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OBSERVER WATCHDOG

Nursing homes' silent pain

Rules let N.C. facilities stay quiet

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If you are considering a nursing home in North Carolina for an elderly relative, you might never learn about certain serious injuries and deaths that may have occurred there.

Federal and state rules require nursing homes to be vigilant in reporting suspected abuse, neglect or mistreatment, and injuries when the cause is unknown.

However, injuries can escape reporting when nursing home officials know how the injuries occurred and they don't suspect abuse, neglect or mistreatment.

When such cases are not reported, there is no state investigation into how the incident occurred and how to prevent it from happening again. That means no state official looks for larger patterns of safety problems or checks to see whether nursing home staff is properly trained. If the state has no record of such incidents, neither do families vetting nursing homes.

When nursing homes don't report serious incidents to their state oversight agency, "then you just have the facility investigating itself," said Alice Hedt, executive director of the National Citizens' Coalition for Nursing Home Reform in Washington.

After an Observer inquiry, a U.S. senator is pushing to close this "reporting loophole" in the federal regulations. But those regulations affect only nursing homes that accept Medicare and Medicaid patients, which is the majority. N.C. licensing rules would have to change to make sure every nursing home in the state reported such incidents.

No N.C. official is actively working to change those rules.

Nursing home advocacy groups and the federal Centers for Medicare & Medicaid Services say they do not know how many states have reporting requirements that are more detailed or stricter than the federal rules.

In South Carolina, nursing homes must report many categories of serious injuries and unexpected deaths, no matter whether the cause is known. If the report leads to an investigation that cites violations, the home must take corrective action.

In the past five years, N.C. officials received 8,457 reports from nursing homes and other sources about problems such as abuse, neglect and injuries where the cause was unknown. They investigated 1,933 and substantiated 634. But since injuries where the cause is known are not reported in North Carolina, nobody knows how often they occur.

In one case two years ago, 89-year-old Cora Elliott slipped from a mechanized lift administered by Statesville nursing home assistants and later died. Since Autumn Care of Statesville knew how her fatal injuries occurred, and they did not involve abuse, neglect or mistreatment in the home's judgment, Elliott's case was not reported to or investigated by the state.

Officials at Autumn Care and parent company Autumn Corp. of Rocky Mount declined comment. In October, Autumn Corp. settled a wrongful death suit in Iredell County Superior Court with Elliott's son, Johnny Elliott of Cornelius, for \$300,000.

"There needs to be something to protect the other people," Elliott said. "It's not going to help my mom."

In lawmakers' hands

Last month, after the Observer contacted Sen. Charles Grassley, R-Iowa, the finance committee chairman asked the administrator for the Centers for Medicare & Medicaid Services to survey which states require reporting of nursing home injuries when the cause is known. Grassley, who has for years pushed to improve nursing home accountability and increase consumer access to such information, requested a plan of action for closing the loophole by March 22.

In North Carolina, the General Assembly sets licensing and reporting requirements for nursing homes. The Division of Facility Services within the N.C. Department of Health and Human Services enforces both the state and federal rules.

The licensure and certification chief for Facility Services says it's the legislature's responsibility, not his department's, to set policy.

"That's something the General Assembly would have to take up," Jeff Horton said.

Craig Souza, president of the N.C. Health Care Facilities Association, said it's not necessary to beef up state reporting standards.

"What's one more report?" he said. "(Nursing homes) report probably more than any health provider."

Souza said he believes "adequate safeguards" already protect patients and inform nursing home consumers. "Yet another regulation or requirement is not what we need," he said.

But when serious injuries occur, it shouldn't be up to the nursing home to decide whether an outside investigation is warranted, said Toby Edelman, a senior policy attorney at the Center for Medicare Advocacy in Washington.

"What if they do an inaccurate assessment?" she said. "What's the consequence? Not much."

A quiet tragedy

On Dec. 27, 2002, two nursing assistants prepared to transfer an immobile Cora Elliott from her bed to her wheelchair using a mechanized lift, as her daughter, Mary Frances Elliott Rives, watched from a nearby chair. (Rives described the event in a lawsuit deposition before she died of cancer.)

The assistants placed her in the lift sling, a sort of padded seat attached to metal, and lifted her five feet in the air. One assistant adjusted her position and steadied the seat.

Suddenly, the lift tilted and Elliott slipped through the space between the seat bottom and the seat back.

Her head hit the metal bed railing. She was transferred to a nearby emergency room and then Carolinas Medical Center. It was the day before her 90th birthday.

On Feb. 1, 2003, after never waking from a coma, she died.

Autumn Care took statements from the assistants the day Elliott was injured, then sent them home, according to lawsuit deposition testimony of one of the nursing assistants. The assistants lost their jobs.

But because the incident wasn't reported to the state, it does not appear on the state health care personnel registry used by employers to screen nursing assistants. One of the aides later found a new nursing assistant job, according to her testimony.

Three months after Elliott's death, North Carolina cited Autumn Care during its annual review for failing to provide adequate supervision to prevent accidents.

In a 15-resident sample group from the review, one resident who used a wheelchair and needed supervision had fallen four times in two months, once resulting in a pelvic fracture, the state report said. One of the falls occurred when the resident tried to reach the bathroom by herself after staff told her she needed to do more on her own, the report said.

Autumn Care was required to institute changes within the month to increase precautions against patient falls. A follow-up visit by the state found the home had done so.

State officials say they can't now investigate Elliott's death because the incident occurred more than a year ago. The one-year rule exists because older cases are difficult to investigate accurately, said Beverly Speroff, deputy chief for N.C. nursing home licensure and certification.

Speroff said the Elliott family should have lodged a complaint with her office immediately after the incident, which could have triggered a timely investigation. When N.C. residents are admitted to nursing homes, their guardians or relatives are supposed to receive information on how to file complaints, she said.

No matter the reporting requirements, families must remain vigilant about the nursing home care of their relatives, said Mary Kahn, a Centers for Medicare & Medicaid Services spokeswoman.

"They've got to understand that they are the best eyes and ears to protect the health care that person is getting," she said.

After his mother was injured, Johnny Elliott said he assumed the incident had been or would be reported to state authorities.

As to why he didn't report it at the time just in case, he said: "I was busy trying my best to see if I could try and save my mother." This is "Sunshine Week," when newspapers and other media are emphasizing public access to government documents, records and meetings. Learn how such access contributed to this story at the end, on 10A.