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United States Senate

COMMITTEE ON SMALL BUSINESS
WASHINGTON, DC 20510-6350

November 10, 1999

VIA FACSIMILE

202-690-6262

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
Room 314G
200 Independence Ave., SW
Washington, DC 20201

Dear Administrator DeParle:

On October 21, 1999, your office responded to the General Accounting Office (GAO) report entitled *Nursing Home Care: Enhanced HCFA Oversight of State Programs Would Better Ensure Quality* (Report) with "Comments of the Health Care Financing Administration (HCFA)" on the Report (Comments).¹ In light of the Comments, the enclosed letter from a Missouri constituent, and other information I continue to receive from Missouri residents about the quality of care in Missouri nursing homes, I request further information, in addition to the requests made in my letter dated November 4, 1999.

The enclosed constituent letter highlights a number of allegations regarding abuse and neglect occurring in Missouri nursing homes. Unfortunately, these "horror stories" do not stand alone. As annual reports from the Missouri Division of Aging reveal, reports of institutional abuse, neglect and regulatory violations in long-term-care facilities rose steadily from 5,471 reports in fiscal year 1992 to 7,056 in 1995. Although these reports decreased slightly between 1995 and 1997, they jumped to a new high of 7,408 reports in 1999 — a 25 percent increase from 1997. If these numbers are a true depiction of how Missouri's frail elders are treated in long-term-care facilities, the state of affairs appears grim.

Based on this information, I request the following:

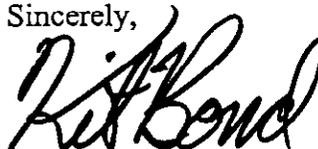
- ▶ First, your Comments identified several improvement initiatives launched by HCFA, including measures to increase monitoring of states. Specifically, you state that "HCFA has identified facilities in each state for more frequent inspection and intense monitoring, based on results of [the] most recent annual inspections and any unsubstantiated complaints during the previous two years." *Please provide my staff with copies of all information pertaining to facilities identified and selected for enhanced oversight within Missouri.*

¹(GAO/HEHS-00-6, November 1999).

- ▶ Second, in response to Report recommendation (1c), your Comments state that “[i]n August 1999, the Director of the Center of Medicaid and State Operation directed all regions to report to the state agency Director at least monthly on survey process errors, omissions and significant findings resulting from Federal Monitoring Surveys.” ***Please provide my staff with copies of these reports for the period of September 1, 1999 through October 31, 1999, as well as any other “performance information,” given to the Missouri state agency Director. Furthermore, please forward all future reports to my staff on a monthly basis.***

I would appreciate receiving this information no later than November 17, 1999. If you or your staff have any questions regarding this matter, please do not hesitate to contact Dan Donovan at 202-224-5175. Thank you in advance for your assistance with these additional requests.

Sincerely,



Christopher S. Bond
Chairman

cc: Michael M. Hash
Deputy Administrator
Health Care Financing Administration

Mr. Thomas W. Lenz
ARA, DMSO
Health Care Financing Administration
Kansas City Regional Office
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November 8, 1999

Honorable Senator Christopher "Kit" Bond
United States Senate
Russell Senate Office Bldg
Washington, DC 20210

Re: Missouri Nursing Home Cases

Honorable Senator Bond:

I am an attorney practicing in Jefferson City, Missouri. I am writing to you in response to several remarks attributed to you recently in the media regarding nursing homes and the deplorable care that they provide to your constituents. I represent more than a dozen Missouri families with loved ones in nursing homes, and unfortunately, the heirs and estates of several former Missouri residents of nursing homes. My clients, or their loved ones in nursing homes, have endured the most damnable treatment you could imagine. They have been assaulted, abused, neglected, and treated worse than most state prisoners. What little dignity they may have enjoyed before their confinement in the nursing home, it was quickly stripped from them on admission. At the mercy of overworked and grossly underpaid strangers, they relied on their caregivers to their detriment. On their behalf I am writing to you to request that your office take steps toward improving both the quality of care, and the quality of life of nursing home residents in Missouri.

Senator Bond you have a laudable record of achievement as it respects education and our children. My clients are, as one artist put it, motherless children. At eighty to ninety years old, they have become as dependent on care from others as a two month old child. I know that if there is anyone who can help my clients it is you sir. I would respectfully like to share with you, without violating any privileges, some facts with respect to several of the matters which I am handling. I would ask only that you respect the confidentiality of these clients as these are sensitive matters pending litigation.

Although I could share literally hundreds of "horror stories" with you, I will share only four such stories because while the names and dates change, the basic allegations of neglect fall into four categories: assault, emotional abuse, physical neglect, emotional neglect.

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Assault

We represent the heirs and the estate of an elderly man who had mild dementia and/or early Alzheimer's disease. Although the case is still under investigation, some facts are known. Mr. A. was pleasant enough most of the time, but like many patients with mild senile dementia, he could be difficult to deal with. Employee X at one defendant facility did not appreciate Mr. A., and this employee had a hair-trigger temper. We believe he struck Mr. A. with something, possibly his hand, resulting in a bloody lip and bruising about the head.

The original blow or a combination of blows caused bruising of the brain – a phenomenon known as subdural hematoma. The client's sensorium deteriorated over the next day and the third day following the incident the patient was found obtunded, and cyanotic. A MRI revealed the brain injury, and he later succumbed to his injuries at a local hospital.

In another incident an elderly client of ours cowered when my clients approached her to brush her long flowing white hair. "Please don't hit me," she pleaded. Upon examination my clients found bruises the size of golf balls on her head where she had been hit over the head with a wooden hairbrush. The client was 92 years old, and weighed less than 90 pounds.

Another patient at the same facility was pulled around by his rather large ears when staff wanted him to do something. Still another was bathed in ice cold water when water heaters went out. These are not acts of mere negligence, or improper use of restraints – these are acts of physical abuse.

Emotional Abuse

Mr. B is a sixty-five year old stroke victim who is paralyzed on the right side. He had been the victim of numerous assaults by aides and had been a frequent target of aides who went through his personal belongings looking for cigarettes, candy, and other things that could be stolen without sanction. He had been reminded often that his life was in the hands of the people who went through his things, and that a smart person wouldn't say anything about it.

About the only joy left in Mr. B's life is his addiction to nicotine, an unhealthy past-time, but one that brings him some measure of comfort in the waning days of his life. One of the nurses at the facility did not like smoking or smokers. She would frequently keep him from going outside (even though others were allowed to go outside and sit or smoke) because she simply did not like Mr. B.

One day she told Mr. B "I am going to be after you till the day you die." Mr. B responded "I didn't know you loved me that much."

She replied: "I don't; I hate you that much."

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Imagine Mr. B's consternation. Here is a man who can't move his left side. He has been smothered by pillows and horrifically treated by aides. He had stage IV decubitus ulcers pretty much non-stop for the last four years of his life. He is totally dependent on others for his care. And now he was told that the person who was responsible for caring for him and protecting him from harm, hated him.

Mr. B was removed from the facility in September because burns were found on the underside of his leg and no one could explain how they got there. Within 18 days of arriving at a new facility, Mr. B's decubitus ulcers were healing over, and his entire personality and outlook on life changed dramatically for the better.

Physical Neglect

Mrs. C. was a ninety year old patient with good cerebral function who suffered from congestive heart failure. Her heart failure was medically managed, although she had difficulty moving and walking and required a great deal of care.

Her first six weeks in the nursing home were generally good ones. Then, when the family began to complain about the failure to change bed linens and other staff failures, care became much worse.

Bed sheets were not changed for sometimes three weeks at a time. At one point the family marked in red lipstick at the bottom of the bed the date on which the linen was found soiled. Three weeks later the same bottom sheet with the same lipstick marking was still on the bed and the family, unable to get anyone from the home to change the bed linens, changed them on their own.

When family would visit, they would find Mrs. C in a pool of her own urine or feces. Repeated use of the call bell would sometimes result in an aide making it down, promising to return, and then never returning. At one point the family waited nearly four hours (the family was unable to safely move the resident and change the bed linens on their own) for an aide to come clean up their family member.

Mrs. C would be asked to sit in her own rocking chair with her Depends. When the Depends would get filled, it would leak out onto the chair. Because Mrs. C was a diabetic, she "spilled sugar" into her urine, and the floor was frequently sticky and smelly as a result of this. As Mrs. C's life began to slip away, the staff told the family that the rocking chair, with its built in foam cushion, had been taken away and thrown in the trash because it was soiled from urine and was drawing "bugs." Later that day the family found ants crawling on their mother's arm.

When they called the nursing station, the nurses said "are those things back again?" Over the next few days, as Mrs. C slowly slipped away and died, her family frequently had to brush ants off her face and arms. The family members still have nightmares about their mother dying with ants crawling all over her. And sir, our tax dollars paid for that "care."

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Emotional Neglect

Mr. D was an elderly stroke patient with Alzheimers-like symptoms. He was assigned to a "freedom unit" that allowed him to be as unrestrained as possible. The freedom there was illusory. The staff frequently yelled at the older people and screamed instructions to them, as if this would do any good with a patient suffering from this form of dementia.

When Mr. D was "bad" a certain nurses aide would take this diabetic patient and tell him that he could not have his meal that night. She would then put him in his room, facing his wheelchair in such a way as that he could see only the wall.

Mr. D's medical condition required that he be in a quiet place and that he be treated gently. The vascular problems from which he suffered were exacerbated by anything that caused tension or stress on the unit. *In spite of this*, the aides frequently turned on violent television programming, including allowing (and encouraging) residents to watch movies like "Fatal Attraction."

Mr. D was a stroke patient, but he could walk pretty well. When he was occasionally allowed to be up and walk, aides would shout at him. This caused marked confusion and, at one point may have produced the stimulus for Mr. D's final stroke. Immediately following the shouting incident, he curled up in a fetal position and laid down on his bed. He was never upright again, and died several days later.

Mr. D. did not have to die in that manner. He had the ability to walk, but had forgotten how to find the bathroom (a common problem with Alzheimer's patients). He was made to wear Depends not because he could not control his flow of urine, but because it was easier for the staff to make him wear these than it was to see to it that he got taken to the toilet at regular intervals. Thus in the waning days of his life, this once-proud gentleman was stripped of the dignity that had been his companion throughout his life, and he died, at least in part, from the constant emotional abuse heaped upon him by the staff.

Conclusion

There are more stories than these. Stories of unauthorized and unlawful transfers and of civil commitments without even colorable due process. Some are worse than those above, and some are simply exemplary of the poor care and awful staffing in the homes. One resident reports that unless she wheels herself to the nursing station, she never gets water. This in spite of the fact that studies show that 95% of the residents in nursing homes don't get enough fluids. The lack of water is explained by telling the residents and their families that people who drink tend to urinate, and if they provide enough fluids to the residents this is simply "too hard on the CNA's" who work there.

Senator Bond, the Nursing Home Industry is asking the Senate for more money. It claims that, unlike the hospitals in this country who have adapted to a prospective payment system and continued to thrive, it cannot adapt to such a system and it needs federal help. Yet the dollars pumped into nursing homes

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through Medicare and Medicaid do not carry with them the simply guarantee that the federal government gets from its defense contractors. When Boeing sells a jet or a part to the federal government, it must certify that it meets specifications. When nursing homes send in their claims, frequently the care they bill for is not even close to the care they provide. Lengthy state appellate procedures, and a HCFA review procedure for fines that is more than three years long makes any hope of punitive federal or state sanctions laughable. That leaves enforcement of the law to private attorneys like me. And there are very few attorneys who handle nursing home cases.

I would urge you to make meaningful reform of nursing homes a high priority. If I or my office can be of assistance to you in this matter, you have but to ask.

Sincerely,

A handwritten signature in black ink, appearing to read "A L DeWitt". The signature is written in a cursive, somewhat stylized font.

Anthony L. DeWitt
Attorney