

Videotape at Nursing Home Records Abuse

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By Valarie Honeycutt Spears

The family of an 84-year-old resident of a Richmond nursing home hid a video camera in the woman's room after they discovered dozens of bruises all over her body and didn't get satisfactory answers from the staff.

The videotape shows nursing assistants at Madison Manor physically abusing and taunting Armeda Thomas of Irvine and failing to feed and clean her.

The Kentucky Attorney General's Office is conducting a criminal investigation, and the facility has received the most serious citation state nursing home inspectors can give.

After the criminal investigation began in September, further checking by the nursing home staff revealed "injuries of unknown origin" on 17 residents who were cognitively impaired, according to records obtained by the Herald-Leader under the Freedom of Information Act.

Thomas' family aimed a hidden camera at her bed without the nursing home's knowledge in August, said her granddaughter Deborah Hamilton, who is a child protective worker employed by the Cabinet. She said her job was unrelated to her role as a caretaker for her grandmother. But she said that as a state social worker, she knew which problems needed to be reported.

"We were just so desperate to know the truth and for other people to know the truth," said Hamilton. "Almost everyone has a relative who gets care in a facility. You want to be able to go to sleep at night knowing that your loved one is well cared for and not scared."

On Oct. 6, the inspector general's office of the Kentucky Cabinet for Health and Family Services issued a Type-A citation to the 96-bed facility on Meadowlark Drive in Richmond. The office determined that the nursing home failed to adequately investigate the injuries on the 17 patients.

Cabinet spokeswoman Gwenda Bond said the issues that led to the citation have been corrected. State records showed that the immediate danger to patients was corrected Nov. 6, but some other deficiencies remained and would continue to be monitored.

Madison Manor is part of the Richmond Health and Rehabilitation Complex, which is owned by Wisconsin-based Extendicare.

"We received the state's findings (in the Thompson case) and submitted a plan of correction, which was accepted," said a statement from Cindi Simpson, regional director of operations for Extendicare. "We were recently resurveyed, and the immediate jeopardy violations were removed and our facility is currently in substantial compliance."

Simpson said that because of federal privacy laws, she could not discuss current or former residents.

Thomas' family cared for her at home after discovering the abuse at the nursing home. She died Nov. 7 of complications related to Alzheimer's disease, Hamilton said.

A review of the incidents videotaped between Aug. 17 and Sept. 8 "demonstrated actual incidents of physical abuse and neglect by the staff," the state's citation said.

Kathy Gannoe, the district ombudsman for the Nursing Home Ombudsman Agency of the Bluegrass, said that since Jan. 1, her agency had received 17 complaints about Madison Manor and had opened 11 cases as a result.

As of last week, 47 percent of the complaints had been resolved to the satisfaction of the people who made them.

Bruises and fractures

Hamilton said her grandmother entered Madison Manor in February 2007.

The citation said that bruises -- which the family first photographed in July -- were handprint bruises and not injuries caused by the patient's own combative behavior.

The nursing home did not appropriately respond to the family's initial concerns about the bruises before the family hid the camera, according to records from the inspector general's investigation.

The nursing home staff found many bruises on Thomas, but thought they had been caused by Thomas' combative behavior, according to the investigation.

The videotape captured the staff "pulling the resident out of bed by her wrists and neck," and "roughly moving the resident from side to side," the investigation showed.

On Sept. 8, three days after an incident in which certified nursing assistants handled the resident roughly, X-rays showed fractures in Thomas' lumbar vertebrae, according to the investigation.

Hamilton said it's unclear whether the injuries were already present or were caused by the nursing assistants' treatment. Either way, she said, Thomas should not have been pulled by her neck.

The videotape also showed instances where nursing assistants did not clean or feed the woman as directed by nursing home officials. And they falsified records about how much she ate. On two occasions, a nursing assistant ate the food herself. One of those times she recorded that Thomas ate all of her food.

At one point, records show, Thomas lost 19 pounds in two weeks.

The videotape also showed nursing assistants mocking and taunting Thomas. One staff member showed her fist to Thomas after Thomas was combative. In another incident, a nursing assistant danced in front of Thomas while other staff forcibly held the resident down, state records show.

In an additional incident on videotape, Thomas lay on the floor for an hour before staff discovered her.

'Failed to protect'

Based on investigations conducted by the Cabinet in September and October, the citation said, "the facility failed to protect residents."

Those failures created an immediate threat that harm, injury or death would occur, the citation said.

Allison Martin, a spokeswoman for the Attorney General's office, said the division of Medicaid Fraud and Abuse could not provide details of the criminal investigation.

Hamilton, Thomas' granddaughter, said she hopes the General Assembly will take notice of the case and strengthen nursing home laws.

"There has got to be more attention given to people who are 100 percent dependent on their caretaker and can't communicate, including people with dementia," Hamilton said, "It's only going to get worse as baby boomers age."

She added, "All nursing home staff should have training in dealing with dementia."

The state does not have a specific patient-to-staff ratio requirement for nursing homes, she said, and more checking should be done by the state on a long-term basis to hold nursing homes accountable.

Gannoe said that over half the states have minimum requirements for staffing. Kentucky nursing homes are only required to follow federal guidelines, which call for one registered nurse to be on duty each day and for a licensed practical nurse to be on duty for other shifts. Otherwise, a nursing home only has to have "sufficient staffing," which Gannoe says is subjective.

Unsanitary conditions

Since January 2007, records show that the state has asked Madison Manor officials to correct problems ranging from poor building maintenance and unsanitary conditions to failing to properly train some nursing assistants.

The nursing home was cited for not properly caring for patients who were immobile or dependent upon feeding tubes. In one case, the state cited the nursing home for not responding quickly enough to patients' concerns about flies, cockroaches and bugs in patient rooms and a dining area.

The facility presented the state with plans for corrective action, including improved oversight, training, and cleaning and building repairs.

According to a September report from the U.S. Department of Health and Human Services, more than 90 percent of nursing homes in the United States were cited for violations of federal health and safety standards last year.

But only 17 percent of nursing homes nationwide had deficiencies that caused "immediate jeopardy" such as the situation involving Thomas at Madison Manor.

"No nursing home sets out to want these things to happen," said Gannoe, "but it's fallout when you don't have good training, adequate supervision and when you don't have a culture that encourages the staff to speak up."