

MICHIGAN



*"PROTECTING THE RIGHTS OF  
PERSONS WITH DISABILITIES"*

PROTECTION & ADVOCACY  
SERVICE, INC.

# ***Nursing Homes: Abuse & Neglect Throughout Michigan***

*November 2011*

## Acknowledgements

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Michigan Protection & Advocacy Service, Inc.  
4095 Legacy Parkway #500  
Lansing, MI 48911  
800.288.5923  
[www.mpas.org](http://www.mpas.org)

## **Washtenaw County**

- ◆ In a survey dated September 2011: A resident of a nursing home required extensive assistance from facility staff with toileting and bathing/showering. The resident had a urinary catheter that required catheter care every shift and as needed. Staff observed maggots in the resident's pubic area. Staff did not shower the resident immediately due to lack of staff. Two weeks before the maggots were observed; staff noticed flies on the resident's leg wounds and around the resident's bed. Facility staff did not complete an incident report because facility management "didn't know how to word it." The facility's "Clinical Corporate Person" wanted staff to call the incident "debridement" (dead tissue) instead of "maggots." The facility could not provide documentation that the resident received regularly scheduled bed baths or catheter care. The resident stated "there were times it was weeks before they cleaned my catheter..." Staff was told to document that the resident refused showers. The resident did, in fact, refuse showers due to complaints of hip pain although gave permission for sponge baths. It was later discovered at the hospital that the resident had a hip fracture. There is no documentation indicating staff was disciplined for neglecting the resident's basic care needs.

## **Oakland County**

- ◆ In a survey dated August 2011: A resident of a nursing home, who was totally dependent on staff for all activities of daily living, began coughing one night. Staff did not assess the resident's breathing appropriately because they were "rushed." The resident continued to cough throughout the night. Two staff observed "white things" in the resident's sputum, mouth, and near the resident's tracheostomy collar. Early the next morning, a staff person looked into the resident's mouth while providing oral care and observed maggots in the resident's mouth. Emergency medical services (EMS) were contacted. EMS found the resident to have an abnormal blood oxygen level and had labored breathing due to a partial airway obstruction. The EMS staff indicated it was difficult to suction the resident due to the "very active maggots in the airway." The resident was admitted to a hospital for breathing problems, tracheostomy complications, and maggot infestation. There is no documentation indicating staff was disciplined for neglecting the resident so severely.

## Overview

Michigan Protection and Advocacy Service, Inc. (MPAS) is the independent, private, nonprofit organization designated by the governor of Michigan to implement the federally authorized protection and advocacy systems. MPAS advocates and protects the legal rights of people with disabilities in Michigan through services including information and referral, short-term assistance, selected individual and legal representation, systemic advocacy, monitoring, and training. As part of our role, MPAS monitors facilities where individuals with disabilities reside and also receives various reports from state departments regarding the use of restraint and seclusion, and survey inspection results of nursing facilities.

State nursing home survey inspections, conducted by the state's Department of Licensing and Regulatory Affairs (LARA) occur on a yearly basis or in response to a complaint. During site visits, resident files are chosen randomly and reviewed for compliance on a number of levels. In addition, other areas are reviewed such as the maintenance and cleanliness of the physical plant.

In some cases when violations are found, the facilities are fined and forced to develop and implement plans of corrections. In some cases staff has been disciplined or their employment has been terminated. In other cases, allegations of abuse or neglect have been reported to law enforcement authorities and some nursing homes have been closed.

Additionally, facilities with a pattern of multiple serious violations over an extended period of time may be placed on the "Special Focus Facility List". Placement on this list prompts a facility to be monitored two times per year and it is expected that within 18-24 months after being put on the list, there will be one of three possible outcomes:

- ◆ Improvement and graduation from the list,
- ◆ Termination from Medicare admissions for new residents, or
- ◆ Extension of time to continue improvement based upon promising progress.

MPAS regularly receives and reviews LARA nursing home inspection surveys in order to identify abuse, neglect and other concerns where MPAS advocacy may be appropriate. When surveys show that a more in-depth investigation is necessary, MPAS will invoke its federally mandated access authority to obtain facility records.

In response to identified concerns, MPAS began filing individual complaints with the Bureau of Health Professions (BHP) against the professional licenses of the facility staff, including nurses and certified nursing assistants. The process of getting the state to investigate complaints against individual licenses is cumbersome and slow at best. Meanwhile, the licensed individuals continue to work and provide care while the Bureau of Health Professions investigates the allegation which may take years to complete and may not result in any finding.

MPAS has found that in some cases, unless there is a criminal conviction, when employment is terminated for abuse or neglect of the residents, there is nothing to stop them from working at another similar facility.

MPAS is calling for local, state, and federal action to be taken to address the systemic failures within Michigan's nursing home industry and the regulatory structures that have failed to assure quality nursing care for people in need. Michigan residents deserve to receive the best care and their families should have peace of mind they are being taken care of when they cannot do it themselves.

The goal of this report is to draw attention to this very important issue and work toward correcting the systemic deficiencies in staffing, monitoring, and reporting that may contribute to abusive and neglectful conditions. The cases used in this report are examples and unfortunately they are not isolated incidents or unique to any particular nursing home. Rather, they are indicative of a statewide failure to provide quality nursing care at all times and protect nursing facility residents from harm – without exception.

## **Case Examples**

What follows are additional examples of abusive and neglectful care identified by MPAS, gathered from “Nursing Home Surveys” conducted and reported by Michigan Licensing and Regulatory Affairs (LARA). The term “Survey” is the terminology used in the federal laws that allows the Centers for Medicare and Medicaid Services (CMS) to monitor and license Nursing Homes. The examples listed are just a few of the many cases where residents are “lucky” enough to be selected during an onsite inspection and their files are reviewed.

It is not the intent of this report to suggest that all nursing staff and facilities provide poor services. Undeniably, there are thousands of nursing home residents who receive the care they need and deserve. MPAS, however, views even one case of abuse and neglect as too many and cannot be tolerated.

### **Calhoun County**

- ◆ In a survey dated October 2010: A resident was administered the wrong medications, which resulted in the resident falling down on two occasions. Staff did not intervene to protect the resident from falling even after discovering the resident had received the wrong medications. The resident was treated at an emergency room for bruising, swelling, and lacerations to their head as a result of the falls. There is no documentation indicating nursing staff was disciplined for administering the wrong medications or for lack of intervention after the resident had fallen.
- ◆ In a survey dated August 2011: A resident of a nursing home refused to shower. The resident's refusal to shower was reported to the facility's director of nursing. The director of nursing pushed the resident down the hallway to the shower room in a wheelchair. The resident was noted as being naked, screaming and kicking while being pushed down the hallway against their will. The incident was not reported to anyone because the nursing facility administrator did not consider the incident abusive. The director of nursing was suspended and finally terminated for unprofessional conduct. It is unknown whether the disciplined employee is working elsewhere within the nursing home industry.

- ◆ In a survey dated October 2010: A resident's medication to treat heart failure was discontinued by nursing facility staff without a physician's order to do so. The resident missed a total of 44 doses of the medication over a 22-day period. The resident experienced increased shortness of breath and gained seven pounds in two weeks. The resident died a few months later from respiratory distress and heart failure. There is no documentation indicating nursing home staff was disciplined for discontinuing the resident's medication without a physician's order.

### **Crawford County**

- ◆ In a survey dated February 2010: A resident walked out of a nursing home through the front lobby door. Facility staff did not notice the resident had eloped from the facility. The resident was found lying on the blacktop in the parking lot. The temperature was 32 degrees Fahrenheit and the resident was only wearing pajama pants, a sweater over a t-shirt and slippers. The resident complained of pain in their right hip and had a scraped elbow. The resident was sent to the hospital and treated for a fractured pelvis. There is no documentation to indicate whether staff was disciplined.

### **Genesee County**

- ◆ In a survey dated June 2011: A resident required supervision and the physical assistance of one staff member while eating. The resident was eating without assistance from staff and began choking. Nursing home staff assessed the resident and incorrectly performed the Heimlich maneuver by hitting them on the back several times. Staff also conducted a blind finger sweep (attempt to remove the foreign body with the finger). The resident was transported to a hospital where a 4 oz. piece of chicken was removed from the resident's airway. The resident died just an hour after the choking incident began. Nursing facility staff was terminated as a result of this incident. It is unknown whether the disciplined employee is working elsewhere within the nursing home industry.

### **Huron County**

- ◆ In a survey dated March 2010: Nursing facility staff administered five doses of Roxanol (morphine) to a resident over a nine hour period. One staff member administered the first three doses, even though the dose was "much higher than she typically saw ordered." Staff failed to provide monitoring or assessment following each dose of Roxanol administered to the resident. After the resident received the second dose of Roxanol, staff noted they were unable to find a blood pressure and the resident's oxygen saturation level was abnormally low. Less than four hours after the fifth and final dose, the resident was found dead. This resident's death was not reported to the state agency. There is no documentation to indicate nursing facility staff was disciplined for administering high doses of Roxanol to a resident even though the dose was known to be too high. There is

also no documentation to indicate staff was disciplined for neglecting this resident (failing to monitor or assess them) after high doses of Roxanol was administered.

- ◆ In a survey dated March 2010 (this is a separate incident from the one noted above): A resident received five times the ordered dose of Roxanol (morphine) in one day. Two hours after the last dose was administered, the resident's physician was notified of the overdose. The physician ordered increased monitoring of this resident. Nursing facility staff could not provide any evidence the resident received any treatments or assessments following the Roxanol overdose. Seven hours after the last dose of Roxanol was administered, the resident could not be aroused, was blue in color, and was in severe respiratory distress. The resident was treated at a hospital for a morphine overdose and was admitted for observation, monitoring, and assessment. The nursing facility did not report this incident to the state agency. There is no documentation indicating staff was disciplined for administering an overdose of the resident's medication.

### **Jackson County**

- ◆ In a survey dated May 2010: A resident with a history of blood clots for which the resident was receiving anticoagulation medication began experiencing nosebleeds. Nursing staff did not notify the physician as required in accordance with the resident's individualized plan of care and the facility's protocol for anticoagulation therapy. Once the physician was notified, the physician ordered testing to be done immediately. The resident was taken to the emergency room for treatment of a life-threatening risk of hemorrhage as evidenced by "panic level" laboratory test results related to anticoagulation therapy. The nursing staff member who failed to notify the physician was disciplined with a temporary suspension and counseling was provided.
- ◆ In a survey dated September 2011: A resident was transferred by a certified nursing assistant (CNA) who did not use a gait belt. The resident's "Patient Information Worksheet" revealed they were identified as requiring a two person transfer with a gait belt. As a result of the improper transfer, the resident sustained bruising from the mid-right breast to chest wall 280 cm in length and from the bottom of the sternum to mid-sternum 90 cm. Bruising was also noted from the left breast to the rear of chest wall under the left arm 190 cm x 80 cm. The CNA who transferred the resident lied about using a gait belt during an internal investigation at the facility. This CNA was suspended.

## **Kalamazoo County**

- ◆ In a survey dated June 2011: Nursing facility staff used physical force to “pry apart” the severely contracted legs of a resident during a catheterization procedure. The physical force used by staff caused muscle and ligament injury, bruising and pain to the resident’s leg and groin area. Facility staff was not disciplined for the injuries sustained by this resident.
- ◆ In a survey dated March 2011: Two nursing facility staff failed to follow a resident’s plan of care, which included not invading the resident’s personal space and also telling the resident that staff are ‘here to keep you safe’. The facility staff physically restrained the resident’s arms and cut the resident’s fingernails, against the resident’s will. The resident sustained bruising to their arms and hands, pain, emotional distress and fear. The two staff involved were in-serviced and suspended as a result of this incident.

## **Kent County**

- ◆ In a survey dated October 2008: A resident experienced sudden respiratory distress while eating breakfast. According to the survey, the resident was “unable to talk” and “was unable to cough” and “sounded as if the resident was choking” and having copious oral secretions. Nursing facility staff was unable to locate suctioning equipment that was either functioning properly or that had all of the necessary equipment. Once staff was able to suction the resident, the suctioning did not relieve the resident of distress. Emergency Medical Services (EMS) was not contacted in a timely manner and was not provided with accurate information regarding the resident’s respiratory distress. The resident died in an ambulance in the parking lot 2 ½ hours after the onset of respiratory distress. The facility did not investigate the incident and did not report the incident to the state agency. Facility staff was not disciplined for being unable to provide appropriate care to a resident having sudden respiratory distress.

## **Marquette County**

- ◆ In a survey dated October 2011: A resident with a known history of substance abuse returned to the nursing home from a leave of absence around 9:00 p.m. on 10/11/2011 with notable lethargy and a significant change in behavior. The nursing facility failed to implement a physician’s order to obtain a urine drug screen in a timely manner and failed to adhere to professional standards of nursing practice. This resident was found dead in their bed less than 7 hours later. The Michigan State Police are involved in investigating this incident.

## **Mecosta County**

- ◆ In a survey dated February 2009: A resident was eating breakfast and began to cough. The resident spit out some of their breakfast, but was observed minutes later collapsed in a chair in the hall, blue in color and lifeless. Several nursing facility staff observed the resident choking on breakfast although did not call 911. One staff member performed the Heimlich maneuver, but it was not effective. The resident died as a result of asphyxia due to aspiration. There is no documentation to indicate whether staff was disciplined.

## **Midland County**

- ◆ In a survey dated October 2010: A resident fell during a transfer from a wheelchair to a shower chair. Nursing facility staff transferred the resident with the wrong lift and without the required number of staff to assist. The resident was transported to a hospital for evaluation after the fall. The resident was diagnosed with a skull fracture, subarachnoid bleed, cerebral contusion and pneumocephalus. The resident died three days later as a result of the subarachnoid bleed. The resident's fall and death was not reported to the state agency. The nursing home staff that performed the transfer was terminated. It is unknown whether the disciplined employee is working elsewhere within the nursing home industry.
- ◆ In a survey dated February 2010: Nursing facility staff was pushing a resident in a wheelchair without foot pedals to another building. The resident's wheelchair hit something on the sidewalk and the resident fell out of the wheelchair, landing face-first on the sidewalk. The resident was transported to a hospital where treatment was provided for a facial laceration, hand lacerations, and two fractures of the neck. The injured resident died three days later as a result of the injuries incurred from the fall. There is no documentation that staff received discipline for transporting the resident in a wheelchair without foot pedals.

## **Muskegon County**

- ◆ In a survey dated July 2011: Nursing home staff restrained a resident to a wheelchair with a gait belt for several hours. There was no order for staff to restrain the resident. The gait belt was secured around the resident's rib cage and the wheelchair. The buckle of the gait belt was at the back of the wheelchair where the resident could not reach it. The resident was unable to stand or remove the gait belt. As a result, the resident sustained serious bruising on their entire chest and rib area. This restraint incident was not reported to state authorities and was not investigated.

## **Oakland County**

- ◆ In a survey dated October 2010: A resident fell while being transferred with a Hoyer lift. This nursing facility's policy requires two staff to assist during transfers. Staff transferred the resident alone and without assistance. The resident was admitted to a hospital and received treatment for rib and spinal fractures as a result of the fall. There is no documentation to indicate the staff person was disciplined for failure to follow facility policy.
- ◆ In a survey dated March 2011: A resident, who had difficulty swallowing, required a pureed diet. It was also recommended the resident receive one-to-one assistance while eating. Nursing facility staff provided this resident with a tray consisting of beef stroganoff, fruit cocktail and broccoli spears. Minutes after the tray was served, the resident was found on the floor with no pulse and not breathing. Emergency medical services (EMS) were contacted and staff performed cardio-pulmonary resuscitation (CPR). When EMS arrived, one technician was unable to intubate the resident due to a four-inch piece of broccoli blocking the resident's airway. The piece of broccoli was removed and the resident was intubated. CPR continued, but was eventually stopped and the resident was pronounced dead. There is no documentation to indicate that nursing home staff was disciplined for failing to provide the resident with an appropriate tray or supervision.
- ◆ In a survey dated May 2010: Nursing home staff failed to develop a plan of care for a resident who was identified as at-risk for eloping from the facility. The resident attempted to elope from the facility, staff intervened and the resident went to their room. Staff went to check on the resident later that same evening and the resident was nowhere to be found. The resident had eloped from the facility by jumping out of their second story bedroom window. The resident was transported to a hospital where they received treatment for a fractured femur, right and left ankle fractures and a sternal fracture. There is no documentation to indicate whether staff was disciplined.

## **Saginaw County**

- ◆ In a survey dated December 2009: A resident eloped from a nursing facility and was observed sitting in a wheelchair on the side of a busy road. The resident was observed going into the road and cars had to slow down and go around them. The resident was returned to the facility, and staff was told not to write an incident report about this. The resident's family and physician were not contacted. The resident was not assessed for injuries. The incident was not reported to the state agency. There is no documentation indicating staff was disciplined for failing to report the incident and neglecting the resident upon the resident's return to the facility.

## **Shiawassee County**

- ◆ In a survey dated June 2010: A resident was transferred improperly with a mechanical lift by nursing facility staff. The resident slipped and fell out of the lift. The resident fell backward, hitting their head on the floor and sustaining a laceration. The resident was transported to the hospital where they were treated for a large acute subdural hematoma, extensive subarachnoid bleed, and soft tissue injury to the skull. This resident died five hours later as a result of the injuries incurred from the fall. The facility staff person who improperly transferred the resident resigned from her position. It is unknown whether the disciplined employee is working elsewhere within the nursing home industry.

## **St. Joseph County**

- ◆ In a survey dated February 2009: A resident was found sitting outside in the snow in temperatures ranging from 6.8-12.2 degrees Fahrenheit. The resident was only wearing flannel pajamas, shoes, and socks. The length of time the resident was sitting in snow is unknown. The nursing facility's director of nursing instructed nursing staff not to send the resident to the hospital and rather "try to heat the resident up in-house." The resident's physician was not contacted and nursing staff did not treat the resident appropriately for possible hypothermia. Nursing staff did not communicate to staff on the next shift of the resident's condition. There is no documentation indicating staff were disciplined for not sending the resident to the hospital for possible hypothermia, for failure to contact the resident's physician, and for failing to treat the resident appropriately for hypothermia.

## **Washtenaw County**

- ◆ In a survey dated July 2010: Facility staff attempted to insert a latex catheter into a resident with a known latex allergy. The resident told the nursing home the catheter was not in the right spot because of the pain. A second nursing home staff assisted with re-inserting the catheter. The resident was short of breath and complained of pressure in the lower abdominal area. One staff member removed the original catheter and noted it looked as if it had coiled up during insertion because it was curled and kinked in some parts. Nursing facility staff did not know if the Foley catheter was a latex catheter. This resident experienced abdominal pain, blood in their urine and around their penis for six days before being taken to the emergency room. During a procedure in the emergency room, it was noted there was obvious trauma to the resident's urethra and the normal course of the urethral tract could not be followed to allow for passage of the catheter into the bladder. There is no documentation to indicate whether staff was disciplined.
- ◆ In a survey dated December 2009: A nursing facility resident received dialysis treatment at a dialysis center. The resident had a surgical fistula (a port) for dialysis treatment. Nursing facility staff never assessed the resident's fistula site and did not even know the location of the resident's fistula site. Nursing facility staff observed the resident sitting in

the doorway of the dining area unresponsive and surrounded by a large pool of blood. The resident's dialysis fistula had ruptured. Nursing facility staff did not provide the resident with cardiopulmonary resuscitation (CPR) and other necessary emergency remedies, despite the resident being a "full code" status. The resident died as a result of the ruptured fistula. Nursing facility staff was not disciplined for neglecting the resident's basic care needs and for not providing CPR when the resident was discovered.

- ◆ In a survey dated July 2011: Nursing home staff "dove" onto a resident's upper chest when the resident began swinging their arms at staff. The staff pushed the resident into the mattress and placed their hands around the resident's neck, choking the resident. As a result, the resident had reddened areas on their arm and the center of their chest. Staff was suspended and arrested for assault.
- ◆ In a survey dated January 2010: Nursing home staff discovered ants on a resident while the resident was lying in bed. Ants "were all over the resident." Nurse's notes read, in part, "Upon entering room (staff members) had sheet/gown pulled back and ants noted everywhere on resident from lower bilateral breast area/abdomen/groin area and also near/around G-tube site. Resident cleaned ants off with soap and water then turned over and ants were all over the bed (covering mattress) and all over resident's back. All dressings removed and inspected and no ants found there..." Ants were observed in the building before, but not on a resident. There is no documentation to indicate staff was disciplined.

## **Wayne County**

- ◆ In a survey dated October 2010: Nursing facility staff used a latex glove to restrain a resident's protective hand mitt to the resident's wrist. The latex glove was found tied tightly around the resident's wrist, causing a pressure-related injury, decreased circulation, a large amount of swelling, deep indentation, and blisters. A different facility staff received disciplinary warnings for not following through on the investigation regarding the incident and received one-to-one counseling related to documenting incidents. There is no documentation regarding discipline for the staff who inappropriately restrained the resident.
- ◆ In a survey dated September 2010: A resident had physician's orders to receive continuous oxygen at two liters per minute by way of a nasal cannula. The resident was observed on three different occasions without the ordered oxygen. Nursing staff determined the resident did not require oxygen, so staff did not apply the oxygen when the resident was outside of the bedroom, despite the physician's order that stated otherwise. There is no documentation indicating staff were disciplined for failure to follow a physician's order for oxygen.
- ◆ In a survey dated June 2009: A resident of a nursing facility was found dead one morning after not receiving appropriate diabetic management the day before. Facility staff failed to administer the resident's insulin, monitor blood glucose levels, and review

the resident's food acceptance record. When nursing home staff found the resident deceased she called for assistance from a nurse. The nurse did not respond and she was observed sleeping at the nurse's station. Facility staff falsified nursing notes at the request of the assistant director of nursing, who was also the mother of the nurse found sleeping. The nurse found sleeping was not terminated for sleeping on duty; rather she was transferred to another facility managed by the same corporation. The assistant director of nursing was disciplined for not following defined procedures although was not disciplined for falsifying documentation.

- ◆ In a survey dated September 2010: A resident with a tracheostomy was identified by facility staff to be at-risk for developing respiratory distress. To ensure the resident's airway remained open, nursing home staff had to ensure appropriate placement and care of the resident's tracheostomy, the outer tracheostomy tube, and the inner cannula. Staff were to provide the resident with tracheostomy care every shift and deliver oxygen via tracheostomy mask. Facility staff were also to position the resident's bed at a certain angle and ensure the resident was not lying flat on the bed. During staff rounds, the resident was observed lying flat, not having an open airway and both tracheostomy cannulas were not in the resident's trachea. The resident's oxygen and air compressor were also turned off. This resident was pronounced dead. Nursing facility staff did not follow the resident's oxygen orders and did not document any tracheostomy care as being provided to the resident on the day they died. There is no documentation indicating staff were disciplined for neglecting this resident.
- ◆ In a survey dated June 2010: A resident was required to be transferred by mechanical lift with assistance by two staff members. The resident was transferred with a mechanical lift by one staff member. During the transfer, the staff member maneuvered the lift and the sling and the resident screamed out. The staff member thought the resident's leg struck the headboard of the bed. The resident was transferred to the hospital and received treatment for a femoral fracture. The staff member who improperly transferred the resident was not disciplined.
- ◆ In a survey dated May 2010: A resident's care plan required staff to "turn and re-position resident every two hours" and "keep resident's linen free of wrinkles." One evening the resident's family member positioned a plastic heating pad under the resident's back while they were lying in bed. An hour and a half after the heating pad was positioned under the resident, staff observed the resident sleeping and did not assess the resident, intervene, or re-position them as required. Nursing home staff did not enter the resident's room again until almost five hours later. Staff did not provide the resident with any necessary care or supervision to ensure their needs were met or to prevent injury. As a result, this resident sustained multiple first and second-degree burns covering a seven inch by ten-inch area of the back after lying on the hearing pad for several hours. The two staff members who failed to provide care to this resident are no longer employed at this facility. It is unknown whether the disciplined employee is working elsewhere within the nursing home industry.

- ◆ In a survey dated June 2010: A resident eloped from a nursing facility with no identification bracelet and wearing only a sweatshirt, pajama pants, socks, and slippers. Staff were unaware the resident was missing until the resident's fiancé informed them. The resident was missing from the facility for over two-and a-half hours. The resident walked out of the facility and spoke with two staff members who did not question the resident about why they were outside and why they were unattended. This resident was discovered sitting on the porch of a house located two blocks from the nursing facility. There is no documentation to indicate staff was disciplined.
- ◆ In a survey dated June 2009: Nursing facility staff indicated a resident, who was dependent on a ventilator, kept pulling themselves off the ventilator and staff could not "get everything done." Staff admitted to tying one of the resident's arms with a gown and the other with a sheet, extending the resident's arms out to the sides. There was no order or consent for the use of wrist restraints or tying the resident to the bed. It was estimated the resident was tied to the bed for approximately three hours. During that time, the resident had no way to call for assistance and was placed at high risk for asphyxiation. There is no documentation that staff were disciplined for tying the resident to the bed without any order or consent to use restraints.
- ◆ In a survey dated June 2009: A resident noted to have poor safety awareness pulled out their tracheostomy three times over a two month period. The third time the resident pulled out the tracheostomy, nursing home staff found the resident in their room in respiratory distress. Staff attempted to re-enter the trach without success and 911 was called. The resident was taken to the emergency room and pronounced dead due to lack of oxygen. Facility staff did not create a care plan for supervision or hand mitt restraints to prevent the resident from removing their tracheostomy. There is no documentation indicating staff was disciplined.

## **Recommendations**

All nursing home residents in Michigan must be assured a safe and healthy environment in which to receive nursing care. In addition, all residents of nursing homes must be in need of nursing care. The state should ensure that all individuals who need nursing care will be assured of receiving quality nursing care by certified/licensed and competent staff, in highly regulated facilities in Michigan.

MPAS proposes the following recommendations to strengthen the system and increase accountability of all responsible parties:

- ◆ Pass pending State legislation to require background checks on all employees of nursing homes and prohibit the hiring of any individual who has had a licensing complaint involving abuse or neglect validated following investigation by a state agency.

- ◆ Pass Senate Bill 462, which expands the reporting obligation to report abuse, neglect or mistreatment to nursing home administrator/director of nursing and the state's Department of Licensing and Regulatory Affairs (LARA).
- ◆ All professional personnel who are mandated reporters of abuse or neglect and who have failed to report, as identified through the nursing home survey inspections, must have their professional license revoked and criminal charges must be filed against them.
- ◆ Increase sanction penalties and ensure fines are collected.
- ◆ Review nursing homes for fraudulent billing of Medicare and Medicaid for services rendered when it has been determined, through the inspection reports, that resident care has been neglected.
- ◆ Nursing homes with a consistent rating below 5 should not be allowed to continue operating in Michigan. Michigan needs to re-evaluate the suitability and effectiveness of the "5 Star" rating system to assure proper care and treatment of nursing home residents. Anything less than a 5 Star should not be acceptable in Michigan.
- ◆ Operators and administrators of nursing homes who fail to protect residents from abuse and neglect should be criminally charged and their license to operate should be immediately revoked. Operators of such facilities should not be allowed to reorganize or operate within the State of Michigan.
- ◆ MCL 750.145m, the Vulnerable Adult Abuse Act, should be amended to make it a crime to cause someone to experience significant pain.
- ◆ Increase the number of nursing home ombudsmen. Currently each ombudsman is responsible for a very large number of facilities.
- ◆ Increase nursing home diversion and discharge planning initiatives. The funding for the MiChoice waiver program is skewed in favor of transitioning residents out of a nursing home, instead of keeping them out in the first place. This disparity should be eliminated and people should receive the services they need in their communities instead of entering a nursing facility. Other advocacy organizations (e.g. Centers for Independent Living) should be active in all areas of the state in working to get people out of nursing homes.
- ◆ Amend the current receivership statute. Presently, the law allows the state or residents to petition a court to place a nursing home in receivership; however, this is only allowed when the state has gone through most of the administrative process. Residents, and/or MPAS, and/or the State Long-term Care Ombudsman should be allowed to petition the court directly for receivership when ongoing lack of care, abuse, or neglect has been demonstrated.
- ◆ Amend outdated minimum staffing requirements for nursing homes so staffing levels are set at realistic levels needed to deliver quality care to all nursing facility residents.