were frequently left laying in their own urine and feces for hours."
- **Specific TDHS findings for Dorothy (4/18/01 and 5/24/01):**
  - **Failure to prevent, assess and treat pressure sores;**
  - **Failure to notify the physician and family of significant changes in Dorothy's condition;**
  - **Lack of prevention of weight loss and malnutrition;**
  - **Failure to prevent dehydration;**
  - **Facility failed to promote healing of Dorothy B.'s pressure sore.**
- **The Nursing Home:**
  - **Repeatedly violated physician's pressure sore treatment orders;**
  - Engaged in severe and chronic understaffing;
  - Failed to address Dorothy's ongoing pain.

36 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES



Stage IV Coccyx Pressure Sore: 8.2 cm x 8.1 cm

- **Developed Stage IV coccyx pressure sore, measuring 8.2 cm x 8.1 cm, 90% black eschar,** 10% slough, with foul odor and erythema;
- **Developed multiple avoidable in-house pressure sores;**
- **Developed life-threatening infection of pressure sores;**
- 18 lb weight loss in a period of under three months despite presence of PEG tube (1/1/01 - 3/29/01);
- **Suffered unrelenting pain due to pressure sores;**
- Developed contractures and limitation of functional ability and mobility;
- Hospital Expenses – $231,077.35.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?..Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

37

13

Resident: JoAnn B.

Nursing Home: Shelby County

Location: Center, TX

Residency: 9/24/98 - 2/6/99 & 5/12/99 - 9/1/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 64;
- Life's Occupation: Education coordinator;
- Primary Diagnosis: Syncope, diabetes mellitus, hypertension, depression and Bell's Palsy;
- Assistance with grooming and bathing but able to feed self;

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- No pain symptoms;
- No terminal disease;
- Wheelchair bound.

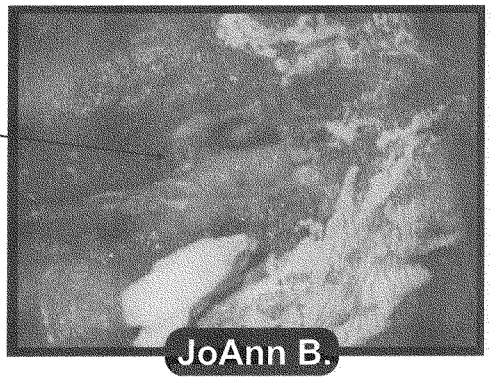
A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Continuously violated the physician's orders to turn and reposition JoAnn, resulting in a massive Stage IV pressure sore;**
  - **Persistently violated the physician's orders for pain medication for JoAnn's massive, painful pressure sores;**
  - Repeatedly violated the physician orders for pressure sore treatments;
  - Failed to timely and accurately assess and monitor the pressure sores;
  - Repeatedly failed to monitor the intake and output of JoAnn, which resulted in hypernatremic dehydration.

Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Necrotic, Stage IV Coccyx Pressure Sore: 9 cm x 7.8 cm, 3.3 cm Deep



- **Developed an infected, Stage IV coccyx pressure sore, measuring 9 cm x 7.8 cm x 3.3 cm, with tunneling of 2.3 cm, and requiring surgical debridement;**
- Developed a Stage III pressure sore to the left ear;
- **Hospitalized 2 times for hypernatremic dehydration;**
- **16 lb weight loss and malnutrition, despite the presence of a feeding tube;**
- Medical Expenses – $80,482.93.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?...No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

39

14

Resident: Flossie S.

Nursing Home: Rusk County

Location: Kilgore, TX

Residency: 7/11/90 – 9/9/95

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 92;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Dysphagia, dementia and congestive heart failure;
- Ambulatory, pleasant and cooperative.

Nursing Home's Description on Admit:

- **No pressure sores;**
- **No symptoms of pain;**
- **No malnutrition;**
- **No dehydration;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Failed to prevent the development pressure sores;**
  - Failed to identify the development of pressure sores and implement treatment;
  - Failed to recognize signs and symptoms of infection in pressures sores;
  - **Failed to prevent physical abuse to Flossie.**
- **TDHS Findings Specific to Flossie:**
  - **Cited facility for failing to have sufficient staff to meet the needs of the residents;**
  - **Cited facility for failing to have trained and competent certified nurse aides;**
  - Cited facility for failing to notify the physician and family of a significant change in condition;
  - Cited facility for failing to provide necessary care services to ensure residents received appropriate and consistent assessment and treatment with acute changes in physical condition;
  - Cited facility for failing to prove necessary individual care to residents;
  - Cited facility for failing to assess residents' need for proper assistance during meals.

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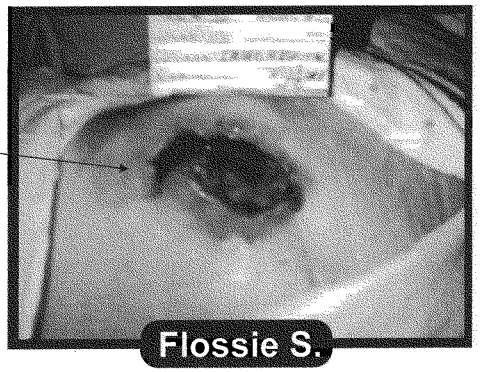
THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV, Infected Coccyx Pressure Sore: 11 cm x 6 cm; Discovered by Hospital, Developed at Nursing Home



- **Developed Stage IV, infected pressure sore to left hip, measuring 14 cm x 7 cm, which was discovered during Flossie's hospitalization;**
- Multiple, avoidable, in-house, Stage III, infected pressure sores;
- Severe and unrelenting pain as a consequence of multiple and severe pressures sores;
- **Hospitalized 2 times for hypernatremic dehydration;**
- **Physically abused by the staff** of the nursing home;
- Significant weight loss despite the presence of a gastrostomy tube;
- Medicare Expenses -$13,801.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?..... *
- Amount of fine paid?.....*
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?..... *
- Did TDHS recommend denial of payment for new admissions?..... .....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?....*
- Did TDHS place nursing home on state monitoring status?.... ..... *
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations – data unavailable.

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5

* **Resident: Mildred S. (Resident #3)**

Nursing Home: Titus County

Location: Mt. Pleasant, Texas

Date of Investigation: 4-13-00

File No. 6

THE BEFORE PICTURE

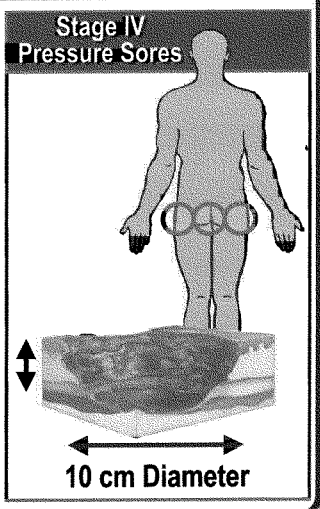
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Alzheimer's disease with brain injury, congestive heart failure, constipation, endarterectomy, history of hip fracture, hypertension, hypothyroidism and weight loss;
- Mildred S. was a totally dependent, helpless resident due to post CVA residual weakness and paresis;
- **No pressure sores noted on admission to the nursing home.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 3/24/00, Mildred S. was admitted to a hospital, where the following severe infected pressure sores were discovered:
  - **Left hip pressure sore was a Stage IV, measuring 10 cm x 9 cm with 2 areas of eschar in the center. The right hip pressure sore was also a Stage IV, measuring 8 cm x 6 cm with 4 cm depth, and undermining. The sacrum was a Stage IV pressure sore, measuring 7 cm x 6 cm, with undermining. Three of these Stage IV pressure sores had a foul odor with obvious necrosis.**
  - Mildred suffered a **26 lb weight loss with an albumin level down to 1.5,** indicating severe visceral protein depletion, complicating healing of pressure sores and diminishing her quality of life.
  - **Extensive debridement surgery was required,** as well as a diverting loop colostomy to treat these pressure sores, which had deteriorated severely.
  - Pressure sores on Mildred S. were found to be infected with staph, Pseudomonas aeruginosa, Klebsiella pneumoniae, and Morganella morganii.



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The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - TDHS had been in the facility approximately 5 weeks prior to 4/13/00 and found that **this resident had developed in-house avoidable pressure sores, which were not receiving treatment or being assessed and monitored weekly.**
  - Despite the resident's worsening pressure sores and significant weight loss, the facility failed to have a dietician reassess the resident, which was the plan of correction for the deficiency that was cited in the previous 5 weeks for this resident.
- **Evidence of Neglect:**
  - **TDHS found the facility had such a severe problem with in-house pressure sore development and worsening of existing pressure sores, that immediate jeopardy to residents' health and safety was found, as well as substandard quality of care.**

...the facility had such a severe problem with in-house pressure sore development and worsening of existing pressure sores that immediate jeopardy to residents' health and safety was found.

- **Evidence of Neglect (Cont.):**
  - TDHS noted the facility failed to ensure adequate licensed nursing staff to meet the needs of the residents. The findings represented widespread immediate jeopardy to residents' health and safety.
    - The facility did not have a full time licensed nursing facility administrator, the DON had resigned, and there was only one other RN employed at the facility, on a part-time basis.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.1001(1)(A)(i) – failed to maintain sufficient staff to meet the needs of residents.
  - 40 TAC §19.1601(1)(C) and 40 TAC §19.1601(3) and 40 TAC §19.1601(C) – failed to maintain an effective infection control program.
  - 40 TAC §19.1902(a)(1) – the facility was not administered effectively and efficiently.
  - 40 TAC §19.1910(1)(2) - failed to maintain clinical records that were complete, accurately documented, readily accessible, and systematically organized.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility? .....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Mary W. (Resident #4)**
Nursing Home: Titus County
Location: Mt. Pleasant, Texas
Date of Investigation: 4-13-00
File No. 8

THE BEFORE PICTURE

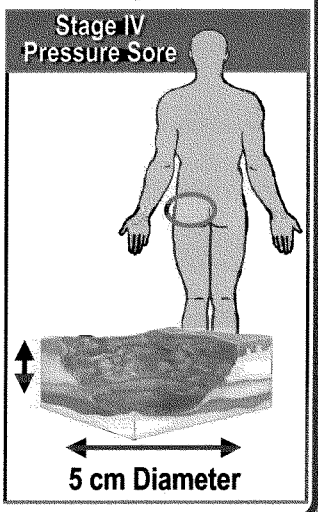
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Anxiety, congestive heart failure, constipation, edema, and thromophlebitis of the leg;
- Helpless, totally dependent nursing home resident who required that her total care needs be met by the nursing home staff;
- **No pressure sores noted on admission to the nursing home.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 4/6/00, Mary S. was hospitalized, where the following was discovered:
  - **Stage IV pressure sore to the left hip**, which measured 5 cm x 5 cm, with yellow slough and foul odor due to infection;
  - **Additionally, Mary W. was discovered to have developed severe hypernatremic dehydration with deadly sodium levels of 182,** with BUN elevated to 53.4, and chlorides very high at 134;
  - **Further, Mary W. was found to be extremely malnourished, with severe visceral protein depletion, with a panic albumin level of 1.2;**
  - **The hospital filed a complaint with TDHS that Mary W. was the victim of nursing home neglect.**



44

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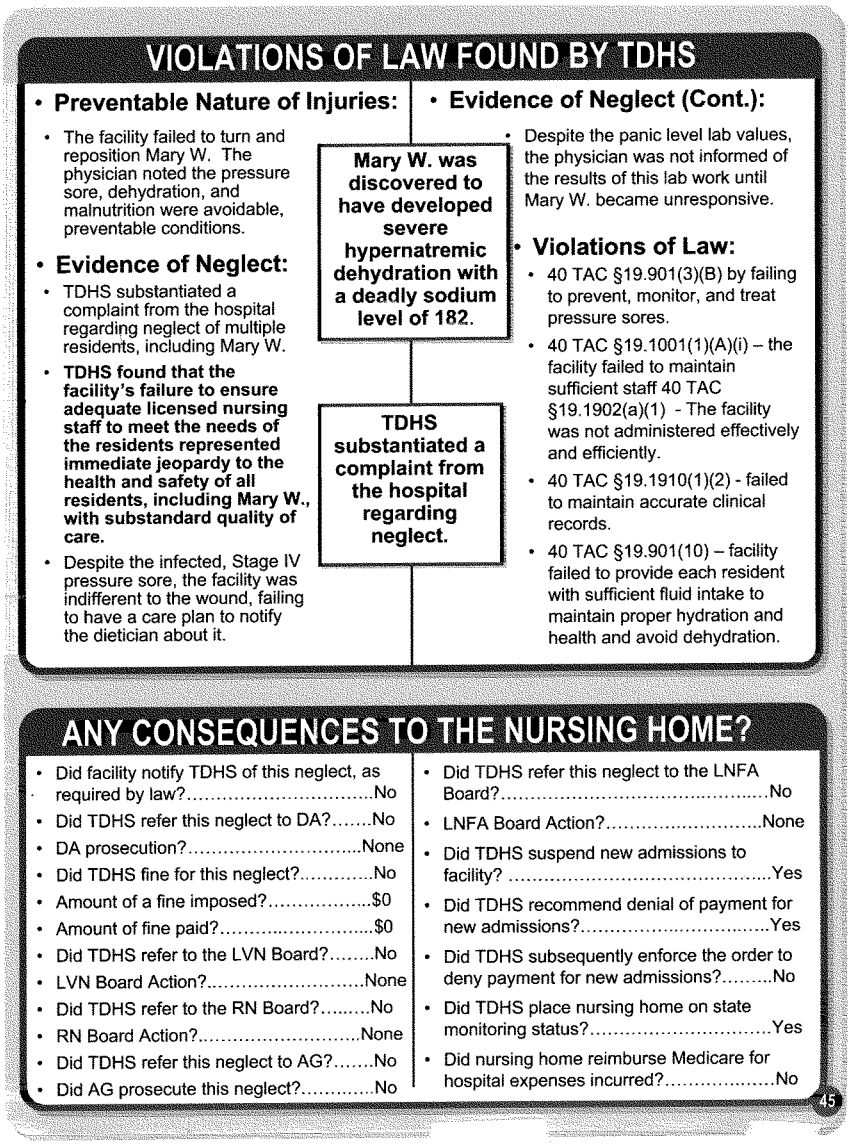
VIOLATIONS OF LAW FOUND BY TDHS
• Preventable Nature of Injuries:
• The facility failed to turn and reposition Mary W. The physician noted the pressure sore, dehydration, and malnutrition were avoidable, preventable conditions.
• Evidence of Neglect:
• TDHS substantiated a complaint from the hospital regarding neglect of multiple residents, including Mary W.
• TDHS found that the facility's failure to ensure adequate licensed nursing staff to meet the needs of the residents represented immediate jeopardy to the health and safety of all residents, including Mary W., with substandard quality of care.
• Despite the infected, Stage IV pressure sore, the facility was indifferent to the wound, failing to have a care plan to notify the dietician about it.
Mary W. was discovered to have developed severe hypernatremic dehydration with a deadly sodium level of 182.
TDHS substantiated a complaint from the hospital regarding neglect.
• Evidence of Neglect (Cont.):
• Despite the panic level lab values, the physician was not informed of the results of this lab work until Mary W. became unresponsive.
• Violations of Law:
• 40 TAC §19.901(3)(B) by failing to prevent, monitor, and treat pressure sores.
• 40 TAC §19.1001(1)(A)(i) – the facility failed to maintain sufficient staff 40 TAC §19.1902(a)(1) - The facility was not administered effectively and efficiently.
• 40 TAC §19.1910(1)(2) - failed to maintain accurate clinical records.
• 40 TAC §19.901(10) – facility failed to provide each resident with sufficient fluid intake to maintain proper hydration and health and avoid dehydration.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....No
• Amount of a fine imposed?.....$0
• Amount of fine paid?.....$0
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....No
• RN Board Action?.....None
• Did TDHS refer this neglect to AG?.....No
• Did AG prosecute this neglect?.....No
• Did TDHS refer this neglect to the LNFA Board?.....No
• LNFA Board Action?.....None
• Did TDHS suspend new admissions to facility?.....Yes
• Did TDHS recommend denial of payment for new admissions?.....Yes
• Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
• Did TDHS place nursing home on state monitoring status?.....Yes
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
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17

*** Resident: Howard C. (Resident #14)**
Nursing Home: Titus County
Location: Mt. Pleasant, Texas
Date of Investigation: 4/13/00
File No. 9

THE BEFORE PICTURE

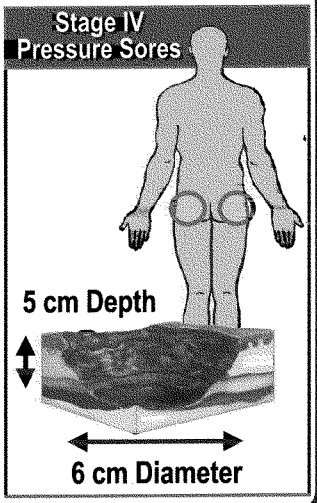
Profile of Resident on Admit to Nursing Home:

- Age: 89 at time of TDHS survey;
- Primary diagnosis: Psychosis, paranoid schizophrenia, urinary retention with neurogenic bladder, Alzheimer's disease with dementia, and congestive heart failure;
- Helpless, dependent nursing home resident who required 2 person assist by nursing home staff to meet all of his needs;
- Upon admission to the facility, Howard C. had a Stage II, 1 cm x 1 cm pressure sore to the left hip, as well as a .5 cm x 1 cm pressure sore to the right hip.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On the 9th day of April 2000, TDHS discovered Howard C. had the following conditions:
  - **Stage IV, right hip pressure sore, measuring 6 cm x 4 cm with a depth of 5 cm, extensive undermining and a thick layer of purulent, gray-brown, foul-smelling drainage;**
  - **Stage IV, left hip pressure sore, measuring 5 cm x 5 cm, with a depth of 5 cm, and extensive undermining and a thick layer of purulent, gray-brown, foul smelling drainage.**



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*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
- TDHS determined that the nursing home engaged in a practice of neglect which contributed to Howard C.'s declining weight, declining protein status, and pressure sores.
- TDHS concluded that the **nursing home's neglectful practices placed all tube fed residents, including Howard C., at immediate jeopardy for malnutrition.**
- **TDHS observations of Howard C.'s care revealed that the nursing home was routinely violating ordered wound care treatments, thus putting this resident at risk for infection and further wound deterioration.**
- **TDHS observations of Howard C.'s tube feedings reveal that feedings were diluted and providing only half of the calories ordered and needed.**
- The Director of Nurses for the nursing home admitted that Howard C.'s **tube feedings were providing only half of the calories needed.**

The 'acting' administrator admitted that 6 tube-fed residents, including Howard C., had received only half of the formula they should have received for an undetermined length of time.

- **Evidence of Neglect (Cont.):**
- **TDHS further found that Howard C. and other tube fed residents' feeding formula was contaminated and were at risk for food borne illness.**
- TDHS determined that the failure by the facility to ensure adequate licensed nursing staff to meet the needs of residents represented widespread immediate jeopardy to residents' health and safety.
- **Violations of Law:**
- 40 TAC §19.901(3)(B) by failing to prevent, monitor, and treat pressure sores.
- 40 TAC §19.1001(1)(A)(i) – the facility failed to maintain sufficient staff to meet the needs of residents.
- 40 TAC §19.1902(a)(1) – administration. The facility was not administered in a manner that enabled it to use it resources effectively and efficiently.
- 40 TAC §19.1910(1)(2). The facility failed to maintain clinical records that were complete, accurately documented, readily accessible, and systematically organized.
- 40 TAC §19.901(7)(B) – the facility failed to ensure that a resident who is fed by a nasogastric or gastrostomy tube, which is the appropriate treatment and services to prevent complications.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility? .....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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18

Resident: Velma C.

Nursing Home: Upshur County

Location: Gladewater, TX

Residency: 9/96 – 9/28/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 78;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Alzheimer's disease;
- Able to ambulate without assistance on all surfaces;
- Able to feed herself with tray set-up;
- Able to toilet herself, continent;
- Able to express herself verbally.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- **No contractures;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **TDHS:**
  - **Cited facility for neglect of Velma's pressure sores.**
- **The Nursing Home:**
  - **Repeatedly violated orders to turn and reposition resulting in severe pressure sores;**
  - **Continually failed to administer pain medication, providing only 9% of the available pain medication doses;**
  - **Violated wound treatment orders 59% of the time (April 2000);**
  - Continually failed to assess pressure sores;
  - Routinely violated dietician's recommendations regarding appetite stimulants;
  - Engaged in chronic understaffing, resulting in widespread care deprivation and injury to residents;
  - Had a long history of dangerous care practices cited by TDHS.

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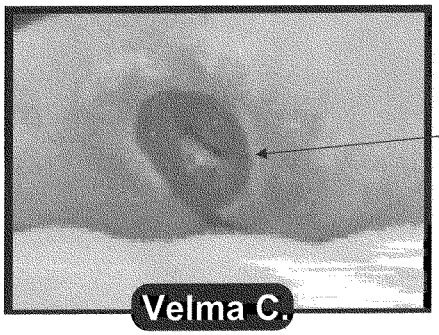
THE AFTER PICTURE: SEVERITY OF INJURIES



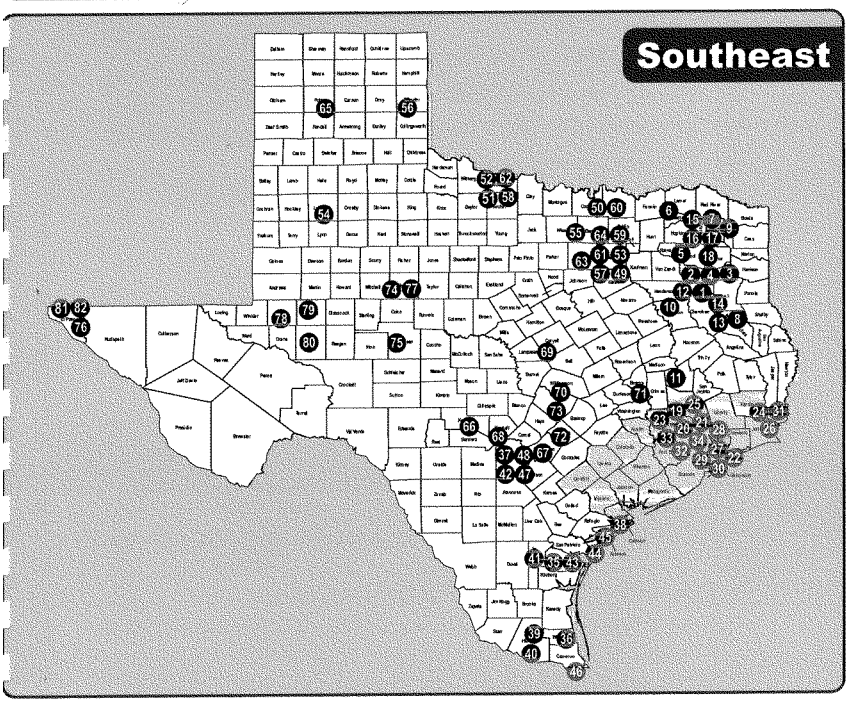
Stage IV, Right Ischial (Buttocks) Pressure Sore: 6.4 cm x 5.8 cm, 4 cm Deep

- **Developed infected Stage IV pressure sore, measuring 6.4 x 5.8 cm and a depth of 4 cm,** with necrotic tissue, foul odor and purulent drainage;
- **Avoidable in-house development of at least 10 pressure sores;**
- **25 lb weight loss** (12/9/99 – 4/13/01);
- **Hypernatremic dehydration**;
- Severe and unrelenting pain as a consequence of multiple and severe pressure sores;
- **Overall decline from being independent to being essentially bedfast** and totally dependent, with significant contractures;
- Hospital Expenses - $9,197.36.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this abuse to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....No
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to the AG?...No
- Did the AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes, 20 hrs. CE and letter of reprimand.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
19	Anna D.	Houston	Harris	SE
20	Beverly G.	Houston	Harris	SE
21	Leo T.	Houston	Harris	SE
22	Josie S.	Galveston	Galvston	SE
23	Raymond C.	Houston	Harris	SE
24	Marvallene H.	Grove	Jefferson	SE
25	Judith F.	Houston	Harris	SE
26	Addie E.	Beaumont	Jefferson	SE
27	Alta D.	Texas City	Galveston	SE
28	Catherine W.	Houston	Harris	SE
29	Inez J.	Texas City	Galveston	SE
30	Leroy W.	Texas City	Galvston	SE
31	Dorothy H.	Port Arthur	Jefferson	SE
32	Aramantha W.	Houston	Harris	SE
33	John F.	Houston	Harris	SE
34	Sam Y.	Houston	Harris	SE

19

Resident: Anna D.

Nursing Home: Harris County

Location: Houston, TX

Residency: 12/30/98 - 6/28/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Nurse;
- Primary Diagnosis: Myasthenia gravis and diabetes;
- Unable to care for herself or provide food, water and shelter;
- Well-oriented, alert, pleasant & cooperative.

Nursing Home's Description on Admit: (per MDS)

- **No dehydration;**
- **No pain symptoms;**
- **No malnutrition;**
- **No pain;**
- Healing right hip sore;
- No end-stage disease;
- No terminal illness.

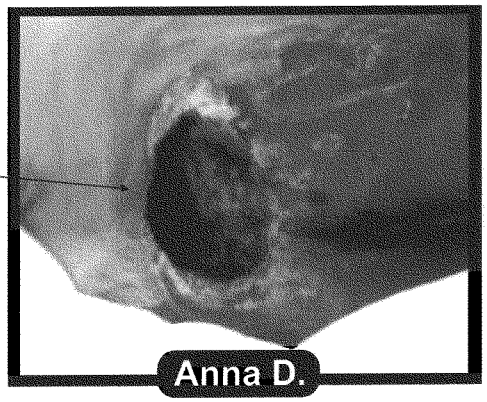
A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - Failed to address Anna's excruciating pain due to massive pressure sore:
    - **Pain was totally ignored at Nursing Home;**
    - **In striking contrast, once hospitalized, patient required continued morphine/narcotics;**
    - **Pain was so severe, three hospital staff were required to hold patient down during pressure sore treatments.**
  - Failed to develop a care plan to address Anna's condition;
  - Repeatedly failed to notify physician of a change in condition;
  - Failed to document accurately and completely;
  - **Routinely failed to turn and reposition Anna, resulting in Stage IV coccyx pressure sore;**
  - Facility ADL Flow Sheets missing or destroyed;
  - Facility Intake Output records missing or destroyed;
  - MDS and Care Plan missing or destroyed.

52 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Necrotic, Stage IV Sacral Pressure Sore: 16 cm x 13 cm, 6 cm Deep



- **Developed massive, infected, in-house, Stage IV, sacral pressure sore, measuring 16 cm x 13 cm, 6 cm deep,** with gray necrosis, foul odor and 7 cm tunneling;
- **Pressure sore exposed the spinal cord;**
- Malnutrition and dehydration, despite G-Tube;
- **Excruciating and unrelenting pain due to pressure sore;**
- Death due to sepsis from pressure sores and pneumonia;
- Hospital Expenses – $25,940.77.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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20

Resident: Beverly G.

Nursing Home: Harris County

Location: Houston, TX

Residency: 9/10/92 - 1/25/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 53;
- Primary Diagnosis: Cerebral Palsy;
- Totally dependent on nursing home for needs and safety;
- Helpless, vulnerable.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Violated statutory and regulatory mandates requiring criminal history checks of employees before direct patient contact;**
    - **Negligently hired and retained male nurse aide without checking and verifying job references;**
    - **Failed to submit a request for criminal history background.**
  - **Rapist, at time of job application, had been convicted of 12 crimes, including assault causing bodily injury;**
  - Perpetrator admitted working the evening of rape **"high on crack cocaine"**, yet his supervisor failed to observe his impairment and assigned him to work with vulnerable female patients (11/16/98);
  - Beverly was raped by perpetrator, yet nurse supervisor failed to assess patient during entire evening shift;
  - **Failed to provide rape trauma care, even after police informed facility of positive DNA findings supporting the rape;**
  - **Manifested callous indifference for how rape affected Beverly;**
  - Employee pled guilty to rape in Harris County Criminal District Court;
  - Rapist sentenced to 10 years in jail and a $500 fine.

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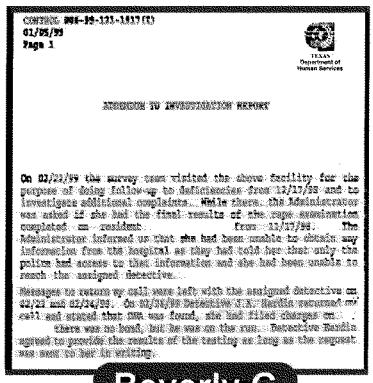
THE AFTER PICTURE: SEVERITY OF INJURIES

"..Detective stated DNA was found, she had filed charges, and there was no bond."

Source: TDHS Investigation Report (Control ..069912 11917)



CONTROL NUM-99-121-11917(1)
01/25/99
Page 1

TEXAS Department of Human Services

ADDENDUM TO INVESTIGATION REPORT

On 02/22/99 the survey team visited the above facility for the purpose of doing follow-up to deficiencies from 12/17/98 and to investigate additional complaints. While there, the Administrator was asked if she had the final results of the rape examination completed on resident from 12/17/98. The Administrator informed us that she had been unable to obtain any information from the hospital as they had told her that only the police had access to that information and she had been unable to reach the assigned detective.

Messages to return my call were left with the assigned detective on 02/23 and 02/24/99. On 02/24/99 Detective S.K. Hardin returned my call and stated that DNA was found, she had filed charges on . there was no bond, but he was on the run. Detective Hardin agreed to provide the results of the testing as long as the request was sent to her in writing.

Beverly G.

- **Beverly, a helpless female, was raped anally and vaginally by a 160 lb male nurse aide;**
- **Despite rapist plea of guilty and positive DNA confirming rape, the nursing home denied the abuse, labeling Beverly as "delusional";**
- Beverly suffered ongoing rape trauma syndrome, which was untreated and aggravated by the facility's post-rape conduct.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this abuse, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution of perpetrator?.....Yes
  Nurse aide rapist guilty, received 17 yrs; no other staff/owner indicted or charged.
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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21

Resident: Leo T.

Personal Care Facility: Harris County

Location: Houston, TX

Residency: 3/9/98 – 8/18/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 81;
- Life's Occupation: Insurance Industry;
- Hospice patient;
- Disabled, helpless;
- Primary Diagnosis: End-stage arteriosclerotic cardiovascular disease, Parkinson's Disease, COPD and asthma.

A PROFILE IN NEGLECT: CORE FACTS

- **What Happened:**
  - Caregiver placed Leo on a mattress, on the floor, where he was stung by fire ants, suffering 2000 to 3000 bites;
  - After discovering the massive fire ant attack, care-giver dragged Leo across the floor, into the hallway, and left him for 3 hours, allowing the fire ants to continue stinging Leo;
  - Seven and a half hours elapsed between the time he was found covered with fire ants and the time he received any medical treatment;
  - When EMS arrived 7.5 hours later, fire ants were still biting Leo.
  - After being transferred to a medical facility, over a dozen fire ants were discovered on Leo.
- **The Personal Care Facility:**
  - Failed to immediately report to physician patient's injuries and condition after tragic incident;
  - Failed to provide adequate staffing and personnel sufficient in numbers to properly care for Leo;
  - Failed to properly train employees in emergency procedures and when to obtain such treatment;
  - Failed to correct a patently dangerous condition on the premises.

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Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Suffered 2000 - 3000 Bites from Fire Ants

Leo T.

- Death due to ant bite poison.

ANY CONSEQUENCES TO THE FACILITY?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Josie S. (Resident #1)**

Nursing Home: Galveston County

Location: Galveston, Texas

Date of Investigation: 8/8/01

File No. 14

THE BEFORE PICTURE

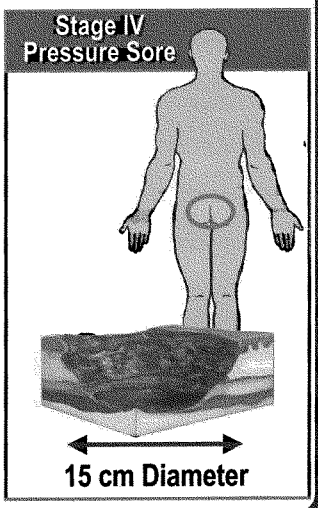
Profile of Resident on Admit to Nursing Home:

- Age: 82;
- Primary diagnosis: History of fractured hip;
- This was a helpless, dependent nursing home resident who required staff assistance for all aspects of care;
- Josie S. was initially admitted to the nursing home for rehabilitation after her hip fracture;
- **On admission to facility, she had no pressure sores.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On the 5th day of August 2001, Josie S. was **admitted to the emergency room** of a local trauma hospital with multiple severe injuries, including:
  - **a massive Stage IV sacral pressure sore, 15 cm in diameter, with necrotic, foul-smelling eschar;**
  - **multiple fire ants crawling out of her diaper;**
  - **fire ant bites on her groin, legs, and diaper area; and,**
  - **dehydrated and malnourished, with a weight of approximately 90 pounds.**



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*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - TDHS determined Josie S.'s pressure sores were avoidable, preventable, wounds.
- **Evidence of Neglect:**
  - Due to the abysmal neglect, **the hospital complained to the state about Josie's pressure sores, neglect, fire ant bites, and mistreatment by the nursing home.**
  - **Josie's massive, necrotic, Stage IV, sacral pressure sore had not even been discovered or treated in the nursing home prior to admission to the hospital ER.**
  - The resident's previously fractured hip was still unhealed, despite Josie S. being admitted to the nursing home for rehabilitation.
  - The hospital social worker was concerned about not only the resident's state, but the resident's roommate and other residents in the facility who could be risk for fire ant bites, as well as undiscovered Stage IV pressure sores.
  - **TDHS determined an immediate jeopardy situation existed due to the failure to provide Josie S. with necessary services to prevent serious injury from ant bites and development of in-house pressure sores.**

Josie's massive, necrotic, Stage IV, sacral pressure sore had not even been discovered or treated in the nursing home prior to admission to the hospital ER.

- **Evidence of Neglect (Cont.):**
  - **In addition to the extensive Stage IV, in-house, sacral pressure sore, the nursing home failed to notify the physician and family of the development of 2 other pressure sores; fire ant bites; and, rapid weight loss.**
  - **TDHS found that the facility's clinical record on Josie S. had no nurse's notes entries regarding the resident being found with ants in her diaper, nor of the pressure sores being present.**
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) by routinely failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.403(k)(1)(A) – the facility failed to notify the resident's physician and family regarding significant changes in the resident's condition, especially regarding the serious fire ants bites and the presence of a very large, in-house, sacral pressure sore.
  - 40 TAC §19.901(9)(A) by failing to ensure that a resident maintain acceptable parameters of nutritional status to prevent further weight loss.
  - 40 TAC §19.601(C) – in that the facility failed to take necessary steps to prevent physical harm and neglect from fire ant bites and development of pressure sores.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?..... ...No
- Amount of a fine imposed?.....$0
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....Yes
- Did the AG prosecute?.....No

  AG said no referral received.

- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes,

  $500 AP, 10 hrs resident care CE & 10 hrs facility management CE.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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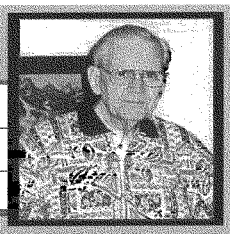
23 Resident: Raymond C.



Nursing Home: Harris County

Location: Houston, TX

Residency: 2/18/99 – 6/1/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 70;
- Life's Occupation: Engineer;
- Primary Diagnosis: Alzheimer's disease and depressive disorder;
- Able to feed self, good appetite;
- Needed total assistance with grooming and bathing.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No nutritional problems;**
- **No weight loss in past 180 days;**
- **No dehydration;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

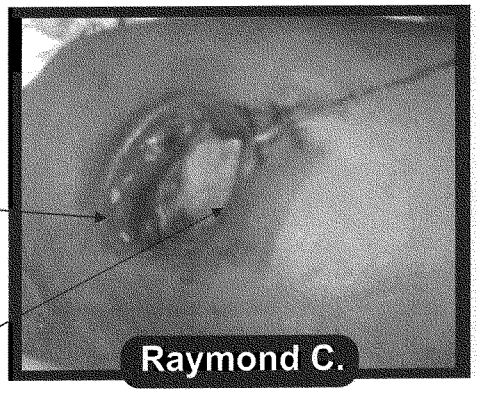
A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Persistently failed to turn and reposition Raymond, resulting in severe, infected pressure sores;**
  - **Routinely violated physician's treatment orders for pressure sores;**
  - Repeatedly failed to assess and notify the physician of pressure sore deterioration and weight loss;
  - **Continually violated the registered dietician's recommendation for diet, health shakes, and nutritional support, resulting in a 50 pound weight loss;**
  - Repeatedly violated physician's orders for hydration;
  - Violated physician's orders for therapy and support devices on an ongoing basis, resulting in contractures of all extremities;
  - Routinely failed to follow the physician's orders to monitor weight weekly;
  - Despite ongoing weight loss, failed to monitor Raymond's meal intake 77% of the time;
  - Failed to protect Raymond from abuse by caregivers, resulting in a dislocated shoulder and numerous lacerations;
  - **Continually failed to medicate Raymond for unrelenting pain from massive pressure sores.**
- **TDHS findings:**
  - **Substantiated findings of abuse and neglect regarding the dislocation of Raymond's shoulder;**
  - The facility failed to perform criminal history checks on employees;
  - There was a history of abuse at this facility.

Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV, Infected Right Hip Pressure Sore with MRSA: 10 cm x 8 cm with 5 cm Tunneling



- **Developed in-house, Stage IV, foul-smelling left hip pressure sore with MRSA and extensive grayish-brown necrosis;**
- **Developed in-house, Stage IV, infected, right hip pressure sore with MRSA,** requiring debridement and a surgical skin flap;
- Contractures of all extremities;
- **Hospitalization for dehydration and malnutrition;**
- **50 lb weight loss in 15 months;**
- Ongoing and excruciating pain from eroding pressure sores (4/12/00 – 7/31/00);
- Hospital Expenses – $54,407.77.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Marvallene H.

Nursing Home: Jefferson County

Location: Beaumont, TX

Residency: 1/7/99 – 2/25/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 73;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Diabetes mellitus and fractured left ankle;
- Alert, friendly, cooperative;
- Needed assistance with activities of daily living.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

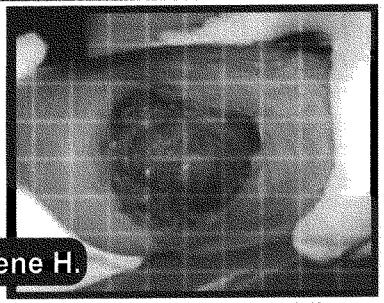
A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Stated Under Oath:**
  - **"It was obvious when Marvallene was admitted to the hospital that she was the victim of profound neglect at the nursing home."**
  - "I was upset when I discovered Marvallene's massive Stage IV wounds at the hospital."
  - "The nursing home failed to provide 80% of the nutrition needed by Marvallene between 1/7/99 and 2/25/99.
  - **"Marvallene's dehydration was inexcusable."**
  - "The nursing home repeatedly violated the standard of care by:
    - failing, on an ongoing basis, to turn and reposition Marvallene;
    - failing to create a care plan for Marvallene's sacral and left heel pressure sores;
    - failing to notify me of significant changes in Marvallene's sacral and left heel sores;
    - violating my treatment orders on a daily basis.
- **The Nursing Home's Registered Dietician Testified:**
  - **The nursing home:**
    - **was grossly negligent in failing to notify her of Marvallene's pressure sores;**
    - **was indifferent to Marvallene's weight loss;**
    - **repeatedly failed to provide Marvallene with nutrition supplements despite weight loss;**
    - **continually failed to notify her of Marvallene's inadequate intake.**

62 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Stage IV Sacral Pressure Sore: 8 cm x 5 cm, Deep to Bone



Infected, Necrotic, Stage IV Left Heel Pressure Sore: 4.5 cm Diameter, to the Bone

- The hospital discovered:
  - **Stage IV, infected sacral pressure sore, measuring 8 cm x 5 cm, extending into the bone;**
  - **Stage IV, infected left heel pressure sore, measuring 4.5 cm in diameter, and covered in necrotic tissue;**
- **Due to the extensive damage, the sacral wound required:**
  - **partial removal of the sacrum;**
  - **A gluteus V-Y advancement flap.**
- **Severe, hypernatremic dehydration;**
- **Severe malnutrition and weight loss;**
- **Horrific, continual pain, which was untreated by the nursing home;**
- Death due to overwhelming sepsis from pressure sores, hypernatremic dehydration and malnutrition;
- Hospital Expenses – $109,550.58.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

25

Resident: Judith F.

Nursing Home: Harris County

Location: Baytown, TX

Residency: 11/10/00 – 4/30/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 54;
- Occupation: Homemaker;
- Primary Diagnosis: Congestive heart failure, COPD, diabetes, depression and obesity;
- Dependent for activities of daily living;
- Bed-bound but alert.

Nursing Home's Description on Admit: (per MDS)

- **No dehydration;**
- **No malnutrition;**
- No pain symptoms;
- No end stage disease;
- Stable condition;
- Small, Stage I – II coccyx pressure area.

A PROFILE IN NEGLECT: CORE FACTS

- The Nursing Home:
  - **Failed to identify or treat the Coccyx pressure sore until it was infected, painful, deep, and draining;**
  - **Repeatedly violated the physician's orders for turning and repositioning;**
  - Failed to develop a care plans for any of Judith's pressure sores;
  - Continuously failed to assess Judith's skin and seek treatment for her pressure sores;
  - **On an ongoing basis, violated the physician's orders for pressure sore treatments;**
  - Failed to monitor fluid intake and output, despite presence of a Foley catheter;
  - Medical records and documentation missing or destroyed;
  - Failed to maintain sufficient staff to meet Judith's needs;
  - Facility admitted to understaffing (clinical records);
  - Routinely ignored Judith's pain, failing to provide pain medication.

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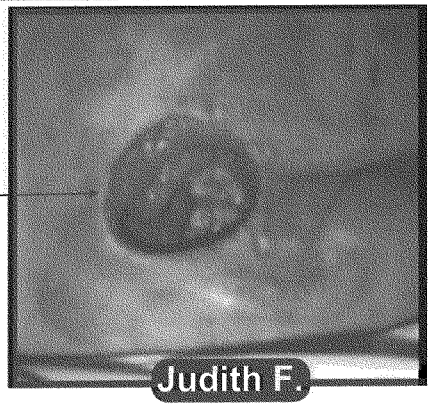
Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Necrotic, Stage IV Coccyx Pressure Sore: 8 cm x 6 cm, 3 cm Deep



- **Developed a Stage IV, infected, necrotic coccyx pressure sore, measuring 8 cm x 6 cm x 3 cm, and required debridement of the sacral bone due to osteomylitis;**
- **Developed right thigh pressure sore, measuring 10 cm with heavy drainage and yellow slough, and requiring debridement;**
- **Surgical myocutaneous flap surgery was required for the coccyx sore;**
- Ongoing pain due to pressure sores;
- Hospital Expenses - $272,441.20.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?..... No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Addie E. (Resident #1)**
Nursing Home: Jefferson County
Location: Beaumont, Texas
Date of Investigation: 11/9/99
File No. 23

THE BEFORE PICTURE

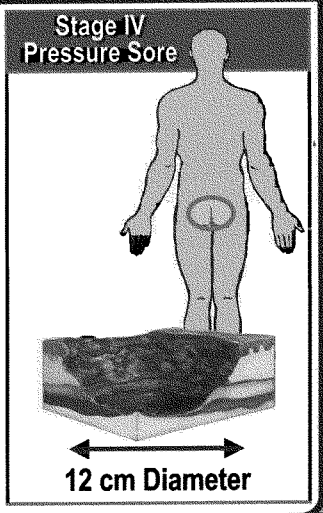
Profile of Resident on Admit to Nursing Home:

- Age: 96 at time of TDHS investigation;
- Primary diagnosis: Cerebral vascular accident, atrial fibrillation, Ascites, dementia, anxiety, osteoporosis, seizures, diabetes, and peripheral vascular disease;
- Addie E. was helpless and totally dependent upon the nursing home staff for all her basic care needs;
- **No pressure sores noted on admission to the nursing home.**

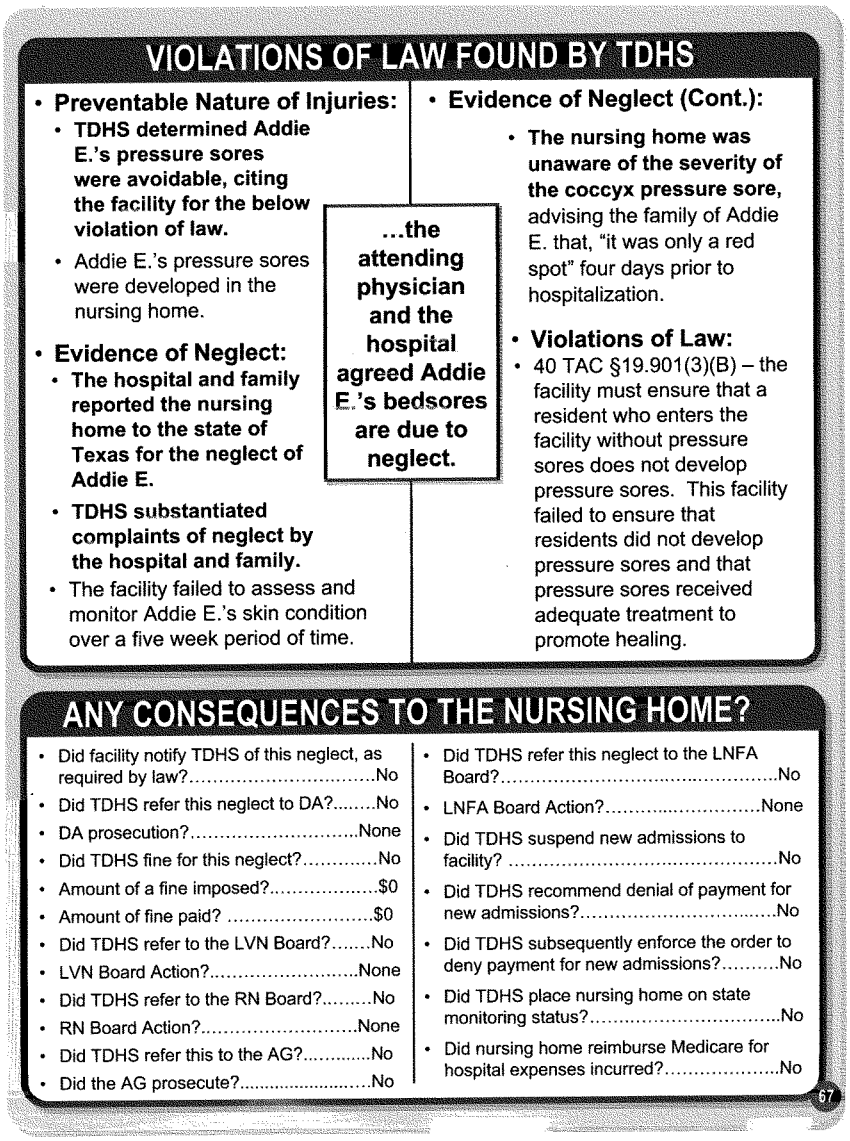
TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 11/3/99, Addie E. was hospitalized with the following findings:
  - **a Stage IV coccyx pressure sore, 12 cm x 10 cm, full thickness wound exposing muscle and/or bone;**
  - **the pressure sore was necrotic with inflamed outer edges and bloody drainage and pus oozing from it.**
- TDHS substantiated that Addie E. was discovered by the hospital to have **"bed sore the size of a grapefruit over her tailbone",** in addition to another pressure sore on her left shin, 12 inches long.
- TDHS further found that Addie E. had **suffered a 23 1/2 pound weight loss in less than 10 months** at the nursing home.
- Due to the extent of the massive pressure sore, plastic surgery was the only hope for repairing the wound.



*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.


VIOLATIONS OF LAW FOUND BY TDHS
• Preventable Nature of Injuries:
• TDHS determined Addie E.'s pressure sores were avoidable, citing the facility for the below violation of law.
• Addie E.'s pressure sores were developed in the nursing home.
• Evidence of Neglect:
• The hospital and family reported the nursing home to the state of Texas for the neglect of Addie E.
• TDHS substantiated complaints of neglect by the hospital and family.
• The facility failed to assess and monitor Addie E.'s skin condition over a five week period of time.
...the attending physician and the hospital agreed Addie E.'s bedsores are due to neglect.
• Evidence of Neglect (Cont.):
• The nursing home was unaware of the severity of the coccyx pressure sore, advising the family of Addie E. that, "it was only a red spot" four days prior to hospitalization.
• Violations of Law:
• 40 TAC §19.901(3)(B) – the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores. This facility failed to ensure that residents did not develop pressure sores and that pressure sores received adequate treatment to promote healing.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....No
• Amount of a fine imposed?.....$0
• Amount of fine paid? $0
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....No
• RN Board Action?.....None
• Did TDHS refer this to the AG?.....No
• Did the AG prosecute?.....No
• Did TDHS refer this neglect to the LNFA Board?.....No
• LNFA Board Action?.....None
• Did TDHS suspend new admissions to facility? .....No
• Did TDHS recommend denial of payment for new admissions?.....No
• Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
• Did TDHS place nursing home on state monitoring status?.....No
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
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Resident: Alta D.

Nursing Home: Galveston County

Location: Texas City, TX

Residency: 9/9/96 - 4/2/97

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 79;
- Life's Occupation: Teacher;
- Primary Diagnosis: Stroke, diabetes mellitus, hypothyroidism and dementia;
- Disabled;
- Dependent on nursing home for basic care needs.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No contractures;**
- **No malnutrition;**
- **No dehydration;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **The Administrator Admitted:**
  - **There was a systemic breakdown in the care. The TDHS findings about Alta were embarrassing, shocking and represent longstanding neglect.**
- **The Director of Nurses Admitted:**
  - The repetitive failure by the facility to provide wound treatments to Alta was "offensive and humiliating".
- **TDHS Findings:**
  - **Found immediate threat to the health and safety of residents based on the systemic breakdown of nursing care services. Significantly, almost one-third of the 50 pages of violations were specifically written about the neglect of Alta.**
- **The Nursing Home:**
  - Out of 325 wound treatments that were to be administered, **110 were not performed; turning and repositioning were routinely ignored** (9/25/96 - 4/2/97);
  - Performed only one skin assessment/decubitus report in the critical 34 day period when this wound was becoming a rotting, festering cavern (12/25/96 - 1/29/97);
  - **Physician's pain medication orders for patient were violated over 60% of the time (2/18/97 - 4/2/97);**
  - Engaged in chronic and dangerous understaffing.

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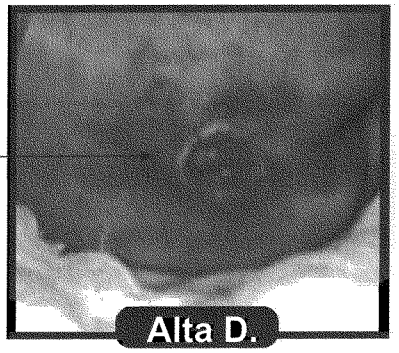
THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Sacral Pressure Sore: 8 cm x 8 cm, 7 cm Deep to Bone, Developed at Nursing Home



- **Developed 15 avoidable, in-house pressure sores;**
- Developed painful contractures due to the repeated failure to provide daily range of motion as specified in her plan of care;
- Was found to have pus contaminated urine which was as thick as gravy and contained sand-like particles when admitted to the hospital (3/97);
- **Severe dehydration, malnutrition and significant weight loss;**
- **Ongoing and excruciating pain due to massive pressure sore (over 100 days);**
- Death due to infected pressure sores and gross neglect (4/2/97);
- Medicare Expenses – $5,907.02.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  10 hrs CE imposed.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Catherine W. (Resident #8)**
Nursing Home: Harris County
Location: Houston, Texas
Date of Investigation: 4-24-00
File No. 15

THE BEFORE PICTURE

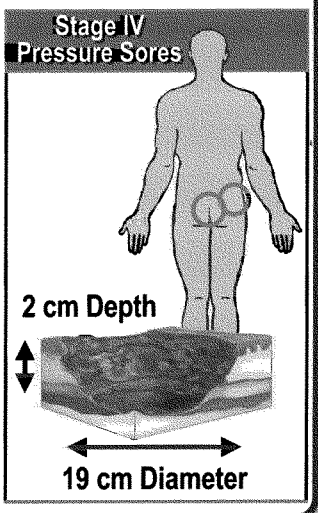
Profile of Resident on Admit to Nursing Home:

- Age: 87;
- Primary diagnosis: History of mastectomy for breast cancer, with radiation burns to chest, bowel and bladder incontinence and gastrostomy tube feedings;
- Helpless, dependent nursing home resident;
- Required extensive assist from nursing home staff for all aspects of care. In addition, she was alert, but non-verbal;
- **On admission to facility, she had no pressure sores.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 4/22/00, Catherine W. was admitted to the hospital for extensive surgical debridement of her massive pressure sores which developed in the nursing home. The hospital discovered the following:
  - **Stage IV coccyx pressure sore, measuring 13 cm x 9 cm, with eschar and tunneling to 4.5 cm with foul odor, necrosis, and infection;**
  - **Stage IV right, lower back pressure sore, near the sacrum, measuring 19 cm x 10 cm x 2 cm with foul odor and infection.**



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*The information contained in this case study derives from official gover[illegible] of TDHS. This is a summary and not the offici[illegible]rd.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - **Interview with the attending physician revealed that the resident had developed the wounds to the upper back towards the sacrum and the sacral area in-house.**
  - **Residents with pressure sores were observed by TDHS to not be turned and repositioned every 2 hours and to have no dressings on their pressure sores. Additionally, residents were lying in urine without dressings on the pressure sores.**
- **Evidence of Neglect:**
  - **TDHS found Catherine W. soaked in urine with a strong urine odor present. This urine was in contact with the wounds with large areas of reddened and raw tissue exposed on 4/21/00.**
  - **Review of the treatment sheets showed that ordered treatments had not been performed.**
  - **When the physician assessed the wounds, he immediately sent Catherine W. to the hospital on 4/22/00.**
  - **Interview with the physician revealed that the licensed staff failed to assess and provide treatments as ordered, and to keep him informed of changes in the wounds.**
  - **TDHS observed Catherine W. on 4/21/00 to have a huge pressure sore to the coccyx area with no dressings in place. When interviewed, the licensed nurse on duty said he was unaware that the resident did not have a dressing on this wound.**

"..failed to ensure that residents did not develop pressure sores and that pressure sores received adequate treatment.."

- **Evidence of Neglect (Cont.):**
  - **The facility's consulting nurse was asked to observe the wounds and when asked if she had observed on the treatment of Catherine W.'s wounds, she said, "she was not happy with what she saw".**
    - **Interview with the DON revealed that treatments are sometimes not done on pressure sores because the treatment nurses told to work on the floor due to staff shortages, and that the administrator is aware of the problem.**
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.1001(1)(A) – failed to ensure that sufficient staff is provided.
  - 40 TAC §19.901(1)(C) – failed to ensure that the ADL needs of dependent residents were met (bathing, dressing, grooming, hair, nail, and mouth care).
  - 40 TAC §19.802(a) – failed to develop a comprehensive care plan for each resident and failed to ensure that that Catherine W.'s care plans addressed pain management, pressure sores, transfers, limited range of motion, and all diagnosis.
  - 40 TAC §19.802(c)(1) – failed to ensure that services provided met professional standards of quality.
  - 40 TAC §19.1901 – the facility was not administered effectively and efficiently. Failed to ensure that all nursing staff were trained, supervised, and competent.
  - 40 TAC §19.1903(8) – failed to ensure that nurse aides receive no less than 12 hours per year of in-service training.
  - 40 TAC §19.1910(a) – failed to ensure that clinical records were complete, accurately documented, readily accessible, and systematically organized.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....Pending, due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  $150 AP and 8 hrs CE for resident care.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Inez J.

Nursing Home: Galveston County

Location: Texas City, TX

Residency: 1/12/99 - 5/15/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Housekeeper;
- Primary Diagnosis: Fracture of right leg, CVA with left side weakness and diabetes mellitus;
- Totally dependent upon nursing home for basic needs;
- Alert to verbal and tactile stimulation.

Nursing Home's Description on Admit: (per MDS)

- Cast on right lower leg;
- Several superficial, Stage II pressure sores on buttocks, healing (largest area was 1.5 cm);
- **No end-stage disease;**
- **No terminal illness;**
- **Stable condition.**

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Routinely violated MD orders for pressure sore treatments – 197 violations** (1/99 – 5/99);
  - **Violated orders to reposition 56% of the time** (1/12/99 - 5/15/99), resulting in massive Stage IV wounds;
  - **Repeatedly failed to administer pressure sore treatments, give medications, perform Fasting Blood Sugar testing, and to obtain weekly weights;**
  - Routinely failed to provide adequate and proper infection control to prevent pressure sores from getting contaminated;
  - Failed, on an ongoing basis, to assess Inez's pain, and administer pain medication;
  - Continually violated physician orders for physical therapy;
  - Failed to monitor Inez's diabetes.

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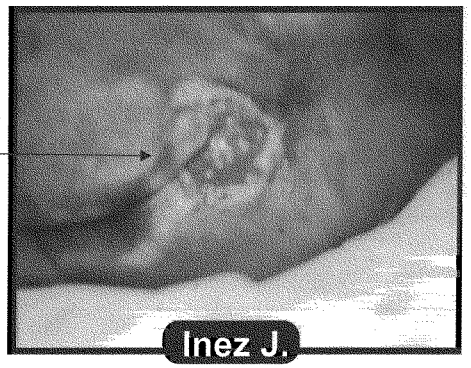
THE AFTER PICTURE: SEVERITY OF INJURIES

Necrotic, Stage IV Sacral Pressure Sore: 10 cm x 8.5 cm, 3.8 cm in Depth



- **Ongoing failure to assess and treat right heel resulted in an in-house, necrotic, festering Stage IV, pressure sore, measuring 20 cm x 10 cm;**
- Developed massive Stage IV necrotic, foul-smelling pressure sore, measuring 10 cm x 8.5 cm with a depth of 3.8 (pictured). Undermining with a 4.5 cm tunneling at 12 o'clock, 2.8 cm tunneling at 6 o'clock and 3.6 cm tunneling at 9 o'clock;
- Sacral pressure sore was a Stage IV for 69 days, with infection and severe relentless pain;
- **Death certificate: Stage IV pressure sores and a non-healed tibia/fibula fracture contributed to death.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Leroy W. (Resident #2)**
Nursing Home: Galveston County
Location: Texas City, Texas
Date of Investigation: 1-12-01
File No. 10

THE BEFORE PICTURE

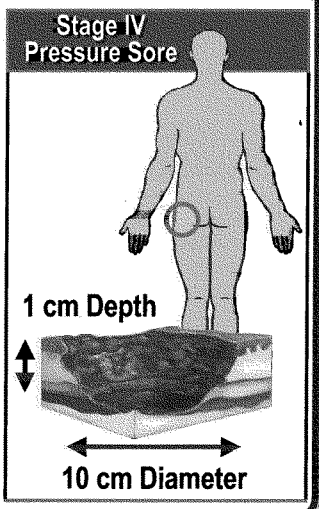
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Dementia, contractures, pseudo bulbar palsy and peripheral vascular disease;
- Helpless and dependent resident;
- Requires 2 person assist for all activities of daily living and transfers;
- **No pressure sores noted upon admission to facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 1/9/01, TDHS observed Leroy W. and discovered that:
  - Leroy W. had developed a pressure sore to the left trochanter, which **was in-house and avoidable;**
  - **the left trochanter pressure sore to be a Stage IV, 10 cm x 9 cm x 1 cm with black necrotic edges. The wound bed was 40% dark red, 10% beefy red, and 50% white slough;**
  - Leroy W. was not administered medication as prescribed.



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*The information contained in this case study derives from official [illegible] TDHS. This is a summary and not the official [illegible]

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - The physical therapist noted Leroy's pressure sore was getting worse, especially in the past week.
  - **During the two days of the TDHS survey, Leroy was observed to be not turned and repositioned all day.**
  - The physical therapist who was treating the wounds stated "it is very important for Leroy W to get turned every 2 hours".
  - Lack of RN staffing contributed to care failures which resulted in this left trochanter, Stage IV pressure sore with significant worsening.

The left hip pressure sore treatments were not being performed as ordered, despite the fact that this wound had been a Stage IV pressure sore for at least six weeks.

- **Violations of Law:**

TDHS found that the facility violated:

- 40 TAC §19.901(3)(B) - routinely failing to prevent, monitor, and treat pressure sores.
- 40 TAC §19.1001(2)(A)(B)(C) - failing to have an RN on duty for 8 consecutive hours each day for 7 days a week.
- 40 TAC §19.802(c)(1) - failing to have services provided or arranged by the facility that meet professional standards of quality.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....No
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions? .....No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Dorothy H.

Nursing Home: Jefferson County

Location: Port Arthur, TX

Residency: 10/13/95 – 7/19/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 80;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Senile dementia, hypertension and lymphedema, gastroenteritis;
- Assistance with activities of daily living;
- Alert, always in pleasant mood.

Nursing Home's Description on Admit: (per MDS)

- **No dehydration;**
- **No malnutrition;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **TDHS Findings Specific to Dorothy:**
  - **" The facility consistently failed to prevent development of pressure sores, and administer treatment to prevent deterioration of existing pressure sores."**
  - "Review of Medical Records on 5/19/00 revealed inconsistency in documentation of pressure ulcers."
  - **"Interview with the Director of Nurses and Assistant Director of Nurses revealed, 'We stopped doing pressure ulcer sheets three weeks ago.' "**
  - "Observation of Dorothy revealed resident had a dressing over coccyx even though orders were for no dressing."
  - **"Interview with 3 charge nurses revealed they were not sure of their duties regarding treatment of pressure sores, and were unaware of many of the skin problems."**
  - **" The facility failed to insure that records were not falsified."**
  - Referred Administrator and Director of Nursing for consideration of disciplinary action due to determination that residents, including Dorothy, had experienced **" actual harm"** and been subjected to substandard quality of care.

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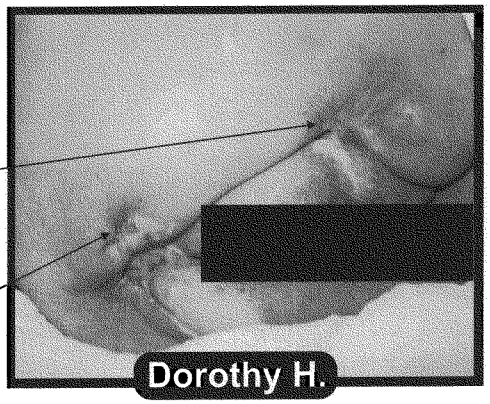
THE AFTER PICTURE: SEVERITY OF INJURIES

Flap Surgery Disfigurement From: Stage IV Right Buttock/Labia Pressure Sore and Stage IV Coccyx Pressure Sore



- **Stage IV coccyx pressure sore, measuring 8 cm x 5.5 cm x 4 cm, which required flap surgery, and existed for 62 weeks;**
- **Stage IV right buttock/labia pressure sore ongoing for 54 weeks;**
- **Developed 6 Stage II to Stage III pressure sores;**
- Staff allowed multiple, severe infections of the pressure sores to develop, which required hospitalization for sepsis;
- **Severe, untreated pain** from massive pressure sores;
- Hospital Expenses – $27,993.41.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$80,000
- Amount of fine paid?.....$45,000
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this to the AG?...Yes, twice
- Did the AG prosecute?.....Yes, $30,000 fines on each of two referrals.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes $250 AP & 20 hrs CE.
- Did TDHS suspend new admissions to facility?.....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes, twice
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Aramantha M. (Resident #5)**
Nursing Home: Harris County
Location: Houston, Texas
Date of Investigation: 4/24/00
File No. 16

THE BEFORE PICTURE

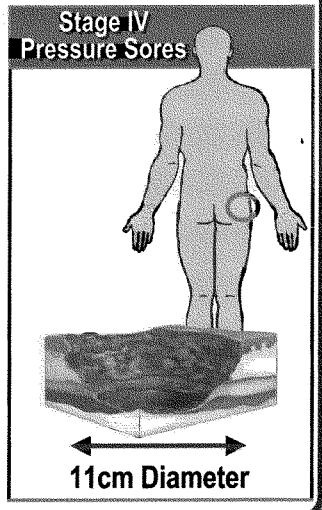
Profile of Resident on Admit to Nursing Home:

- Age: 86;
- Primary diagnosis: Gastrostomy tube for enteral feedings, bowel and bladder incontinence;
- This was a helpless, dependent nursing home resident who required 1 to 2 person assists for all aspects of her care from facility staff members;
- **On admission to facility, she had no pressure sores.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 22nd day of April 2000, Aramantha M., was **hospitalized for infected pressure sores,** where the following were discovered:
  - **right trochanter, Stage IV pressure sore, measuring 11 cm x 11 cm with black necrotic tissue, foul odor and infection;**
- Aramantha M.'s attending physician stated he, "was transferring Aramantha to the hospital for surgical debridement of the right hip pressure sore". Additionally, these in-house pressure sores had formed:
  - left hip, Stage III pressure sore;
  - right ear, Stage III pressure sore.
- TDHS found, in their investigation of the nursing home, that **24 residents had developed in-house pressure sores.**



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TDHS. This is a summary and not the official record

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
- Interview with the attending physician for Aramantha, at the time of hospitalization, revealed that: **Aramantha was admitted to the nursing home on 4/3/00 without any pressure sores.**
- **The attending physician for Aramantha stated he, "was shocked to see the resident with Stage III and Stage IV pressure sores."**
- Prior to hospitalization, **TDHS observed Aramantha M. in the nursing home, in the following state of neglect on 4/20/00:**
  - **Aramantha was lying soaked in urine with no dressing present over her massive pressure sores.**
  - **Aramantha's position had not been changed for some time, not turned every 2 hours.**
- **The facility violated physician's orders for treatment to Aramantha's pressure sores.**
- The facility failed to apply pressure relieving devices.
- The facility did not provide the diet or G-tube feeding as ordered, or secure a nutritional consultation after the development of new pressure sores.

Aramantha was admitted with no pressure sores. The attending physician ...said he "was shocked to see the resident with Stage III and Stage IV pressure sores.

- **Preventable Nature of Injuries (Cont.):**
- TDHS found:
  - **The facility did not provide sufficient numbers of staff to meet the needs of residents.**
  - The systemic breakdown in care placed Aramantha and other residents' health and safety in immediate jeopardy, due to substandard quality of care.
- **Violations of Law:**
- 40 TAC §19.901(3)(B) – by failing to prevent, monitor, and treat pressure sores.
- 40 TAC §19.1001(1)(A) – facility failed to provide sufficient staff.
- 40 TAC §19.901(1)(C) – facility failed to meet the ADL needs of dependent residents (bathing, grooming, nail and oral care).
- 40 TAC §19.802(c)(1) – facility services did not meet professional standards of quality.
- 40 TAC §19.1901 – facility was not administered effectively and efficiently.
- 40 TAC §19.1903(8) – facility failed to maintain complete, accurate and organized clinical records.
- 40 TAC §19.1910(a) – facility failed to ensure that clinical records were complete, accurately documented, readily accessible, and systematically organized.
- 40 TAC §19.403(k) – facility failed to notify physician and family of development of pressure sores.
- 40 TAC §19.901(7)(B) – facility failed to properly administer gastrostomy tube feedings.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....Pending due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  $150 AP and 8 hrs CE for resident care.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: John F.

Nursing Home: Harris County

Location: Houston, TX

Residency: 9/15/99 - 6/11/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 71;
- Life's Occupation: Engineer/Contractor;
- Primary Diagnosis: Alzheimer's disease and diabetes;
- Totally dependent on nursing home staff for all needs;
- Alert and responsive to name and surroundings.

Nursing Home's Description on Admit: (per MDS and Skin Sheets)

- **No dehydration;**
- **No pain symptoms;**
- **No nutritional problems or weight loss in past 180 days;**
- 2 Stage I, 1 –2 cm, pressure area and 1 Stage II, 1 cm, pressure area;
- No terminal illness;
- No end-stage disease;
- Medically stable.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Consistently violated orders to turn and reposition 87% of the time, despite physician orders (5/10/00-6/8/00);**
  - **Routinely provided John with an average of only 141 cc's of fluids per day, despite daily fluid needs of 2200 - 2500 cc's per day (2/3/00-6/1/00);**
  - Routinely failed to monitor John's meal intake more than 85% of the time;
  - Continually failed to provide any ROM exercises or other restorative nursing activities to increase circulation and decrease immobility;
  - **Repeatedly failed to inform the physician of the significant deterioration of the coccyx pressure sore (4/11/00 - 5/10/00);**
  - Violated orders to provide the proper catheter to prevent urine leakage, resulting in continual urine contamination of John's pressure sores and dressings (5/10/00-5/23/00);
  - **Totally failed to administer pain medication or implement a pain control plan in the presence of painful pressure sores that extended into the bone (2/3/00 – 6/11/00);**
  - Facility had no proof that they provided any incontinent care, bathing or grooming activities throughout patient's residence at nursing home.

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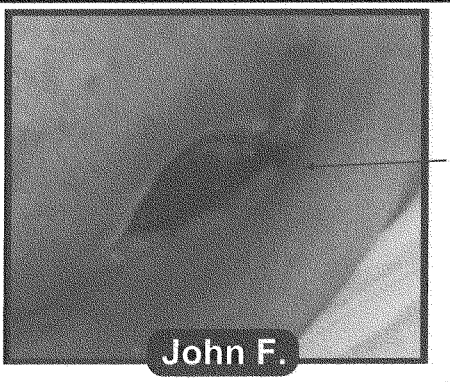
THE AFTER PICTURE: SEVERITY OF INJURIES



Stage IV Coccyx Pressure Sore: 7.6 cm x 3.5 cm x 2.5 cm with 3.2 cm Undermining

- **Developed necrotic, Stage IV coccyx sore, 7.6 cm x 3.5 cm x 2.5 cm with undermining of 3.2 cm (foul-smelling with soggy, black, gray tissue covering 90% of the wound);**
- **Osteomyelitis of Stage IV coccyx wound;**
- **Developed 6 avoidable, in-house pressure sores,** including Stage IV right hip (2/1/00 – 6/11/00);
- **Developed repeated dehydration, and protein calorie malnutrition;**
- **30 lb weight loss** in less than two and a half months (3/27/00 -6/7/00);
- **Hypernatremic dehydration;**
- **Endured excruciating, continual pain (2/3/00 – 6/11/00);**
- Hospital Expenses – $27,755.88.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

34

*** Resident: Sam Y. (Resident #6)**
Nursing Home: Harris County
Location: Houston, Texas
Date of Investigation: 4/24/00
File No. 17

THE BEFORE PICTURE

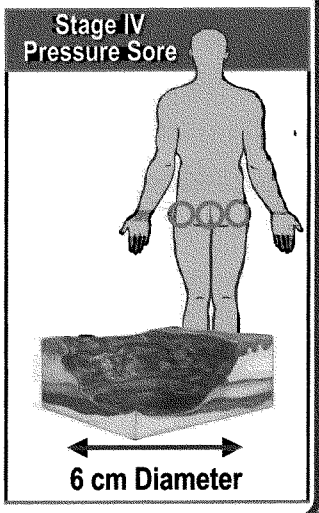
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Dementia;
- Totally, helpless, dependent nursing home resident who required staff assistance for all aspects of care;
- **On admission to facility, Sam had no pressure sores.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On the 22nd day of April 2000, Sam Y. was admitted to the hospital, where the following pressure sores were discovered:
  - **infected left hip Stage IV, measuring 6 cm x 6 cm with purulent drainage and very foul odor;**
  - **infected Stage II coccyx pressure sore, 4 cm x 2 cm; and,**
  - **infected right hip Stage III, 5 cm x 2 cm.**
- **Sam Y. was hospitalized for surgical debridement of the extensive, infected pressure sores formed at the nursing home.**
- **TDHS found that failure of the facility to provide sufficient staff resulted in lack of care. The cumulative skin report for the facility showed that 24 residents had developed in-house pressure sores.**



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*The information contained in this case study derives from official governm

This is a summary and not the official record

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - **TDHS found that Sam Y.'s ordered treatments had not been performed by the nursing home.**
  - The DON noted that due to staffing shortages, the treatment nurse was often pulled to work on the floor; thus, pressure sore treatments were not being done and that the facility's administrator was aware of this problem.
  - **TDHS found that the facility had falsified Sam Y.'s clinical** record. The treatment nurse represented and documented that care had been provided when it actually had not. The treatment nurse admitted to TDHS that she just filled in the treatment record even for days she did not work.
  - TDHS observed Sam Y. in the nursing home with no dressings in place to his pressure sores.

TDHS found that Sam Y.'s ordered treatments had not been performed by the nursing home.

- **Preventable Nature of Injuries (Cont.):**
  - **Residents were observed by TDHS to not have dressings over their pressure sores, to not be turned and repositioned, and to be found lying in urine in contact with the pressure sores.**
  - **TDHS found infection control protocols routinely violated by direct care givers in treating residents' pressure sores, including Sam Y.**
  - **Three residents had been hospitalized for surgical debridement of infected pressure sores on April 22, 2000, as soon as the doctor saw the deteriorating wounds.**
- **Violations of Law:**
  - 40 TAC §19.901 – facility failed to maintain highest quality of care by failing to adequately assess and intervene in response to acute illness episodes.
  - 40 TAC §19.1901 – the facility failed to: 1) ensure that residents were protected from sexual abuse; and, 2) prevent falsification of resident records.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....Pending, due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  $150 AP and 8 hrs CE for resident care.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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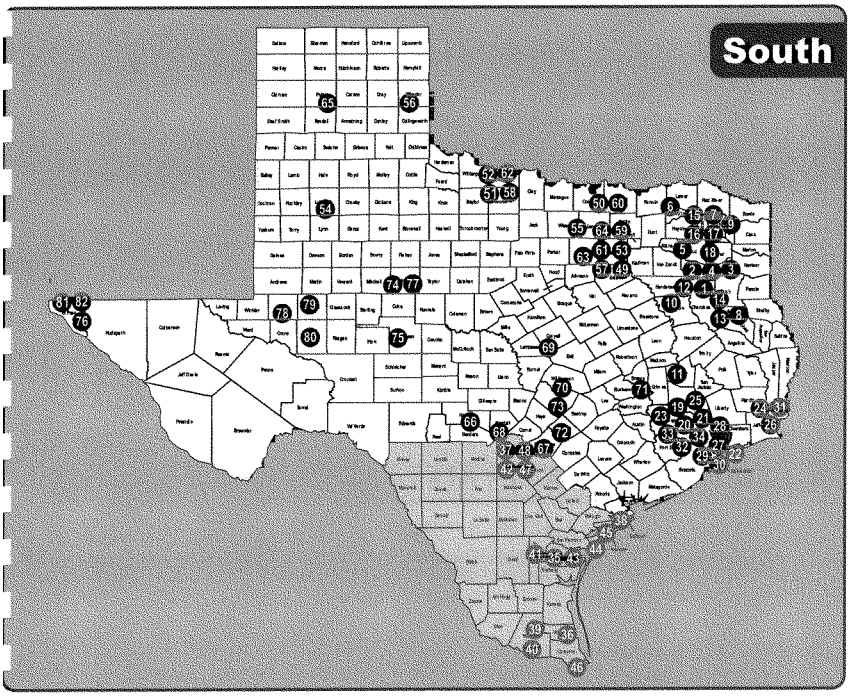
The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
35	Earl D.	Corpus Christi	Nueces	S
36	Isabel R.	Raymondville	Willacy	S
37	Doris T.	San Antonio	Bexar	S
38	Alice R.	Port Lavaca	Calhoun	S
39	Faustino G.	McAllen	Hidalgo	S
40	Luis T.	Weslaco	Hidalgo	S
41	Jesus S.	Alice	Jim Wells	S
42	Gladys B.	Floresville	Wilson	S
43	Ruth H.	Corpus Christi	Nueces	S
44	Noel B.	Aransas Pass	San Patricio	S
45	Herman K.	Rockport	Aransas	S
46	Ms. X.	Brownsville	Cameron	S
47	Isabel H.	San Antonio	Bexar	S
48	Lucille T.	San Antonio	Bexar	S

35

Resident: Earl D.

Nursing Home: Nueces County

Location: Corpus Christi, TX

Residency: 6/18/96 - 5/27/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 60;
- Life's Occupation: Baptist Preacher;
- Primary Diagnosis: Alzheimer's disease, diabetes mellitus and coronary artery disease;
- Independent, requiring some assistance from staff.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- **No end-stage disease;**
- Stable condition;
- No terminal illness.

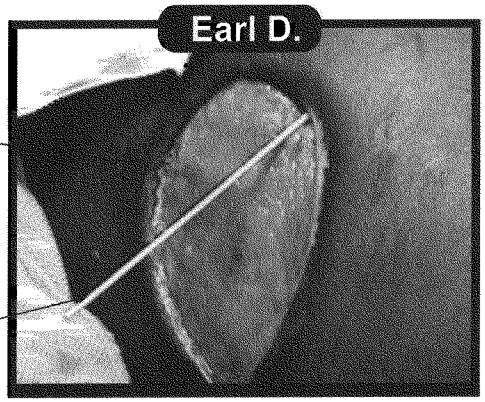
A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Testified:**
  - The nursing home neglect of Earl was **"shocking and constituted knowing abuse of the elderly".**
- **The Facility Director of Nurses Testified:**
  - Earl was the victim of multiple forms of ongoing neglect at the nursing home.
- **Facility Management Admitted That:**
  - **"Earl experienced unrelenting, excruciating pain from rotting, festering pressure sores for over five months."**
  - "Profound neglect caused Earl's pressure sores and hyperglycemic coma."
  - **An admitting hospital complained that Earl had had been neglected at the nursing home.**
- **TDHS Findings:**
  - The facility failed to monitor Earl's blood sugar and administer insulin;
  - Repeatedly warned the facility about life-threatening care and understaffing.
- **The Nursing Home:**
  - Continually failed to administer pain medication 99% of time (2/8/99-5/12/99);
  - Routinely violated orders to turn and reposition, resulting in massive pressure sores;
  - Engaged in a pattern and practice of dangerous understaffing.

86 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Gangrenous, Stage IV Left Hip Pressure Sore: 25 cm Diameter with 5 cm Deep Tunneling



- Developed **multiple Stage IV in-house gangrenous pressure sores with necrotic bone involvement.** Bone grafts required due to osteomyelitis;
- Entire room thick with foul odor from necrotic, draining wounds;
- **61 lb weight loss in less than four months** (6/15/98 – 10/8/98);
- **Hospitalized 5 times for severe dehydration** (4/1/98 – 1/799);
- **Unrelenting and excruciating pain from massive pressure sores (1/99 – 5/99);**
- Death due to overwhelming infection from massive sores (12/27/99);
- Hospital Expenses – $143,092.93.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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36

Resident: Isabel R.

Nursing Home: Willacy County

Location: Raymondville, TX

Residency: 6/19/96 - 2/24/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Hypertension, chronic angina and chronic dizziness;
- Admitted to nursing home to recover from brief hospital stay;
- Able to walk and feed herself independently.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- No contractures;
- Alert, stable.

A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Stated:**
  - "In summary, I feel that the patient's death was primarily caused by overwhelming infection and inability to fight this infection secondary to the patient's malnutrition."
  - **"The overwhelming infection of course was also probably due to her very large decubitus on her sacral area, which would be an obvious portal to infection."**
- **The Nursing Home:**
  - Failed to accurately and adequately assess a care plan for patient's pressure sores;
  - Violated orders to administer pain medication to Isabel, in the face of painful gangrenous sores;
  - **Never referenced a care plan regarding Isabel's excruciating pain in the nursing home records;**
  - Grossly neglected Isabel's nutritional and hydration needs by:
    - **Violating physician's orders to provide nutritional supplements 47% of the time;**
    - **Violating physician orders to monitor weight 86% of the time;**
    - **Depriving Isabel of one-third of the calories ordered by physician during critical period;**
  - Had repeated warnings by TDHS of relevant and related care deficiencies;
  - Engaged in severe and chronic understaffing.

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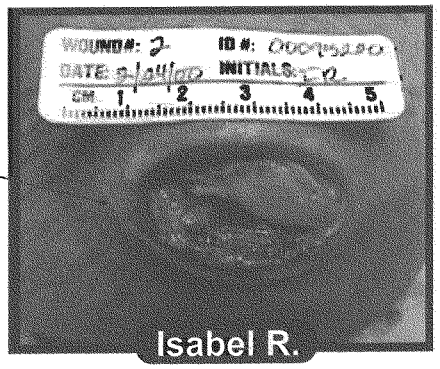
THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Necrotic, Stage IV Sacral Pressure Sore: 15 cm x 6.5 cm, 2.6 cm Deep



- **Developed a huge, gangrenous sacrococcygeal pressure sore, with exposed bone, measuring 15 cm x 6.5 cm x 2.6 cm in depth;**
- **Developed Stage IV elbow sore, measuring 3.1 cm x 2.5 cm in depth, with inside necrosis, with tendon and joint space exposed;**
- Developed multiple avoidable in-house pressure sores;
- Excruciating and unrelenting pain due to pressure sores;
- Developed contractures of lower extremities;
- **Death due to sepsis, bacteremia and gangrene of the sacral pressure sore;**
- Hospital Expenses – $43,395.75.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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37

Resident: Doris T.

Nursing Home: Bexar County

Location: Windcrest, TX

Residency: 5/1/97 - 9/30/97

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 92;
- Life's Occupation: Teacher;
- Primary Diagnosis: CHF, senile dementia and GI bleeding;
- Ambulatory with walker;
- Dependent on staff for basic care;
- Alert, cheerful, cooperative.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores (1 cm area on foot, healed);**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition or recent weight loss;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **The Facility's Director of Nurses and Charge Nurses Admitted:**
  - **"Doris was grossly neglected."**
  - **The facility "consistently violated nursing home policy by failing to turn and reposition Doris".**
  - The facility violated policy by repeatedly failing to notify the physician of:
    - Doris' pressure sores and deterioration;
    - Significant weight loss and poor intake;
    - Dehydration.
  - There was no pain relief offered to Doris for her massive wounds.
  - The care of Doris was "abysmal".
  - Doris' pressure sores were preventable.
  - There was never a care plan for preventing or healing Doris' pressure sores.
  - **"The failure to call the physician about the massive Stage IV pressure sore and rapid weight loss was neglectful and abusive."**

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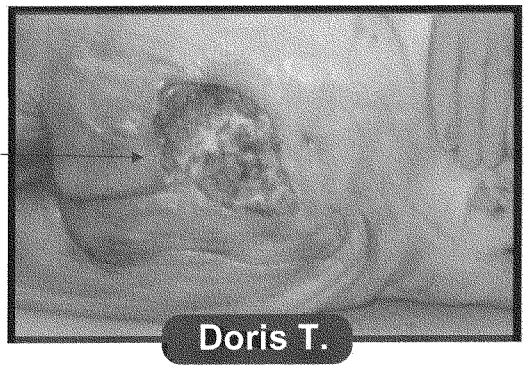
THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Coccyx Pressure Sore: 24 cm x 20 cm Diameter, to the Bone



- **Wet, gangrene and putrification of the sacrum bone;**
- **Acute osteomyelitis of the sacrum;**
- **Developed Stage IV coccyx pressure sore, measuring 24 x 20 cm;**
- Surgical treatment, including **removal of a portion of the sacral bone;**
- **Severe dehydration;**
- **23 lbs weight loss** in 2 weeks and protein calorie malnutrition;
- Unrelenting and excruciating pain (9/10/97-10/19/97);
- Death due to massive, gangrenous pressure sore (10/19/97);
- Hospital Expenses – $16,660.61.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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38

*** Resident: Alice R. (Resident #3)**
Nursing Home: Calhoun County
Location: Port Lavaca, Texas
Date of Investigation: 2/18/99
File No. 12

THE BEFORE PICTURE

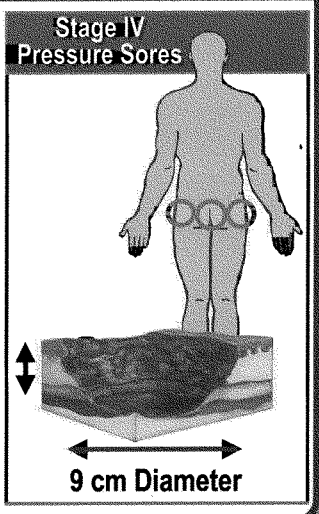
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Cerebral vascular accident, history of colon cancer (survivor), severe contractures of all joints in lower extremities, UTIs, arthritis, pneumonia, anxiety, Alzheimer's disease and Parkinson's disease;
- This was a totally dependent, helpless resident;
- **No pressure sores noted on admission to the nursing home.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 2/3/99, Alice R. was hospitalized, and the staff discovered that she:
  - **had developed 3 in-house, avoidable pressures sores on her bilateral hips and sacrum;**
  - **had developed a Stage IV left hip pressure sore, measuring 8 cm x 8 cm, with black eschar in wound base;**
  - **had developed a Stage IV right hip pressure sore, measuring 9 cm x 7 cm;**
  - **had developed at Stage IV sacral pressure sore, measuring 3 cm x 3 cm with black, full thickness eschar.**



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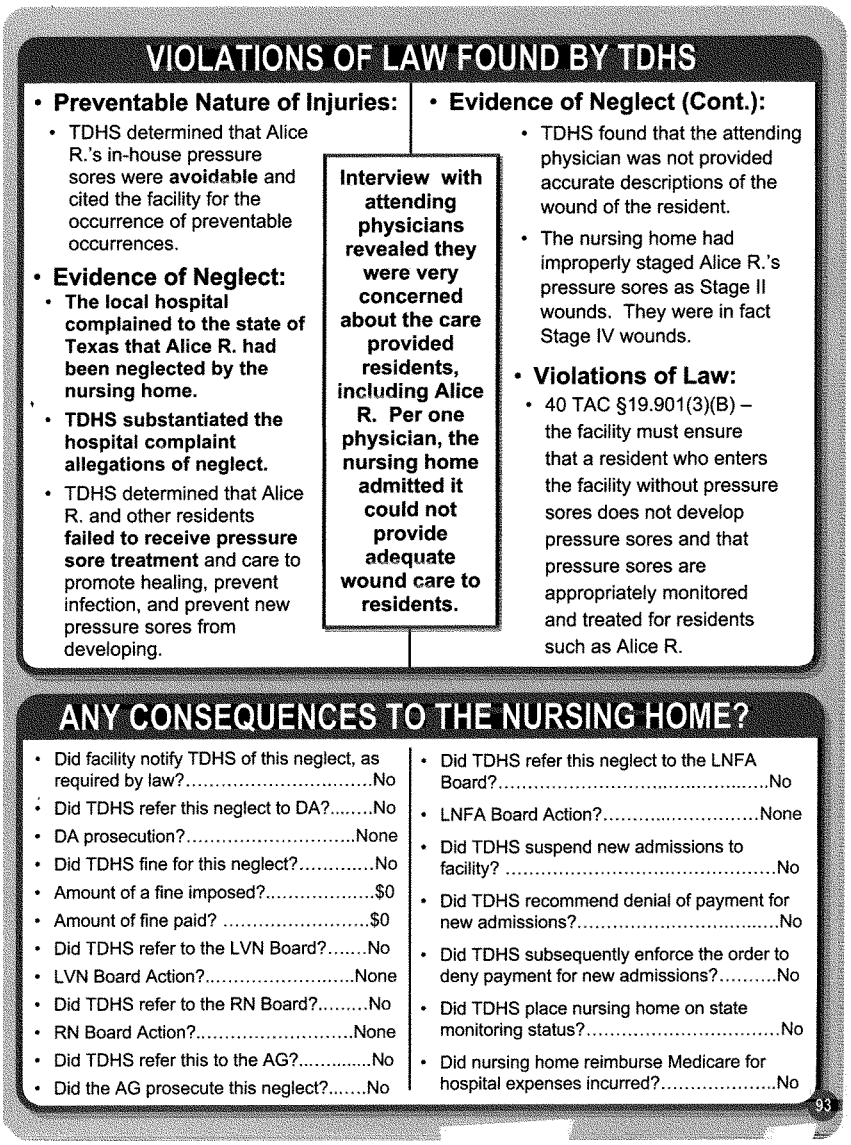

VIOLATIONS OF LAW FOUND BY TDHS
• Preventable Nature of Injuries:
• TDHS determined that Alice R.'s in-house pressure sores were avoidable and cited the facility for the occurrence of preventable occurrences.
• Evidence of Neglect:
• The local hospital complained to the state of Texas that Alice R. had been neglected by the nursing home.
• TDHS substantiated the hospital complaint allegations of neglect.
• TDHS determined that Alice R. and other residents failed to receive pressure sore treatment and care to promote healing, prevent infection, and prevent new pressure sores from developing.
Interview with attending physicians revealed they were very concerned about the care provided residents, including Alice R. Per one physician, the nursing home admitted it could not provide adequate wound care to residents.
• Evidence of Neglect (Cont.):
• TDHS found that the attending physician was not provided accurate descriptions of the wound of the resident.
• The nursing home had improperly staged Alice R.'s pressure sores as Stage II wounds. They were in fact Stage IV wounds.
• Violations of Law:
• 40 TAC §19.901(3)(B) – the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores and that pressure sores are appropriately monitored and treated for residents such as Alice R.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....No
• Amount of a fine imposed?.....$0
• Amount of fine paid? $0
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....No
• RN Board Action?.....None
• Did TDHS refer this to the AG?.....No
• Did the AG prosecute this neglect?.....No
• Did TDHS refer this neglect to the LNFA Board?.....No
• LNFA Board Action?.....None
• Did TDHS suspend new admissions to facility? .....No
• Did TDHS recommend denial of payment for new admissions?.....No
• Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
• Did TDHS place nursing home on state monitoring status?.....No
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
93

39

Resident: Faustino G.

Nursing Home: Hidalgo County

Location: McAllen, TX

Residency: 2/16/94 – 11/1/94

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Handyman/Caretaker;
- Primary Diagnosis: Insulin dependent diabetes mellitus, Parkinsons and Anemia.

Nursing Home's Description on Admit:

- **No pressure sores;**
- **No pain symptoms;**
- **No nutritional problems;**
- No dehydration;
- Able to walk with limited assistance.

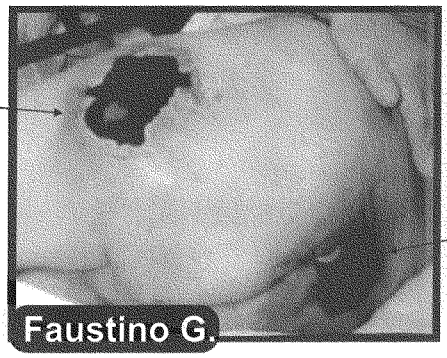
A PROFILE IN NEGLECT: CORE FACTS

- **Former Direct Caregiver Testified to Negligent Care:**
  - "I knew wound care and dressing changes were not being done because after I would date and initial mine, I would look at the chart, and the chart would show that the treatment was done, but in fact, it hadn't been done because my dressing was still on there."
- **The Nursing Home:**
  - **Persistently violated physician's orders in regard to pressure ulcer care;**
  - Did not adequately communicate with physician on staging and condition of pressure sores;
  - Failed to monitor weight, fluid and food intake resulting in inadequate nutrition, hydration and weight loss;
  - Was chronically and dangerously understaffed;
  - Negligent care resulted in increase of susceptibility to skin breakdown;
  - **Routinely violated policy and procedures requiring turning and repositioning of Faustino every 2 hours, resulting in massive wounds;**
  - Failed to implement any pain management program.

94 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Gangrenous, Stage IV Left Hip Pressure Sore: 10 cm



Gangrenous, Stage IV Sacral Pressure Sore: 10 cm

- **Developed in-house, Stage IV, massive sacrum pressure sore, measuring 10 cm diameter, to the bone;**
- **Developed in-house, Stage IV, necrotic right hip pressure sore measuring 10 cm in diameter;**
- **Osteomyelitis of the sacral area (severe bone infection);**
- **Gangrene** of multiple pressure sores;
- **Developed a total of 13 infected pressure sores;**
- Infection of pressure sore led to amputation of toe;
- **Malnutrition, with 16 lb weight loss;**
- Ongoing, excruciating pain;
- Death due to gangrenous pressure sores.
- Medical Expenses - in excess of $15,000.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....*
- Did TDHS refer this neglect to DA?.....*
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?.....*
- Amount of fine paid?..... *
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this neglect to AG?.....*
- Did AG prosecute this neglect?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....*
- Did TDHS recommend denial of payment for new admissions for this neglect?.....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....*
- Did TDHS place nursing home on state monitoring status due to this neglect?....*
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations.

95

40

*** Resident: Luis T. (Resident #23)**
Nursing Home: Hidalgo County
Location: Weslaco, Texas
Date of Investigation: 5-22-00
File No. 18

THE BEFORE PICTURE

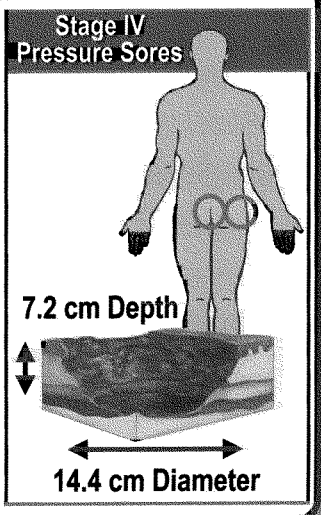
Profile of Resident on Admit to Nursing Home:

- Age at time of investigation: 77;
- Primary diagnosis: Insulin diabetes (IDDM), renal disease, anemia, gastritis, duodenitis, hypertension and cellulitis;
- Helpless and totally dependent resident;
- **No pressure sores noted on admission.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 5/00, Luis T. was transferred to the hospital, where the following was discovered:
  - Luis had developed at least 4 in-house pressure sores in the facility;
  - **Luis had a Stage IV right hip pressure sore, all the way down to the bone, measuring 14.4 cm in length with 7.2 cm of undermining and yellow-green drainage;**
  - **Luis had a Stage IV sacral pressure sore, measuring 14 cm in diameter, with the sacral bone exposed and yellow-green, foul odor drainage;**
- Hospital notes also noted pressure sores on the left and right ankle **with bone exposed;**
- Hospital staff also confirmed that Luis entered the hospital with **large amounts of black and necrotic tissue covering the pressure sores,** and, when these were removed, more black tissue was exposed and there were large amounts of purulent drainage from the wounds.



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The information contained in this case study derives from official gov

TDHS: This is a summary and not the official record

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **A complaint was given and substantiated by TDHS by the hospital social worker and physical therapist regarding the neglect of Luis.**
  - The hospital staff felt the facility was not turning the resident often enough and not keeping Luis clean and dry.
  - TDHS found that failure of the facility to accurately assess residents for and reassess pressure sore intervention placed residents at risk of deterioration of the sores, unnecessary suffering and pain.
  - **It was noted that Luis expired 10 days after the TDHS investigation was completed, from the infected infected Stage IV pressure sores.**
  - **The facility only sent the resident to the hospital at the urging of the family members.**

A complaint was given and substantiated by TDHS by the hospital social worker and physical therapist regarding the neglect of Luis.

- **Evidence of Neglect (Cont.):**
  - The facility failed to perform required assessments and to maintain care plans. **In fact, none of the pressure sores were care planned prior to this resident's death.**
  - TDHS also found that by not having management present to enforce accountability, the facility was in a state of crisis and systematic breakdown.
  - TDHS found the facility failed to ensure infection control guidelines were followed, placing residents at risk for serious infections.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - failing to prevent and treat pressure sores.
  - 40 TAC §19.1001(2) - failing to maintain sufficient staffing in that there was no registered nurse present in the building 8 hours a day, 7 days a week.
  - 40 TAC §19.801(2)(D) - failing to ensure that residents are assessed using the quarterly review instrument (MDS) by an interdisciplinary team.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....No, DA found no referral in this matter.
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$75,250
- Amount of fine paid?.....$25,000
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes, 4 hrs patient care & 4 hrs facility management CE.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

41

Resident: Jesus S.

Nursing Home: Jim Wells County

Location: Alice, TX

Residency: 4/7/93 – 1/16/97

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 80;
- Life's Occupation: Rancher;
- Primary Diagnosis: COPD; resolving pneumonia; arterosclerotic and cardiovascular disease.

Nursing Home's Description on Admit:

- **No pressure sores;**
- **No terminal illness;**
- **No pain symtoms;**
- **No malnutrition;**
- Totally dependent.

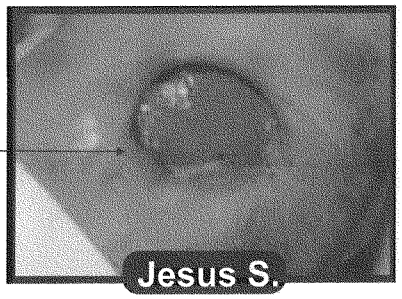
A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Stated:**
  - **" I saw his foot and was stunned, and wondered what was going on over there."**
  - **Voiced concerns to nursing home over the number of residents, including Jesus S., being admitted to the hospital dehydrated.**
- **The Nursing Home:**
  - **Frequently left Jesus lying in dried urine and feces for many hours at a time;**
  - **Failed to provide any pain relief for massive pressure sores;**
  - Failed to ensure that resident's nutritional needs were met;
  - **Failed to provide proper hydration on routine basis;**
  - Persistently failed to monitor daily fluid intake;
  - **Routinely failed to turn and reposition Jesus and clean his skin;**
  - Failed to provide proper nursing care, nutritional care;
  - Failed to maintain accurate records;
  - Failed to prevent development of and worsening of multiple pressure ulcers;
  - Falsified entries in Jesus' medical chart.

98 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Left Hip, Stage IV Pressure Sore: 10 cm x 5 cm, 3 cm to the Bone



- **Developed left trochanter pressure sore, measuring 8 cm x 5 cm x 3 cm, increasing to 10 cm. The sore eroded into the bone, resulting in partial removal of the hip bone;**
- **Developed multiple, in-house pressure sores:**
  - Left buttocks, Stage IV, measuring 3.5 cm x 2 cm;
  - Right buttocks, Stage II, measuring 2.5 cm x .5 cm x .5 cm;
  - Coccyx, Stage II, measuring 1.5 cm x .5 cm;
  - Right scrotum, measuring 4 cm;
  - Right ankle, measuring 4.5 cm x 3 cm;
  - Right outer foot, Stage III, measuring 4 cm x 3.5 cm;
  - Left inner heel, measuring 5 cm x 2.5 cm;
- **Severely infected wounds (MRSA) resulted in right leg amputation;**
- **Malnutrition – lost 50 lbs;**
- **Hospitalized for dehydration 3 times;**
- Suffered incessant unmanaged pain from wounds;
- Hospital Expenses – $115,618.75.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....*
- Did TDHS refer this neglect to DA?.....*
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?.....*
- Amount of fine paid?.....*
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this neglect to AG?.....*
- Did AG prosecute this neglect?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....*
- Did TDHS recommend denial of payment for new admissions for this neglect?.....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?....*
- Did TDHS place nursing home on state monitoring status due to this neglect?.....*
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations.

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42

*** Resident: Gladys B. (Resident #14)**
Nursing Home: Wilson County
Location: Floresville, Texas
Date of Investigation: 8-23-01
File No. 20

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 81;
- Primary diagnosis: Acute MRI by history, Alzheimer's disease, congestive heart failure and renal tumor;
- Helpless, dependent resident;
- **No pressure sores on admission.**

TDHS FINDINGS OF FACT

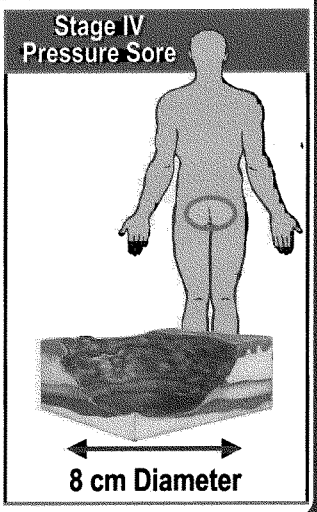
Nature of Injuries Discovered:

– On 8/22/01, TDHS discovered that:

Gladys B. had developed at least 3 in-house, avoidable pressure sores due to facility neglect:

- **sacral/coccyx sore, observed to be a Stage IV, measuring approximately 8 cm x 6 cm with reddened borders all around, yellow sloughing in the center, and draining an odorous discharge;**
- **bilateral heel sores were also present;**
- **coccyx sore was especially painful for Gladys B, who informed the surveyor that her "bottom was hurting";**

– **Gladys B. had also suffered a right hip fracture in 7/01, due to facility neglect.**



100

*The information contained in this case study derives from official governmental records. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **The attending physician was upset with the condition of the pressure sore, as he had not been informed of the deterioration of the coccyx pressure sore prior to the TDHS survey.**
  - An interview with the nurse revealed that the physician was not informed of the initial development of the sacral pressure sore for a period of 5 to 6 days. By that time, the pressure sore had worsened from a Stage II to a Stage III. New pressure sores on the heel were not reported to the physician at all.
  - The facility failed to perform a significant change of condition assessment and **failed to have a care plan for a Stage IV pressure sore.**
  - The facility failed to accurately document the status of the pressure ulcers, especially regarding the size, undermining necrotic tissue odor, and exudate of the wounds.

The attending physician was upset with the condition of the pressure sore, as he had not been informed of the deterioration of the coccyx pressure sore prior to the TDHS survey.

- **Evidence of Neglect (Cont.):**
  - The facility failed to perform systematic skin inspections.
  - Due to the facility failures, Gladys B. fell in the facility, fracturing her right hip, which decreased her mobility and required her to have surgical intervention with an ORIF performed.
- **Violations of Law:**
  - 40 TAC §19.901(3)(A) - failing to prevent and treat pressure sores.
  - 40 TAC §19.403(k)(1)(B) - failing to inform the resident's physician when there is a significant change in the resident's condition.
  - 40 TAC 19.601 (b) – failing to prevent abuse and neglect of residents.
  - 40 TAC §19.801(2)(C)(ii) - failing to conduct a comprehensive assessment of resident on a timely basis after a significant change in condition has occurred.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$2,500
- Amount of fine paid?.....$2,500
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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43

Resident: Ruth H.

Nursing Home: Nueces County

Location: Corpus Christi, TX

Residency: 7/1/93-1/14/95

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 90;
- Life's Occupation: Homemaker;
- Primary Diagnosis: CHF, UTI, anemia, rheumatoid arthritis and contractures;
- Total care patient.

Nursing Home's Description on Admit:

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition.**

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Continually failed to turn and reposition due to dangerous understaffing, resulting in Stage IV pressure sores;**
  - **Repeatedly failed to provide basic hygienic and sanitary care, resulting in inhumane conditions;**
  - Routinely failed to provide adequate nutrition and hydration;
  - Persistently violated orders for nutritional assessment and caloric count;
  - Violated physician orders to provide aggressive prevention of heel pressure sore;
  - **Resident entered the emergency room from nursing home with full dried feces on buttocks, hips, coccyx, cast and peri area.**
  - **Emergency room described upon admittance: "her urine was like pus".**

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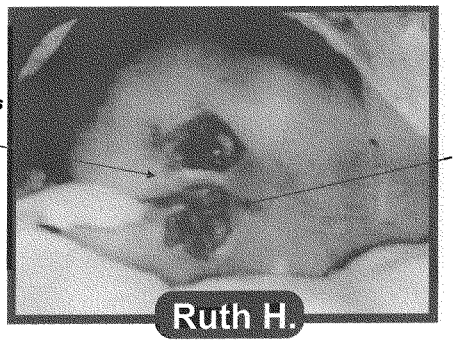
THE AFTER PICTURE: SEVERITY OF INJURIES



Stage IV Left Sacrum, Pressure Sore: 8 cm x 6 cm, 1.5 cm Deep

- **Developed multiple, in-house pressure sores:**
  - **Stage IV, left sacrum, measuring 8 cm x 6 cm X 1.5 cm;**
  - **Stage IV, right side of sacrum, measuring 8 cm x 6 cm x .5 cm;**
  - **necrotic, right heel measuring 10 cm in diameter;**
- **Left leg found with bone sticking through skin, severely infected;**
- **Bilateral and right leg fractures;**
- Developed multiple infection sites due to inadequate treatment;
- **Malnutrition - 24 lb weight loss;**
- **Severe, unrelenting pain;**
- Developed fatal sepsis from pressure sores;
- Hospital Expenses — $127,211.62.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....*
- Did TDHS refer this neglect to DA?.....*
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?.....*
- Amount of fine paid?.....*
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this neglect to AG?.....*
- Did AG prosecute this neglect?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....*
- Did TDHS recommend denial of payment for new admissions for this neglect?.....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....*
- Did TDHS place nursing home on state monitoring status due to this neglect?.....*
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations.

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*** Resident: Noel B. (Resident #1)**
Nursing Home: San Patricio County
Location: Aransas Pass, Texas
Date of Investigation: 5-13-99
File No. 21

THE BEFORE PICTURE

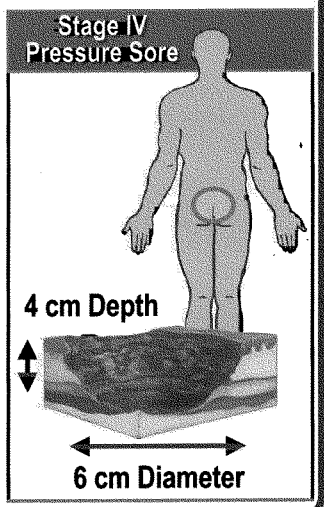
Profile of Resident on Admit to Nursing Home:

- Age: 77;
- Primary diagnosis: History of CVA and diabetes;
- Helpless, totally dependent upon nursing home for basic care;
- **No pressure sores noted on nursing home admission.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- In 5/00, Noel B. was hospitalized, where the hospital staff discovered at least 4 avoidable pressure sores which had developed in the nursing home.
- The largest sore was a **Stage IV on the coccyx, which was last measured to be 6 cm x 5 cm at a depth of 4 cm, with tunneling of 2 cm,** and was black and necrotic when Noel B. was admitted to the hospital.
- **Due to the neglectful condition of Noel B. on admission to the hospital, the staff reported the nursing home for neglect and care deprivation, which resulted in multiple, infected pressure sores, dehydration and malnutrition.**



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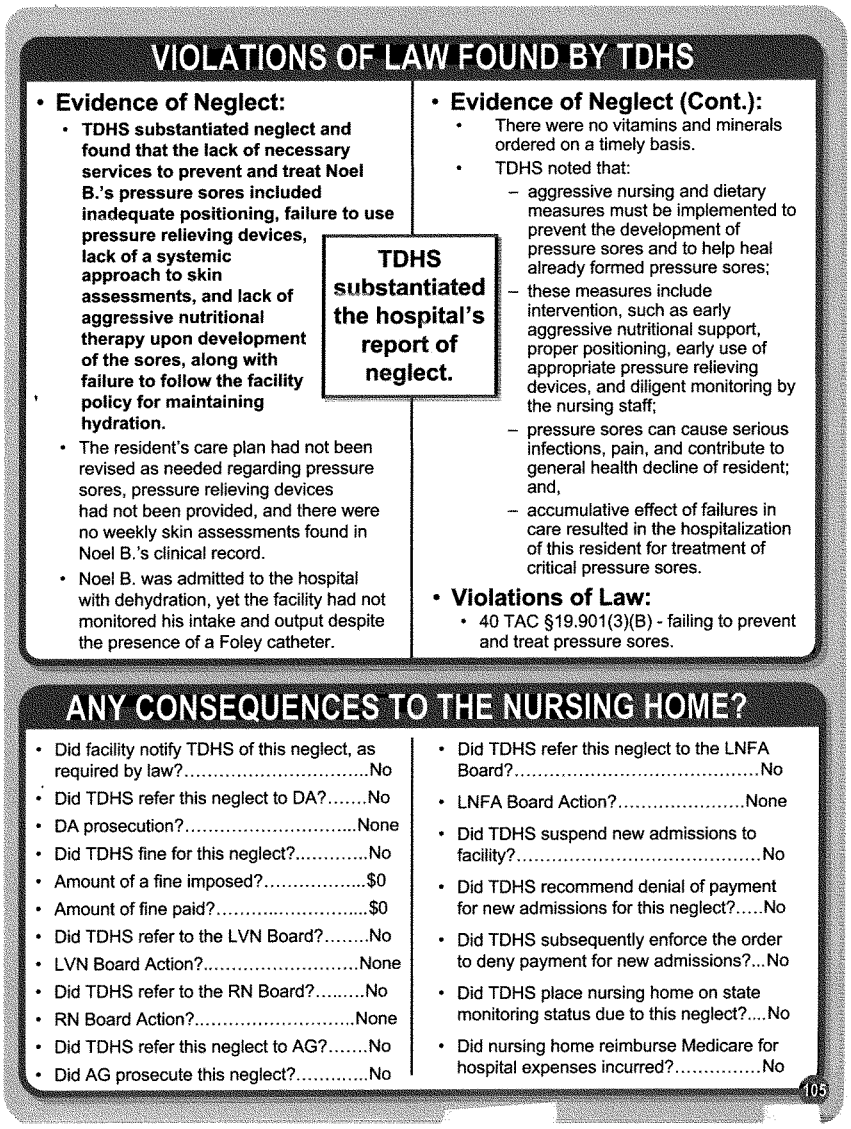
VIOLATIONS OF LAW FOUND BY TDHS
• Evidence of Neglect:
• TDHS substantiated neglect and found that the lack of necessary services to prevent and treat Noel B.'s pressure sores included inadequate positioning, failure to use pressure relieving devices, lack of a systemic approach to skin assessments, and lack of aggressive nutritional therapy upon development of the sores, along with failure to follow the facility policy for maintaining hydration.
• The resident's care plan had not been revised as needed regarding pressure sores, pressure relieving devices had not been provided, and there were no weekly skin assessments found in Noel B.'s clinical record.
• Noel B. was admitted to the hospital with dehydration, yet the facility had not monitored his intake and output despite the presence of a Foley catheter.
TDHS substantiated the hospital's report of neglect.
• Evidence of Neglect (Cont.):
• There were no vitamins and minerals ordered on a timely basis.
• TDHS noted that:
– aggressive nursing and dietary measures must be implemented to prevent the development of pressure sores and to help heal already formed pressure sores;
– these measures include intervention, such as early aggressive nutritional support, proper positioning, early use of appropriate pressure relieving devices, and diligent monitoring by the nursing staff;
– pressure sores can cause serious infections, pain, and contribute to general health decline of resident; and,
– accumulative effect of failures in care resulted in the hospitalization of this resident for treatment of critical pressure sores.
• Violations of Law:
• 40 TAC §19.901(3)(B) - failing to prevent and treat pressure sores.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....No
• Amount of a fine imposed?.....$0
• Amount of fine paid?.....$0
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....No
• RN Board Action?.....None
• Did TDHS refer this neglect to AG?.....No
• Did AG prosecute this neglect?.....No
• Did TDHS refer this neglect to the LNFA Board?.....No
• LNFA Board Action?.....None
• Did TDHS suspend new admissions to facility?.....No
• Did TDHS recommend denial of payment for new admissions for this neglect?.....No
• Did TDHS subsequently enforce the order to deny payment for new admissions?...No
• Did TDHS place nursing home on state monitoring status due to this neglect?....No
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
105

45

Resident: Herman K.

Nursing Home: San Patricio County

Location: Rockport, TX

Residency: 3/15/95-6/22/95

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 81;
- Life's Occupation: U.S. Army & National Guard;
- Primary Diagnosis: status post hip fracture;
- Admitted for hip fracture;
- Total patient care.

Nursing Home's Description on Admit:

- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- **No pain symptoms;**
- Alert, stable.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Failed to ensure that Herman, who entered the nursing home without pressure sores, did not develop pressure sores by continually violating policies and procedures to turn and reposition;**
  - Failed to monitor weight, fluid and food intake, resulting in inadequate nutrition and hydration, weight loss, and susceptibility to skin breakdown;
  - **Once skin breakdown occurred, routinely failed to implement preventative measures to reduce chances of further skin breakdown and advancing deterioration;**
  - **Repeatedly failed to provide proper care, monitoring and treatment of decubitus ulcers, which resulted in worsening of decubitus ulcers including an infection resulting in a thick, foul-smelling, greenish drainage, and further skin breakdown;**
  - Failed to provide proper wound care and treatment, resulting in osteomyelitis (severe bone infection), a pseudomonas infection, methicillin-resistant infection and an e. coli infection;
  - Failed to adequately communicate with a physician on the stage and condition of Herman's decubitus ulcers;
  - Habitually operated the nursing home on an under staffed basis with staff who were incompetent, untrained, uncertified, and/or unqualified;
  - Violated physician's orders to give medication and control pain.

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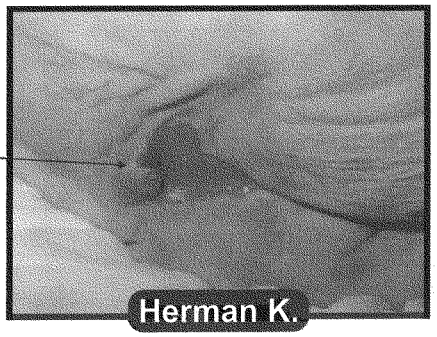
THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Coccyx Pressure Sore: 10 cm x 6 cm



- **Huge, open, Stage IV coccyx pressure sore, measuring 10 cm x 6 cm, with MRSA infection and strong odor;**
- **Osteomyelitis** (severe bone infection) of pressure sores resulted in double leg amputation;
- Developed multiple Stage IV pressure sores;
- Fractured hip;
- **Severe malnutrition and dehydration;**
- **Ongoing, severe pain;**
- Hospital Expenses – $81,158.57.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....*
- Did TDHS refer this neglect to DA?.....*
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?.....*
- Amount of fine paid?.....*
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this neglect to AG?.....*
- Did AG prosecute this neglect?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....*
- Did TDHS recommend denial of payment for new admissions for this neglect?.....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?....*
- Did TDHS place nursing home on state monitoring status due to this neglect?.....*
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations.

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46

* **Resident: Ms. X (Resident #13)**

Nursing Home: Cameron County

Location: Brownsville, Texas

Date of Investigation: 2-11-00

File No. 37

THE BEFORE PICTURE

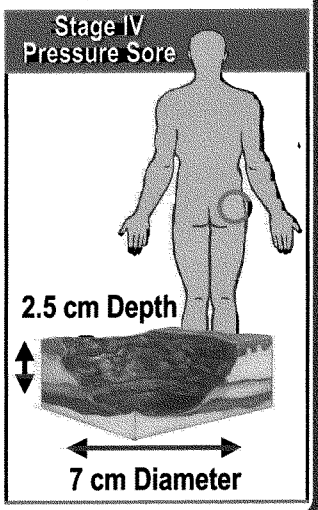
Profile of Resident on Admit to Nursing Home:

- Primary Diagnosis: Congestive heart failure, anemia, insomnia, Lupus and history of nephrectomy and anorexia;
- Totally dependent, helpless nursing home resident, requiring one to two person assistance with all aspects of her care;
- Upon admission to facility, there was a Stage I pressure sore to the coccyx, which subsequently healed.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 1/18/00, Ms. X was hospitalized for flap surgery to repair a severe, Stage IV right hip pressure sore, which was discovered by the hospital to measure 7 cm x 6 cm, with a depth of 2.5 cm, with tunneling and necrotic tissue throughout.**
- **TDHS found that Ms. X had developed at least 5 in-house pressure sores** in the facility, including a sacral pressure sore, which at the time of the 1/18/00 hospitalization, was draining a yellow-green exudate.
- **TDHS found that despite the presence of a feeding tube, Ms. X was malnourished and had lost weight down to 84 lbs, with evidence of dehydration.**



*The information contained in this case study derives from official government... his is a summary and not the official record...

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - **TDHS found that the development of all of the in-house pressure sores was preventable.**
  - **The physician had not been informed regarding the rapid deterioration of the pressure sores and the need for extra protein, calories, vitamins or zinc in Ms. X's diet.**
- **Evidence of Neglect:**
  - TDHS found that despite the presence of a feeding tube and problems with weight loss, **the facility had not monitored the intake and output** completely with multiple gaps in the I & O record.
  - The nursing home's registered dietician had not addressed any of Ms. X's pressure sores.

TDHS found all of the in-house sores were preventable.

The nursing home failed to inform the physician of the sores.

- **Evidence of Neglect (Cont.):**
  - **The MDS and care plan noted the need for pressure sore prevention; however, there was no evidence that turning, repositioning, or other interventions, as outlined in the care plan and MDS, were followed.**
- **Violations of Law:**
  - 40 TAC §19.901(3)(A) – facility failed to prevent, monitor, and treat pressure sores for Ms. X and other residents.
  - 40 TAC §19.901(10) – the facility failed to provide Ms. X with sufficient fluid intake to maintain proper hydration and health, prevent dehydration and ensure accurate intake and output records.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions? .....No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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47

*** Resident: Isabel H. (Resident #1)**

Nursing Home: Bexar County

Location: San Antonio, Texas

Date of Investigation: 8-11-00

File No. 30

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 82;
- Primary diagnosis: Alzheimer's disease, diabetes, hypertension, anxiety disorder, psychosis and hypothyroidism;
- Ambulatory nursing home resident with a history of eloping and wandering tendencies.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 8/7/00, at 4:37 p.m., EMS was dispatched to the facility for a "sick person" call where the paramedic discovered:**
  - **Isabel lying in a bed of cactus in cardiac arrest, with fire ants crawling over her face and neck, and a temperature of 107.5 degrees.**
  - **She had first, second, and third degree burns to both legs and right arm, with multiple puncture wounds and bruising to the entire body.**
  - After the EMS arrived, she was pronounced dead.
- TDHS found that residents were in immediate jeopardy to their health and safety as evidenced by the fact that Isabel H. wandered from the facility, where she was found unresponsive, with pupils fixed and dilated, and a **body temperature of 108.7 degrees.**
- **The facility waited 35 to 40 minutes after finding Isabel's body before calling EMS to remove the fire ants and cool down the body, not performing any CPR.**
- When ice cold towels were finally placed on her to bring down her body temperature, **Isabel's skin on her lower extremity peeled back and off.**

The facility waited 35 to 40 minutes after finding Isabel's body before calling EMS to remove the fire ants and cool down the body, not performing any CPR.

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*The information contained in this case study derives from official govern IS. This is a summary and not the official record

VIOLATIONS OF LAW FOUND BY TDHS

• Evidence of Neglect:

- Isabel had displayed wandering behavior since the time of her admission to the facility, and she frequently wandered out of the facility and followed staff around. There was no system to address the danger of wandering.
- **The facility had a non-functioning door alarm monitoring system, and failed to prevent wandering residents from leaving the facility.**
- **The cumulative effect of multiple system failures resulted in actual harm and death to Isabel, who was subjected to overexposure to the sun, which resulted in visible burns.**
- At 1:30 p.m. on 8/7/00, an occupational therapist could not find Isabel H. It was not until 3:15 p.m. that the nursing administration was notified that Isabel H. was missing.
- **She was found at 4:15 p.m. in back of the building, lying on the ground, unresponsive but still breathing, and fire ants were crawling on her face and neck. She was foaming at the mouth and nose.**
- There was no proof that the family or the attending physician were notified of the resident's status.
- **The facility staff commented they were not able to routinely meet residents' needs due to shortages in staff.**

TDHS substantiated the neglect of Isabel H., leading to her death, in two complaints (from EMS and the emergency room at the hospital).

• Evidence of Neglect (Cont.):

- There was no documentation in the clinical records that CPR measures were attempted, although EMS patient forms revealed the resident was in full cardiac arrest when they arrived at 4:45 p.m. Although the resident had a full code status order, **the facility staff stated "there was just not enough staff to go around to do everything that was required."**

• Violations of Law:

- 40 TAC §19.601(c)(1)(A) - failed to prevent abuse and neglect and ignored the needs of residents who wandered by failing to: 1) ensure the door alarm system was operable; 2) ensure that nurse aides assigned to wanderers were competent to keep them safe; 3) provide social services to identify triggers for strategies to minimize wandering behavior, 4) maintain enough facility staff to monitor residents leaving/attempting to leave the facility, and, 5) provide social services and activities to wandering resident Isabel H.
- 40 TAC §19.1001 – the facility failed to have sufficient staff members.
- 40 TAC §19.403(k)(1)(B)(C) – the facility staff failed to inform Isabel H. 's attending physician and responsible party in a timely manner of the resident's acute medical changes.
- 40 TAC §19.1701(3)(B) – the facility failed to have a functioning door alarm monitoring system that would assist facility staff in preventing wandering residents from leaving the facility.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....No
  No referral found.
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$130,900
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute this?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  30 day probated suspension, 10 hrs in ethics, 10 hrs in facility management and final report required from receptor.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions? .....No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Lucille T.

Nursing Home: Bexar County

Location: San Antonio, TX

Residency: 7/5/95 – 11/30/96

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 80;
- Life's Occupation: Bookkeeper and apartment complex manager;
- Primary Diagnosis: Dementia.

Nursing Home's Description on Admit: (per MDS)

- No end-stage disease;
- At ease interacting with others.

A PROFILE IN NEGLECT: CORE FACTS

- **Hospital Emergency Room Staff:**
  - **Reported the nursing home for the abuse and neglect of Lucille.**
- **TDHS:**
  - **Substantiated the neglect of Lucille based on violation of physician orders.**
- **The Nursing Home:**
  - **Repeatedly violated doctor's orders stating that bed rails were to be kept up for the patient's safety, resulting in death due to head trauma;**
  - **Took steps to conceal the neglect:**
    - Administrator, in letters to TDHS, denied that Lucille had been judged at-risk for falls, and denied that they had ever had orders for bedrails;
    - Contended that death was due to a seizure unrelated to the trauma she experienced;
    - Misinformed a TDHS investigator visiting the facility regarding the identity of the assistant director of nurses, in an attempt to keep his testimony from reaching TDHS;
  - Engaged in chronic understaffing;
  - Was indifferent to physician orders and prior hospitalization of Lucille caused by violation of safety precautions.

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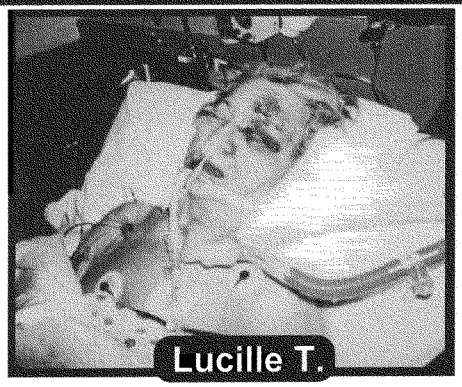
THE AFTER PICTURE: SEVERITY OF INJURIES

Hospitalization From Fatal Fall in Nursing Home



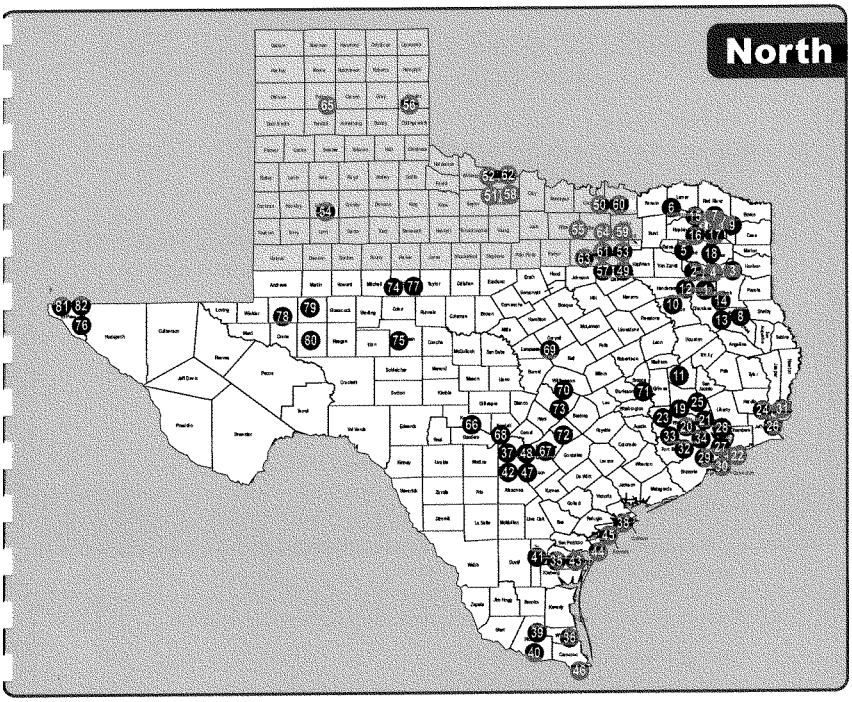
- Sustained numerous injuries due to falls while residing at the nursing home, because of facility indifference for safety precautions;
- **Despite knowledge that Lucille had repeatedly fallen and suffered injury due to an unfit bed with no side rails, the nursing home, in direct violation of doctor's orders, placed her back in the dangerous bed;**
- Within hours after readmission to nursing home from hospital after first fall, Lucille T. fell from her bed, which had no side rails, and suffered intracerebral hematoma (second fall in one day);
- Suffered pain and trauma due to falls;
- **Died due to intracerebral hemorrhage due to hematoma.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....*
- Did TDHS refer this neglect to DA?.....*
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....*
- Amount of a fine imposed?.....*
- Amount of fine paid?.....*
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this neglect to AG?.....*
- Did AG prosecute this neglect?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....*
- Did TDHS recommend denial of payment for new admissions for this neglect?.....*
- Did TDHS subsequently enforce the order to deny payment for new admissions?....*
- Did TDHS place nursing home on state monitoring status due to this neglect?.....*
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

*Unable to retrieve TDHS data due to computer retention limitations.

The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
49	Sarah M.	Dallas	Dallas	N
50	J.W.H.	Sherman	Grayson	N
51	Grover B.	Electra	Wichita	N
52	Helen H.	Irving	Wichita	N
53	Jose M.	Dallas	Dallas	N
54	Jose C.	Lubbock	Lubbock	N
55	Jimmie K.	Flower Mound	Denton	N
56	Mr. E.	Shamrock	Wheeler	N
57	Pearlie R.	Dallas	Dallas	N
58	Mary C.	Wichita Falls	Wichita	N
59	Frances G.	Plano	Collin	N
60	Edna F.	Sherman	Grayson	N
61	Max A.	Dallas	Dallas	N
62	Mary H.	Wichita Falls	Wichita	N
63	Oralee H.	Dallas	Dallas	N
64	Dottie B.	Celina	Collin	N
65	Zita	Amarillo	Potter	N

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Resident: Sarah M.

Nursing Home: Dallas County

Location: Dallas, TX

Residency: 5/14/98 – 11/20/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 72;
- Occupation: Homemaker;
- Primary Diagnosis: Stroke and Parkinson's Disease;
- Disabled;
- Totally dependent upon nursing home for basic needs;
- Alert, cooperative, smiling.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- **No end-stage disease;**
- Stable condition;
- Good rehabilitation candidate;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Testified That:**
  - Sarah's pressure sores, dehydration and malnutrition were the result of **"shocking neglect"**.
  - **Sarah's neglect and injuries amounted to "knowing injury to the elderly".**
- **The Facility Administrator Stated:**
  - **"Systematically, the facility was broken."**
  - **"Despite the crisis, corporate demanded we increase patient census. The effects were devastating to care."**
- **The Nursing Home:**
  - **Violated physician's orders to turn and reposition 73% of the time;**
  - **Routinely violated physician's orders for coccyx treatment 57% of the time;**
  - **Violated doctor's orders for dietary supplement 75% of the time (8/19 -11/4/98);**
  - Despite severe weight loss, the facility ignored doctor's orders to weigh Sarah 64% of the time (6/14/98 - 11/4/98);
  - Despite severe pain, there were no pain control measures implemented;
  - **Despite repeated findings of dehydration, the facility ignored physician's orders to increase hydration.**

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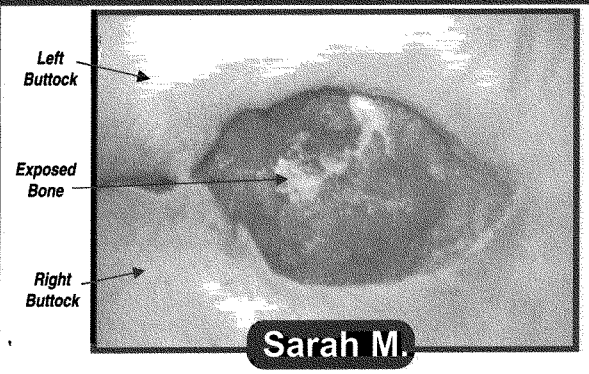
THE AFTER PICTURE: SEVERITY OF INJURIES



Infected, Stage IV Coccyx Pressure Sore: 15 cm x 6 cm, 4 cm Deep

- Developed infected, Stage IV, in-house coccyx pressure sore measuring **15.2 x 5.8 cm x 4 cm in depth with bone destruction** and bloody, purulent drainage (10/1/98 – 12/9/98);
- Developed 6, avoidable, in-house pressure sores at facility;
- Hospitalized **4 times for dehydration,** including hypernatremia (7/12/98 – 11/4/98);
- **50 lb weight loss** (5/14/98 – 11/4/98);
- Excruciating and ongoing pain caused by neglect (10/1/98 – 12/9/98);
- Death due to infected pressure sore, and gross neglect (12/9/98);
- Hospital Expenses – $117,004.16.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
  Unrelated fines imposed 11/4/98.
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: J.W.H. (Resident #1)**
Nursing Home: Grayson County
Location: Sherman, Texas
Date of Investigation: 1-19-01
File No. 2

THE BEFORE PICTURE

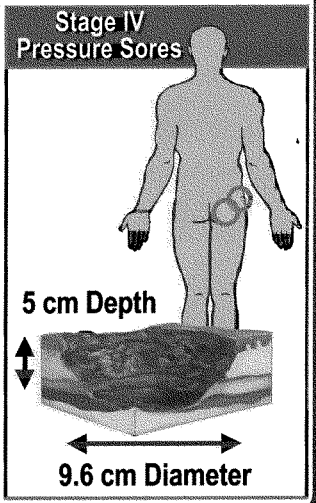
Profile of Resident on Admit to Nursing Home:

- Age: 83;
- Primary diagnosis: Peripheral vascular disease, chronic renal failure (hemo-dialysis), cardiovascular disease, and pulmonary artery disease;
- Helpless, totally dependent upon nursing home for all aspects of care;
- **No pressure sores upon admission to the nursing home;**
- Good eater, no malnourishment.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On the 1st day of January 2001, J. W. H. was admitted to the intensive care unit with deep, infected, foul-smelling pressure sores on his right hip and sacrum, **with exposed bone and muscle.**
- The hospital also discovered J. W. H. was in a **critical state of malnutrition,** with albumin of only 1.5.
- The **pressure sores discovered by the hospital** developed at the nursing home and are described as follows:
  - **right hip, Stage IV, 8.8 cm x 5.9 cm with a depth of 2 cm, with exposed bone and undermining;**
  - **right gluteal area, Stage IV, 9.6 cm x 7 cm with depth of 5 cm, with exposed bone.**
- **Due to the extensive bone necrosis at the base of the sacrum wound, extensive surgery was recommended, including hip disarticulation, possible removal of one-half of the pelvis bone, and massive flap surgery to attempt to correct the damage from the infected wounds.**



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"The information contained in this case study derives from official government... DHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - **J. W. H.'s physician determined that:**
    - **the resident had no pressure sores upon admit to the nursing home;**
    - the resident had no evidence of malnutrition and was eating well when admitted to the nursing home;
    - **the in-house pressure sores and weight loss caused by the nursing home were preventable.**
  - **TDHS determined that J. W. H.'s pressure sores and malnutrition were preventable conditions.**

Due to the severity of the pressure sores, the surgeon recommended splitting the hip joint, removing half of the pelvic bone, and performing extensive flap surgery.

- **Evidence of Neglect:**
  - **The local hospital reported the nursing home to the state for the neglect of J. W. H.**
  - **J. W. H's attending and hospital physicians agreed with the hospital's report of neglect,** concluding that J.W.H.'s "state of disrepair was due to inadequate care, poor nutrition, and neglect".
- **Violations of Law:**
  - TDHS found the facility violated:
    1) 40 TAC §19.901(3)(B) routinely failing to prevent, monitor, and treat J.W.H.'s pressure sore; and,
    2) 40 TAC §901 failing to ensure that J. W. H. received appropriate assessment and timely intervention following acute changes in his skin and nutritional status.
  - TDHS further found that the facility failed to provide needed nutritional supplements and ignored J.W.H.'s needs for increased caloric intake.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....*
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$85,000
- Amount of fine paid? $30,000
- Did TDHS refer to the LVN Board?.....*
- LVN Board Action?.....*
- Did TDHS refer to the RN Board?.....*
- RN Board Action?.....*
- Did TDHS refer this to the AG?.....*
- Did the AG prosecute?.....*
- Did TDHS refer this neglect to the LNFA Board?.....*
- LNFA Board Action?.....*
- Did TDHS suspend new admissions to facility?.....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions? .....Yes
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

* Facility closed 1/27/01.

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Resident: Grover B.

Nursing Home: Wichita County

Location: Electra, TX

Residency: 2/24/92 - 10/14/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 82;
- Life's Occupation: Carpenter;
- Primary Diagnosis: Organic brain syndrome, dehydration, convulsions and history of seizure disorder;
- Disabled.

Nursing Home's Description on Admit: (per MDS)

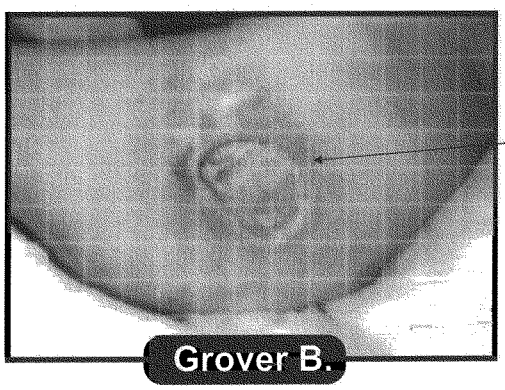
- **No pressure sores;**
- **No dehydration;**
- **No malnutrition;**
- No end-stage disease;
- No terminal illness;
- Stable condition.

A PROFILE IN NEGLECT: CORE FACTS

- **TDHS Findings of Neglect Specific to Grover B. :**
  - **TDHS found Grover was neglected in September 1999 and in April 2000;**
  - **TDHS issued over 100 pages of deficiency reports for September and April. The vast majority of the reports specifically address Grover's profound neglect;**
  - **TDHS determined the facility failed to:**
    - **provide ordered wound treatments to Grover;**
    - **notify the attending physician of significant changes in Grover's sores;**
    - **assess Grover's skin, and provide needed nutrition.**
- **Facility Direct Care Employees Admitted:**
  - **Grover was continuously and grossly neglected by the facility;**
  - Grover's sore was "big and deep – you could put your hand in it, and the foul odor made you want to throw up". "They were the worst sores I have ever seen."
  - **Grover was in excruciating pain** from his sores for at least one year. Despite such pain, no pain management program was implemented;
  - Facility was chronically understaffed, resulting in residents not being fed, lying in feces and urine, not being bathed, and not receiving dressing changes.

Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES



Deep, Necrotic and Infected Stage IV Pressure Sore: 13 cm x 8 cm, to the Bone

- **Developed 23 avoidable, in-house pressure sores,** 9 of which deteriorated into infected, Stage IV pressure sores;
- **Severe and untreated pain for 393 days from his massive pressure sores (9/17/99-10/14/00);**
- **Hospitalized 3 times for dehydration** (9/17/99-10/14/00);
- **41.5 lb weight loss** (28 lb weight loss in 4 months);
- Death due to multiple, infected pressure sores.
- Hospital Expenses – $11,472.53

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes, once
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$31,000
- Amount of fine paid?.....$31,000
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes, 2 times
- LNFA Board Action?.....Yes
  1. 30 days suspension, working under preceptor. 2.Dismissed for lack of evidence.
- Did TDHS suspend new admissions to facility?.....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes, two times
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?..Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Helen H. (Resident #17)**
Nursing Home: Dallas County
Location: Irving, Texas
Date of Investigation: 4-16-99
File No. 1

THE BEFORE PICTURE

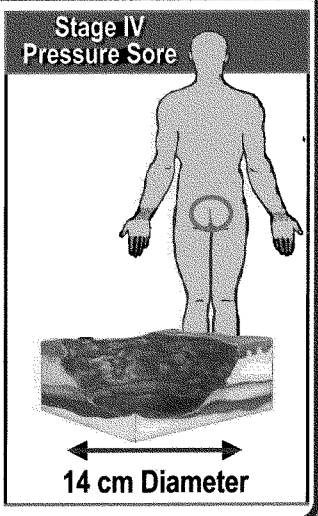
Profile of Resident on Admit to Nursing Home:

- Age: 87;
- Primary diagnosis: Dementia, bowel and bladder incontinence;
- Able to ambulate and participate in her care prior to fracturing her humerus in the facility on 2/28/99 as a result of resident-to-resident abuse. After the fracture, she was totally dependent upon the nursing home for basic care;
- **No pressure sores noted upon admission to facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **During a hospitalization on 3/18/99, the hospital discovered an in-house, avoidable, Stage IV pressure sore to the coccyx, measuring 14 cm x 14 cm, with a 6 cm x 4 cm blackened area in the center, draining frank blood,** which required surgical debridement.
- Helen H. groaned in pain when TDHS observed her in the hospital.
- Helen H. died after the hospitalization due to the infected pressure sore and malnutrition.



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5. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - Helen H.'s pressure sore development was preventable had the facility turned and repositioned her, addressed her nutritional needs, and heeded her pain, per TDHS.
  - **According to TDHS, failure to reassess and monitor Helen, following a fracture, placed her in immediate jeopardy and contributed to her pressure sore development as well as her death.**
- **Evidence of Neglect:**
  - **TDHS concluded that the lack of turning and positioning, as admitted by facility staff, caused the development of Helen H.'s huge, Stage IV coccyx pressure sore.**
  - The family was told this was a Stage I pressure sore immediately prior to the resident's admission to the hospital.
  - Lack of incontinent care contributed to pressure sore development.

TDHS concluded that the lack of turning and positioning, as admitted by facility staff, caused the development of Helen H.'s huge Stage IV coccyx pressure sore.

- **Evidence of Neglect (Cont.):**
  - The physician explained to TDHS and the family that the resident was now terminal due to her poor nutritional status and Stage IV pressure sore. The hospital could not heal Helen, due to her poor nutritional status secondary to her pain and lethargy.
  - TDHS found residents, including Helen H., had been placed in immediate jeopardy with substandard quality of care.
- **Violations of Law:**
  - **TDHS substantiated neglect for the development of the in-house, avoidable, painful Stage IV coccyx pressure sore, and failure to create a care plan for Helen H for a period of 2 years.**
  - 40 TAC §19.601(c)(2) - failing to investigate abuse and neglect.
  - 40 TAC §19.901- facility failed to appropriately assess and intervene and communicate changes in resident care needs to the appropriate staff, especially regarding pressure sores.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$50,000
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....Pending, due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  30 day probated license, 10 hrs CE, preceptor to supervise and report.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Jose M.

Nursing Home: Dallas County

Location: Dallas, TX

Residency: 6/17/98 – 11/27/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 74;
- Life's Occupation: Restaurant Worker;
- Primary Diagnosis: Left and right, above the knee, amputations, Diabetes Mellitus and CVA with left hemiplegia;
- Assistance with activities of daily living but able to feed self;
- Alert, cooperative, did not speak English.

Nursing Home's Description on Admit: (per MDS)

- **Double amputee;**
- **No pressure sores;**
- **No malnutrition;**
- **No dehydration;**
- Staff and resident believed he was capable of increased independence in activities of daily living;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Repeatedly failed to assess and monitor the skin condition of Jose;**
  - **Continuously failed to monitor intake and output status of Jose despite 4 hospitalizations for hypernatremic dehydration;**
  - Repeatedly failed to have an appropriate plan of care for his severe and painful pressure sores;
  - Repeatedly failed to monitor the weight of Jose despite the placement of a gastrostomy tube and two periods of time in which he lost 19 pounds in 1month;
  - Repeated violations of physician's orders for pressure sore treatments;
  - Failed to follow physician's order for pain medication to alleviate Jose's pain;
  - **Routinely failed to turn and reposition;**
  - Lost or destroyed 2 months of key medical records.

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THE AFTER PICTURE: SEVERITY OF INJURIES

Jose M.

Infected, Stage IV Coccyx Pressure Sore: 12cm in Diameter, 2.4 cm Deep, with Bone Exposed

- **Developed infected, Stage IV pressure sore to coccyx, measuring 12 cm in diameter x 2.4 cm, with exposed bone;**
- Multiple Stage II and III pressure sores;
- **Hospitalized 4 times for hypernatremic dehydration;**
- **Hospital discovered 10 liter fluid deficit upon admit;**
- **Hospitalized 3 times for malnutrition;**
- Hospital Expenses – $53,151.26.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Jose C. (Resident #2)**

Nursing Home: Lubbock County

Location: Lubbock, Texas

Date of Investigation: 3-13-98

File No. 11

THE BEFORE PICTURE

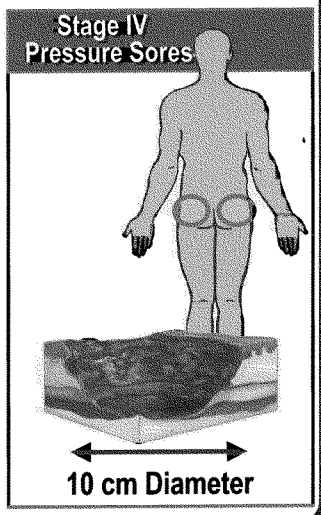
Profile of Resident on Admit: to Nursing Home:

- Primary diagnosis: Alzheimer's disease, Parkinson's disease, COPD (chronic obstructive pulmonary disease), hypertension, and swallowing difficulty with gastrostomy tube placement;
- Helpless;
- Totally dependent upon nursing home staff for basic care needs;
- **No pressure sores upon admission.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 3/11/98, Jose C. was hospitalized for infected, in-house, Stage IV pressure sores of the right hip and sacrum.
- **The largest pressure sore was on the right hip, measuring 10 cm x 9 cm with soppy, smelly, gray-black eschar, while the left hip pressure sore measured 8 cm x 7 cm with an area of eschar in the center.**
- **The right hip pressure sore was down to the bone and measured 11 cm x 10.5 cm after the debridement procedure, while the left hip pressure sore was beyond the muscle tissue and at least 7 cm in depth.**
- **The resident expired two days after admission to the hospital due to complications from the infected pressure sores with sepsis.**
- **The registered dietician recommended that the gastrostomy tube feeding be increased by 720 cc's. Those recommendations were violated, resulting in the resident receiving only 763 calories per day. Over a 37 day period, Jose was deprived of 30,000 calories, causing significant weight loss and malnutrition.**



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*The information contained in this case study derives from official gc ; of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - Interview with physician revealed that the nurses in the **facility had told him that the resident's pressure sores were only Stage II's,** all the way to the time of his hospital admission (3/11/98); thus, he had not prescribed the appropriate treatment. **The pressure sore development was avoidable.**
- **Evidence of Neglect:**
  - **TDHS found that these failures caused actual harm to this resident, with weight loss, malnutrition, and avoidable pressure sore development.**
  - **An interview with this resident's physician revealed that there was no reason that the resident should have developed these pressure sores on his hip.**
  - The consultant plastic surgeon, who saw this resident in the hospital, confirmed that there was little hope that these pressure sores could heal and **that nothing could be done to close these areas because the resident would probably not survive the extensive surgery which would be required.**

TDHS found that these failures caused actual harm to this resident, with weight loss, malnutrition, and avoidable pressure sore development.

- **Evidence of Neglect (Cont.):**
  - The failure of the facility staff to correctly interpret the registered dietician's recommendations resulted in the resident losing weight and becoming nutritionally compromised. This resulted in the resident suffering actual harm when he developed these Stage IV pressure sores, which resulted in his death a few days after hospital admission.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) – the facility failed to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.901 – the facility failed to ensure that physician's orders were carried out in a timely manner and in failing to ensure that physician was informed of significant changes in resident's condition.
  - TDHS substantiated allegations of neglect relevant to Jose C.'s injuries.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this?.....Yes, reached compromise and settlement.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

55

Resident: Jimmie K.

Nursing Home: Denton County

Location: Flower Mound, TX

Residency: 10/21/98 – 2/5/02

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 67;
- Life's Occupation: Customer service;
- Primary Diagnosis: Multiple sclerosis, hypertension with renal failure and paraplegia;
- Alert, friendly;
- Electric wheelchair for mobility.

Nursing Home's Description on Admit: (per MDS)

- **No dehydration;**
- **No malnutrition;**
- No terminal illness;
- No pain symptoms;
- Total assistance with activities of daily living.

A PROFILE IN NEGLECT: CORE FACTS

- **TDHS:**
  - **Substantiated neglect for the in-house occurrence of Jimmie's coccyx and buttocks pressure sores.**
- **The Nursing Home:**
  - **Failed, on an ongoing basis, to turn and reposition Jimmie;**
  - **Repeatedly failed to follow physician's orders for hydration;**
  - Continuously failed to monitor the intake and output of Jimmie;
  - **Repeatedly failed to follow physician's ordered treatments to Jimmie's multiple pressures sores;**
  - Continuously failed to apply physician ordered protective appliances, resulting in multiple, severe Stage IV pressure sores to bilateral heels and leg, as documented by the attending physician on multiple occasions;
  - Continuously failed to prevent infection of the gastrostomy site;
  - Failed to ensure the g-tube was in proper placement, resulting in abdominal wall cellulitis and requiring hospitalization.

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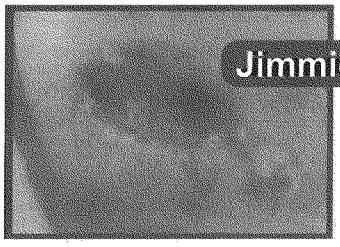
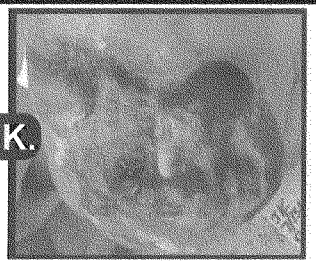
THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Right Hip Pressure Sore



Jimmie K.



Stage IV Right Heel Pressure Sore

- **Developed Stage IV right hip pressure sore, measuring 10 cm x 6 cm, with exposed femoral head, osteomylitis and MRSA;**
- **Developed a Stage IV right foot pressure sore, measuring 16 cm x 11 cm;**
- **Developed Stage IV left buttock pressure sore, measuring 9 cm x 8 cm x 1 cm, with exposed ischium and MRSA;**
- Developed Stage IV left shin pressure sore, measuring 10 cm x 4 cm, with MRSA;
- **Developed Stage IV right ischial pressure sore, measuring 7 cm x 5 cm x .5cm, with MRSA;**
- Developed Stage III left tibial pressure sore, measuring 10 cm x 2.3 cm, with MRSA;
- Severe and painful contractures of all extremities (elbows, wrists, fingers, hips, knees, ankles), preventing special treatment measures for the severe, multiple stage IV pressure sores;
- **Hospitalized 2 times for dehydration;**
- **76 lb weight loss over 33 months, despite a g-tube placement during that timeframe.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
  Unrelated fines imposed 3/27/01 & 2/8/02.
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

56 * **Resident: Mr. E. (Resident #1)**

Nursing Home: Wheeler County

Location: Shamrock, Texas

Date of Investigation: 8-5-98

File No. 34

THE BEFORE PICTURE

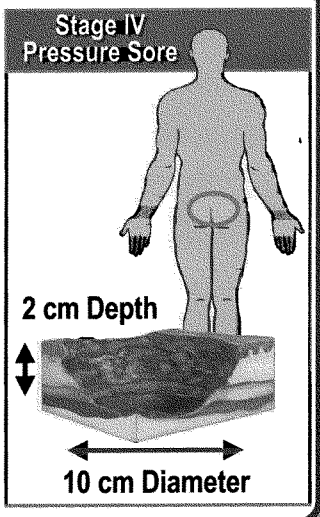
Profile of Resident on Admit to Nursing Home:

- Age: 82;
- Primary diagnosis: Alzheimer's, blood pressure and heart problems;
- Helpless;
- Totally dependent upon nursing home for basic care;
- **No pressure sores upon admit.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 8/3/98, Mr. E. was transferred to the local hospital. EMS paramedics discovered Mr. E. had developed 4 in-house pressure sores with the coccyx becoming a **Stage IV wound which measured 10 cm in diameter and 2 cm in depth.**
- At the hospital on 8/5/98, the **Stage IV coccyx pressure sore on Mr. E. was observed to be covered with odorous, thick, leathery, black necrotic tissue, with the tailbone visible.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - EMS found Mr. E. to have crusty, dried stool on his coccyx wound and strong fecal odor.
  - **TDHS substantiated complaint of neglect of Mr. E. given by paramedic/EMS.**
  - Interviews with 8 facility staff members revealed that the facility had not addressed the issue of pressure sores, did not know how to evaluate pressure sores, and did not have pressure sore relieving devices for residents.
  - The facility failed to contact Mr. E.'s physician regarding the existence of a Stage IV pressure sore.
  - **At time TDHS discovered Mr. E.'s massive pressure sore, facility's director of nurses stated, "The resident had only one Stage II pressure sore."**
  - Facility's director of nurses admitted she did not know how to stage pressure sores beyond a Stage II.

The tailbone was clearly visible when the brownish, green, gummy exudate and pus were cleaned from the crater... EMS paramedic stated, "He had never seen such neglect of a resident."

- **Evidence of Neglect (Cont.):**
  - In addition, 4 other residents were observed at the facility to have pressure sores. According to TDHS, 3 out of 5 of these residents did not receive adequate care to prevent or treat their pressure sores. The facility was putting castor oil on Mr. E.'s coccyx pressure sore.
  - When TDHS arrived to perform its investigation, the facility administrator stated, **"We expected the State to come in because we had overheard that EMS was calling in a complaint." When TDHS entered the building, the parking lot was overflowing with employee cars.**
  - The facility failed to have a functioning system in place which ensured assessment, pressure relieving devices, repositioning, and medical treatments to pressure sores.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - routinely failing to prevent and treat pressure sores.
  - 40 TAC §19.801(2)(D) - by failing to routinely and accurately assess Mr. E.'s pressure sores.
  - 40 TAC §19.802(b)(3) - failing to provide a care plan that addressed Mr. E.'s pressure sores.
  - 40 TAC §19.1903(4) - failing to enroll nurse aides in state required training.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes, 10 hrs CE in resident care.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Pearlie R.

Nursing Home: Dallas County

Location: Lancaster, TX

Residency: 4/7/98 - 4/7/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 84;
- Life's Occupation: Housewife;
- Primary Diagnosis: Hypertension, Alzheimer's Disease, depressive disorder, and neurotic disorder;
- Disabled;
- Dependent upon nursing home for basic needs.

Nursing Home's Description on Admit: (per MDS & Admit Records)

- **No pressure sores;**
- **No contractures;**
- **No malnutrition;**
- No end-stage disease;
- No terminal illness;
- Good candidate for rehabilitation.

A PROFILE IN NEGLECT: CORE FACTS

- **Facility Charge Nurse and Key Direct Care Givers Admitted:**

– Pearlie was neglected because the nursing home:

- Waited 106 days to perform an initial comprehensive assessment and 109 days to develop a care plan;
- **Routinely violated physician's orders, which caused contractures and wasted limbs;**
- Consistently failed to monitor and assess Pearlie's skin;
- **Repeatedly violated physician's orders to treat Pearlie's pressure sores;**
- Failed to inform the attending physician of the progression and worsening of Pearlie's wounds;
- **Persistently failed to turn and reposition Pearlie;**
- Failed to notify dietary department on progression of Pearlie's wounds;
- Failed to update the care plan and address Pearlie's wound progression;
- Knew the consequences of not turning and not providing the ordered treatments to Pearlie;
- Falsified Pearlie's medical chart to make it appear as though care was provided.

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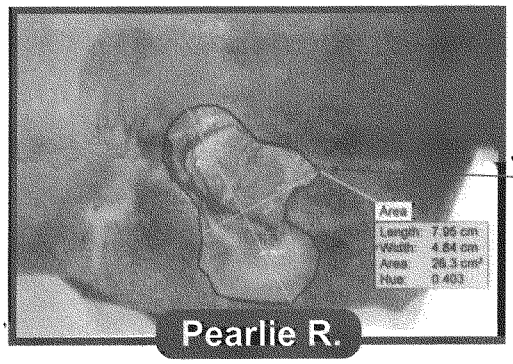
THE AFTER PICTURE: SEVERITY OF INJURIES



Infected, Stage IV Sacral Pressure Sore: 7.95 cm x 4.84 cm, with Tendon Visible

- Developed sacral pressure sore, measuring 15 cm x 6 cm upon debridement, width 4.84 cm, with the tendon visible, tunneling, foul odor, and necrosis;
- **Pearlie's pressure sores required over 100 debridements;**
- Extremities wasted and contracted, resulting in continual pressure to left heel;
- Developed multiple severe pressure sores, including a Stage IV left heel pressure sore, that resulted in the amputation of her left leg;
- **Multiple episodes of dehydration, including hypernatremic dehydration, combined with malnutrition, despite presence of a PEG tube;**
- Multiple, painful debridements of pressure sores.
- Hospital Expenses - $55,735.66.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
  Unrelated fine imposed 11/4/98.
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Mary C. (Resident #2)**
Nursing Home: Wichita County
Location: Wichita Falls, Texas
Date of Investigation: 4-20-99
File No. 22

THE BEFORE PICTURE

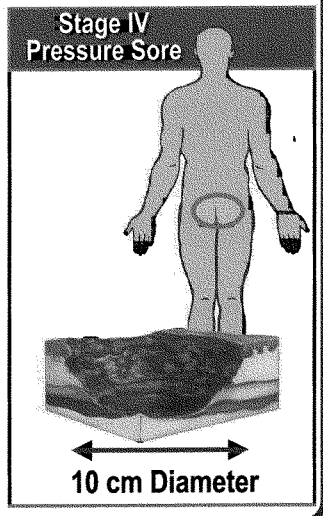
Profile of Resident on Admit to Nursing Home:

- Primary Diagnosis: Dementia, Foley catheter for bladder incontinence;
- Helpless;
- Totally dependent upon nursing home for basic care;
- Upon admission to nursing home, had red areas to bilateral ankles; otherwise, no skin concerns or pressure sores noted.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 4/19/99, TDHS discovered Mary C. to have multiple, in-house pressure sores; at least three were Stage IV's, including the coccyx, which was a Stage IV, measuring 10 cm x 6 cm,** with Stage IV pressure sores present on her feet.
- **Facility failures caused Mary C. to be hospitalized in February, 1999 for these infected pressures sores, as well as dehydration.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **The facility failed to prevent the deterioration of pressure sores by failing to keep the resident turned and repositioned, and by failing to provide pressure relieving devices to the feet bilaterally, according to TDHS.**
  - TDHS found that residents at risk for skin breakdown should be monitored closely through weekly skin rounds, meeting nutritional needs, turning and repositioning, and ensuring pressure relieving devices are utilized. These were not done by the facility for Mary C.
  - A foot cradle which was ordered to be placed over the resident's feet to protect the Stage IV pressure sores was not in place, nor were the heel booties that had been ordered. Observation of this resident by TDHS revealed that her feet and back were in direct contact with the mattress, with unrelieved, obvious pressure, directly on the pressure sores.

The facility repeatedly failed to reposition Mary C. for prolonged periods of time.

- **Evidence of Neglect (Cont.):**
  - **TDHS found that Mary C. was left on her back for prolonged periods of time,** despite the facility acknowledging the need to turn this resident at least every 2 hours.
  - The clinical record review revealed that Mary C. was receiving anti-psychotic medications without being monitored for side effects, compromising her quality of life and affecting pressure sore healing.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) routinely failing to prevent and treat pressure sores.
  - 40 TAC §19.902(b)(3) failing to develop a comprehensive care plan for each resident.
  - 40 TAC §19.901(12) (A)(iii) failing to ensure that each resident drug regime must be free from unnecessary drugs.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Frances G.

Nursing Home: Collin County

Location: Plano, TX

Residency: 3/23/95-4/21/95

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 72;
- Life's Occupation: Housewife;
- Primary Diagnosis: History of CVA's with right-sided paralysis, diabetes, deep vein thrombosis, and aphasic;
- Followed activity with eyes, had a social smile, cooperative and pleasant;
- Totally dependent on staff for all ADL needs.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No dehydration;**
- **No malnutrition;**
- Aphasic but could communicate her needs with her left hand;
- Good rehabilitation candidate to maintain some ADL functions of her own.

A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Testified:**
  - **"The care at the nursing home was shocking."**
  - **"Frances was the victim of gross nursing home neglect. Her pressure sores and dehydration were inexcusable."**
- **A Charge Nurse Testified:**
  - "Frequently, there wasn't enough staff on unit **to even allow 30 minutes of time** for a nurse aide to spend with a patient during the day."
  - **The facility repeatedly violated physician's ordered treatments to the pressure sores.**
- **The Nursing Home:**
  - Repeatedly failed to turn and reposition Frances;
  - Routinely violated physician ordered treatments to the pressure sores;
  - Repeatedly violated physician ordered gastrostomy feedings, resulting in weight loss;
  - Repeatedly violated physician's orders for monitoring intake and output;
  - Continuously failed to hydrate Frances;
  - Failed to implement any pain management program for Frances.

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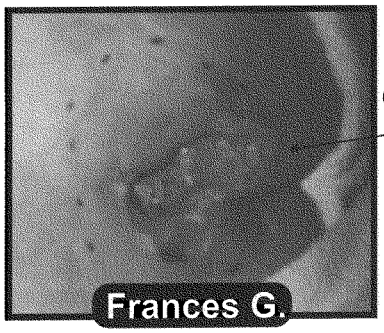
THE AFTER PICTURE: SEVERITY OF INJURIES



Infected, Stage IV Coccyx Pressure Sore: 11 cm x 9 cm, Penetrated to Bone

- **Developed a massive, Stage IV coccyx pressure sore, measuring 11 cm x 9 cm, which penetrated to the bone, and was necrotic and infected;**
- Developed a Stage III pressure sore of the right gluteal fold, covered with brown eschar;
- **Hypernatremic dehydration,** despite the fact Frances' fluid intake was controlled by staff who were required to hydrate her through gastrostomy tube;
- 21 lb weight loss in 30 days, despite a g-tube placement;
- Endured excruciating, continual pain from her pressure sores;
- Hospital expenses - $5,048.35.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?..... .$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Edna F. (Resident #6)**
Nursing Home: Grayson County
Location: Sherman, Texas
Date of Investigation: 4/21/99
File No. 3

THE BEFORE PICTURE

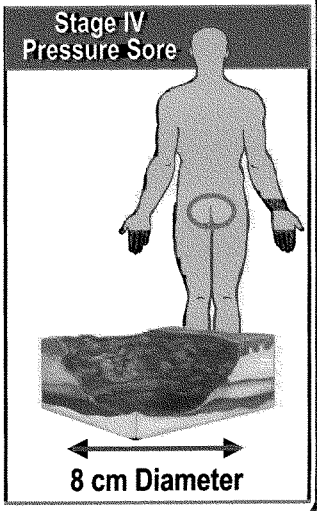
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Foley catheter, acute urinary tract infections, bilateral above the knee amputations, and feeding tube;
- Helpless, dependent nursing home resident who required 1 to 2 person assistance for all aspects of her care on a daily basis;
- **No pressure sores on admit.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On the 7th day of April 1996, TDHS discovered Edna F. with the following conditions:
  - **Stage IV coccyx pressure sore, measuring 8 cm x 7 cm;**
  - **The urine in Edna F.'s Foley catheter appeared to be grossly infected, with a foul, rotten egg odor, blood streaks, and significant sediment.**
- **The attending physician had not been made aware of these significant conditions,** and a urinary tract infection was diagnosed.



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HS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
- TDHS determined that Edna had been deprived of basic care to ensure her safety and well-being.
- **TDHS determined that Edna F. and other residents in the facility were placed in immediate jeopardy by facility practices with substandard quality of care.**
- **TDHS found that 16 of 19 facility staff members stated they were aware of, or had been asked to participate in, the falsification of medication sheets, treatment sheets, I & O documents, flow sheets, and pressure sore assessments under the direction of the Director of Nurses or Assistant Director of Nurses.**

"..falsification of resident records was a common and pervasive practice throughout the facility.."

- **Evidence of Neglect (Cont.):**
  - **TDHS determined through staff interviews and record reviews that falsification of resident records was a common and pervasive practice throughout the facility.**
  - **TDHS further found that facility was endangering the lives of residents by writing physician's orders without actually speaking to a physician.**
  - **Additionally, TDHS found the facility attempted to cover up eye witness reports of sexual abuse of residents.**
- **Violations of Law:**
- 40 TAC §19.901 – facility failed to maintain highest quality of care by failing to adequately assess and intervene in response to acute illness episodes.
- 40 TAC §19.1901 – the facility failed to: 1) ensure that residents were protected from sexual abuse; and, 2) prevent falsification of resident records.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....No,
  AG said no referral received.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  $750 AP, 10 hrs resident care CE & 10 hrs facility management CE.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?...Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Max A.

Nursing Home: Dallas County

Location: Dallas, TX

Residency: 12/1/97 - 7/18/01

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 77;
- Life's Occupation: Electrician;
- Primary Diagnosis: Parkinson's and Alzheimer's Diseases and CHF;
- Alert, cooperative;
- Assistance and supervision required with activities of daily living.

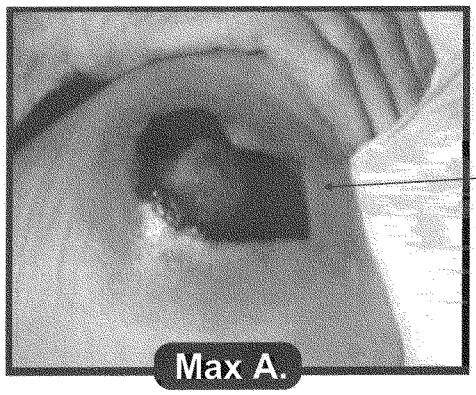
Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No malnutrition;**
- **No pain symptoms;**
- **No dehydration;**
- Stable condition;
- No end-stage disease.

- **The Nursing Home:**
  - Had an outbreak of severe, in-house pressure sores;
  - **Continually failed to turn and reposition Max which resulted in a severe, painful Stage IV pressure sore;**
  - Continuously failed to monitor the intake and output of Max A., and provide sufficient fluids;
  - **Repeatedly violated physician's orders for treatment to right hip;**
  - No pain medication administered despite physician's order to alleviate the severe pain;
  - Was dangerously understaffed, resulting in ongoing care deprivation of critical services.

140 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES



Infected, Stage IV Right Hip Pressure Sore to the Bone: 7 cm x 5.4 cm

- **Stage IV, necrotic, infected, foul-smelling, right hip pressure sore, to the bone, measuring 7.0 cm x 5.4 cm;**
- Multiple Stage II and Stage III pressure sores;
- **Malnutrition** with 28 lb weight loss - 154 lbs to 126 lbs;
- **Hospitalized 2 times for dehydration;**
- Hospital Expenses – $48,600.82.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Mary H. (Resident #1)**
Nursing Home: Wichita County
Location: Wichita Falls, Texas
Date of Investigation: 3/30/98
File No. 13

THE BEFORE PICTURE

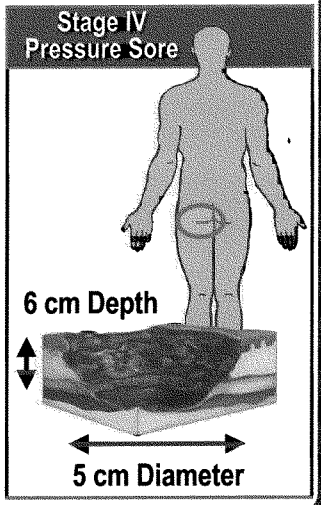
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Insulin-dependent diabetes, Multiple Sclerosis, schizophrenic disorder, and anemia;
- Helpless, totally dependent nursing home resident;
- This resident is usually alert and very social;
- **No pressure sores on admit.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On March 22, 1998, **Mary H. was admitted to the emergency room with numerous Stage IV pressure sores on her buttocks and hips. The pressure sores, discovered by the hospital, developed in the nursing home and were described as follows:**
  - **left groin pressure ulcer, 5 cm diameter, 6 cm deep, with significant undermining of 2 to 4.5 cm at 12 o'clock, 3 o'clock and 9 o'clock. Jagged bone exposed, draining foul exudate.**
  - **left upper thigh pressure sore over 23 cm in length x 13 cm wide, with tan eschar.**
  - right inner buttocks, 9 cm in length x 4 cm wide.
  - right ischium, 6 cm in diameter.
- **The hospital also discovered that Mary H.:**
  - **had developed such severe contractures of the left leg that the left hip had to be surgically severed from the joint;**
  - **was infested with head lice upon admission to the hospital.**
- TDHS further found that 4 months prior to the 3/22/98 hospitalization, Mary H. had been dropped by the nursing home, resulting in fractures of her tibia and fibula.



*The information contained in this case study derives from official governments. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - The hospital reported the nursing home to the state of Texas for neglect of Mary H.
  - The attending physician at the hospital also determined and complained about Mary H.'s neglect.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) failing to routinely prevent, monitor, and treat pressure sores.
  - 40 TAC §19.801(2)(C)(ii) – facility failed to conduct assessments promptly after a significant change in the residents physical and mental condition by failing to complete an assessment after a significant change on Mary H.

Mary H. had developed such severe contractures that the left hip had to be surgically severed to adequately allow treatment of her wounds.

- **Violations of Law (cont.):**
  - 40 TAC §19.1601(9)(A) failing to establish an infection control program and that the facility failed to recognize and take proper measures to prevent the spread of head lice to Mary H.
  - **TDHS further found that the facility had repeatedly violated physician's orders to treat Mary H.'s buttocks and groin wounds from 3/4/98 to 3/11/98, and had failed on an ongoing basis to perform skin assessments from 1/6/98 to 3/14/98.**
  - No pain relief. TDHS determined that despite repeated complaints of pain by Mary H., **no pain medication was administered and no pain assessment was completed.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....No, AG unable to locate referral.
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?....No
- Did TDHS place nursing home on state monitoring status due to this neglect?...Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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63

*** Resident: Oralee H. (Resident #20)**
Nursing Home: Dallas County
Location: Dallas, Texas
Date of Investigation: 3-1-00
File No. 19

THE BEFORE PICTURE

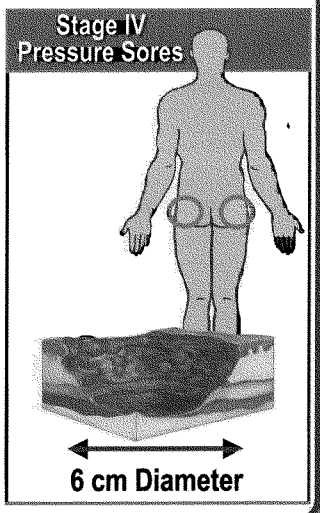
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Incontinence of bowel and bladder and dementia;
- Totally helpless;
- Completely dependent upon nursing home staff for all basic care needs;
- **No pressure sores noted upon admission to facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 2/28/00, TDHS discovered Oralee H. had developed in-house pressure sores to the right and left hip.
- TDHS found that the **left hip pressure sore was a Stage IV, measuring 6 cm x 4.5 cm and the right hip pressure sore was also a Stage IV, measuring 5 cm x 4.5 cm.** Both wounds were covered with an undated, saturated dressing which emanated a foul odor.
- **TDHS found these pressure sores to be avoidable.**



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*The information contained in this case study derives from official gov[illegible]HS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **TDHS observed the resident going for extended periods of time, much greater than 2 hours, without being turned or repositioned.**
  - TDHS stated that **the facility's failure to provide the necessary care and services, such as turning and repositioning and anti-pressure devices and timely incontinent care, contributed to the deterioration of the resident's pressure sores and greatly diminished her quality of care.**
  - **TDHS found the problems originated from lack of staff.**
  - TDHS observed that pressure dressing changes were not being done as ordered.
  - Interviewing with Oralee's daughter; she often comes into the facility and finds her mother wet with the dressings saturated.

TDHS observed the resident to be saturated with urine from the top seam of the sheet to almost the total width of the sheet, extending below the resident's knees, with the sheet appearing to have been saturated and dried and then another incontinent episode having occurred and dried above that.

- **Evidence of Neglect (Cont.):**
  - This resident did not have any type of anti-pressure devices on her bed until the TDHS surveyor brought this to the facility's attention.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - routinely failing to prevent and treat pressure sores.
  - 40 TAC §19.1001 - failing to have enough staff to meet the needs of the residents.
  - 40 TAC §19.1001(2)(B) - failing to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
  - 40 TAC §19.901(1)(C) - failing to ensure that a resident who is unable to carry out activities of daily living receives necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Dottie B. (Resident #1)**

Nursing Home: Collin County

Location: Celina, Texas

Date of Investigation: 8-22-00

File No. 31

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 88;
- Primary diagnosis: Alzheimer's Disease, chronic obstructive pulmonary disease, osteoporosis, ataxia, and tendency to wander;
- Family had informed facility that resident was being admitted to nursing home was because she had the tendency to wander around, and the family was unable to supervise her safely at home;
- Facility was aware of Dottie's propensity to wander.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 8/17/00, Dottie B. was found to be missing from the facility. She was discovered in a shallow ditch, deceased, in 104 degree heat, approximately 50 feet from the facility, at about 5:00 p.m., in the field behind the facility, covered with fire ants and her rectal temperature was 108 degrees.**
- An autopsy revealed that Dottie B. had fallen and fractured her left hand and fingers prior to her death, and that **significant hemorrhaging indicated that she was alive "for a considerable time" prior to her eventual death.**
- Dottie B. had multiple bruises and abrasions to her face and neck, indicating that she struggled for some time before she died. **The medical examiner ruled that the death was a heat/stress related death and was "accidental".**

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*The information contained in this case study derives from official governmental records of TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

• Evidence of Neglect:

- Interviews conducted with local law enforcement personnel during the investigation of the elopement and subsequent death of Dottie B. indicated that **on several occasions, especially in the evenings, police officers noted upon arrival in the facility that there were no staff members available.** One officer stated that "it always takes a while to locate a nurse or anybody that works there." **A complaint given by law enforcement was substantiated regarding the neglect of Dottie B.**
- **One resident who was interviewed revealed that the residents themselves provided more supervision to Dottie B. than the facility staff did.**
- TDHS concluded that the facility failed to assess and supervise Dottie B. for elopement, failed to ensure that alarms were functional and set according to policies, and failed to investigate, in-service, and implement corrective actions, resulting in an immediate jeopardy situation to Dottie B. and other residents.

TDHS found that there was insufficient staff to provide for the needs of the residents in the facility, and to adequately monitor/ supervise Dottie B., resulting in her eloping and her painful death.

• Evidence of Neglect (Cont.):

- TDHS noted the clinical record nurse's notes did not describe Dottie B.'s appearance, extent of injury, position/location of body, or fire ant bites (hundreds).
- Dottie B. frequently loitered around the front door of the facility attempting to leave, and had on several occasions exited the premises per staff interview, although there was no documentation in the clinical record or care plan to reflect these episodes.
- The facility still had not initiated an investigation into the incident, and no in-services had been conducted, although 2 days had passed since Dottie B. had eloped and been found dead.

• Violations of Law:

- 40 TAC §19.901(8)(B) – the facility failed to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. The facility failed to provide supervision, resulting in the death of Dottie B.
- 40 TAC §19.1001 – facility failed to have sufficient nursing staff.
- 40 TAC §19.601 (c) – the facility failed to protect residents, especially Dottie B., from abuse and neglect and investigate and report suspected abuse and neglect.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....No,
  DA could not find referral.
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$23,050
- Amount of fine paid? $0
  Action pending to this date - offset Medicaid;
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....Yes
- Did the AG prosecute this?.....Yes,
  reached compromise and $30,000 CP.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  $250 AP & 10 hrs resident care CE.
- Did TDHS suspend new admissions to facility? .....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....Yes
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Zita B. (Resident #2)**

Nursing Home: Potter County

Location: Amarillo, Texas

Date of Investigation: 11-17-97

File No. 36

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 56 at time of TDHS investigation;
- Primary diagnosis: Dementia and Pick's Disease;
- Helpless, dependent, confused resident.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 11/9/97, a facility employee walked in to find Zita B. being sexually penetrated by a male resident with a history of inappropriate sexual behavior (witnessed sexual abuse).
- Another staff member reported that she had found Resident #1 and Zita B. in Zita B.'s room, on the bed, with the sexually aggressive male resident laying on top of Zita B. in the past. The staff member reported that this incident had been reported to licensed staff member.
- Hospital rape examination of Zita B. confirmed sexual intercourse occurred.

"...a facility employee walked in to find Zita B. being sexually penetrated by a male resident with a history of inappropriate sexual behavior..."

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VIOLATIONS OF LAW FOUND BY TDHS

- **Preventable Nature of Injuries:**
  - The week before the sexual penetration of Zita B., facility staff reported that on at least 3 prior occasions Resident #1, a male resident with a history of sexually inappropriate behavior, had attempted to have sexual intercourse with Zita B.
  - **Although three staff members reported their concerns to the administrative staff, no action was taken by the staff to ensure the safety of Zita B.**
  - Despite multiple staff reports to the administrative personnel regarding this behavior, **no action was taken to protect Zita B. from further sexual abuse.**
- **Evidence of Neglect:**
  - TDHS found the facility failed to take appropriate steps to protect the safety of Zita B.
  - Significantly, the next month, Zita B. was sexually abused by another male resident.

...facility staff reported that on at least prior 3 occasions Resident #1, a male resident with a history of sexually inappropriate behavior, had attempted to have sexual intercourse with Zita B.

- **Evidence of Neglect (Cont.):**
  - TDHS concluded that facility failed to have a functioning system in place that would ensure all allegations of sexual abuse, and were thoroughly investigated, as required.
  - Despite the TDHS intervention and incident investigation, it was reported by a facility nurse aide that the next week after the TDHS investigation, Resident #1 was still in the facility, and was still sexually abusing female residents.
- **Violations of Law:**

TDHS found that the facility violated:

- 40 TAC §19.601(b)- failed to prevent confused ita B., from being sexually abused.
- 40 TAC §19.601(c)(2-4) – the facility failed to promptly report 3 allegations of sexual abuse to the facility administrator, local law enforcement, and the state agency and failed to thoroughly investigate the allegations and failed to prevent further sexual abuse to confused Zita B.

ANY CONSEQUENCES TO THE NURSING HOME?

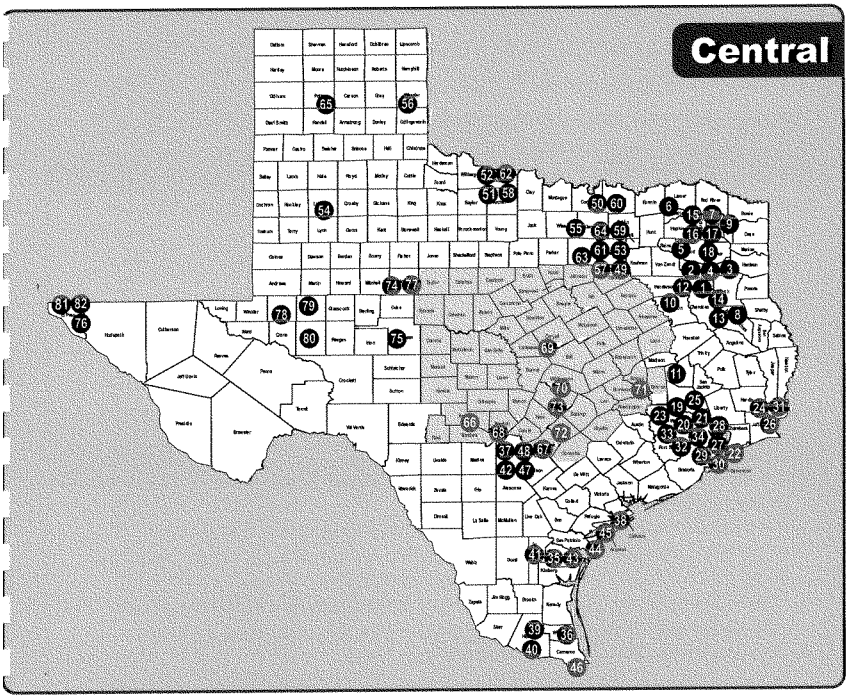
- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....No,

  No facility employees/owners indicted or prosecuted.
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....None

  Case dismissed for lack of evidence.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....Yes

  Imposed 1/13/98 to 12/31/99, facility closed.
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
66	Viola H.	Kerrville	Kerr	C
67	Juanita Z.	Seguin	Guadalupe	C
68	Martha L.	Boerne	Kendall	C
69	Pat H.	Copperas Cove	Coryell	C
70	Irene B.	Cedar Park	Wiliamson	C
71	Hans B.	College Station	Brazos	C
72	Margaret H.	Lockhart	Caldwell	C
73	Vera M.	Austin	Travis	C

66

Resident: Viola H.

Nursing Home: Kerr County

Location: Kerrville, TX

Residency: 4/10/98 - 4/27/98

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 96;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Congestive heart failure and anemia due to bleeding ulcer;
- Totally dependent upon nursing home for basic needs;
- Alert but confused.

Nursing Home's Description on Admit: (per MDS)

- No pressure sores;
- No symptoms of pain;
- No cellulitis;
- No dehydration;
- No malnutrition or nutritional problems;
- Stable condition;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **The Attending Physician Testified:**
  - "Viola had been the victim of prolonged nursing home neglect."
  - "The presence and severity of Viola's necrotic pressure sores, maggots in her wounds, dehydration, cellulitis and severe pain were shocking."
  - "The nursing home never informed me of the progression of the conditions."
  - "Given the kind of neglect that happened to this lady, the nursing home knowingly caused injury to an elderly person."
  - "The nursing home's callous indifference for Viola's welfare and safety was the cause of her death."
- **Admissions of Neglect by Facility Management and Nurses:**
  - The ongoing failure to:
    - notify the doctor was "gross neglect";
    - offer pain relief was "inhumane".
  - The development of gangrenous, stage IV pressure sores, severe dehydration, repeated failure to provide adequate fluids, and to report Viola's pain and cellulitis, were the result of "callous neglect".
  - The facility failed to take measures to prevent and treat the occurrence of in-house pressure sores.
  - The facility falsified Viola's medical records.

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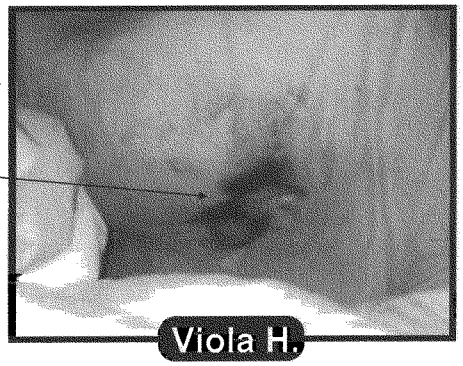
Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Gangrenous, Stage IV Sacral Pressure Sore: 15 cm in Diameter, Deep to the Bone, Discovered by The Hospital



- **Maggots were discovered in the sacral wound by the hospital;**
- **Hypernatremic dehydration;**
- **Profound malnutrition;**
- Cellulitis of the arm;
- **Excruciating and horrible pain;**
- **Death from sepsis due to pressures sores 48 hours after admission to the hospital;**
- Hospital Expenses - $15,806.20.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Juanita Z.

Nursing Home: Guadalupe County

Location: Seguin, TX

Residency: 1/24/00 - 2/20/00

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 58;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Acute MI, Diabetes Mellitus, stroke, renal failure and coronary artery disease;
- Extensive dependence on staff for basic care;
- Bed-bound.

Nursing Home's Description on Admit: (per MDS)

- **No pain symptoms;**
- **No end-stage disease;**
- **No terminal illness;**
- Stage II, 10 cm coccyx pressure area;
- Resident expresses preference to return home. Direct care staff believe resident is capable of increased independence.

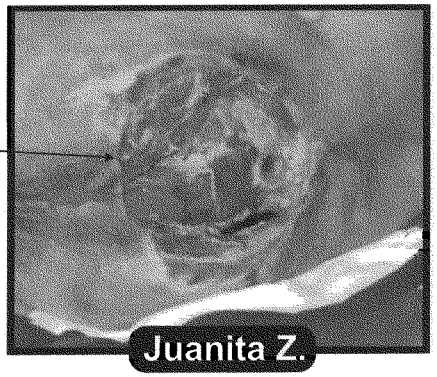
A PROFILE IN NEGLECT: CORE FACTS

- **The Nursing Home:**
  - **Continuously failed to turn and reposition Juanita;**
  - **Repeatedly failed to medicate for horrible pain;**
  - **Failed 100% of the time to monitor Juanita's diabetic condition;**
  - **Repeatedly failed to inform the attending physician of drastic changes that were occurring with the pressure sore;**
  - Failed to recognize and seek treatment for Juanita's severe septic state;
  - Repeatedly failed to monitor Juanita's nutritional status resulting in a drop in her albumin level from 3.7 to 2.5, and a 13 lb weight loss in one month.
- **The Facility Director of Nurses Testified:**
  - The facility failed to notify the physician of significant changes in Juanita's pressure sores;
  - The facility routinely failed to document the presence of pressure sores;
  - **The facility violated physician's orders by failing to perform weekly skin assessments;**
  - The facility misrepresented the weekly skin assessments to TDHS.

154 *Family permission granted for use of this information.*

THE AFTER PICTURE: SEVERITY OF INJURIES

Gangrenous, Stage IV Coccyx Pressure Sore: 20 cm x 20cm



- Gangrene and MRSA of the massive coccyx wound;
- **Wound deep, down to spinal cord;**
- **Coccyx pressure sore eroded into Juanita's rectum and coccyx bone;**
- **Coccyx bone became necrotic and osteomyeletic;**
- **Extensive surgeries performed in an attempt to save Juanita's life;**
- Ongoing and excruciating pain endured for 45 days;
- Death caused by overwhelming sepsis from massive pressure sore (3/13/00);
- Hospital Expenses - $79,000.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Martha L. (Resident #1)**

Nursing Home: Kendall County

Location: Boerne, Texas

Date of Investigation: 9-5-02

File No. 24

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 87 at time of TDHS investigation;
- Primary diagnosis: Dementia, history of pressure sores, non-verbal, non-ambulatory, severely contractured, gastro-esophageal disease, hypothyroidism and depression;
- **This resident was helpless and totally dependent on facility staff for her needs;**
- This resident was unable to communicate, essentially non-verbal.

TDHS FINDINGS OF FACT

Rape and Neglect:

- **The facility had concerns that a staff member identified as Staff JD, was the perpetrator and that Martha L. had actually been sexually abused, yet no action had been taken to ensure that staff member JD had no resident contact during the investigation of the allegations.**
- **On 9/4/02, Martha L. was admitted to an emergency room from the nursing home where a Sexual Abuse Forensic Examination (SAFE) revealed she was raped.**
- The SAFE nurse reported to TDHS in a complaint that Martha L. had general redness of her labia minora at 9 o'clock with multiple lacerations, avulsions and abrasions, which were **"indicative of sexual abuse".**
- **Dr. Mendelsohn examined Martha L. and stated that the vaginal tearing looked suspicious (for sexual assault) on 9/4/02.**
- A complaint was given by the sexual assault nurse examiner that **the SAFE unit found severe genital trauma and sperm indicative of rape/sexual abuse on Martha L. on 9/4/02.**

The SAFE unit found severe genital trauma and sperm indicative of rape/sexual abuse on Martha L. on 9/4/02.

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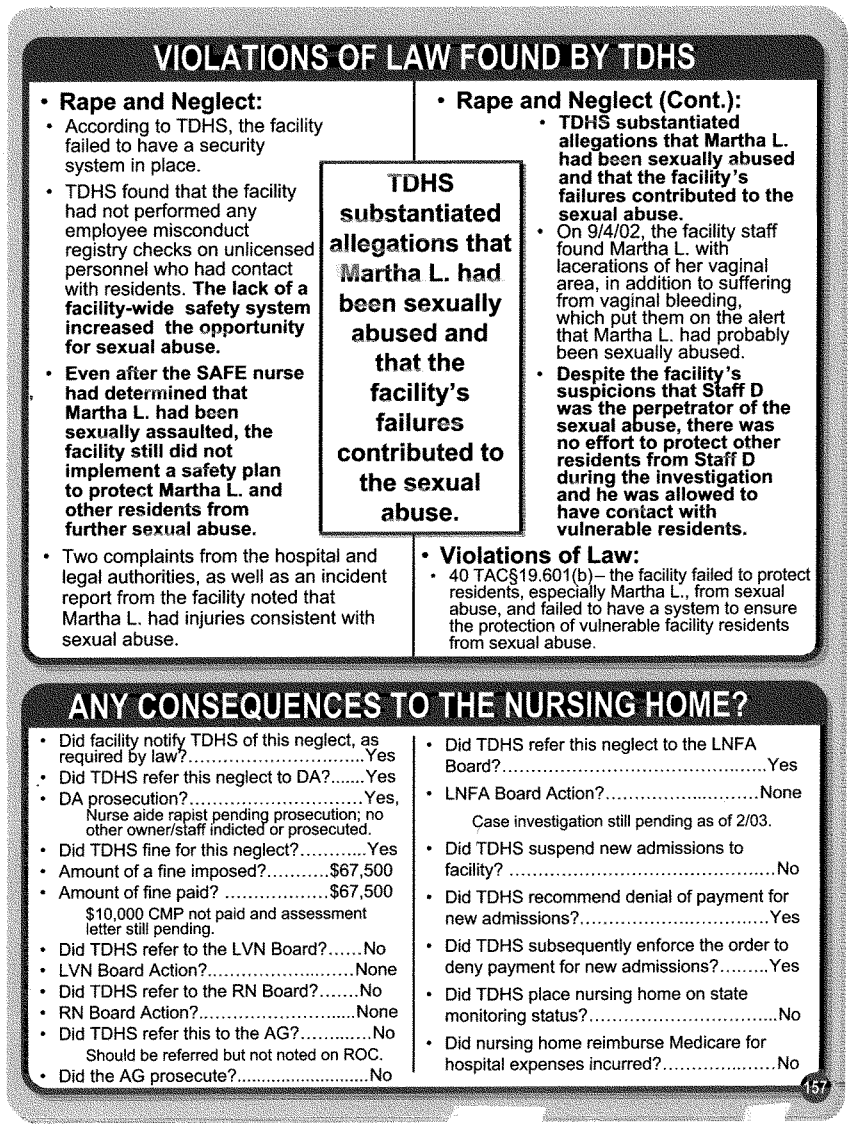
VIOLATIONS OF LAW FOUND BY TDHS
• Rape and Neglect:
• According to TDHS, the facility failed to have a security system in place.
• TDHS found that the facility had not performed any employee misconduct registry checks on unlicensed personnel who had contact with residents. The lack of a facility-wide safety system increased the opportunity for sexual abuse.
• Even after the SAFE nurse had determined that Martha L. had been sexually assaulted, the facility still did not implement a safety plan to protect Martha L. and other residents from further sexual abuse.
• Two complaints from the hospital and legal authorities, as well as an incident report from the facility noted that Martha L. had injuries consistent with sexual abuse.
TDHS substantiated allegations that Martha L. had been sexually abused and that the facility's failures contributed to the sexual abuse.
• Rape and Neglect (Cont.):
• TDHS substantiated allegations that Martha L. had been sexually abused and that the facility's failures contributed to the sexual abuse.
• On 9/4/02, the facility staff found Martha L. with lacerations of her vaginal area, in addition to suffering from vaginal bleeding, which put them on the alert that Martha L. had probably been sexually abused.
• Despite the facility's suspicions that Staff D was the perpetrator of the sexual abuse, there was no effort to protect other residents from Staff D during the investigation and he was allowed to have contact with vulnerable residents.
• Violations of Law:
• 40 TAC§19.601(b)– the facility failed to protect residents, especially Martha L., from sexual abuse, and failed to have a system to ensure the protection of vulnerable facility residents from sexual abuse.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....Yes
• Did TDHS refer this neglect to DA?.....Yes
• DA prosecution?.....Yes, Nurse aide rapist pending prosecution; no other owner/staff indicted or prosecuted.
• Did TDHS fine for this neglect?.....Yes
• Amount of a fine imposed?.....$67,500
• Amount of fine paid? $67,500
$10,000 CMP not paid and assessment letter still pending.
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....No
• RN Board Action?.....None
• Did TDHS refer this to the AG?.....No
Should be referred but not noted on ROC.
• Did the AG prosecute?.....No
• Did TDHS refer this neglect to the LNFA Board?.....Yes
• LNFA Board Action?.....None
Case investigation still pending as of 2/03.
• Did TDHS suspend new admissions to facility? .....No
• Did TDHS recommend denial of payment for new admissions?.....Yes
• Did TDHS subsequently enforce the order to deny payment for new admissions?.....Yes
• Did TDHS place nursing home on state monitoring status?.....No
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
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* **Resident: Pat H. (Resident #1)**

Nursing Home: Coryell County

Location: Copperas, Texas

Date of Investigation: 1-29-01

File No. 27

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 77, at time of TDHS investigation;
- Primary diagnosis: Dementia, bowel and bladder incontinence;
- Helpless, dependent resident, unable to communicate effectively.

TDHS FINDINGS OF FACT

Rape, Cover-up and Neglect:

- On 1/20/01, Pat H. was found to have a diaper full of blood. She was cut and bruised between her legs, with apparent vaginal bleeding.
- A 3 cm vaginal laceration was noted by the nurse aide and LVN caring for Pat H., who recommended that Pat H. be sent to the hospital.
- **The staff suspected that Pat H. had been sexually abused, but the ADON refused to send her to the hospital.**
- When the next shift of nurses came on duty, another LVN also expressed concerns about Pat's vaginal tear. **At this time, the ADON told the staff not to mention anything about the sexual abuse, and agreed to send Pat H. to the emergency room.**
- **Despite staff suspicions that Pat H. was sexually abused, the ADON told TDHS she did not suspect abuse and that this resident had a history of vaginal bleeding in the past, so it was "not a big issue".**
- TDHS could find no documentation, after extensive clinical record review, of any history of vaginal bleeding. An interview with nursing staff revealed that there was **no history of vaginal bleeding** prior to the incident.

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VIOLATIONS OF LAW FOUND BY TDHS

- **Rape, Cover-up and Neglect:**
  - On 2/2/01, Copperas Cove Police Investigator L.H. informed TDHS that a **male nurse aide at the facility had failed the lie detector test and then confessed to sexually assaulting Pat H. at the facility.** The male was referred to the nurse aide registry for sexual abuse.
  - TDHS substantiated allegations that Pat H. had been sexually abused by a male nurse aide as alleged in the complaint given by a staff member on 1/24/01.
  - The ADON refused to consider sexual abuse as a possible cause of Pat injuries; thus, emergency room staff, TDHS and local law enforcement authorities were not informed, as required by law, of the alleged sexual abuse so investigations and DNA testing could be performed on a timely basis.

...a male nurse aide at the facility, had failed the lie detector test and then confessed to sexually assaulting Pat H...

- **Nature of Injuries Discovered (Cont.):**
  - **The facility never reported the suspected sexual abuse to TDHS. It was 5 or 6 days after the incident before the facility contacted the Copperas Cove Police Department.**
- **Violations of Law:**

TDHS found that the facility violated:

- 40 TAC 19.403(k)(1)(A)(B)(D) by failing to disclose complete and accurate information to two physicians, resulting in delayed medical intervention.
- 40 TAC §19.601(b) – the facility failed to protect residents from abuse.
- 40 TAC §19.601(c)(2)(3) – facility failed to promptly report allegations of sexual abuse and failed to thoroughly investigate the allegations and prevent further sexual abuse.
- 40 TAC §19.1901 – the facility was not administered effectively and efficiently.
- 40 TAC §19.1901 – the facility was not administered effectively and efficiently.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....Yes,
  CNA plead guilty to aggravated sexual assault; sentenced to 15 yrs in TDCJ.
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....Yes,
  Revoked DON's license until remedial education completed.
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes,
  $1,000 AP & 20 hrs CE.
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?..Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?...No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Irene B.

Nursing Home: Williamson County

Location: Cedar Park, TX

Residency: 3/1/94 - 1/11/99

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 86;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Alzheimer's Disease and hypothyroidism;
- Able to ambulate, feed self and participate in activities of daily living;
- Independent with some staff assistance.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No malnutrition;**
- Stable condition;
- No end-stage disease;
- No terminal illness.

A PROFILE IN NEGLECT: CORE FACTS

- **Specific TDHS Findings of Neglect on Irene B.:**
  - **The facility neglected Irene's pressure sore and basic nutritional needs;**
  - **The facility failed to prevent the occurrence of an avoidable stage IV pressure sore.**
- **Former Direct Care Staff Testified That:**
  - "Facility was routinely short-staffed. It was common to find residents in dried urine and feces."
  - **"Irene was in a lot of pain - a lot of times she would spend it crying."**
- **The Nursing Home:**
  - **Was severely understaffed on a chronic basis;**
  - Failed to implement adequate and necessary nursing interventions to prevent, monitor and treat Irene's painful pressure sores;
  - Documented only 21 entries in the nurse's notes during entire calendar year of 1998, revealing lack of nursing intervention and staffing (1/98-12/98);
  - **Continually failed to administer pain medication despite excruciating and ongoing pain from the severe wounds;**
  - Failed to establish care plan to address resident's pain.

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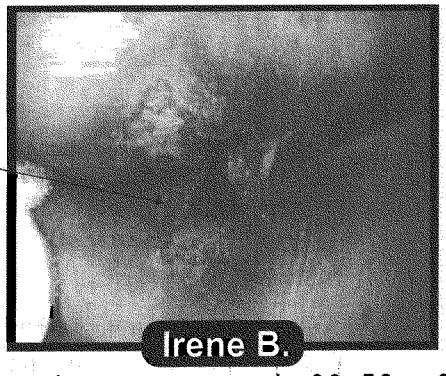
Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Infected, Stage IV Sacral Pressure Sore: 9.6 cm x 7.2 cm, 3 to 4 cm Deep with Bone Exposed



- Developed infected, Stage IV sacral pressure sore, **measuring 9.6 x 7.2 cm, 3 to 4 cm deep, with bone exposed**, and necrotic tissue within the wound;
- Developed multiple avoidable pressure sores;
- **Required at least 5 months at specialty hospital for intensive wound care therapy;**
- Still has persistent wound and site prone to breakdown;
- Endured ongoing excruciating pain (12/21/98 – 1/11/99);
- Suffered **severe protein calorie malnutrition;**
- **Became essentially wheelchair bound and totally dependent for all aspects of care due to neglect;**
- Hospital Expenses – $195,000.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Hans B. (Resident #8)**

Nursing Home: Brazos County

Location: College Station, Texas

Date of Investigation: 2-24-99

File No. 4

THE BEFORE PICTURE

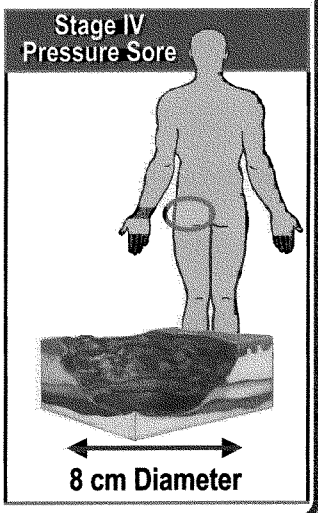
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Hypertension, recurrent UTI's, with nephrectomy, Foley catheter, gall bladder removal, feeding tube inserted for inability to eat, congestive heart failure and acute renal failure. History of urosepsis, dehydration and pneumonia.
- Totally dependent, helpless resident with contractures.
- Requires two person assist for all aspects of care.
- **No pressure sores noted upon admission to facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 2/17/99, Hans B. was admitted to a hospital in "grave condition" with multiple, infected, in-house pressure sores, including **a Stage IV wound on the left hip, measuring 8 cm x 8 cm down to the bone; in fact, the bone was protruding from his left hip pressure sore, with massive infection present.**
- Hans B. was diagnosed with septic shock and urosepsis from a Foley catheter which was described as having 400 ccs of thick, greenish-yellow, foul-smelling urine with a large amount of sediment in the tubing and leaking of very foul smelling urine.
- Despite the presence of a feeding tube, this resident was dehydrated upon admission to the hospital.
- The attending physician documented that "the indwelling Foley catheter was filthy" and photographs were taken of the pressure sores, as well as the Foley catheter and drainage bag upon admission to the hospital.



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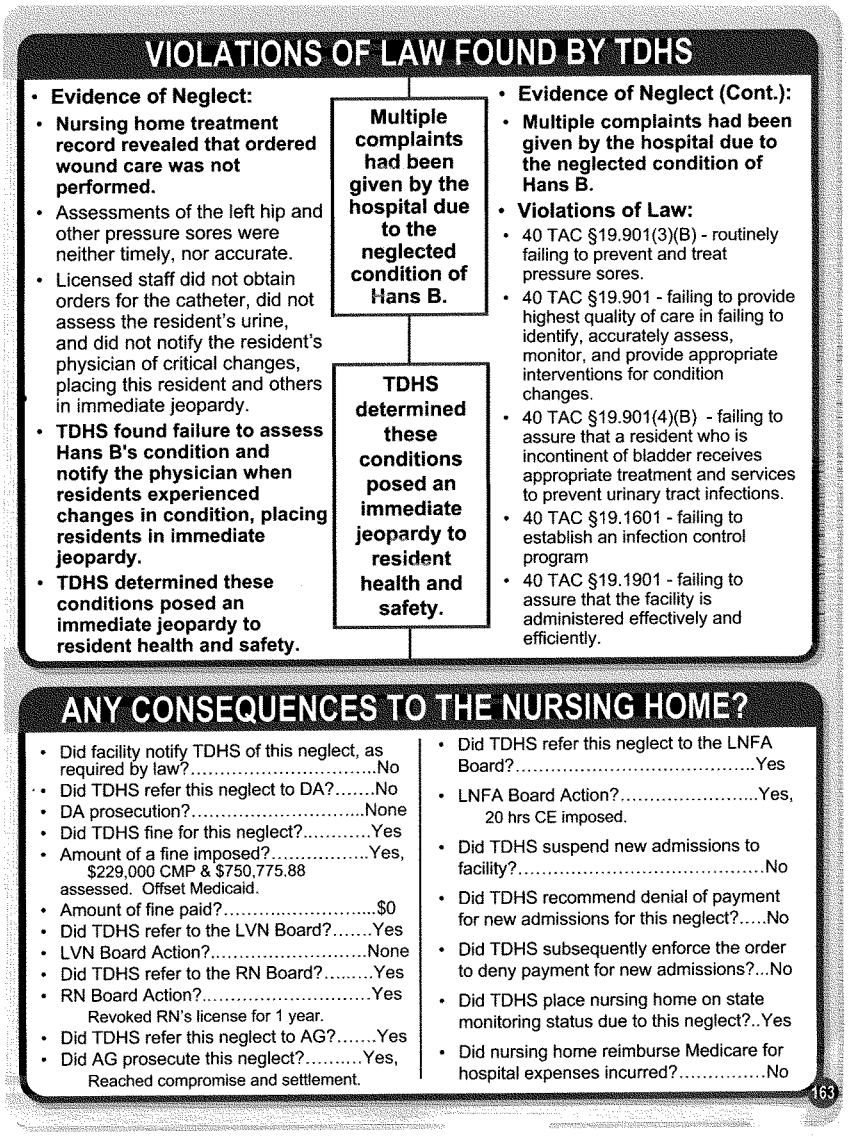
VIOLATIONS OF LAW FOUND BY TDHS
• Evidence of Neglect:
• Nursing home treatment record revealed that ordered wound care was not performed.
• Assessments of the left hip and other pressure sores were neither timely, nor accurate.
• Licensed staff did not obtain orders for the catheter, did not assess the resident's urine, and did not notify the resident's physician of critical changes, placing this resident and others in immediate jeopardy.
• TDHS found failure to assess Hans B's condition and notify the physician when residents experienced changes in condition, placing residents in immediate jeopardy.
• TDHS determined these conditions posed an immediate jeopardy to resident health and safety.
Multiple complaints had been given by the hospital due to the neglected condition of Hans B.
TDHS determined these conditions posed an immediate jeopardy to resident health and safety.
• Evidence of Neglect (Cont.):
• Multiple complaints had been given by the hospital due to the neglected condition of Hans B.
• Violations of Law:
• 40 TAC §19.901(3)(B) - routinely failing to prevent and treat pressure sores.
• 40 TAC §19.901 - failing to provide highest quality of care in failing to identify, accurately assess, monitor, and provide appropriate interventions for condition changes.
• 40 TAC §19.901(4)(B) - failing to assure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections.
• 40 TAC §19.1601 - failing to establish an infection control program
• 40 TAC §19.1901 - failing to assure that the facility is administered effectively and efficiently.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....Yes
• Amount of a fine imposed?.....Yes, $229,000 CMP & $750,775.88 assessed. Offset Medicaid.
• Amount of fine paid?.....$0
• Did TDHS refer to the LVN Board?.....Yes
• LVN Board Action?.....None
• Did TDHS refer to the RN Board?.....Yes
• RN Board Action?.....Yes
Revoked RN's license for 1 year.
• Did TDHS refer this neglect to AG?.....Yes
• Did AG prosecute this neglect?.....Yes,
Reached compromise and settlement.
• Did TDHS refer this neglect to the LNFA Board?.....Yes
• LNFA Board Action?.....Yes,
20 hrs CE imposed.
• Did TDHS suspend new admissions to facility?.....No
• Did TDHS recommend denial of payment for new admissions for this neglect?.....No
• Did TDHS subsequently enforce the order to deny payment for new admissions?...No
• Did TDHS place nursing home on state monitoring status due to this neglect?..Yes
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
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Resident: Margaret H.

Nursing Home: Caldwell County

Location: Lockhart, TX

Residency: 9/7/96 – 10/21/96

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 78;
- Life's Occupation: Homemaker;
- Primary Diagnosis: Hip and wrist fracture;
- Required short-term rehabilitation for fractures.

Nursing Home's Description on Admit: (per MDS)

- **No pressure sores;**
- **No pain symptoms;**
- **No malnutrition;**
- **No dehydration;**
- Stable condition.

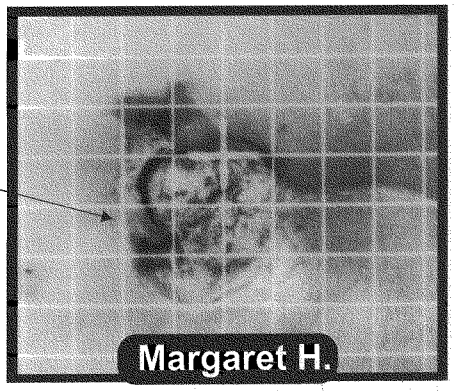
A PROFILE IN NEGLECT: CORE FACTS

- **Attending Physician Testified:**
  - **"Margaret's was one of the worst cases I have seen among patients referred to the hospital from a nursing home,** because she was extremely dehydrated and had a large number of advanced pressure sores."
  - "This should be a wake-up call to corporate medicine. If they can't see a way to take care of people properly and still make a profit, then they need to get out of the business."
- **The Nursing Home:**
  - Routinely and consistently violated facility policy by:
    - Failing to turn and reposition Margaret;
    - Address Margaret's ongoing pain;
    - Not providing hygiene care;
    - Not providing fluids and nutrition;
    - Not notifying the physician of significant changes in Margaret's condition.

Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

Stage IV Coccyx Pressure Sore: to the Bone



- Developed infected, Stage IV coccyx pressure sore, measuring 4.5 cm x 3.0 cm x 2 cm deep, foul-smelling, purulent drainage, and Stage IV sores to both heels;
- **Infected pressure sores, several of which were Stage IV to the bone sores;**
- Urosepsis secondary to streptococcus;
- Incessant and horrible pain;
- **Malnutrition and dehydration;**
- **Death due to infected pressure sores and malnutrition;**
- Hospital Expenses – $30,000.00.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Vera M. (Resident #1)**

Nursing Home: Travis County

Location: Austin, Texas

Date of Investigation: 4-1-99

File No. 35

THE BEFORE PICTURE

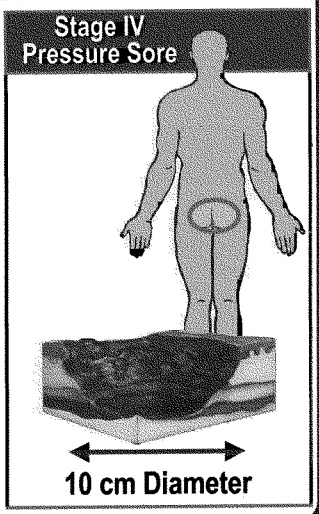
Profile of Resident on Admit: to Nursing Home:

- Primary diagnosis: Urinary tract infection, urosepsis, dehydration, congestive heart failure, bi-polar diagnosis with depression, hypertension, hypothyroidism; non-insulin dependent diabetes, and senile dementia.
- Helpless resident;
- Totally dependent on nursing home for basis care;
- **No pressure sores noted upon admission.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 3/29/99, Vera M. was discovered by TDHS to have developed an in-house pressure sore to her sacral area, which had become a 10 cm x 8 cm eschar covered Stage IV, with extremely foul-smelling drainage.
- **On 3/31/99, the day before the TDHS exit interview, Vera M. died in the facility due to complications associated with her infected Stage IV sacral pressure sore.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **TDHS found that the facility had not been changing Vera M.'s dressing, as ordered by the physician.**
  - **TDHS found that the cause of Vera M.'s death was most likely complications associated with an infected Stage IV sacral pressure sore.**
  - TDHS substantiated an allegation that the facility failed to bathe Vera M. on a regular basis.
  - **TDHS noted that failure to change Vera's wound dressings when they became soiled predisposes the resident to infection and sepsis,** as well as the psychosocial consequences associated with wearing a foul smelling dressing for an extended period of time, such as decreased appetite, isolation, and depression.

TDHS found that the facility had not been changing Vera M.'s dressing, as ordered by the physician.

- **Evidence of Neglect (Cont.):**
  - When TDHS observed Vera M. on 3/29/99, she was noted to be in need of oral care with a thick white layer of sticky appearing substance covering her lower teeth. There were white flakes around her eyes and when she turned to her side, an extremely foul odor permeated the room.
  - A large dressing was observed over the pressure sore in the sacral area. The lower half of the pressure sore dressing was off and all layers of the dressing were saturated with serosanguinous drainage.
- **Violations of Law:**
  - 40 TAC §19.901(3)(B) - the facility failed to prevent, monitor, and treat pressure sores for Vera M.
  - TDHS substantiated that the facility failed to meet the activities of daily living (ADL) needs for Vera M., such as bathing, dressing, grooming, hair, nail, and oral care for dependent residents like Vera M.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$14,000
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospice expenses incurred?.....No

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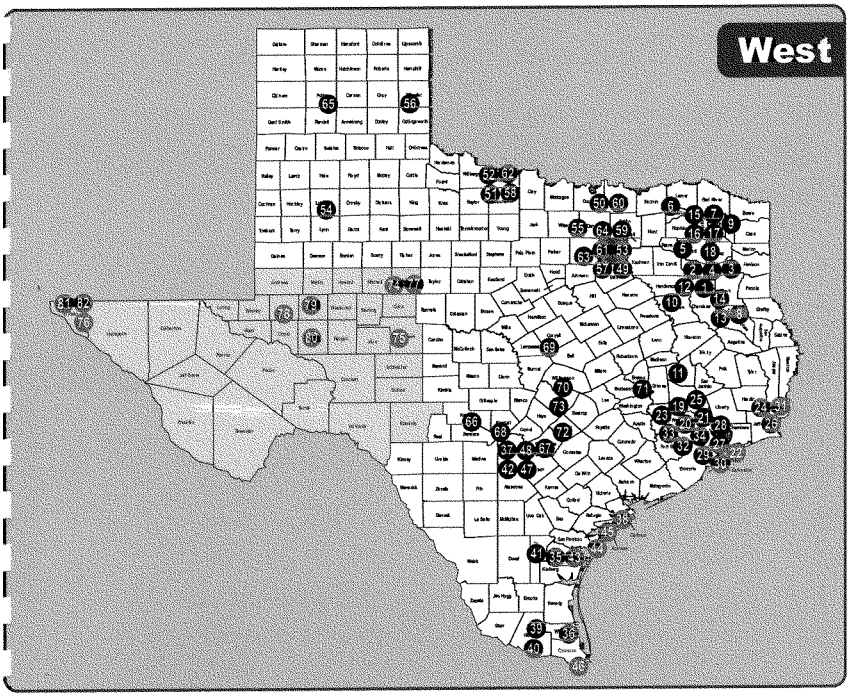
The Continuing Epidemic of Abuse and Neglect



Case Study No.	Resident Name / Identifier	City	County	Texas Area
74	Grace M.	Sweetwater	Nolan	W
75	Estelle F.	San Angelo	Tom Green	W
76	Jesus F.	El Paso	El Paso	W
77	Lorene B.	Sweetwater	Nolan	W
78	Drucilla S.	Odessa	Ector	W
79	Dorothy C.	Midland	Midland	W
80	Ms. J.	Upton	Upton	W
81	Abraham J.	El Paso	El Paso	W
82	Dalicia M.	El Paso	El Paso	W

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* **Resident: Grace M. (Resident #1)**

Nursing Home: Nolan County

Location: Sweetwater, Texas

Date of Investigation: 1-28-02

File No. 25

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Dependent upon nursing home staff for care;
- Alert, oriented to person and place.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 1/6/02, around midnight, Grace M. was raped by a male nurse aide. Grace said he "hurt me in the way that men sometimes do to women".** Grace M. was motioning to her vaginal area. There were no incident reports to the rape, nor any investigation performed by the nursing home.
- **After the rape, Grace M. was found lying in fetal position in her bed, holding her groin area, stating that she was hurting there and said, "Don't let that man come in here."** Grace M. stated the male nurse aide had hurt her "between her legs". "He hurt me, he hurt me bad, don't let that man back in here, he hurt me between my legs."
- TDHS found that the facility administration failed to protect residents by ensuring a system was in place to ensure all allegations of abuse were reported immediately and thoroughly investigated. The administrator was notified of the immediate jeopardy situation.
- On 1/22/02, the nurse aide confessed to the rape/sexual assault and was arrested, charged with two counts of aggravated sexual assault.

After the rape, Grace was found lying in fetal position in her bed, holding her groin area, stating that she was hurting there and said, "Don't let that man come in here."

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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - On investigation, TDHS substantiated the allegation of sexual abuse to Grace M. **The local police department arrested the perpetrator, a male CNA, who confessed to the rape and was charged with aggravated sexual assault, a first degree felony.**
  - TDHS found the facility placed residents in immediate jeopardy due to the nursing home's failure to investigate allegations of abuse which resulted in up to 17 residents potentially being sexually abused by this same male perpetrator nurse aide.

.. the nursing home's failure to investigate allegations of abuse resulted in up to 17 residents potentially being sexually abused by this same male perpetrator nurse aide.

- **Evidence of Neglect (Cont.):**
  - **Despite the female nurse aide reporting her suspicions that Grace had been sexually abused to the charge nurse, the report went no further and was not fully investigated.**
- **Violations of Law:**
  - 40 TAC §19.601(b) - failed to ensure that dependent and cognitively impaired residents were free from physical and/or sexual abuse.
  - 40 TAC §19.601(c)(2-4) - failed to ensure all violations of abuse were reported immediately or that these allegations were thoroughly investigated and failed to protect residents from potential abuse during the investigation of suspected abuse, and failed to implement the written procedures to prohibit abuse.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....Yes,
  Nurse aide plead guilty to 1 of 3 charges; no other owner/staff indicted or prosecuted.
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$94,000
- Amount of fine paid? $0
  Hearing set regarding fines.
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....Yes
- Did the AG prosecute this?.....Pending
  due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  Revoked license and $1,000 AP.
- Did TDHS suspend new admissions to facility? .....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No,
  Recommended but not enforced.
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Estelle F. (Resident #3)**

Nursing Home: Tom Green County

Location: San Angelo, Texas

Date of Investigation: 8/18/00

File No. 39

THE BEFORE PICTURE

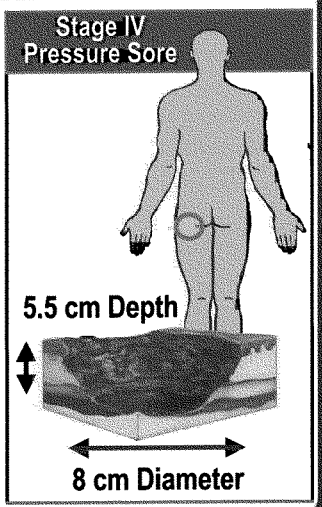
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Cerebral vascular accident with hemiparesis and hemiplegia of the lower extremities, HTN, dementia, anemia, bowel and bladder incontinence, and a Foley catheter;
- Totally dependent, helpless resident;
- **No pressure sores present on admission to the facility**.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On admission to the hospital on 8/10/00, the staff found Estelle F. had developed **"severe Stage IV decubitus ulcer on the left gluteal region" with a diameter of 8 cm, depth of 5.5 cm, and tunneling with purulent drainage, infected wound with red surrounding tissue.**
- When observed by TDHS investigators in the hospital on 8/18/00 even after rigorous treatment, Estelle's infected, left lower buttock pressure sore had a **foul odor with tan-brown drainage**. The severity of the pressure sore required that Estelle endure a lengthy stay at a wound care center for aggressive treatment.
- Estelle had lost weight and was malnourished since admission to the nursing home, negatively affecting the ability to heal her wound.
- Estelle's pressure sore was infected with MRSA when cultured by the hospital on admission.



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*The information contained in this case study derives from official go

TDHS. This is a summary and not the official record.

VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **Complaints given by the hospital staff and Estelle's family, due to the neglected state Estelle** demonstrated on admit to hospital 8/10/00, were substantiated by TDHS regarding pressure sores and infection.
  - The pressure sores discovered by the hospital originally developed in the nursing home on 5/22/00 due to the Foley catheter tubing incorrectly positioned by nursing staff, causing pressure on buttocks.
  - The LNFA was referred to the LNFA Advisory Board for TDHS **findings of substandard quality of care with actual harm to Estelle and others.**
  - The DON was referred to BNE due to falsifying documents and allowing "impaired and sanctioned" LVNs to work without direct supervision as required by LVN Board Rules.

TDHS found that "failure to provide the care and services necessary to prevent an avoidable pressure sore resulted in Estelle's developing a pressure sore, tissue damage, permanent loss of tissue, and an infection resistant to antibiotics".

- **Evidence of Neglect (Cont.):**
  - The facility failed to have an infection control program and hand-washing protocol. As a result, infections with sepsis were occurring to residents like Estelle.
- **Violations of Law:**
  - 40 TAC §19.901(3)(A) – failing to prevent, monitor and treat Estelle's pressure sores.
  - 40 TAC §19.601(C) - failing to prohibit abuse and neglect, lack of supervision of employees who had been found by the LVN Board to be impaired or incompetent without supervision.
  - 40 TAC §19.1601(2) - lack of an effective infection control program including failure to provide running water and hand-washing for one or more hours every day for the past 4-6 months.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$10,000
- Amount of fine paid? $6,500
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....No
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  Reprimand, 10 hrs regulatory and 10 hrs facility management continuing education.
- Did TDHS suspend new admissions to facility? .....Yes
- Did TDHS recommend denial of payment for new admissions?.....Yes*
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....Yes*
  * Admissions suspended 8/25/00.
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Jesus F. (Resident #13)**

Nursing Home: El Paso County

Location: El Paso , Texas

Date of Investigation: 2/4/99

File No. 42

THE BEFORE PICTURE

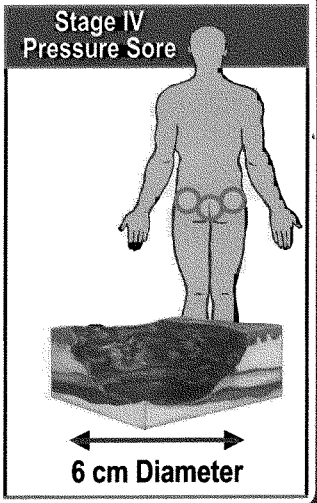
Profile of Resident on Admit to Nursing Home:

- Age: 48;
- Totally dependent, helpless nursing home resident;
- **Admitted to facility with no pressure sores.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 1/2/99, Jesus was admitted to a hospital where it was discovered that he had **three in-house, avoidable Stage IV pressure sores:**
  - **one on the right hip, which measured 6 cm x 4 cm;**
  - **one on the left hip, measuring 6 cm x 4 cm;**
  - **one on the coccyx, measuring 3 cm x 3 cm.**
- **All the pressure sores were necrotic, covered with eschar, and had very foul odors.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **TDHS substantiated the hospital's complaint of neglect regarding Jesus' condition** on admission to the hospital on 1/2/99.
  - **Jesus had been in the hospital in 10/98 and had no pressure sores at that time.**
  - **The facility had falsified treatment records to show treatments had been performed when they had not been done.**
  - **The facility failed to obtain and follow physician's orders regarding pressure sore treatments for Jesus and other residents.**
  - **TDHS found that 8 of 13 residents in the facility had developed skin concerns,** with at least 4 residents, including Jesus, developing severe, in-house, avoidable pressure sores.
  - The facility had failed to assess Jesus' pressure sores as required.

The facility's failure to provide necessary treatment and services to promote healing placed all the residents with pressure sores at risk of compromised physical and emotional well-being, according to TDHS.

- **Evidence of Neglect (Cont.):**
  - TDHS noted that the failure to carry out physician's orders as written, and to treat residents without physician's orders, placed residents at risk for inappropriate treatment and inconsistent care delivery.
  - There was inadequate documentation and lack of care plans regarding Jesus' pressure sores, per TDHS.
  - The facility's failure to provide necessary treatment and services to promote healing placed all the residents with pressure sores at risk of compromised physical and emotional well-being, according to TDHS.
- **Violations of Law:**
  - 40 TAC §19.901(3)(A)(B) – by failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.802(c)(1) – by failing to ensure acceptable professional standards were met and failing to carry out physician's orders.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No,
  CMP for separate infraction imposed 3/19/99 and appealed.
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....No
- Did AG prosecute this neglect?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?...Yes
- Did TDHS place nursing home on state monitoring status due to this neglect?....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Lorene B. (Resident #3)**

Nursing Home: Nolan County

Location: Sweetwater, Texas

Date of Investigation: 1-23-02

File No. 26

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 90 at time of TDHS investigation;
- Primary diagnosis: Wheelchair bound, non-ambulatory;
- Helpless, dependent resident.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 1/28/02 at 9:30 a.m., Lorene B. reported to facility employee that she had been raped by a male nurse aide, stating, "That man raped me."**
- **Various nurse aides heard Lorene B. screaming and yelling. Upon entering her room, the nurse aides described observing the male perpetrator CNA standing beside her bed, with the side rail up with Lorene B.'s neck and hands bleeding.**
- Lorene kept saying that the perpetrator was crazy, to get him out of her room, and that Lorene B., was angry, upset, mad, and kept asking, "Why did he do that to me?", and "Why did this happen to me?"
- After the incident, Lorene B. was very agitated and didn't want anyone to touch her and was heard to say over and over, "Why did he do this to me?" and "Don't let him back in my room."
- **Lorene's incident report** was undated and only noted that the perpetrator was assisting Lorene B. with her position change when she became agitated and pulled away, causing 3 skin tears. **Nothing was documented regarding Lorene's statement that the nurse aide raped her**, and that Lorene did not want the male nurse aide in her room.

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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - The male perpetrator had been the only male in the facility on the night that Lorene B. said she had been raped. He confessed on 1/22/02.
  - **Lorene had never made any similar allegations of sexual abuse in the past.**
  - The DON assessed Lorene and found bleeding skin tears to the back side of her right hand and to her left ear with a bruise on her left shoulder.
  - Additionally, nothing was documented regarding bruising,or the staff's concerns that the perpetrator had done something.

On 1/22/02, the nurse aide confessed to rape/sexual assaults on several female residents, including Lorene B. He was arrested on two counts of aggravated sexual assault.

- **Violations of Law:**
  - 40 TAC §19.601(b) - failed to ensure that dependent and cognitively impaired residents were free from physical and/or sexual abuse.
  - 40 TAC §19.601(c)(2-4) - failed to ensure all violations of abuse were reported immediately or that these allegations were thoroughly investigated and failed to protect residents from potential abuse during the investigation of suspected abuse, and failed to implement the written procedures to prohibit abuse.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....Yes
- DA prosecution?.....Yes
  Nurse aide plead guilty to 1 of 3 charges; no other owner/staff indicted or prosecuted.
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$94,000
- Amount of fine paid?.....$0
  Hearing set.
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to AG?.....Yes
- Did AG prosecute this neglect?.....Pending, due to bankruptcy.
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes,
  Revoked license with $1,000 AP.
- Did TDHS suspend new admissions to facility?.....Yes
- Did TDHS recommend denial of payment for new admissions for this neglect?...Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?..No
- Did TDHS place nursing home on state monitoring status due to this neglect?..Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Drucilla S. (Resident #1)**
Nursing Home: Edgar County
Location: Odessa, Texas
Date of Investigation: 2/25/98
File No. 41

THE BEFORE PICTURE

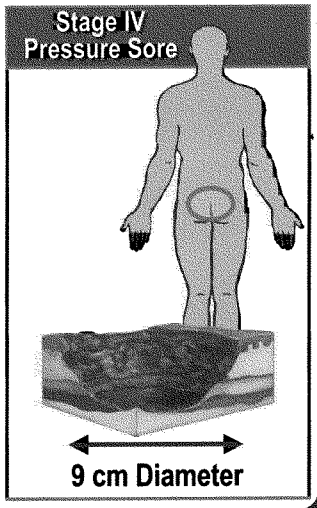
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Cancer of the bladder, anxiety, respiratory difficulties and bladder incontinence;
- Totally dependent, helpless resident;
- **No pressure sores on admission to the facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 1/28/98, Drucilla was admitted to the hospital, where it was discovered that she had an **in-house, Stage IV sacral/coccyx pressure sore, measuring 9 cm x 6 cm, with at least 2 inches of the spine visible.**
- Additional in-house pressure sores had developed on the right buttocks and the thoracic spine, both heels, and bilateral hips.
- **Drucilla S. died in February 1998, due to the severity of her wounds, according to her physician.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - TDHS substantiated the family's complaint of neglect.
  - **Neither the family nor the physician had been informed regarding the deterioration of this coccyx pressure sore – the family had not even been informed that pressure sores were present until after Drucilla was hospitalized.**
  - The facility failed to properly assess the pressure sores and to write care plans addressing the wounds.
  - TDHS found that the pressure relieving device and air mattress were frequently noted to be deflated, thus no pressure relief was provided.

Neither the family, nor the physician, had been informed regarding the deterioration of this coccyx pressure sore – the family had not even been informed that pressure sores were present until after Drucilla was hospitalized.

- **Evidence of Neglect (Cont.):**
  - The facility documentation showed that Drucilla S. was found very wet with urine.
  - **TDHS found that Drucilla S. suffered pain due to the pressure sores and also experienced muscle wasting and weight loss.**
- **Violations of Law:**
  - 40 TAC §19.901(3)(A)(B) – by failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.403(a)(b)(1)(2)(3)(4)(c)(d) – by failing to inform residents of their rights.
  - TDHS substantiated the allegation that the physician and the family were not informed of significant changes in resident's condition.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$37,000
  Possibly unrelated.
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this neglect to the AG?..No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
  Unrelated referral.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions for this neglect?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status due to this neglect?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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Resident: Dorothy C.

Nursing Home: Midland County

Location: Midland, TX

Residency: 1/21/91 – 9/23/93

THE BEFORE PICTURE

Profile of Resident on Admit:

- Age: 62;
- Primary Diagnosis: Stroke, paralyzed left side, COPD, hypertension & ASVD;
- Wheelchair-bound, dependent;
- Incontinent, required peri-care;
- Alert, cooperative and good mental clarity.

Dorothy's Description from 1/91 to 4/93:

- Pleasant;
- Sleeps well most nights;
- No withdrawing from touch;
- No refusing peri-care;
- No refusing changes of wet clothes;
- No locking legs in side rails, resisting touch from staff.

A PROFILE IN NEGLECT: CORE FACTS

- On 10/7/92, a male nurse aide, Gordon, was hired by Texas Health Enterprises (T.H.E.) to work as a nurse aide in the Midland facility where Dorothy resided.
- **Gordon had previously been fired by Texas Health Enterprises for aggravated physical abuse in a T.H.E. facility in Odessa 1 year earlier.**
- Despite this known history of aggravated abuse, Gordon was assigned to bathe and provide incontinent care to helpless females, including Dorothy, without the assistance or supervision of other employees.
- **In June of 1993, the Charge Nurse, who had fired Gordon for abuse from the Odessa facility, was shocked to find that Gordon had been reemployed at T.H.E.'s Midland facility.**
- **The Charge Nurse reported her discovery to T.H.E., and recommended immediate firing.**
- **Charge Nurse reports about Gordon's violent history were ignored by T.H.E.**
- **Despite Charge Nurse warning and recommendation for terminating, Gordon continued to be assigned to provide personal care to Dorothy.**
- **From 5/3/93 to 7/20/93, Gordon repeatedly sexually abused and raped Dorothy.**
- On 7/20/93, 2 nurse aides discovered semen on Dorothy's pubic area and stomach.
- **Gordon threatened to kill Dorothy if she told anyone of the abuse.**
- Gordon subsequently confessed to police.

"Evidently, Dorothy was sexually abused on several occasions, not just on 7/20/93."

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Family permission granted for use of this information.

THE AFTER PICTURE: SEVERITY OF INJURIES

- **The Facility Assistant Director of Nurses Stated:**
  - **"Evidently, Dorothy was sexually abused on several occasions, not just on July 20, 1993."**
- **Significant Changes in Behavior from 5/3/93 to 7/20/93:**
  - Dorothy resisted peri-care;
  - Dorothy refused to allow staff to change her wet clothes;
  - Dorothy withdrew to touch;
  - Dorothy locked her legs in the side rails to resist being unclothed;
  - Dorothy frequently cried out at night, upset;

Despite Gordon's confession, the facility provided no post-rape therapy to Dorothy.

- **Post-Rape Consequences for Dorothy:**
  - **Despite Gordon's confession, the facility provided no post-rape therapy to Dorothy;**
  - **Dorothy became fearful and frightened of staff for the remainder of her life.**

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....No
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid?.....$0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....No
- LNFA Board Action?.....None
- Did TDHS suspend new admissions to facility?.....No
- Did TDHS recommend denial of payment for new admissions?.....No
- Did TDHS subsequently enforce the order to deny payment for new admissions?...No
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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*** Resident: Ms. J. (Resident #1)**
Nursing Home: Upton County
Location: McCamey, Texas
Date of Investigation: 11/8/01
File No. 43

THE BEFORE PICTURE

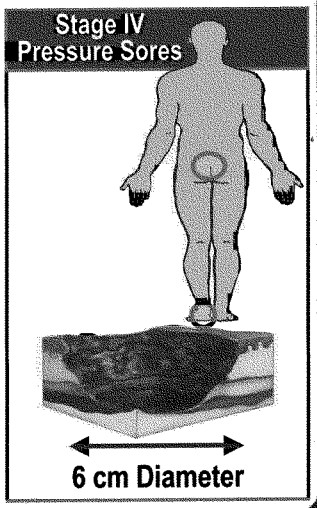
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Fractured pelvis, bowel and bladder incontinence, history of CVA with left sided hemiplegia, and hypertension;
- Due to a fractured pelvis, Ms. J. was totally dependent on nursing home staff for care;
- Alert and able to communicate. Prior to her retirement, she had been a nurse for 11 years, until she fell at home and fractured her hip, requiring nursing home placement;
- **No pressure sores on admission to facility.**

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 11/5/01, TDHS discovered Ms. J. had **developed multiple, in-house, avoidable pressure sores, with a Stage IV on the coccyx.**
- The worst pressure sore was a **left heel Stage IV, measuring 6 cm in diameter, with deep underlying tissues exposed, draining yellow discharge with blood.** The area around the pressure sore was white, with retracted wound edges, and macerated in appearance.
- **Significant pain and deterioration to the heel wound was caused by illegal and harmful surgery performed by an LVN at the nursing home.**



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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - TDHS found the facility treatment LVN had caused the deterioration in the left heel pressure sore by **performing surgery with a scalpel and suture removal kit, without a physician's order, or training, on at least 3 occasions.**
  - **This LVN treatment nurse had no training in wound debridement and had continued to perform manual debridement without orders on Ms. J., despite the resident's complaints of pain.**
  - TDHS observed this treatment nurse contaminate Ms. J. and other residents' wounds during dressing changes, with improper infection control techniques.
  - **Ms. J. told the TDHS investigator, "They don't believe me, that it (the pressure sore) hurts. I know right from wrong, why should I put on, I was a nurse for 11 years."**
  - **The facility had not obtained orders for Ms. J.'s pressure sore treatments.**

TDHS found the facility treatment LVN had caused the deterioration in the left heel pressure sore by performing surgery with a scalpel and suture removal kit, without a physician's order, or training, on at least 3 occasions.

- **Evidence of Neglect (Cont.):**
  - **Ms. J. complained of constant pain from her pressure sores, yet was not given sufficient pain medication, per TDHS.**
  - The D.O.N. said there was not a facility policy and procedure to allow an L.V.N. to perform mechanical debridement of wounds.
  - TDHS found that residents in the facility were being placed in immediate jeopardy to their health and safety with substandard quality of care and referred the L.V.N., R.N., and administrator to the licensing board for neglect.
- **Violations of Law:**
  - 40 TAC §19.901(3)(A)(B) – by failing to prevent, monitor, and treat pressure sores.
  - 40 TAC §19.802(c)(1) – by failing to ensure acceptable professional standards were met for Ms. J., who received dangerous interventions and care for her pressure sores by the LVN.
  - 40 TAC §19.1001(2)(B) – by failing to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
  - 40 TAC §19.1601(2) – by failing to establish an infection control program.
  - 40 TAC §19.1902(a)(1) – by failing to administer the facility efficiently and effectively.

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....No
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....Yes
- Amount of a fine imposed?.....$47,700
- Amount of fine paid? $47,700
- Did TDHS refer to the LVN Board?.....Yes
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....Yes
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....No
- Did the AG prosecute?.....No
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes
  - 6 hrs facility management & 4 hrs resident care continuing education.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
- Did TDHS place nursing home on state monitoring status?.....Yes
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Abraham J. (Resident #1)**

Nursing Home: El Paso County

Location: El Paso, Texas

Date of Investigation: 4-17-02 & 4-26-02

File No. 33

THE BEFORE PICTURE

Profile of Resident on Admit to Nursing Home:

- Age: 77;
- Primary diagnosis: Atrial fibrillation, venous thrombosis, pulmonary embolus and peripheral vascular disease;
- Resident was ambulatory and required 24 hour supervision;
- Resident had a history of wandering and elopement behaviors since his admission to the facility on 11/30/01.

TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- **On 4/7/02, Abraham was found to be missing from the facility. On 4/14/02, a week later, Abraham J.'s badly decomposed body was found in an arroyo (shallow ditch) near the facility.**
- The autopsy performed on Abraham J.'s body by the medical examiner showed that the identification had to be made by personal effects only as **the body was so badly decomposed, it was not possible to make a physical identification.**

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VIOLATIONS OF LAW FOUND BY TDHS

- **Evidence of Neglect:**
  - **The resident was a known wanderer** and had at least 3 documented episodes of leaving the facility since 2/15/02.
  - The care plan noted that supervision would need to be provided for Abraham J.; however, no other nurses notes after 2/15/02 were found to discuss the resident's elopement risk or the monitoring of the Wanderguard for placement and function.
  - There were no plans, goals, or approaches in the care plan addressing the risk of elopement or monitoring of the placement and functioning of the Wanderguard.
  - **On 4/7/02, after noting Abraham J. was missing, the facility stated that the resident was last observed by staff shortly before the noon meal. The facility told the police that they felt the resident would be going to visit his family in Mexico.**

TDHS determined the facility was indifferent to Abraham J.'s need for (1) monitoring, (2) a Wanderguard, and (3) response when the Wanderguard was triggered.

- **Evidence of Neglect (Cont.):**
  - The police report indicated that the Wanderguard was still on the resident when his badly decomposed body was found on 4/14/02, and when police took the resident's Wanderguard to the facility, it activated when they entered the front door.
  - TDHS determined the facility was indifferent to Abraham J.'s need for:
    - monitoring;
    - a Wanderguard
    - response when the Wanderguard was triggered.
- **Violations of Law:**
  - 40 TAC §19.601(c) – failed to prevent abuse and neglect of residents. Failed to provide appropriate supervision and monitoring to residents, especially those who had elopement risks and who wore Wanderguard bracelets for safety .

ANY CONSEQUENCES TO THE NURSING HOME?

- Did facility notify TDHS of this neglect, as required by law?.....Yes
- Did TDHS refer this neglect to DA?.....No
- DA prosecution?.....None
- Did TDHS fine for this neglect?.....No
- Amount of a fine imposed?.....$0
- Amount of fine paid? $0
- Did TDHS refer to the LVN Board?.....No
- LVN Board Action?.....None
- Did TDHS refer to the RN Board?.....No
- RN Board Action?.....None
- Did TDHS refer this to the AG?.....Yes
- Did the AG prosecute?.....Case pending
- Did TDHS refer this neglect to the LNFA Board?.....Yes
- LNFA Board Action?.....Yes

  Letter of reprimand issued.
- Did TDHS suspend new admissions to facility? .....No
- Did TDHS recommend denial of payment for new admissions?.....Yes
- Did TDHS subsequently enforce the order to deny payment for new admissions?.....Yes
- Did TDHS place nursing home on state monitoring status?.....No
- Did nursing home reimburse Medicare for hospital expenses incurred?.....No

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* **Resident: Dalicia M. (Resident #12)**

Nursing Home: El Paso County

Location: El Paso , Texas

Date of Investigation: 4/1/98

File No. 40

THE BEFORE PICTURE

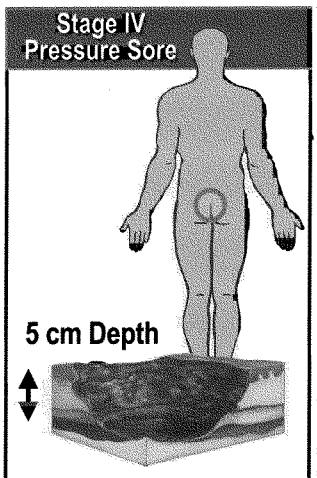
Profile of Resident on Admit to Nursing Home:

- Primary diagnosis: Diabetes and Foley catheter with urinary incontinence;
- Totally dependent resident;
- **Admitted to facility with no pressure sores.**

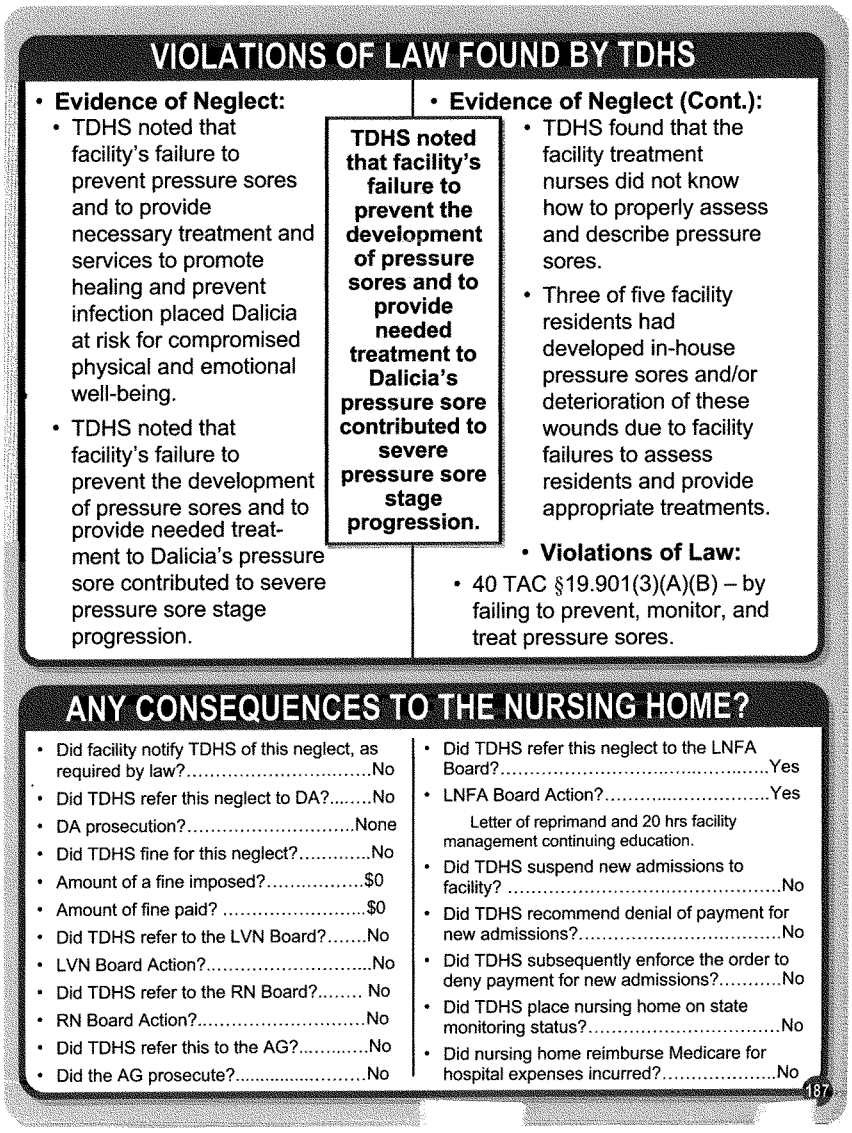
TDHS FINDINGS OF FACT

Nature of Injuries Discovered:

- On 3/19/98, TDHS surveyors discovered Dalicia to have a **large, in-house, avoidable Stage IV coccyx pressure sore, with a depth of 5 cm (2 inches) and deep undermining.**
- **Dalicia and other residents had experienced significant deterioration of pressure sores** with onset of necrosis and infection in the previous 2 months.
- **In addition, Dalicia had developed an in-house, avoidable right heel pressure sore, measuring 3 cm.**



The information contained in this case study derives from official governm DHS. This is a summary and not the official record.


VIOLATIONS OF LAW FOUND BY TDHS
• Evidence of Neglect:
• TDHS noted that facility's failure to prevent pressure sores and to provide necessary treatment and services to promote healing and prevent infection placed Dalicia at risk for compromised physical and emotional well-being.
• TDHS noted that facility's failure to prevent the development of pressure sores and to provide needed treatment to Dalicia's pressure sore contributed to severe pressure sore stage progression.
TDHS noted that facility's failure to prevent the development of pressure sores and to provide needed treatment to Dalicia's pressure sore contributed to severe pressure sore stage progression.
• Evidence of Neglect (Cont.):
• TDHS found that the facility treatment nurses did not know how to properly assess and describe pressure sores.
• Three of five facility residents had developed in-house pressure sores and/or deterioration of these wounds due to facility failures to assess residents and provide appropriate treatments.
• Violations of Law:
• 40 TAC §19.901(3)(A)(B) – by failing to prevent, monitor, and treat pressure sores.
ANY CONSEQUENCES TO THE NURSING HOME?
• Did facility notify TDHS of this neglect, as required by law?.....No
• Did TDHS refer this neglect to DA?.....No
• DA prosecution?.....None
• Did TDHS fine for this neglect?.....No
• Amount of a fine imposed?.....$0
• Amount of fine paid? $0
• Did TDHS refer to the LVN Board?.....No
• LVN Board Action?.....No
• Did TDHS refer to the RN Board?..... No
• RN Board Action?.....No
• Did TDHS refer this to the AG?.....No
• Did the AG prosecute?.....No
• Did TDHS refer this neglect to the LNFA Board?.....Yes
• LNFA Board Action?.....Yes
Letter of reprimand and 20 hrs facility management continuing education.
• Did TDHS suspend new admissions to facility? .....No
• Did TDHS recommend denial of payment for new admissions?.....No
• Did TDHS subsequently enforce the order to deny payment for new admissions?.....No
• Did TDHS place nursing home on state monitoring status?.....No
• Did nursing home reimburse Medicare for hospital expenses incurred?.....No
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Nursing Home Conditions in Texas:
Many Nursing Homes Fail to Meet Federal Standards for Adequate Care

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Prepared for Rep. Ciro D. Rodriguez
Rep. Gene Green

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

October 28, 2002

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EXECUTIVE SUMMARY

Many families are becoming increasingly concerned about the conditions in nursing homes. Federal law requires that nursing homes " provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." But recent studies by the U.S. General Accounting Office and others have indicated that many nursing homes fail to meet federal health standards.

To address these growing concerns, Reps. Ciro D. Rodriguez and Gene Green asked the Special Investigations Division of the minority staff of the Committee on Government Reform to investigate the conditions in nursing homes in the state of Texas. There are 1,148 nursing homes in Texas that accept residents covered by Medicaid or Medicare. These facilities serve almost 85,000 residents. This report examines the results of state inspections to assess conditions in the nursing homes.

The report finds that there are serious deficiencies in many of the nursing homes in Texas. Eighty-six percent of Texas nursing homes violated federal health standards during recent state inspections. Over one-third of the nursing homes had violations that caused actual harm to residents or placed them at risk of death or serious injury. Moreover, over 90% of the nursing homes in Texas did not meet the recommended minimum staffing levels identified by the U.S. Department of Health and Human Services (HHS).

A. Methodology

Under federal law, HHS contracts with the states to conduct annual inspections of nursing homes and to investigate nursing home complaints. These inspections assess whether facilities are meeting federal standards of care, such as preventing residents from developing pressure sores (commonly known as bed sores), providing sanitary living conditions, and protecting residents from accidents. During these inspections, the state inspectors also record the staffing levels in the nursing homes.

This report is based on an analysis of recent annual inspections and complaint investigations of Texas nursing homes. These inspections and investigations were conducted from March 2001 to August 2002. In addition, this report examines staffing data maintained by HHS for the period from March 2001 to August 2002.

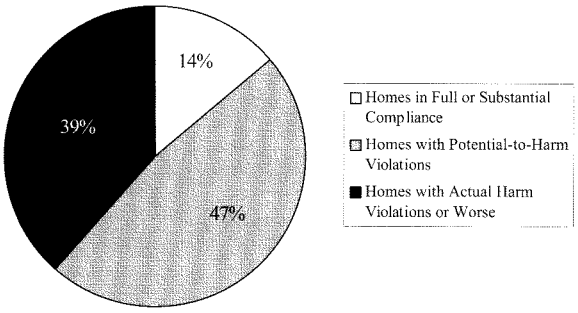
Because this report is based on recent state inspections and investigations, the results are representative of current nursing home conditions in Texas. However, compliance records and staffing levels in individual facilities can change. New management or enforcement activities can bring rapid improvement; other changes can lead to sudden deterioration. For this reason, the report should be considered a representative " snapshot" of overall conditions in nursing homes in Texas, not an analysis of current conditions in any specific facility. Conditions could be better – or worse – at any nursing home today than when the facility was last inspected.

B. Findings

The vast majority of nursing homes in Texas violated federal standards governing quality of care. State inspectors consider a nursing home to be in full compliance with federal health standards if no violations are detected during the inspection. They will consider a home to be in " substantial compliance" with federal standards if the violations at the home do not have the potential to cause more than minimal harm. Of the 1,148 nursing homes in Texas, only 161 facilities (14%) were found to be in full or substantial compliance with the federal standards. In contrast, 987 nursing homes (86%) had at least one violation with the potential to cause more than minimal harm to residents or worse. On average, each of these 987 nursing homes had 9.8 violations of federal quality of care requirements.

Many nursing homes in Texas had violations that caused actual harm to residents. Of the 1,148 nursing homes in Texas, 443 facilities – 39% of all facilities – had a violation that caused actual harm to nursing home residents or placed them at risk of death or serious injury (see Figure 1). The 443 nursing homes with actual harm violations or worse serve 37,417 residents and are estimated to receive over $440 million each year in federal and state funds.

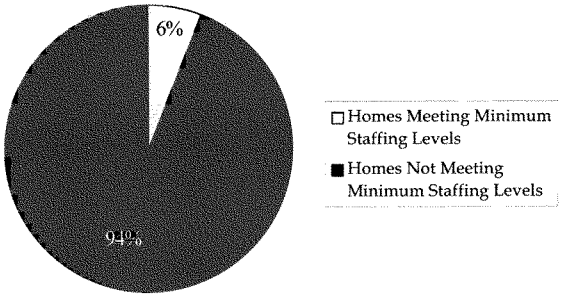
Figure 1: 86% of Nursing Homes in Texas Did Not Meet Federal Standards Governing Quality of Care



Most nursing homes in Texas did not provide adequate staffing. During their most recent annual inspections, the vast majority of nursing homes in Texas – 1,060 of the 1,124 facilities for which staffing data was available (94%) – did not meet minimum staffing levels identified by HHS in a recent report to Congress (see Figure 2). Compared to other states, Texas nursing homes rank 43rd in the nation in hours of nursing care provided to residents each day. Texas nursing homes that failed to meet the minimum staffing levels were over three times as

likely to have violations that caused actual harm to residents compared to nursing homes that met all minimum staffing levels.

Figure 2: 94% of Texas Nursing Homes Did Not Meet Minimum Staffing Levels



Nursing home conditions remain poor in Texas. Two years ago, in October 2000, the Special Investigations Division assessed nursing home conditions in Texas for Rep. Ciro D. Rodriguez. That report found serious problems in Texas nursing homes, with 84% of the facilities in the state violating federal health standards. Over the past two years, little has changed.

I. GROWING CONCERNS ABOUT NURSING HOME CONDITIONS

A. Conditions in Nursing Homes

Increasingly, Americans are facing difficult decisions about nursing homes. The decision to move a loved one into a nursing home raises very real questions about how the resident will be treated at the nursing home. Will the resident receive proper food and medical treatment? Will the resident be assisted by staff with basic daily activities, such as bathing and dressing? Will the resident be able to live out his or her life with dignity and compassion? These are all legitimate concerns – and they are becoming more common as America ages.

In 1966, there were 19 million Americans 65 years of age and older.[1] That figure has now risen to 35 million Americans, or 12.4% of the population.[2] By 2030, the number of Americans aged 65 and older is expected to increase to 70.3 million, or 20% of the population.[3]

This aging population will increase demands for long-term care. In 2000, there were 1.5 million people living in more than 17,000 nursing homes in the United States.[4] The Department of Health and Human Services (HHS) has estimated that 43% of all 65 year olds will use a nursing home at some point during their lives. Of those who do need the services of a nursing home, more than half will require stays of over one year, and over 20% will be in a nursing home for more than five years.[5] By 2050, the total number of nursing home residents is expected to quadruple from the current 1.5 million to 6.6 million.[6]

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[1]Health Care Financing Administration, *Medicare Enrollment Trends, 1966 - 1999* (available at http://www.hcfa.gov/stats/enrltrnd.htm).

[2]U.S. Census Bureau, *Profiles of General Demographic Characteristics: 2000 Census of Population and Housing, United States* (May 2001).

[3]U.S. Census Bureau, *Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045* (December 1999).

[4]American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook*, vii (2001) (hereinafter "*Facts and Trends*").

[5]HCFA Report to Congress, *Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-Regulatory Initiatives, and Effectiveness of the Survey and Certification System*, §1.1 (July 21, 1998).

[6]*Facts and Trends*, *supra* note 4, at vii.

Most nursing homes are run by private, for-profit companies. Of the 17,023 nursing homes in the United States in 2000, over 11,000 (65%) were operated by for-profit companies.[7] During the 1990s, the nursing home industry witnessed a trend toward consolidation as large national chains bought up smaller chains and independent homes. As of December 2000, the six largest nursing home chains in the United States operated 2,163 facilities with almost 260,000 beds.[8]

Through the Medicaid and Medicare programs, the federal government is the largest payer of nursing home care. Under the Medicaid program, a federal-state health care program for the needy, all nursing home and related expenses are covered for qualified individuals. Under the Medicare program, a federal program for the elderly and certain disabled persons, skilled nursing services are partially covered for up to 100 days. In 2002, it is projected that federal, state, and local governments will spend $65.9 billion on nursing home care, of which $51.5 billion will come from Medicaid payments ($32.8 billion from the federal government and $18.7 billion from state governments) and $12 billion from federal Medicare payments. Private expenditures for nursing home care are estimated to be $37.8 billion ($26 billion from residents and their families, $7.7 billion from private insurance policies, and $4.1 billion from other private funds).[9] The overwhelming majority of nursing homes in the United States receive funding through either the Medicaid program or the Medicare program, or both.

Under federal law, nursing homes that receive Medicaid or Medicare funds must meet federal standards of care. Prior to 1987, these standards were relatively weak: they focused on a facility's ability to provide adequate care, rather than on the level of care actually provided. In 1986, a landmark report by the Institute of Medicine found widespread abuses in nursing homes.[10] This report, coupled with national concern over substandard conditions, led Congress to pass comprehensive legislation in 1987 establishing new standards for nursing homes. This

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[7] *Id.* at viii.

[8] Aventis Pharmaceuticals, *Managed Care Digest Series 2001* (available at http://www.managedcaredigest.com/edigests/is2001/is2001.shtml).

[9] All cost projections come from: HCFA, *Nursing Home Care Expenditures Aggregate and per Capita Amounts, Percent Distribution and Average Annual Percent Change by Source of Funds: Selected Calendar Years 1980 - 2011* (available at http://www.hcfa.gov/stats/nhe%2Dproj/proj2001/tables/t14.htm).

[10] Committee on Nursing Home Regulation, Institute of Medicine, *Improving the Quality of Care in Nursing Homes* (1986). The IOM report concluded: " [I]ndividuals who are admitted receive very inadequate – sometimes shockingly deficient – care that is likely to hasten the deterioration of their physical, mental, and emotional health. They are also likely to have their rights ignored or violated, and may even be subject to physical abuse." *Id.* at 2-3.

law requires nursing homes to " provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."[11]

Implementing regulations were promulgated by HHS in 1990 and 1995. The 1987 law and the implementing regulations limit the use of physical and chemical restraints on nursing home residents. They require nursing homes to prevent pressure sores, which are painful wounds or bruises, caused by pressure or friction, that can become infected. They also establish other health standards for nursing homes, such as requiring that residents are properly cleaned and bathed, receive appropriate medical care, and are supervised to prevent falls and accidents. The regulatory requirements are codified at 42 C.F.R. Part 483.

Recently, investigators have begun to examine whether nursing homes are meeting the requirements of the 1987 law and its implementing regulations. The results have not been encouraging. Certain abusive practices documented by the Institute of Medicine in 1986, such as the improper use of physical restraints and antipsychotic drugs, have been reduced.[12] But health violations appear to be widespread. In a series of 1999 reports, the U.S. General Accounting Office (GAO), an investigative arm of Congress, found that " more than one-fourth of the homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury";[13] that these incidents of actual harm "represented serious care issues . . . such as pressure sores, broken bones, severe weight loss, and death";[14] and that " [s]erious complaints alleging that nursing home residents are being harmed can remain uninvestigated for weeks or months."[15]

B. Purpose of this Report

In light of the growing concern about nursing home conditions, Reps. Ciro D. Rodriguez and Gene Green asked the Special Investigations Division of the minority staff of the Government Reform Committee to investigate the prevalence of health violations in nursing

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[11]42 U.S.C. §1396r(b)(2).

[12]The percent of residents in physical restraints dropped from 38% in 1987 to 15% in 1998; the percent of residents being administered anti-psychotic drugs dropped from 33% to 16% during the same time period. Testimony of Michael Hash, Deputy Administrator of HCFA, before the Senate Special Committee on Aging (July 28, 1998).

[13]GAO, *Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards*, 3 (March 1999) (hereinafter "*Additional Steps Needed*").

[14]GAO, *Nursing Homes: Proposal to Enhance Oversight of Poorly Performing Homes Has Merit*, 2 (June 1999).

[15]GAO, *Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents*, 2 (March 1999).

homes in Texas. Reps. Rodriguez and Green also requested that the report examine whether facilities in Texas have enough staff to care for their residents. The report is a follow-up to a congressional report released by Rep. Rodriguez in October 2000.[16]

II. METHODOLOGY

To assess the compliance records and staffing levels of nursing homes in Texas, this report analyzed two sets of data: (1) the Online Survey, Certification, and Reporting (OSCAR) database maintained by HHS, which compiles the results of nursing home inspections and staffing information reported by facilities; and (2) the nursing home complaint database maintained by HHS, which contains the results of state complaint investigations.

A. Determination of Compliance Status

Data on the compliance status of nursing homes in Texas comes from the OSCAR database and the complaint database. These databases are compiled by the Centers for Medicare and Medicaid Services (CMS), a division of HHS.[17] CMS contracts with states to conduct annual inspections of nursing homes and to respond to nursing home complaints. During these inspections and investigations, 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 standards observed by the inspectors are cited by the inspection team, reported by the states to CMS, and compiled in the OSCAR and complaint databases.[18]

The OSCAR and complaint databases use a ranking system in order to identify the violations that pose the greatest risk to residents. The rankings are based on the severity (degree of actual harm to residents) and the scope (the number of residents affected) of the violation. As shown in Table 1, 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 has the potential to cause death or serious injury). Homes

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[16]Minority Staff, Special Investigations Division, House Committee on Government Reform, *Nursing Home Conditions in Texas: Many Homes Fail to Meet Federal Standards for Adequate Care* (October 2000) (hereinafter "*October 2000 Report*").

[17]Prior to 2001, CMS was known as the Health Care Financing Administration (HCFA).

[18]In addition to tracking the violations at each facility, the OSCAR database compiles the following information about each nursing home: the number of residents and beds; the type of ownership (*e.g.*, for-profit or nonprofit); whether the facility accepts residents on Medicare and/or Medicaid; and the characteristics of the resident population (*e.g.*, number of incontinent residents, number of residents in restraints). To provide public access to this information, CMS maintains a website (http://www.medicare.gov/nhcompare/home.asp) where the public can obtain data about individual nursing homes.

with violations in categories A, B, or C are considered to be in "substantial compliance" with the law. Homes with violations in categories D, E, or F have the potential to cause " more than minimal harm" to residents. Homes with violations in categories G, H, or I are causing "actual harm" to residents. And homes with violations in categories J, K, or L are causing (or have the potential to cause) death or serious injury to residents.

Table 1: CMS's Scope and Severity Grid for Nursing Home Violations

Severity of Deficiency	Scope of Deficiency		
	Isolated	*Pattern of Harm*	*Widespread Harm*
Potential for Minimal Harm	A	B	C
Potential for More Than Minimal Harm	D	E	F
Actual Harm	G	H	I
Actual or Potential for Death/Serious Injury	J	K	L

To assess the compliance status of nursing homes in Texas, this report analyzed the OSCAR database to determine the results of the most recent annual inspections of each nursing home. These inspections were conducted between March 2001 and August 2002. In addition, the report analyzed the complaint database to determine the results of any nursing home complaint investigations that were conducted during this same time period. Following the approach used by GAO in its reports on nursing home conditions, this report focused primarily on violations ranked in category G or above. These are the violations that cause actual harm to residents or have the potential to cause death or serious injury.

B. Determination of Staffing Levels

Data on the staffing levels in nursing homes in Texas also comes from the OSCAR database. During the annual inspections, the nursing homes provide the state inspectors with data on their staffing levels for the two weeks prior to the inspections. This information on staffing levels is then reported by the states to CMS and entered into the OSCAR database.[19]

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[19]According to some experts, this data may overestimate the number of staff involved in resident care. Researchers have suggested that nursing homes may increase their staff during the period around the survey, meaning that reported staffing levels would be higher than the staffing levels found at the nursing homes during most periods of the year. Charlene Harrington, et al., *Nursing Home Staffing and Its Relationship to Deficiencies*, 17 (August 1999). HHS research also suggests that the OSCAR data may overestimate actual staffing levels in some instances. HHS compared the staffing data in the OSCAR database with the staffing data contained in "Medicare Cost Reports," which are audited cost statements that are prepared by nursing homes in order to receive Medicare payments. Although the HHS analysis found that in the aggregate average staffing levels in the OSCAR database and in the Medicare Cost Reports were similar, the analysis also found that for homes with lower staffing levels, the staffing levels reported in the OSCAR database were higher than the staffing levels reported in the Medicare Cost Reports.

The staffing data used in this report is the data gathered during the most recent annual inspections of nursing homes in Texas. These inspections were conducted between March 2001 and August 2002. Prior to analyzing the data, the Special Investigations Division removed reported data that was erroneous or inconsistent or did not otherwise meet standards of accuracy. The report compared these staffing levels to the minimum staffing levels necessary to provide adequate care identified by HHS.[20]

C. Interpretation of Results

The results presented in this report are representative of current conditions in nursing homes in the state of Texas as a whole. In the case of any individual facility, however, current conditions may differ from those documented in the most recent inspection report, especially if the report is more than a few months old. 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 facility 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.[21] Furthermore, staffing turnover in nursing homes is high, and the addition or subtraction of individual staff or individual residents could change staff hours and staff-to-resident ratios in a short time.

For these reasons, this report should be considered a representative "snapshot" of nursing home conditions in Texas. It is not intended to be – and should not be interpreted as – an analysis of current conditions in any individual nursing home. Conditions could be better or worse, and staff-to-resident ratios could be higher or lower, at any individual nursing home today than when the most recent annual inspection was conducted and the most recent staffing data was reported.

The report also should not be used to compare violation rates in nursing homes in Texas with violation rates in other states. Data regarding violation rates comes from state inspections that can vary considerably from state to state in their thoroughness and ability to detect

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This indicates that for homes with lower staffing levels, the OSCAR database could overestimate actual staffing levels. *See* HHS, *Report to Congress: Appropriateness of Minimum Nursing Staffing Ratios in Nursing Homes*, 8-7–8-8 (Spring 2000).

[20]HHS, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Phase II Final Report*, 1-6 (December 2001) (hereinafter "*Phase II Final Report*").

[21]*Additional Steps Needed*, *supra* note 13, at 12-14.

violations. According to GAO, "[c]onsiderable inter-state variation still exists in the citation of serious deficiencies."[22]

III. NURSING HOME CONDITIONS IN TEXAS

There are 1,148 nursing homes in Texas that accept residents whose care is paid for by Medicaid or Medicare. These nursing homes have 121,187 beds that were occupied by 84,859 residents during the most recent round of inspections. The majority of these residents, 60,809, rely on Medicaid to pay for their nursing home care. Medicare pays the cost of care for 8,097 residents. Eighty-two percent of the 1,148 nursing homes in Texas are private, for-profit facilities.

The results of this investigation indicate that the conditions in these nursing homes fall below federal standards. Many residents are not receiving the care that their families expect and that federal law requires. This report also finds that the vast majority of the nursing homes do not meet the minimum staffing levels identified by HHS as necessary for adequate care.

A. Prevalence of Violations

Only 161 of the nursing homes in Texas were found by the state inspectors to be in full or substantial compliance with federal health requirements. The remaining 987 nursing homes – 86% of all facilities in Texas – had at least one violation that had the potential to cause more than minimal harm to their residents or worse. Table 2 summarizes these results.

Table 2: Nursing Homes in Texas Had Numerous Violations that Placed Residents at Risk

Most Severe Violation Cited by Inspectors	Number of Homes	Percent of Homes	Number of Residents
Complete Compliance (No Violations)	75	7%	3,075
Substantial Compliance (Risk of Minimal Harm)	86	7%	5,263
Potential for More than Minimal Harm	544	47%	39,104
Actual Harm to Residents	364	32%	30,840
Actual or Potential Death/Serious Injury	79	7%	6,577

Many nursing homes had multiple violations. State inspectors found a total of 9,624 violations in facilities that were not in complete or substantial compliance with federal requirements, an average of 9.8 violations per noncompliant home.

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[22]GAO, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, 16 (September 2000) (hereinafter "*Sustained Efforts Are Essential*").

B. Violations Causing Actual Harm to Residents

According to GAO, some of the greatest safety concerns are posed by nursing homes with violations that cause actual harm to residents or have the potential to cause death or serious injury. As shown in Table 2, 79 nursing homes were cited for violations that caused or had the potential to cause death or serious injury. An additional 364 nursing homes were cited for violations that caused actual harm to residents. In total, 443 nursing homes in Texas – 39% of all facilities – had serious violations that caused actual harm to residents or had the potential to cause death or serious injury. These 443 nursing homes serve 37,417 residents and are estimated to receive over $440 million in federal and state funds each year.

Many of these facilities had multiple, actual harm violations. The 443 facilities had 1,160 violations that caused actual harm to residents or had the potential to cause death or serious injury. Over half of the nursing homes – 238 of 443 facilities – had two or more actual harm or worse violations. Fifty-eight facilities had five or more such violations.

Some of the most common actual harm violations included:

- Failing to prevent physical or sexual abuse of residents or other forms of mistreatment and neglect (209 violations);
- Failing to prevent or properly treat pressure sores (156 violations);
- Failing to prevent falls and accidents, such as failing to provide proper supervision or assistance devices to residents (155 violations);
- Improper or inadequate medical care, such as failing to provide proper treatments or drugs to residents (136 violations); and
- Failing to provide adequate nutrition and hydration to residents (111 violations).

C. Potential for Underreporting of Violations

The report's analysis of the prevalence of nursing home violations was based on the data from state inspections reported to CMS. According to GAO, even though this data is "generally recognize[d] . . . as reliable," it may "understate the extent of deficiencies."[23] 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

[23] *Additional Steps Needed*, *supra* note 13, at 30.

normal operations."[24] A second problem is that state inspectors often miss significant violations. A recent GAO report found that when federal inspectors examine nursing homes after state inspectors have inspected the facilities, the federal inspectors find more serious care problems than the state inspectors in 70% of the nursing homes. The federal inspectors also find many more violations of federal health standards.[25] Consequently, the prevalence of violations causing potential or actual harm may be higher than what is reported in this study.

IV. NURSING HOME STAFFING IN TEXAS

There are 1,148 nursing homes in Texas that receive Medicaid or Medicare payments. For 1,124 of these facilities (98%), there is sufficient data in the OSCAR database to evaluate staffing levels. The vast majority of these nursing homes – over 90% – fail to provide adequate staffing to residents. Compared to other states, Texas ranks 43rd in the median number of daily hours of nursing care provided to residents.

A. HHS Minimum Staffing Levels

Nursing homes cannot provide a high level of care unless they have enough well-trained staff to care for their residents. However, the staffing requirements under the 1987 federal nursing home law are minimal. In general, the law allows each nursing home to decide for itself how many hours of nursing care to provide to residents each day.

The 1987 federal law recognizes three types of nursing staff: registered nurses; licensed nurses; and nursing assistants. Different standards apply for each type of nursing staff:

- Registered nurses, who are often in a supervisory position, are nurses who have gone through two to four years of nursing education.[26] Under the 1987 law, all nursing homes must have a registered nurse on duty for at least eight hours per day.[27] This standard applies regardless of the size of the nursing home or the number of residents. The law does not specify a minimum registered nurse-to-resident ratio.

- Licensed professional nurses provide a level of care between the nursing assistant and the registered nurse. Licensed nurses generally undergo a 12 to 18 month period of training

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

[25]*Sustained Efforts Are Essential*, *supra* note 22, at 43.

[26]Institute of Medicine, *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, 69, 74-75 (1996) (hereinafter " IOM Report").

[27]42 U.S.C. § 1396r(b)(4)(c)(i).

in basic bedside nursing in order to provide care under the supervision of a registered nurse.[28] Under the 1987 law, nursing homes must have a licensed nurse on duty 24 hours a day.[29] Again, this standard applies regardless of the size of the nursing home or the number of residents and does not specify a minimum licensed nurse-to-resident ratio.

- Nursing assistants provide the majority of care in most facilities. Federal law requires that nursing assistants receive a minimal amount of special training.[30] The law does not, however, contain any requirements regarding the level of staffing by nursing assistants. Rather, each nursing home is permitted to determine for itself how many hours of nursing assistant care it will provide residents each day.

There is a widespread consensus among nursing home experts that current federal staffing requirements need to be improved. To assess the need for new staffing standards, HHS released the final results of a ten-year study, entitled *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*, in April 2002.[31] In order to determine whether minimum nursing home staffing ratios could be identified, researchers analyzed detailed staffing and resident data from over 5,000 nursing homes. The analysis examined the ratio of nursing assistants, licensed nurses, and registered nurses to nursing home residents, and assessed whether staffing ratios affected resident outcomes, such as the risk of hospitalization or the risk of developing pressure sores.

The report found that there are minimum staffing levels below which nursing homes are at substantially greater risk for quality of care problems. The report found that facilities that fell below these standards were significantly more likely to have high numbers of residents with problems such as urinary tract infections, respiratory infections, pressure sores, and unexpected weight loss.

Based on these findings, the HHS report identified minimum staffing levels necessary to provide adequate care for residents. For nursing homes that predominantly housed residents with long-term stays of 90 days or more, the staffing levels identified by HHS would require that each resident receive at least 4.1 hours of individual care per day, including at least 2.8 hours of individual care by nursing assistants and 1.3 hours of individual care by registered or licensed

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[28]IOM Report, *supra* note 26, at 76.

[29]42 U.S.C. § 1396r(b)(4)(c)(i).

[30]The 1987 federal nursing home law requires that nursing assistants receive 75 hours of training and testing for competency within four months of employment. Nursing assistants must also receive 12 hours of additional training annually. IOM Report, *supra* note 26, at 157.

[31]*Phase II Final Report*, *supra* note 20.

nurses, with at least 0.75 hours of care by registered nurses.[32] *According to the HHS report, nursing homes that fail to meet these staffing levels for short- and long-term residents can have "markedly increased quality problems."*[33]

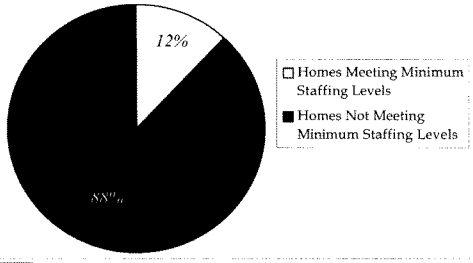
B. Most Nursing Homes Failed to Meet the HHS Staffing Level for Total Nursing Hours

The minimum staffing levels identified by HHS recommend that each nursing home resident receive a minimum of 4.1 hours of daily nursing care. In total, 917 of the 1,124 nursing homes (82%) failed to provide the recommended 4.1 hours of care to residents each day. These nursing homes provided care for over 74,000 residents. Moreover, over one-third of the facilities – 412 of 1,124 – provided less than 3.0 hours of nursing care per resident per day.

C. Most Nursing Homes Failed to Meet the HHS Staffing Level for Registered and Licensed Nurses

HHS identified a minimum staffing level of 1.3 hours of daily care for each resident by registered and licensed nurses, with at least 0.75 hours of this care provided by registered nurses. In total, 992 of the 1,124 nursing homes (88%) failed to meet this minimum staffing level (see Figure 3). These 992 nursing homes provide care for over 80,000 residents.

Figure 3: 88% of Nursing Homes in Texas Did Not Meet the Minimum Staffing Levels for Registered and Licensed Nurses



[32] *Id. at 1-6. The HHS report also identified minimum staffing levels for a nursing home with a mix of residents that are predominantly in the facility for short-term stays. The HHS report found that these nursing homes must have sufficient staff to provide each short-term resident at least 3.55 hours of individual care per day, including at least 1.15 hours of individual care by registered or licensed nurses, and at least 0.55 hours of care by registered nurses, in order to meet the minimum staffing level. Id.*

[33] *Id. at 2-22.*

D. The Vast Majority of the Nursing Homes Failed to Meet All Minimum Staffing Levels

Only 6% of the nursing homes in Texas – 64 out of 1,124 facilities – met all of the minimum hourly nursing staff levels identified by HHS. A total of 1,060 nursing homes (94%) did not meet at least one of the minimum staffing levels. These 1,060 facilities serve over 82,000 residents. Table 3 summarizes the results.

Table 3: Most Nursing Homes in Texas Did Not Provide Sufficient Staff to Meet Minimum Staffing Levels Identified by HHS

Status of Nursing Home	Number of Homes	Percent of Homes	Number of Residents
Met All Minimum Staffing Levels	64	6%	1,481
Failed to Meet Minimum Staffing Level for Total Daily Care	917	82%	74,623
Failed to Meet Minimum Staffing Levels for Registered and Licensed Nurses	992	88%	80,515
Failed to Meet at Least One Minimum Staffing Level	1,060	94%	82,553

E. Texas Ranks Near the Bottom in Staffing

It is difficult to compare rates of violations of health standards among states because the thoroughness of state inspections can vary considerably from state to state. In the case of nursing home staffing, however, state comparisons are feasible because all nursing homes report hours of daily nursing care using the same criteria. Such a comparison shows that Texas ranks near the bottom of the 50 states in nursing home staffing.

The median nursing home in Texas provided just 3.19 hours of daily nursing care per resident. This figure ranks 43rd in the nation in the number of hours of daily nursing care per resident (see Appendix).

The median nursing home in Texas provided just 21 minutes of daily care by registered nurses for each resident – less than half of the HHS minimum. This ranks 46th in the nation (see Appendix).

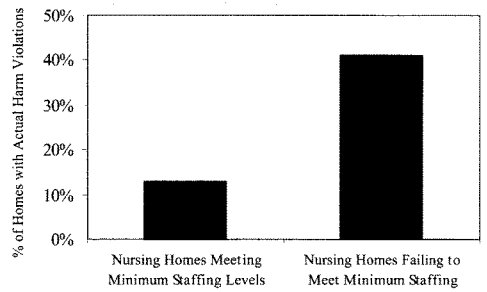
F. Inadequate Staffing Is Linked to Inadequate Care

There was a direct correlation between inadequate staffing and inadequate care. The nursing homes that did not meet the minimum staffing levels identified by HHS were more likely to have serious violations of federal health standards than nursing homes that met the minimum staffing levels.

There are 64 nursing homes in Texas that met all of the minimum staffing levels identified by HHS. Only eight of these facilities that met the minimum staffing levels (13%)

were cited during annual inspections or complaint investigations for a violation that caused actual harm to residents. In contrast, 430 of the 1,060 facilities (41%) that failed to meet at least one of the minimum staffing levels were cited for a violation that caused actual harm to residents. Thus, nursing homes that failed to meet at least one of the minimum staffing levels were over three times as likely to have violations that caused actual harm to residents (see Figure 4).

Figure 4: Nursing Homes That Did Not Meet Minimum Staffing Levels Were More Likely to Have Actual Harm Violations



As discussed above, 917 nursing homes in Texas did not provide the recommended 4.1 hours of daily nursing care per resident. Forty-two percent of these nursing homes – 384 of 917 – were cited during recent annual inspections or complaint investigations for a violation that caused actual harm to residents. In contrast, of the 207 facilities that met the minimum staffing level of 4.1 hours, 54 facilities (26%) had violations that caused actual harm to residents. Thus, nursing homes that did not meet the minimum hourly staffing level were over 60% more likely to have violations that caused actual harm to residents.

V. CONDITIONS REMAIN POOR IN TEXAS NURSING HOMES

In October 2000, the Special Investigations Division assessed nursing home conditions in Texas for Rep. Rodriguez.[34] The earlier report for Rep. Rodriguez analyzed the results of the annual inspections and complaint investigations conducted from March 1998 to August 2000. It found widespread, serious deficiencies in many nursing homes in Texas.

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[34] *October 2000 Report, supra* note 16.

There appears to have been little change in nursing home conditions since October 2000. Since the release of the October 2000 report, there has been a slight increase in the percentage of Texas nursing homes violating federal health standards (from 84% in the October 2000 report to 86% in this report) and a slight decrease in the percentage of nursing homes cited for violations that caused or had the potential to cause death or serious injury (from 8% in the October 2000 report to 7% in this report).

Staffing levels have also not changed measurably between reports. The October 2000 report found that Texas ranked 40th among the 50 states in the median number of daily hours of nursing care provided to residents; the current report finds that Texas ranks 43rd. In terms of the number of hours of daily nursing care provided to individual residents, the median nursing home in Texas in the October 2000 report provided 3.14 hours of care, compared to 3.19 hours in this report. Thus, over the past two years, Texas facilities have added only three minutes to the amount of daily nursing care provided to residents. Moreover, there has been a 5% decrease in the number of hours of care by registered nurses provided by nursing homes in Texas from the October 2000 report to this report.

In one area, however, there has been a more significant change. The percentage of nursing homes cited for violations that caused actual harm to residents dropped from 47% in the October 2000 report to 32% in this report.

VI. CONCLUSION

The 1987 nursing home law was intended to stop abuses in nursing homes by establishing stringent federal standards of care. Although the law and its implementing regulations require appropriate standards of care, compliance by the nursing homes in Texas has been poor. This report reviewed the OSCAR and complaint databases and found that many nursing homes in Texas are failing to provide the care that the law requires and that families expect. Furthermore, this report found that most nursing homes in Texas did not meet the minimum staffing levels identified by HHS as necessary to provide adequate care to residents.

Appendix: State by State Rankings of Nursing Home Staffing Levels

State Rankings by Total Hours of Nursing Care

Ranking	State	Median Total Daily Hours of Nursing Care
1	Alaska	5.33
2	Maine	4.15
3	Idaho	4.09
4	Hawaii	4.04
5	Alabama	3.88
6	Vermont	3.87
7	Washington	3.83
8	North Dakota	3.76
9	Kentucky	3.75
10	Florida	3.70
11	Ohio	3.69
12	Massachusetts	3.64
13	Maryland	3.63
14	Montana	3.62
15	Delaware	3.61
16	North Carolina	3.60
17	New Hampshire	3.58
17	Wyoming	3.58
17	California	3.58
20	Pennsylvania	3.57
21	Oregon	3.54
22	Connecticut	3.52
23	South Carolina	3.51
24	Colorado	3.48
25	Michigan	3.47
26	New York	3.45
27	Arizona	3.42
28	Nevada	3.40
29	Mississippi	3.39
29	New Jersey	3.39
31	Utah	3.38
32	Wisconsin	3.34
33	Rhode Island	3.33
34	Arkansas	3.32
35	Nebraska	3.31
35	Missouri	3.31
37	West Virginia	3.27
38	Virginia	3.26
39	New Mexico	3.25
40	Minnesota	3.22
41	Oklahoma	3.21
42	Georgia	3.20
43	Texas	3.19
43	Kansas	3.19
45	Tennessee	3.14
46	Indiana	3.11
46	South Dakota	3.11
48	Louisiana	2.93
49	Iowa	2.88
50	Illinois	2.80

State Rankings by Daily Hours of Care by Registered Nurses

Ranking	State	Median Daily Hours of Care by Registered Nurses
1	Alaska	1.17
2	Maine	0.81
2	New Hampshire	0.81
4	Hawaii	0.76
5	Montana	0.74
6	Washington	0.73
6	Wyoming	0.73
8	Massachusetts	0.72
8	Delaware	0.72
10	Connecticut	0.70
10	Vermont	0.70
12	South Dakota	0.69
13	Pennsylvania	0.67
13	Rhode Island	0.67
15	Idaho	0.66
16	Oregon	0.65
16	Colorado	0.65
18	Wisconsin	0.62
19	Ohio	0.61
20	New Jersey	0.60
20	Nevada	0.60
22	North Dakota	0.58
22	Maryland	0.58
24	Michigan	0.57
25	Utah	0.56
25	Arizona	0.56
27	New York	0.55
28	Illinois	0.54
28	New Mexico	0.54
28	Kentucky	0.54
31	Iowa	0.53
31	North Carolina	0.53
33	Florida	0.52
33	Nebraska	0.52
35	Kansas	0.51
36	California	0.50
37	Indiana	0.48
38	Minnesota	0.47
39	Virginia	0.43
39	South Carolina	0.43
41	Alabama	0.42
42	Mississippi	0.41
43	West Virginia	0.40
44	Missouri	0.38
45	Tennessee	0.37
46	Texas	0.35
47	Georgia	0.30
48	Oklahoma	0.28
49	Arkansas	0.27
50	Louisiana	0.22