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I. Introduction

Each year, hundreds of thousands of older Americans are abused or neglected in nursing homes.[1] The problem is underreported. For every case of elder abuse, neglect, or exploitation reported to authorities, five go unreported.[2] In a study in which 2,000 nursing home residents were interviewed, 44 percent said they had been abused and 95 percent said they had been neglected or seen another resident being neglected.[3] Even nursing home staff members acknowledge there is problem. In a 2010 study, more than 50 percent of long-term care (LTC) staff polled admitted to mistreating older patients (e.g., by means of physical violence, mental abuse, or neglect) within the prior year; two-thirds of those incidents involved neglect.[4]

Abuse and neglect of nursing home residents is not a new problem. For decades, nursing homes have been plagued with reports suggesting prevalent maltreatment of residents, including abuse and neglect.[5] The overwhelming reports of abuse and neglect to authorities were a major factor in the passage of the nursing home reforms contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA-87).[6] This article provides an overview of the most prevalent types of abuse and neglect that occur in the nursing home setting, discusses the ways in the which the original OBRA-87 reforms have attempted to address them, and alerts the reader to new changes in the regulations aimed at achieving more effective redress.

II. Omnibus Budget Reconciliation Act of 1987 — The Nursing Home Reform Act

In 1986, at the request of Congress, the Institute of Medicine conducted a study, which found that residents of nursing homes were being abused, neglected, and given inadequate care.[7] The Institute of Medicine proposed significant reforms, most of which became law in 1987 with the passage of the Nursing Home Reform Act (NHRA) as part of OBRA-87.

The OBRA-87 reforms, the most sweeping set of legislative changes to nursing home regulation since the passage of Medicaid and Medicare, address multiple areas of resident care and quality of life.[8] They also specify that residents have the right to be free from verbal, sexual, physical, and mental abuse, including corporal punishment and involuntary seclusion; they also limit the use of physical restraints and psychotropic medications.[9]

The NHRA also established the minimum health and safety standards, set

1 Natl. Ctr. on Elder Abuse at Am. Pub. Human Servs. Assn./Westat, Inc., *The National Elder Abuse Incidence Study: Final Report* 1-1, https://www.acl.gov/sites/default/files/programs/2016-09/AbuseReport_Full.pdf (Sept. 1998).

2 *Id.* at 1-4.

3 K. Broyles, *The Silenced Voice Speaks Out: A Study of Abuse and Neglect of Nursing Home Residents* (Atlanta Long Term Care Ombudsman Program & Atlanta Leg. Aid Socy. 2000).

4 Merav Ben Natan & Ariela Lowenstein, *Study of Factors That Affect Abuse of Older People in Nursing Homes,* 17(8) Nursing Mgt. 20 (2010).

5 R.L. Douglass et al., *A Study of Maltreatment of the Elderly and Other Vulnerable Adults* (U. Mich. Inst. of Gerontology 1980); *see also* F. Moss & V. Halamandaris, *Too Old, Too Sick, Too Poor, Too Bad* (Aspen Sys. Corp. 1977).

6 Pub. L. No. 100-203, 101 Stat. 1330 (1987).

7 Inst. of Med. Comm. on Nursing Home Reg., *Improving the Quality of Care in Nursing Homes* (Natl. Acad. Press 1986).

8 42 U.S.C. § 1396r (2010).

9 *Id.* at § 1396r(c)(A)(ii); 42 C.F.R. § 483.12 (2016); *see also* C. Hawes, *The Institute of Medicine Study: Improving Quality of Care in Nursing Homes, in Advances in Long-Term Care* (P. Katz et al. eds., Springer 1990).

forth in 42 C.F.R. part 483, subpart B, that nursing homes must meet to participate in federal programs such as Medicare and Medicaid. In other words, nursing homes receive Medicare and Medicaid payments for long-term care of residents only if the state certifies that the facilities are in substantial compliance with NHRA requirements. A basic objective of the NHRA is to ensure that nursing home residents receive quality care that enables them to achieve or maintain their "highest practicable" physical, mental, and psychosocial well-being. Despite this federal law, however, continued reports of abuse and neglect over the next three decades necessitated additional reforms.

A. Recent Changes to the Law Governing Nursing Homes

The minimum health and safety requirements for nursing homes were largely unchanged for nearly 30 years. It was not until September 2016 that the Centers for Medicare & Medicaid Services (CMS) published revisions to the requirements for nursing homes. These revisions became effective on November 28, 2016, and are being implemented in three phases over the course of 3 years.

Phase 1 became effective on November 28, 2016. Phases 2 and 3 were scheduled to become effective on November 28, 2017, and November 28, 2019, respectively. On June 30, 2017, CMS announced that it would delay for 1 year the use of enforcement remedies (including monetary penalties, denial of payment, and termination of Medicare and/or Medicaid participation) for failure to meet certain Phase 2 requirements.[10] On November 24, 2017, CMS announced it would delay the use of enforcement remedies for 18 months.[11] According to CMS, the delay was issued in response to providers' concerns regarding the scope and timing of the Phase 2 requirements.

Importantly, the 18-month delay in enforcement was not a change in the required Phase 2 implementation date. If a facility was not in compliance with Phase 2 requirements by November 28, 2017, CMS required the facility to undergo a directed plan of correction or additional directed in-service training.

Due to the current and ongoing changes in this area of the law, it is critical for elder law attorneys to seek the most current information and remain informed.

B. Commonly Used Terminology and Regularly Cited Regulations

Although not exhaustive, the following definitions and regulations are critical tools for evaluating any case involving a nursing home.

1. Terminology: Abuse, Neglect, and Exploitation

Nursing home residents have the "right to be free from abuse, neglect … and

10 Memo from David R. Wright, Dir., Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stands. & Quality/Survey & Certification Group, to St. Survey Agency Dirs., S&C 17-36-NH, *Revision to State Operations Manual (SOM) Appendix PP for Phase 2, F-Tag Revisions, and Related Issues*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Survey-and-Cert-Memo-Revision-SOM-Appendix-PP-Phase-2.pdf (June 30, 2017).

11 Memo from David R. Wright, Dir., Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stands. & Quality/Survey & Certification Group, to St. Survey Agency Dirs., S&C 18-04-NH, *Temporary Enforcement Delays for Certain Phase 2 F-Tags and Changes to Nursing Home Compare,* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-04.pdf (Nov. 24, 2017).

exploitation."[12] "Abuse" and "neglect" are terms commonly used when discussing nursing home cases. "Abuse" is the *willful* infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.[13] In addition, it includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.[14] It also consists of verbal, sexual, physical, and mental abuse, including abuse facilitated or enabled through the use of technology.[15] "Neglect" is the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.[16] Neglect, unlike abuse, is not willful.

In addition to abuse and neglect, it is common to hear that a resident has been exploited. The regulations define "exploitation" as taking advantage of a resident for personal gain through the use of manipulation, intimidation, threats, or coercion.[17] Exploitation is a type of abuse.

2. Regulations: Resident's Rights and Other Frequently Cited Regulations

The regulations included in 42 C.F.R. part 483, subpart B, Requirements for Long Term Care Facilities, are critical to any case that involves a nursing home. Although not exhaustive, the following regulations, which in part are paraphrased from the above-mentioned statute(s), are helpful for evaluating a nursing home case:

Notification of Changes.[18]

A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s), when there is:

- An accident involving the resident that results in injury and has the potential for requiring physical intervention;
- A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
- A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
- A decision to transfer or discharge the resident from the facility ….

Safe Environment.[19]

The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. This requires the facility to ensure that care and services are provided safely and that the physical layout does not pose a safety risk.

Freedom From Abuse, Neglect, and Exploitation.[20]

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility must not use verbal, mental, sexual, or physical abuse and must ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to

12 42 C.F.R. at § 483.12.
13 *Id.* at § 483.5.
14 *Id.*
15 *Id.*
16 *Id.*
17 *Id.*
18 *Id.* at § 483.10(g)(14)(i)(A–D).
19 *Id.* at § 483.10(i).
20 *Id.* at § 483.12.

treat the resident's medical symptoms.

Resident Assessment.[21]

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

- **Admission orders.**[22] When a resident is admitted, the facility must have physician's orders for the resident's immediate care.
- **Comprehensive assessments.**[23] The resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care. The resident assessment must include the resident's needs, strengths, goals, life history, and preferences. Further, the assessment must include information about cognitive patterns, communication, vision, mood and behavior patterns, psychosocial well-being, physical functioning, continence, disease diagnoses, dental and nutritional status, skin condition, and medications.

Comprehensive Person-Centered Care Planning.[24]

- **Baseline care plans.**[25] The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality. The baseline or a comprehensive care plan must be developed within 48 hours of admission. A baseline care plan must include initial goals, physician orders, dietary orders, therapy services, and social services. A comprehensive care plan must be developed and implemented, which includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. It must include the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan must be developed within 7 days after completion of the comprehensive assessment and prepared by an interdisciplinary team. It must be reviewed and revised by the interdisciplinary team after each assessment. The services provided must meet professional standards of quality and be provided by a qualified person according to the resident's plan of care.

Quality of Life.[26]

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. The facility must ensure that a resident's abilities in activities of daily living (ADLs) do not diminish unless circumstances of the individual's clinical condition make this unavoidable and must provide appropriate treatment and services and basic life support, such as cardiopulmonary resuscitation (CPR), subject to the resident's advance directives. ADLs include bathing, walking, toileting, and eating. "Highest practicable physical, mental, and psychosocial well-being" is defined as the resident's highest possible level of functioning and well-being, taking into account the resident's medical condition and normal aging process.

21 *Id.* at § 483.20.
22 *Id.* at § 483.20(a).
23 *Id.* at § 483.20(b).
24 *Id.* at § 483.21.
25 *Id.* at § 483.21(a).
26 *Id.* at § 483.24.

Quality of Care.[27]

Quality of care is the fundamental principle that applies to all treatment and care. Based on the resident's comprehensive assessment, the facility must ensure that the resident receives treatment and care in accordance with professional standards of practice, the resident's comprehensive person-centered care plan, and the resident's choices.

- **Skin integrity — Pressure ulcers.**[28] The facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and that he or she does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. A resident who does develop pressure ulcers must receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing.
- **Accidents.**[29] The facility must ensure that the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents.
- **Incontinence.**[30] A resident who is incontinent of bladder must receive appropriate treatment and services to prevent urinary tract infections.
- **Assisted nutrition and hydration.**[31] The facility must ensure that each resident maintains acceptable parameters of nutritional status, such as usual body weight and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or the resident's preferences indicate otherwise. Each resident must be offered sufficient fluid intake and offered a therapeutic diet when ordered.
- **Bed rails.**[32] The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a side or bed rail is to be used, the facility must assess the resident's risk of entrapment; review the risks and benefits of bed rails with the resident; obtain informed consent prior to installation; and ensure correct installation, use, and maintenance.

Nursing services.[33]

The facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required by 42 C.F.R. § 483.70.

Food and Nutrition Services.[34]

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.

III. Common Issues in Nursing Home Abuse and Neglect Cases

Following are descriptions of 15 issues that are common in nursing home abuse and neglect cases. The descriptions are intended to highlight these issues to make them more readily identifiable when they appear in an actual case. As noted previ-

27 *Id.* at § 483.25.
28 *Id.* at § 483.25(b)(1).
29 *Id.* at § 483.25(d).
30 *Id.* at § 483.25(e).
31 *Id.* at § 483.25(g).
32 *Id.* at § 483.25(n).
33 *Id.* at § 483.35.
34 *Id.* at § 483.60.

ously, if a nursing home accepts payments from Medicare and/or Medicaid, it must comply with the minimal health and safety standards set forth in 42 C.F.R. part 483. Presumably, such compliance would ensure that neglect and abuse would not occur. The regulations, therefore, provide invaluable guidance in pursuing any nursing home abuse and neglect case.

A. Falls

"Every second of every day in the United States an older adult falls, making falls the number one cause of injuries and deaths from injury among older Americans."[35] Falls result in more than 2.8 million injuries treated in emergency departments annually, including more than 800,000 hospitalizations and more than 27,000 deaths.[36] Importantly, falling once doubles an elderly person's chances of falling again.[37]

Many falls do not cause injury. Still, one out of five falls does cause a serious injury such as a broken bone or head injury.[38] Each year at least 300,000 older people are hospitalized for hip fractures.[39] Falling causes more than 95 percent of hip fractures.[40] Further, falls are the most common cause of traumatic brain injury.[41] Adults age 75 and older have the highest rates of traumatic brain injury-related hospitalizations and death.[42] As illustrated in one study, elderly traumatic brain injury patients have worse mortality and functional outcomes than nonelderly patients who present with head injury.[43] Falls and fall-related injuries pose a significant risk to residents in long-term care facilities. Nursing homes are aware of the problem and have a duty to implement reasonable interventions to prevent falls and fall-related injuries.

The regulations require that each resident be assessed for his or her fall risk.[44] The fall risk assessment, which should be performed as part of the comprehensive assessment, is used to determine whether a resident has a low, moderate, or high fall risk. A plan of care to prevent falls must

35 Ctrs. for Disease Control & Prevention, *Falls Are Leading Cause of Injury and Death in Older Americans,* www.cdc.gov/media/releases/2016/p0922-older-adult-falls.html (last reviewed Sept. 22, 2016).

36 Ctrs. for Disease Control & Prevention, *Injury Prevention & Control, Welcome to WISQARS* [Web-Based Injury Statistics Query and Reporting System], https://www.cdc.gov/injury/wisqars/index.html (accessed Apr. 23, 2018).

37 J.L. O'Loughlin et al., *Incidence of and Risk Factors for Falls and Injurious Falls Among the Community-Dwelling Elderly,* 137 Am. J. Epidemiology 342 (1993).

38 B.H. Alexander et al., *The Cost and Frequency of Hospitalization for Fall-Related Injuries in Older Adults,* 82(7) Am. J. Pub. Health 1020 (1992); *see also* D.A. Sterling et al., *Geriatric Falls: Injury Severity Is High and Disproportionate to Mechanism,* 50(1) J. Trauma Injury, Infection Critical Care 116 (2001).

39 U.S. Dept. of Health & Human Servs., Agency for Healthcare Research & Quality, *HCUPnet, Healthcare Cost and Utilization Project: Free Healthcare Statistics,* http://hcupnet.ahrq.gov (accessed Apr. 23, 2018).

40 W.C. Hayes et al., *Impact Near the Hip Dominates Fracture Risk in Elderly Nursing Home Residents Who Fall,* 52 Calcified Tissue Intl. 192 (1993).

41 T.E. Jager et al., *Traumatic Brain Injuries Evaluated in U.S. Emergency Departments,* 1992–1994, 7(2) Academic Emerg. Med. 134 (2000).

42 H.J. Thompson et al., *Traumatic Brain Injury in Older Adults: Epidemiology, Outcomes, and Future Implications,* 54(10) J. Am. Geriatrics Socy. 1590 (2006).

43 M. Susman et al., *Traumatic Brain Injury in the Elderly: Increased Mortality and Worse Functional Outcome at Discharge Despite Lower Injury Severity,* 53 J. Trauma Acute Care Surgery 219 (2002).

44 42 C.F.R. at § 483.20.

be developed.[45] The care plan must include interventions appropriate to meet the needs of the resident. Common interventions to prevent falls and injuries from falls include supervision, a room near the nurse's station, bed and chair alarms, floor mats, motion sensor alarms, and a bed placed close to the ground. Using bed rails is not an appropriate intervention for preventing falls.[46] The risk of entrapment outweighs any potential fall prevention benefit.

The care plan should identify the level of assistance a resident needs with transferring and ambulating. A resident who is independent has a lower fall risk. But if the resident needs assistance with transferring, it must be determined whether he or she needs the assistance of one or two staff members or needs to be transferred mechanically via a sit-to-stand lift or Hoyer lift.[47]

Falls can be broken down into two categories: assisted and unassisted. An assisted fall is one that occurs while a resident is being assisted by a caregiver or other staff member; for instance, when a resident is being transferred via a Hoyer or sit-to-stand lift. Falls from a Hoyer lift commonly occur when a staff member is untrained or careless or only one staff member is assisting the resident. Falls from a sit-to-stand lift commonly occur when a staff member is untrained, the resident does not have the necessary upper body strength to hold onto the handles, or the back strap is not used or is used improperly.

Unassisted falls occur when a resident is not being attended to by a caregiver or other staff member. A frequent unassisted fall is a fall from a toilet, which can occur when a resident finishes toileting and calls for help, but help does not come. Such a fall can also occur when a resident needs supervision while on the toilet but does not receive it.[48]

Unassisted falls frequently occur when a resident suffering from confusion or dementia attempts to self-transfer. For example, if such a resident presses the call light for assistance, but staff does not promptly respond, he or she may unsafely transfer out of bed or a chair or begin walking unassisted and fall.[49]

B.Pressure Injuries

A pressure ulcer is localized damage to the skin or underlying soft tissue, usually over a bony prominence (e.g., sacrum, heels, buttocks, hip/trochanter, ischium). The injury occurs as a result of intense or prolonged pressure or pressure in combination with shear. The pressure impairs the circulation of blood into the area, which decreases the delivery of oxygen to the tissue and, if not promptly addressed, the tissue may die.[50] In 2016, the National

45 *Id.* at § 483.21.

46 *Id.* at § 483.25(n).

47 A Hoyer lift, whether manually or battery operated, is used to carry and transfer a patient, such as to or from a chair or bed. A large sling enables the patient to rest comfortably and safely while being transferred. A Hoyer lift requires two staff members to assist with the transfer. If a patient is able to bear some weight, a sit-to-stand, or stand-assist, lift may be appropriate. A sit-to-stand lift is also used to transfer a patient between seated surfaces. Unlike a Hoyer lift, a sit-to-stand lift raises the patient to a partial or full standing position. This lift is designed to support only the patient's upper body; therefore, it is necessary for the patient be able to safely bear at least some weight.

48 42 C.F.R. at § 483.25(d).

49 *Id.*

50 Once a pressure ulcer is identified, the next step is to stage the degree of skin damage using standard definitions NPUAP developed for each stage of pressure injury:

Pressure Ulcer Advisory Panel adopted the term "pressure injury" to replace "pressure ulcer."[51] However, the latter term is still used by CMS.

Pursuant to 42 C.F.R. § 483.25(b)(1), residents at risk for developing pressure ulcers must be identified. Upon admission, a resident's skin must be evaluated for pressure ulcers and the resident's risk for them must be assessed. The Braden Scale for Predicting Pressure Sores is widely used to assess such risk. If a resident is at risk for developing pressure ulcers, the development and implementation of a plan of care to reduce the risk is vital. Prevention is the cornerstone of pressure ulcer management.

Risk factors for pressure ulcers include impaired mobility, comorbid conditions, cognitive impairment, exposure of the skin to urine and feces resulting from incontinence, malnutrition and insufficient hydration, and a history of healed pressure ulcers. Common pressure ulcer prevention strategies include (a) turning and repositioning, (b) adequate nutrition and hydration, (c) a wheelchair cushion, (d) a mattress overlay or specialty mattress, (e) heel boots, (f) positioning devices, and (g) staff monitoring of skin condition. The pressure ulcer prevention strategies that are implemented must be continuously monitored and assessed for effectiveness, and the care plan must be revised as appropriate.

If a resident with a pressure ulcer is admitted, or the resident acquires one in the nursing home, there is a risk of wound infection. The risk of infection is especially high with a Stage 2 or higher wound located on the sacrum, buttocks, or hips of an incontinent resident. The exposure of bacteria to the open wound increases the risk of infection.[52] Signs and symptoms of infection include malodor, increased pain, redness, warmth, purulent drainage, increase in wound size, and change in mental status such as confusion. When

- **Stage 1.** "Intact skin with a localized area of non-blanchable erythema [redness] … ."
- **Stage 2.** "Partial-thickness loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or rupture serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible."
- **Stage 3.** "Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. … Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed."
- **Stage 4.** "Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location."
- **Deep-Tissue.** Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. "The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss." *Id.*

See also AMDA (Socy. for Post-Acute & Long-Term Care Med.), *Pressure Ulcers and Other Wounds in the Post-Acute and Long-Term Care Setting Clinical Practice Guideline* (AMDA 2017).

51 Natl. Pressure Ulcer Advisory Panel, *National Pressure Ulcer Advisory Panel (NPUAP) Announces a Change in Terminology From Pressure Ulcer to Pressure Injury and Updates the Stages of Pressure Injury,* http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury (Apr. 13, 2016).

52 N.J. Livesley & A.W. Chow, *Infected Pressure Ulcers in Elderly Individuals,* 35(11) Clinical Infectious Diseases 1390 (2003).

a pressure ulcer is present, its location and stage must be noted.[53]

Sepsis, a potentially life-threating complication of infection, is a significant danger with an infected pressure ulcer. It occurs when chemicals released into the bloodstream to fight an infection trigger inflammatory responses throughout the body. Sepsis can cause rapid multi-organ failure and death[54] and must be treated as quickly as possible.

The federal regulations require nursing homes to provide care and services to ensure that residents remain free of pressure ulcers unless clinically unavoidable. Nursing homes also must prevent infections and promote the healing of pressure ulcers if they do develop.[55] An "avoidable" pressure ulcer is one a resident develops when the facility fails to do one or more of the following: evaluate the resident's clinical condition and pressure ulcer risk factors; define and implement interventions that are consistent with the resident's needs and goals and professional standards of practice; monitor and evaluate the impact of the interventions; or revise interventions as necessary.[56] An "unavoidable" pressure ulcer is one a resident develops even though the facility performed one or more of these steps.

To determine whether a pressure ulcer was avoidable, the following must be reviewed: the skin assessment performed upon admission; the pressure ulcer risk assessment; the care plan to prevent pressure ulcers; implementation of the care plan; identification of the pressure ulcer; notification of the physician, resident, and resident's family; implementation and compliance with physician orders; revision of the care plan with changes in condition; and monitoring of the pressure ulcer for worsening and signs of infection.

C. Choking

The resident assessment should indicate the type of diet a resident should follow.[57] A resident who has problems with swallowing, choking, or eating too fast requires a specialized diet and supervision. A mechanical soft diet, which consists of chopped, ground, and pureed foods, is required for individuals who have trouble chewing or swallowing.[58] A pureed diet, which consists of foods that do not need to be chewed, is required for individuals who cannot effectively chew.[59] If a resident does not receive the correct meal, he or she could choke. If the resident does experience a choking event, staff must respond appropriately, including clearing the airway, performing the Heimlich maneuver, suctioning, and performing CPR if the resident has no pulse and/or stops breathing. If the resident requires supervision, staff must supervise and help the resident eat his or her meals and drink fluids.

53 42 C.F.R. at § 483.25(b)(ii).

54 Mayo Clinic, *Sepsis,* www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214 (Jan. 3, 2018).

55 42 C.F.R. at § 483.25(c).

56 *Windsor Place v. U.S. Dept. of Health & Human Servs.,* 649 F.3d 293, 298–299 (5th Cir. 2011).

57 42 C.F.R. at § 483.25(g)(1)–(5).

58 U. Wis. Hosps. & Clinics Auth., Clinical Nutrition Servs. Dept. & Dept. of Nursing, *Mechanical Soft Diet, UW Health: Health Facts for You,* www.uwhealth.org/healthfacts/trauma/363.pdf (May 2017).

59 Meml. Sloan Kettering Cancer Ctr., *Eating Guide for Pureed and Mechanical Soft Diets,* www.mskcc.org/cancer-care/patient-education/eating-guide-pureed-and-mechanical-soft-diets (last updated Apr. 4, 2018).

D. Medication Errors

Nursing home residents suffer 1.9 million adverse drug events every year, 70 percent of which are preventable. As many as 86,000 of these events are fatal or life-threatening.[60] All medication errors, including administering the wrong dosage and/or the wrong medication, and administering medication at the wrong time and/or to the wrong patient, are preventable.

Immediately upon admission, a facility must have a resident's physician orders for medication,[61] including the dosage and frequency of administration. The facility must confirm that the physician orders are received upon admission and when a medication is prescribed or changed. For example, if a resident has atrial fibrillation, it is likely that he or she will be on an anticoagulant, such as Coumadin (or its generic equivalent, warfarin). Atrial fibrillation puts the resident at risk for a blood clot, embolism, and stroke; therefore, upon admission, the resident needs the medication. A delay in the administration of the medication for any reason, including the lack of physician orders, puts the resident at risk for the aforementioned complications.[62]

It is critical for nurses to administer the correct dosage of medication at the right time. Further, nurses must observe the resident's response to the medication. For example, let us say that a doctor prescribes a resident a post-surgery narcotic. First, the medication should only be administered if the resident's pain level is sufficient to warrant it. Second, the resident's response to the medication must be observed. Narcotics carry a risk of nausea and somnolence.[63] A resident can vomit and aspirate the vomit, causing pneumonia and even death.[64]

E. Infection

Pursuant to 42 C.F.R. § 483.80, facilities must "establish and maintain an infection prevention and control program." The most common type of infection is a urinary tract infection (UTI), which can lead to urosepsis. Urinary incontinence is extremely common in nursing home residents,[65] especially residents with an in-

60 J.H. Gurwitz et al., *Incidence and Preventability of Adverse Drug Events in Nursing Homes,* 109 Am. J. Med. 87 (2000).

61 42 C.F.R. at § 483.20(b)(xiv).

62 Many elderly persons take anti-coagulants, commonly referred to as "blood thinners." If a resident is on an anti-coagulant, his or her international normalized ratio (INR) level must be monitored. The INR, a laboratory measurement of how long it takes blood to form a clot, is used to determine the effects of oral anticoagulants on the clotting system. In high-risk situations, the safe level is 2.3. L. Dharmarajan & T.S. Dharmarajan, *Prescribing Warfarin Appropriately to Meet Patient Safety Goals,* 1(6) Am. Health Drug Benefits 26 (2008). A physician orders INR testing and bases the dosage of anti-coagulant based on the INR level. If the testing is not done as ordered, or if the results are not provided to the doctor, the resident could receive too much or too little. Too much causes the resident's blood to be over anti-coagulated, or too thin. The resident can suffer internal bleeding and die. Too little and the blood is under anti-coagulated, or too thick, which increases the risk of formation of blood clots and stroke. This is just one example of the importance of properly administering medication and observing the resident for his or her response to the medication.

63 E. Rogers et al., *Four Strategies for Managing Opioid-Induced Side Effects in Older Adults,* 21(4) Clinical Geriatrics (2013).

64 S. Dublin et al., *Use of Opioids or Benzodiazepines and Risk of Pneumonia in Older Adults: A Population-Based Case-Control Study,* 59(10) J. Am. Geriatrics Socy. 1899 (2011).

65 F.W. Leung & J.F. Schnelle, *Urinary and Fecal Incontinence in Nursing Home Residents,* 37(3)

dwelling catheter. A resident who is incontinent of bladder or bowel is at increased risk for a UTI. This is especially true if the resident's fluid intake is inadequate. Fluids are helpful in flushing bacteria out of the urinary tract. Signs and symptoms of a UTI include confusion, lethargy, fever, pain during urination, cloudy and/or foul-smelling urine, and falls. UTIs are generally responsive to antibiotic treatment, but an untreated UTI can quickly lead to sepsis and death. Physician notification, therefore, is necessary to ensure proper treatment.

Another common infection is pneumonia. The signs and symptoms of pneumonia include confusion, sudden change in mental state, chills, shortness of breath, and even symptoms similar to the common cold.[66] Pneumonia in the elderly may be difficult to detect because the symptoms may be fewer and milder than those commonly seen in younger people.[67] Importantly, if pneumonia is undetected and untreated in the elderly, it may lead to sepsis, pleural effusion, renal failure, and respiratory failure,[68] all of which can be fatal.

Clostridium difficile infection, often referred to as C. diff, is another recurrent infection among residents in LTC facilities.[69] The majority of C. diff cases occur when people are exposed to health care settings, including nursing homes.[70] Spores from C. diff bacteria are passed in feces and spread to food, surfaces, and objects when people who are infected do not wash their hands thoroughly.

In recent years, C. diff infections have become more frequent and difficult to treat. People taking antibiotics are at elevated risk for C. diff.[71] Antibiotics — in addition to destroying harmful bacteria — also destroy some of the normal, helpful bacteria. Without enough healthy bacteria to fight C. diff, the infection can quickly grow out of control. Additionally, the elderly are at increased risk for C. diff.[72] One study found that people over the age of 65 are 10 times more likely to develop C. diff infection.

Some of the most common signs and symptoms of C. diff include diarrhea, abdominal cramping, fever, dehydration, weight loss, swollen abdomen, and nausea.[73] If untreated, C. diff can lead to severe dehydration, kidney failure, bowel perforation, and death.[74] Even mild to moderate C. diff infections can quickly become fatal if not treated promptly.

If an infection, including an infection resulting from a pressure ulcer, as mentioned previously, goes undetected and untreated, a resident may develop sepsis.[75] Sepsis is the body's inflammatory response to infection — usually as the result of the body's attempt to fight severe infection. It occurs when the bloodstream is overwhelmed with bacteria.[76] Respiratory and

Gastroenterology Clinics N. Am. 697 (2008).

66 Natl. Heart, Lung & Blood Inst., *Pneumonia*, www.nhlbi.nih.gov/health/health-topics/topics/pnu/signs, scroll down to and click on *Signs, Symptoms, and Complications* (accessed Apr. 26, 2018).

67 *Id.*

68 *Id.*

69 Mayo Clinic, C. *difficile Infection,* www.mayoclinic.org/diseases-conditions/c-difficile/symptoms-causes/syc-20351691 (June 18, 2016).

70 *Id.*

71 *Id.*

72 *Id.*

73 *Id.*

74 *Id.*

75 G.S. Martin et al., *The Effect of Age on the Development and Outcome of Adult Sepsis,* 34 Critical Care Med. 15 (2006).

76 M.M. Levy et al., *2001 SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference,* 31 Critical Care Med. 1250 (2003).

genitourinary infections most commonly trigger sepsis in the elderly.[77] Early detection and treatment of infection is critical to prevent sepsis. Once a resident is septic, his or her condition can deteriorate rapidly and lead to septic shock and/or death.

Signs and symptoms of sepsis in the elderly include altered mental state, delirium, weakness, anorexia, malaise, falls, and urinary incontinence,[78] all of which are typical in other diseases common in the elderly population, making a diagnosis difficult. Thus, it is critical for those involved in the care and treatment of nursing home residents to be aware of the high risk of mortality if infections go undetected and untreated and to understand the importance of continuous assessment of each resident.

F. Dehydration

Dehydration is an excessive loss of body water.[79] Dehydration is a form of fluid/electrolyte (sodium and potassium) imbalance,[80] and it occurs more frequently in the elderly population.[81] Dehydration may be caused by insufficient fluid intake or excessive fluid loss. Because the elderly have a decreased sense of thirst, they are less likely to notice that they should be drinking water.[82] Common signs and symptoms of dehydration include confusion, postural hypotension and/or dizziness, weight loss, poor skin turgor, dry eyes and/or mouth, lethargy and weakness, falling, not urinating or defecating, and UTIs.[83]

It is necessary, therefore, to make water accessible to residents.[84] Water should be kept nearby, and residents should be encouraged to drink throughout the day, especially at meals. If a resident is not eating well, it is likely that he or she is not drinking enough either since much fluid intake occurs with meals.

Dehydration is an extremely serious condition.[85] Dehydration can cause the volume of fluid in the body to decrease and blood pressure to fall.[86] This can lead to decreased blood flow to vital organs, cause vital organs to fail, and lead to hypovolemic shock, which interferes with the heart's ability to pump blood, also causing organ failure. Uncorrected dehydration can lead to multi-organ failure and death.

G. Malnutrition

Unintentional weight loss and malnutrition are significant areas of concern for the elderly population.[87] Contrary to

77 P. Nasa et al., *Severe Sepsis and Septic Shock in the Elderly: An Overview,* 1(1) World J. Critical Care Med. 23 (2012).

78 T.D. Girard et al., *Insights Into Severe Sepsis in Older Patients: From Epidemiology to Evidence-Based Management,* 40 Clinical Infectious Diseases 719 (2005).

79 D.R. Thomas et al., *Understanding Clinical Dehydration and Its Treatment,* 9(5) J. Am. Med. Dirs. Assn. 292 (2008).

80 *Id.*

81 J.D. Stookey, High Prevalence of Plasma Hypertonicity Among Community-Dwelling Older Adults: Results From NHANES III, 105 J. Am. Dietetic Assn. 1231 (2005).

82 I. Davies et al., *Age-Associated Alterations in Thirst and Arginine Vasopressin in Response to a Water or Sodium Load,* 24 Age Ageing 151 (1995).

83 Risa J. Lavizzo-Mourey, *Dehydration in the Elderly: A Short Review,* 79(10) J. Natl. Med. Assn. 1033 (1987).

84 42 C.F.R. at § 483.25(g)(2).

85 Davies et al., *supra* n. 82, at 151.

86 Gautam Bhave & Eric G. Neilson, *Volume Depletion Versus Dehydration: How Understanding the Difference Can Guide Therapy,* 58(2) Am. J. Kidney Diseases 302 (2011).

87 C. Evans, Malnutrition in the Elderly: A Multifactorial Failure to Thrive, 9(3) Permanente J. 38 (2005).

a widespread assumption, malnutrition is not an inevitable side effect of aging. However, many changes associated with the process of aging can promote malnutrition.[88] For instance, as people age, their ability to taste and smell and their level of physical activity decreases, all of which may affect nutrient intake.[89] Malnutrition and unintentional weight loss in the elderly are generally caused by one or more of the following factors: nutritionally deficient food choices, illnesses that increase nutrient requirements, poor nutrient absorption, or a combination of these factors.[90] Any change in food intake can lead to malnutrition and its grave consequences.

Older adults who are hospitalized or who live in nursing homes are at greater risk for unintentional weight loss and malnutrition. Therefore, it is critical that nutritional assessment and treatment be a routine part of care for all elderly — especially those who are hospitalized or living in a nursing home.[91]

H. Unsafe Wandering and Elopement

Wandering is the "aimless or purposeful motor activity that causes a social problem such as getting lost, leaving a safe environment, or intruding in inappropriate places."[92] It is estimated that up to 31 percent of nursing home residents with dementia wander at least once.[93] Distinct from wandering, elopement occurs when a resident leaves a health care facility without staff knowledge.[94] Residents with confusion and/or dementia may exhibit unsafe wandering and elopement behavior. People who elope are generally distinguished from those who wander by their purposeful attempts to leave the premises.

The nursing home industry has been aware of the danger of unsafe wandering and elopement since the late 1990s.[95] A CNA study found that elopement was the primary allegation in 23 insurance claims closed between January 1, 2007, and December 31, 2011.[96] The study authors state, "The high level of payments reflects the seriousness of injuries and the general expectation that elopement should never occur."[97]

Residents who unsafely wander are at risk for falls, exposure to unsafe conditions such as traffic and environmental hazards, and exposure to the elements, which could lead to hypothermia or hyperthermia. Residents who unsafely wander or who are at risk for elopement must be identified. Strategies to limit the unsafe wandering and keep residents safe must be implemented.[98]

A resident may be placed in a locked unit that prevents him or her from leav-

88 F. Landi et al., *Body Mass Index and Mortality Among Older People Living in the Community,* 4(7) J. Am. Geriatrics Socy. 1072 (1999).

89 S.E. Gariballa & A.J. Sinclair, *Nutrition, Ageing and Ill Health,* 80 Brit. J. Nutrition 7 (1998).

90 R.H. Demling & L. DeSanti, *Involuntary Weight Loss and Protein-Energy Malnutrition: Diagnosis and Treatment* (Medscape 2001).

91 42 C.F.R. at § 483.25(g)(1).

92 L. Morishita, *Wandering Behavior, in Alzheimer's Disease: Treatment and Long-Term Management* 157 (J.L. Cummings & B.L. Miller eds., (Marcel Dekker 1990).

93 C.K.Y. Lai & D.G. Arthur, *Wandering Behaviour in People With Dementia,* 44(2) J. Advanced Nursing 173 (2003).

94 *Id.* at 173.

95 ECRI, *Hazardous Wandering and Elopement* (2005); D.K. Kiely et al., *Identifying Nursing Home Residents at Risk for Falling,* 46(5) J. Am. Geriatrics Socy. 551 (1998).

96 CNA Fin. Corp., *CNA Aging Services: Data Analysis Supporting the Need for Industry Change* (2012).

97 *Id.*

98 42 C.F.R. at § 483.20(k)(1).

ing the safety of the building. A facility may install a WanderGuard or other wander management system, which indicates when a resident leaves his or her room, unit, or building. A facility may use surveillance cameras to monitor doors, post clearly marked and visible signs, install an elopement warning alarm, and/or conduct 15-minute checks to observe residents at risk. A facility must also have a system in place to respond to residents who elope or go missing, such as a procedure for calling 911, searching inside and outside the facility, and notifying the administrator and the family.

I. Physician and Family Notification

Whenever there is a significant change in the resident's condition, the regulations require that the physician and the family be notified.[99] For example, if a pressure ulcer is identified, the resident suffers a fall with injury, or there is an allegation of abuse or neglect, the physician and family must be notified. Additionally, the physician needs to be notified of any lab results so that he or she can determine what, if any, course of treatment or medication is necessary. This is especially important with residents who have a UTI. Failing to notify the physician can lead to serious health consequences and death. Further, the resident's family must know what is happening with the resident and what is being done to address a situation so that it can be involved in the care planning process and decisions about future care.

J. Cardiopulmonary Resuscitation

Prior to 2013, some nursing homes adopted facility wide "no CPR" policies. In other words, the facility would not perform CPR on a resident who was pulseless and not breathing. This was problematic because it interfered with a resident's right to formulate an advance directive and potentially prevented the implementation of a resident's advance directive.[100]

As of October 18, 2013, CMS requires all facilities, prior to the arrival of emergency medical services, to provide basic life support, including the initiation of CPR, to a resident who experiences cardiac arrest in accordance with the resident's advance directive or in the absence of an advance directive or a do not resuscitate (DNR) order.[101]

K. Restraints

As noted in the regulations,[102] physical and chemical restraints are illegal unless a physician orders them and their benefits outweigh the risks. Notably, residents cannot be physically tied down to keep them from harming themselves. Prior to the NHRA, physical restraints could be used to prevent residents from falling out of chairs or bed or to keep them from wandering. Staff members also used restraints to make their work lives easier.

Bed and side rails are other physical restraints used frequently to keep residents from falling out of bed. However, bed rails create the danger of entrapment,[103] lead-

99 *Id.* at § 483.10(g)(14)(i)(A–D).

100 Memo From Thomas E. Hamilton, Dir., Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stands. & Quality/Survey & Certification Group, S&C 14-01-NH, *Cardiopulmonary Resuscitation (CPR) in Nursing Homes,* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-01.pdf (Oct. 18, 2013; rev. Jan. 23, 2015).

101 *Id.*

102 42 C.F.R. at § 483.10(e)(1).

103 F.M. Feinsod et al., *Eliminating Full-Length Bed Rails From Long Term Care Facilities,* 5 Nursing Home Med. 257 (1997).

ing to strangulation and broken bones.[104] Eventually, CMS issued guidance on the use of bed and side rails stating, "The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over, or around side rails are at risk for injury or death."[105]

Finally, the other type of restraint, a chemical restraint, is a form of restraint in which a drug is used to restrict a resident's freedom or movement and in some cases to sedate him or her. A person is considered chemically restrained if a drug not required to treat his or her medical symptoms is administered for discipline or staff convenience.[106] Unfortunately, the use of chemical restraints remains a problem in nursing homes. In fact, the Food and Drug Administration found that roughly 15,000 nursing home residents have died from unnecessary antipsychotic use.[107]

L. Wheelchair Injuries

Many nursing home residents use a wheelchair for mobility. Residents may not be able to walk long distances or have the ability to walk at all. As a result, residents are commonly transported to meals and other activities in a wheelchair. Frequently, leg rests and footrests are not installed on wheelchairs — especially those used to transport residents short distances. If the wheelchair does not have leg rests and footrests, a resident's foot may get caught on the ground, causing a foot, ankle, or leg fracture or causing the resident to fall out of the wheelchair and break a hip or suffer a brain bleed.

Although seemingly simple, nursing home staff all too frequently fail to implement safety measures to prevent injury related to wheelchairs. Putting a resident in a wheelchair does not relieve staff of the duty to provide ongoing supervision.[108] To ensure the safety of residents in wheelchairs, nursing home staff must use leg and footrests while transporting them, keep residents away from fall hazards and unguarded stairs, park wheelchairs in an area where the ground is level, and confirm that locks on the wheels are set when the resident is sitting in one area or is incapable of appreciating surrounding hazards. Wheelchair-related injury is preventable.

M. Sexual Abuse

Sexual abuse, nonconsensual sexual contact of any type with a resident,[109] is a serious issue in nursing homes. In fact, about 83 percent of victims of elder sexual abuse reside in an institutional care center, such as a nursing home.[110] Further, one study found that in more than 80 percent of elder sexual abuse cases, the perpetrator is a caregiver.[111] Sexual abuse can occur between staff and resident, resident and resident, and/or visitor and resident.

Nursing home residents are vulnerable to sexual abuse. Elderly victims of sexual abuse often have medical issues that result

104 K. Parker & S.H. Miles, *Deaths Caused by Bed Rails,* 45 J. Am. Geriatrics Socy. 797 (1997).

105 Ctrs. for Medicare & Medicaid Servs., *Appendix PP – Guidance to Surveyors for Long Term Care Facilities, in State Operations Manual (SOM),* rev. 36 (Aug. 1, 2008).

106 Ctrs. for Medicare & Medicaid Servs., *Appendix PP – Guidance to Surveyors for Long Term Care Facilities, in State Operations Manual (SOM),* rev. 168 (Mar. 8, 2017).

107 Rhidian Hughes, *Chemical Restraint in Nursing Older People,* 20(3) Nursing Older People 33 (2008).

108 42 C.F.R. at § 483.25(c)(1–3).

109 *Id.* at § 483.5.

110 P.B. Teaster et al., Sexual Abuse of Older Adults: Preliminary Findings of Cases in Virginia, 12(3-4) J. Elder Abuse Neglect 1 (2001).

111 *Id.*

in confusion, memory loss, and the inability to communicate. All of these disabilities interfere with their ability to report abuse. As a result, the incidence of elder sexual abuse at nursing homes is thought to be significantly underreported.

N. Resident-to-Resident Elder Mistreatment

Resident-to-resident elder mistreatment (RREM) is "negative physical, sexual, or verbal interactions between long-term care residents that in a community setting would likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient."[112]

RREM among elderly residents of LTC facilities is "common" based on reports from nursing home staff.[113] The majority of the RREM is verbal; however, there also are reports of physical and sexual RREM.[114] A resident may act out in a sexually inappropriate way. Such a resident must be monitored and necessary interventions must be implemented to keep all residents at the facility free from harm and abuse.

RREM, although seemingly harmless in some cases, can have devastating consequences. The frailty of many nursing home residents makes minor incidents potentially catastrophic. Residents who suffer from dementia may act out violently. Sadly, there are multiple examples of residents being injured or killed by another resident. A resident who is violent must be safely supervised to ensure that he or she does not harm himself or herself or others. Failure to provide necessary supervision for a violent resident can lead to injury and even death of the resident, other residents, staff members, or visitors.

O. Social Media Abuse

During the past several years, a disturbing trend has emerged that involves nursing home employees using social media platforms, such as Facebook, Twitter, Snapchat, and Instagram, to post demeaning photos and videos of residents. These include photos and videos of residents who were naked or covered in fecal matter and even residents who are deceased.[115] CMS released a memo to address the issue of social media abuse.[116] In part, the memo states, "Treating a nursing home resident in any manner that does not uphold a resident's sense of self-worth and individuality dehumanizes the resident and creates an environment that perpetuates a disrespectful and/or potentially abusive attitude towards the resident(s)."[117]

Suspected social media abuse must be reported as soon as possible. Further, anytime a nursing home receives an allegation of abuse, including one involving the posting of an unauthorized photograph or recording of a resident on social media, the facility not only must report the

112 Natl. Consumer Voice for Quality Long-Term Care, *Resident-to-Resident Elder Mistreatment in Nursing Homes: Findings From the First Prevalence Study,* theconsumervoice.org/uploads/files/issues/Feb22016_Webinar_Slides.pdf (Feb. 2, 2016).

113 *Id.*

114 *Id.*

115 C. Ornstein & J. Huseman, *Federal Officials Seek to Stop Social Media Abuse of Nursing Home Residents,* National Public Radio (2016).

116 Memo From David R. Wright, Dir., Ctrs. for Medicare & Medicaid Servs., Ctr. for Clinical Stands. & Quality/Survey & Certification Group, to St. Survey Agency Dirs., S&C 16-33-NH, *Protecting Resident Privacy and Prohibiting Mental Abuse Related to Photographs and Audio/Video Recordings by Nursing Home Staff,* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-16-33.pdf (Aug. 5, 2016).

117 *Id.*

alleged violation to the administrator and other officials but also must initiate an immediate investigation and prevent further abuse.[118]

IV. Reporting Suspected Abuse, Neglect, and Exploitation

Throughout this article, several references are made to the importance of reporting suspected abuse, neglect, exploitation, and concerns about health care, treatment, or services. Reports of suspected abuse and neglect, often called "complaints," should be filed with the state survey agency, which is responsible for regulating all nursing homes in the state. As part of this responsibility, the agency must investigate a complaint to determine whether it can be substantiated (i.e., a violation of federal or state regulations occurred). Although it varies from state to state, generally, if a complaint is substantiated, the facility is issued a citation and must submit a plan of correction to the state agency.

A citation is important for several reasons. First, it forces the facility to correct its failure to comply with state and federal regulations, which benefits all residents of the facility. Second, the citation becomes part of the public record. Medicare rates nursing homes on a 5-star scale. A nursing home's rating is available on Medicare.gov, which gives members of the public important information concerning the quality of care being provided at the facility. Information regarding a facility's track record is invaluable in a nursing home case. For these reasons, it is critical that your client file a complaint with the state survey agency and you request all records and materials from the agency regarding the client's complaint.

For more information on how to file a complaint in your state, visit Medicare.gov.[119]

V. Conclusion

Nursing home abuse and neglect is an issue plaguing the elderly throughout the country. As the elderly population continues to grow at an increasingly rapid rate, the number of people in nursing homes will inevitably increase. As a result, the number of mothers, fathers, sisters, brothers, and friends in these facilities will grow. As advocates, elder law attorneys must hold nursing homes accountable for complying with the minimum health and safety standards established by the NHRA and for treating the elderly with the dignity and respect they deserve. Staying up to date on the regulations and topics at the center of nursing home cases is the first step in representing an elderly person who has been abused and neglected. With increased knowledge and enforcement of the regulations, abuse and neglect in nursing homes can be — in large part — prevent.

118 *Id.*

119 Medicare.gov, *Nursing Home Compare: State Websites and Contact Information,* https://www.medicare.gov/NursingHomeCompare/Resources/State-Websites.html (accessed Apr. 26, 2018).