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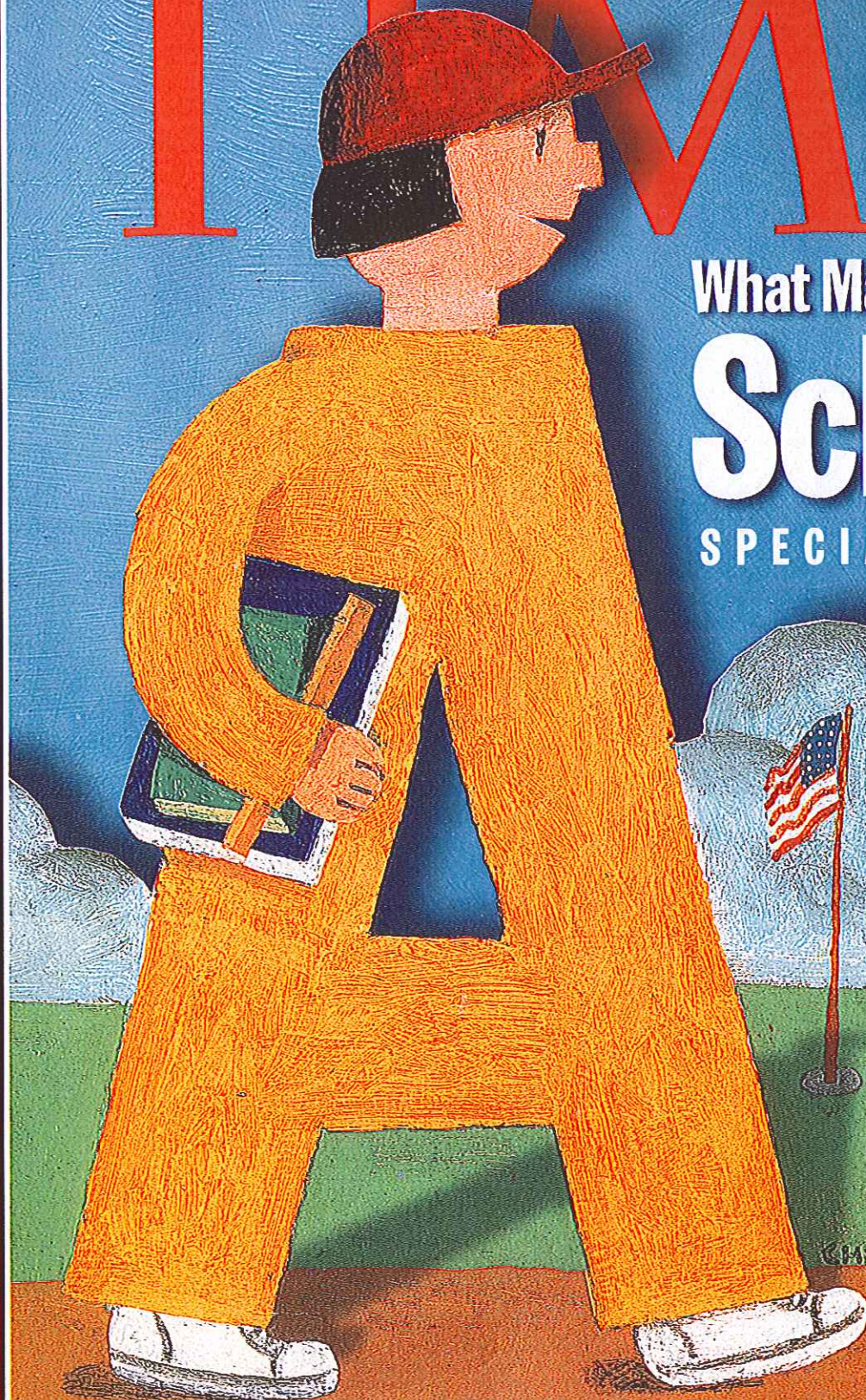
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FATAL NEGLECT

In possibly thousands of cases, nursing-home residents are dying from a lack of food and water and the most basic level of hygiene

By MARK THOMPSON

ONCE SHE MOVED INTO CREEK-side Care Convalescent Hospital, it didn't take Bessie Seday long to realize that the promises made to her by the nursing home before she arrived had evaporated. "I couldn't get anybody's attention, starting on the fourth day," recalls the bed-bound 84-year-old. "You'd have your call light on for hours, but nobody came." What made her waiting more desolate was the near total deprivation of sunlight during her four months at Creekside. "It was a dungeon," she says. "I really would have liked to see the sunshine, but they never put us outside." Things only got worse when the sun set, and the

staff ignored calls for help or pain-killers. "The screaming is what got to me the worst, the screaming when the lights went out," she says. "I couldn't fall asleep until 1 or 2 in the morning with all that screaming going on."

Bessie's daughter Ann used to visit her mother in the home, some 50 miles northeast of San Francisco, and find her lying immobile in a filthy bed. "She was not turned and kept clean and dry, which led to the bedsores," Ann recalls. A bedsore on Bessie's left hip turned into a gaping wound that would not heal, despite repeated whirlpool baths. Creekside nurse Patricia Lloyd knew why: the special washing machine for cleaning dirty bedpans had broken down. "So we washed bedpans in the whirlpool," she says, "and then we'd put patients with big bedsores, like Bessie Seday, in there."

Fixing Bessie's wound required repeated surgery, including the removal of her left buttock and part of her pelvis. "They were washing her," says Lesley Clement, her attorney, "in a damn cesspool."

Bessie, who now lives with her daughter, was lucky to get out alive. A TIME investigation has found that senior citizens in nursing homes are at far greater risk of death from neglect than their loved ones imagine. Owing to the work of lawyers, investigators and politicians who have begun examining the causes of thousands of nursing-home deaths across the U.S., the grim details are emerging of an extensive, blood-chilling and for-profit pattern of neglect. In Chicago last week a 73-count indictment was returned against a hospice operator charged with bilking Medicare and others of \$28 million for services to the

terminally ill that were never delivered. In Detroit a nursing home that was part of a chain whose owner was convicted of Medicaid fraud 17 years ago was cited again last year for bad hygiene, inattention to frail residents and incompetent staff. In Texas attorney general Dan Morales has filed 50 lawsuits against nursing homes this year for neglect and failure to medicate.

In California a team of lawyers specializing in fraud has begun to investigate what's killing people in the state's 1,400 nursing homes. In Washington, Senator Charles Grassley of Iowa, chairman of the Senate's Special Committee on Aging, last week dispatched three investigators from the General Accounting Office to California to pore over data, confer with state officials and visit suspect nursing homes. One of their first stops was Creekside (now oper-

ating as Vacaville Rehabilitation and Care Center), which denied the investigators access to medical records—until they returned with a subpoena. Grassley calls the California data "troubling" and says the situation "requires immediate attention."

Palo Alto attorney Von Packard has studied the death certificates of all Californians who died in nursing homes from 1986 through 1993. More than 7% of them succumbed, at least in part, to utter neglect—lack of food or water, untreated bedsores or other generally preventable ailments. If the rest of America's 1.6 million nursing-home residents are dying of questionable causes at the same rate as in California, it means that every year about 35,000 Americans are dying prematurely, or in unnecessary pain, or both. The investigations bear out something many Americans have suspected all

along: in a recent survey published in the *Journal of the American Geriatrics Society*, 30% of those polled said they would rather perish than live in a nursing home. Packard, who has spent nearly two years tracking the data, says, "We believe thousands would have lived significantly longer had they been taken care of."

Neglectful caregivers are preying not only on elderly residents but also on American taxpayers. More than \$45 billion in government funds, mostly from Medicare and Medicaid, is pumped into nursing homes annually, an amount that comes to nearly 60% of the national tab for such eldercare. In order to pocket a larger slice of the federal stipend, many nursing homes—largely for-profit enterprises—provide a minimal level of care, if that.

Packard and his investigators, referred

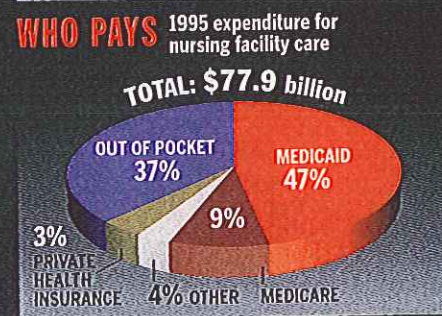
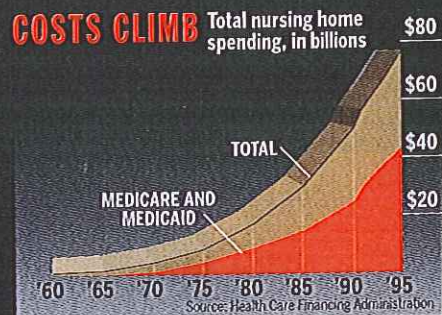


Residents of a nursing home near Detroit cited repeatedly for violations

Of **26,097** nursing-home sanctions recommended last year, only **571** resulted in fines and penalties



GUMSHOES Investigators Von Packard and Dina Rasor behind the stack of death certificates that mobilized the feds



to as "hearse chasers" by some in the nursing-home trade, have begun contacting relatives of deceased patients whose California death certificates cite malnutrition, dehydration and other signs of neglect. They're often shocked to learn what killed their loved ones. "They don't know their parents died of malnutrition," says Dina Rasor, an investigator working for Packard, "until we tell them." Even more telling, the causes of death on California death certificates are often listed by doctors affiliated with the nursing home involved, suggesting that Packard's list may well understate the number of deaths in which neglect played a role. Packard and his investigators are gathering death certificates for five more states, which they decline to name.

DEATH COMES TO THE ELDERLY IN MANY ways, including heart and lung failure, chronic disease and plain bad luck. But David Hoffman, an assistant U.S. attorney in Philadelphia, thought he spied something else at work last year, when he saw festering bedsores eating away the flesh of three residents in a local nursing home. He knew the home had been pocketing government money the residents were given to ensure good care, and he saw the bedsores as proof that they weren't getting it. He investigated and later sued Geriatric and Medical Companies Inc., which operated the Tucker House nursing home. The nursing-home company settled the case for \$600,000, sent condolences to the families of the three residents and—perhaps most important—set off probes by law firms around the country seeking similar evidence of poor care and

the resulting fraud. Their plan: to present evidence of widespread fraud to the Justice Department in the hope that the government will take the lead in the case and share in any damages awarded.

The idea of using death certificates to try to prove fraud was born at the Creekside facility. Shortly after Rhoda Johnson moved into Room 52 of the nursing home in 1992, her daughter Ila Swan became concerned about her care. Swan, a 57-year-old former telephone worker, says her anxiety grew when she saw a woman in Room 51, across the hall, try to climb out of bed after her calls for a nurse went unanswered for an hour. According to the woman's roommate, as the woman struggled to get out of the bed, she toppled and struck her head on the tile floor. She lay there for 20 minutes, her cries for help going unanswered by the staff as a pool of blood grew around her. She died a short time later. Swan visited the county records office to review the woman's death certificate and those of others who had died while residing at Creekside and other nearby nursing homes. She was startled to find 10 questionable causes of death listed on the first 30 she reviewed. "They'd listed malnutrition, dehydration, bedsores and urinary-tract infections as causes of death," Swan says. "These nursing homes were killing people."

Soon Rasor and investigator Robert Bauman heard of Swan's work. Intrigued, they began working with Packard to obtain records listing the cause and place of death for every Californian who died from 1986 to 1993. More than 300,000 had died in nursing homes.

What happened next surprised Rasor

and Bauman most. Nearly 22,000 of the nursing-home deaths were attributed to lack of food or water, infections or internal obstructions—all preventable, at least in theory.

Packard and his investigators didn't add deaths to their list if the deceased suffered from other ailments that exacerbated those four causes. So people who died of both cancer and malnutrition, for example, were not counted.

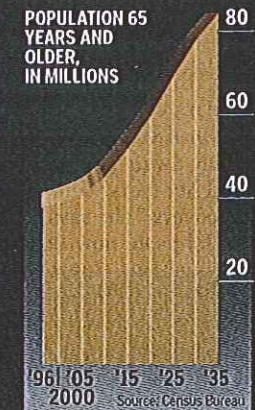
Many nursing homes have become dangerous places largely because they are understaffed—and underregulated. The Federal Government doesn't dictate staffing levels, and state efforts at regulating quality are meager. With 2 of every 3 dollars spent by nursing homes going to payrolls, the most tempting way to increase profits is to cut personnel.

Generally, the nursing-home industry likes to settle lawsuits quietly and often hands over money only in exchange for silence. But that didn't happen at Creekside, where lawsuits alleging neglect have recently been getting into the public record. Four former residents of Creekside have won more than \$2 million in settlements after alleging poor care. An additional four suits are pending. In fact, Packard's California death list contains the names of dozens of people who died there.

Creekside, which opened in 1989, is a handsome place, its fieldstone-walled foyer graced by a big aquarium. Its brochure boasted of private patios and a recreation director who "understands the subtle limitations of age." It promised "all the comforts of home" plus "state-of-the-art



THE EXPLOSION



NIGHTMARE

Seday's four months in Creekside Care Convalescent Hospital included screams at night, no sunlight by day

en were doing nothing, one was participating, and "one resident was eating Play-Doh." In February 1993 inspectors found up

MARK RICHARDS—CONTACT FOR TIME

nursing equipment" for its 120 residents.

Court records and interviews tell a different story. "The whole place was a fiasco," says nurse Patricia Lloyd, who moved away from California after she testified against Creekside, where she had worked for four years, until 1995. "Everybody was sick; everybody was having problems." Did such care lead to premature deaths among Creekside residents? "Absolutely," Lloyd says firmly and quickly. "I'm 100% sure. People would come in, they'd get depressed, stop eating and start falling. Then they'd get tied down to a chair, and they'd rapidly decline and die. That was something that was pretty common at Creekside."

Feeding was always a problem, says Suzanne Cologgi, a former Creekside nurse's aide. "The staff would give up really quickly, so the patient wouldn't get enough food," Cologgi says. "Because there wasn't enough staff, a lot of people went without eating or sat in dirty diapers." Many times Cologgi would have 20 minutes to feed seven residents, all of whom depended on her to spoon every bit of food into their mouth. "Sometimes you'd need 30 minutes for one," she recalls. "Full trays would go back untouched."

Patients who ate poorly were supposed to get 240-calorie liquid supplements to help them gain weight. "We didn't even pass them out, even though we signed [forms indicating] that they got

them," Lloyd says. "Sometimes, patients who could talk would ask for them, and get them, but the patients who couldn't talk didn't—and they were the ones who really needed them." Medical charts, Lloyd says, were routinely falsified.

State inspectors told similar tales in their regular reports on Creekside. In early 1993 restraints were being used on 62 of 112 Creekside residents, some without consent. The family of a severely impaired woman at Creekside in 1992 had chosen a relative to make decisions regarding her care. Yet a state inspector found that the patient herself had signed consent forms allowing tranquilizers and physical restraints to be used on her. Such drugs were administered for "purposes of discipline or convenience" of Creekside's staff, a state report said.

There were pitiful examples of Creekside residents not getting enough to eat. A female resident sat in the dining room picking occasionally at her food for 25 minutes but didn't eat. Another resident complained that his food card—which specified that he disliked broccoli—was routinely ignored. "We don't look at the cards," a kitchen worker told him. A state inspection came upon a Dickensian scene: Creekside's cook violating federal regulations by adding water to pureed meat. "We usually use water," she said, "to thin the pureed meat." During another inspection, of nine residents supposedly playing a game, sev-

to 35 residents parked in wheelchairs in common areas of the nursing home "for long periods of time (i.e., four hours or more) with no apparent meaningful activities."

When the laundry room's hot-water heater broke for a week, the staff washed bedding in cold water, which failed to do the job. Bedding and gowns "have yellow or brown stains and/or urine or fecal odors," the state reported. Towels were so rare that nurse's aides would wet and soap one end to wash residents and use the other half to dry them. Sheets were used for diapers.

Creekside attorney James Geary says Creekside was unexceptional. "It was probably no better, and no worse," he says, "than any other nursing home." Except that Creekside is paying for its lack of care. Bessie Seday, for example, collected a \$862,500 settlement last December stemming from the infected bedsores she contracted while living at Creekside.

Rhoda Johnson, Ila Swan's mother, lived at Creekside nearly two years, until July 1993. Her family alleged in a lawsuit that the nursing home essentially abandoned Johnson: she was often left lying in her own waste, hungry, cold, unfed and unturned. One day she complained to Swan that her hip hurt. With her sons' help, Swan lifted her mother out of the bed, pulled up her nightgown and collapsed in sobs. "She had this bed sore on her hip that was so deep," her daughter re-

Sixty percent of the payments to nursing homes comes from tax dollars; not enough goes for care

calls, "that I could see the hip socket and leg bone moving inside the hole." Her bottom was bruised and caked with dried feces, which Swan peeled off with her fingers amid her tears. "I never had looked under the covers," she says. "I didn't think I had to." Johnson, now 98 and living in a Utah nursing home, doesn't talk much about her experience. "Creekside was mean to me," she says. "They didn't give me a drink, they yelled at me, they hurt me." She received a \$775,000 settlement in May 1996.

Creekside owner Richard Schachten, who trained and spent his early years as an undertaker, disputes any suggestion that neglect was endemic. "The quality of care was very good," says Schachten, who sold the business in 1995. "I have not paid one dime in fines, there's never been an admission of guilt, and the facility's license was never revoked or suspended."

Implicit in Schachten's defense is the presumption that the government keeps a keen eye on nursing homes. A decade ago, Congress passed a major nursing-home reform bill, which did help to cut down on the use of physical restraints and tranquilizers. But in 1995 a quarter of the nation's nursing homes failed even to assess each patient's needs or develop individual care plans, federal records show. Even more failed to ensure sanitary food, and about 1 in 5 didn't provide proper treatment for bedsores.

That year the Federal Government got the power to punish nursing homes in ways

other than denying them federal funds. The government can now levy fines, deny payments for new patients to nursing homes and mandate training for their staffs. Yet the government seems mighty miserly when it comes to holding nursing homes accountable.

In the past year nearly 10,000 of the 15,000 nursing homes inspected by the states had violations, and many were forwarded to federal officials with proposed punishments. But fines or other penalties were imposed in only 2% of the cases. State inspectors recommended to U.S. authorities that 5,458 nursing homes—1 in every 3—be barred from collecting money for new patients. Washington cut that figure to 156. The states urged Washington to order special training for the staffs in 3,039 nursing homes; Washington ordered such training for only 103. And state inspectors urged Washington to fine 2,935 nursing homes for violations. The Federal Government fined only 228 (and those that paid without appealing had to pay only 65% of the fine).

Officials of the Health Care Financing Administration, a section of the Department of Health and Human Services that enforces federal nursing-home rules, were unable to justify to *TIME* the gap between recommended penalties and those that were ultimately exacted. The officials say nursing homes "have a right" to correct problems before penalties are imposed. But a former government inspector disagrees. "Congress said to impose these

penalties, and they're not," says Charles Bailey, a lawyer who left the HCFA this year after spending nearly seven years trying to punish bad nursing homes.

California fined nursing homes \$2.4 million last year but has collected only \$500,000 (the state gives nursing homes a 50% discount on fines that are not appealed).

And then there are the maggots. In 1994 a nurse at the Fairfield Health Care Center in Fairfield, Calif., found about 40 maggots in a bedsore on the left heel of an 87-year-old man. State inspectors recommended a \$24,000 fine, but the nursing home appealed, saying the wriggling larvae didn't constitute evidence of poor care. Besides, the nursing home argued, maggots are good for eating away dead tissue inside a wound. The state hearing officer agreed with the nursing home and threw out the fine.

Brenda Klutz, deputy director of licensing for California's health department, calls that decision "very distressing and emotional," but she doesn't call it wrong. In fact, she echoes the nursing home's argument. "In an era of alternative medicine, maggots are being used for debridement of dead tissue," she says. "The fact that these sorts of eggs and maggots can hatch in a 24-hour period may not even mean that there was improper wound care." With regulators like that, the elderly in nursing homes may have more to fear than either the maggots or the nursing-home operators.

—With reporting by James L. Graff/Chicago and S.C. Gwynne/Austin

How to **CHOOSE** a Nursing Home That Actually Cares

MAKING THE DECISION TO MOVE A PARENT INTO A NURSING home is painful. Finding the right place can be just as trying. Here are some tips to help guide you.

► **Consult the state's survey of inspections.** Each state conducts inspections about once a year and issues a survey of its findings that should be available at all nursing homes. Even a good home may be cited for deficiencies, but they should be minor and promptly fixed. Bad signs: problems affecting residents' health, or an inability to produce the most recent surveys.

Federal law requires each state to have an ombudsman's office with information on all nursing homes. To contact your ombudsman, call the National Citizens' Coalition for Nursing Home Reform in Washington at (202) 332-2275.

► **Make an unannounced visit to prospective nursing homes.** Look, listen—and smell. Wander hallways; speak to residents and staff, get a sense if both enjoy being there. A nursing home that won't let you visit unannounced may well

have something to hide. Look for clean, well-groomed residents. Discreetly try to assess oral hygiene. Listen for the staff's tone in dealing with residents. Make sure that nurses and aides mingle with residents and don't view their charges as widgets on an assembly line. While most nursing homes occasionally smell of urine and feces, there should be no persistent stench or overwhelming scent of air fresheners.

► **Keep your eyes open.** Watch the call lights that residents use to summon help. See how long it takes for help to arrive; more than five minutes is too long. Look for obstacles or puddles left in corridors that could endanger frail residents with failing vision. Visit during a meal: assess the food, and check that those who can't feed themselves are helped. Keep your eyes peeled for residents in restraints; the more you see the more leery you should be.

► **Once you've picked a home, visit frequently.** Residents with an attentive family and regular visits tend to receive better treatment than those who are essentially abandoned. —M.T.