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HEADLINE: Nurse says Del. officials ordered reports of abuse be toned down;
Report shows complaints increased more than 30 percent

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BODY:

By BETH MILLER The News Journal

DOVER – Complaints about long–term care facilities such as nursing homes and group homes increased by more than 30 percent from 2003 to 2004 and sanctions against those facilities increased, too, according to a report released Thursday by the state Division of Long Term Care Residents Protection to the Joint Sunset Committee.

The complaints covered everything from "cold coffee to lost socks to serious abuse and neglect," division Director Carol Ellis told committee members. She believes the number of complaints rose because of better employee training about what must be reported, not because abuse is increasing.

But a former division employee, speaking at the same hearing, said the threat to residents might be worse than Ellis reported Thursday.

A nurse who conducted nursing–home surveys for the state for four years – following up on charges of abuse, neglect, mistreatment or financial exploitation – said Ellis sometimes ordered those reports to be altered, removing violations that otherwise would have been reported to federal authorities.

Dianne Roberts, a nurse with 24 years of experience in hospitals and nursing facilities, said among the violations removed from reports were a malfunctioning alarm bell for a patient who was at risk for falls and improper care of a diabetic.

Other violations were downgraded in severity from those that had actually caused a resident harm to those that could cause a resident harm. When a hospital diagnosed one resident with dehydration and malnutrition, she said, the facility's violation was changed from causing harm to potentially causing harm.

Roberts said she reported a violation she believed had caused a resident to break her hip, but was told that because the resident had osteoporosis, the violation would be considered potentially harmful, a lesser category, since osteoporosis makes bones more susceptible to fracture. She also said the state would not consider weight loss in residents receiving hospice care for terminal conditions to be the result of harmful treatment because their condition may make them at higher risk for weight loss.

Facility was fined

Roberts said she once contacted federal officials and reported that violations had been downgraded by state officials. She said federal officials determined her rating of the violations was accurate and fined the facility $53,000.

Two facilities that had been found "non–compliant" by survey teams were restored to compliant status by Ellis, she said.

Ellis vehemently denied the charges, but said she would rebut them in writing and have her staff available for further testimony when the committee's next hearing on the division is held Feb. 22 in Wilmington.

"I heartily and strongly say that this division does not violate the law or federal processes," she said. " E And I would just say that while much of what [Roberts] said is not accurate, she sincerely believes everything she said. We're certainly called on to rebut accusations and we will do so."

Yrene Waldron, executive director of the Delaware Health Care Facilities Association, said the survey process is subjective at best, and she said judgments made by surveyors are much like grades given by professors. They can be challenged and changed.

"We need to focus on what is best for the patients in the beds," she said. "Otherwise, politics becomes the objective. A lot of these allegations sound very personal."

Roberts said she loved her job at the division, where she worked four years before leaving last spring to take a job at the state's Governor Bacon Health Center in Delaware City. She decided to come forward with her allegations, she said, because the division was on the Sunset Committee's 2006 agenda and she feared life–threatening problems were being ignored or covered up.

Performance review

The committee, chaired by Sen. Robert I. Marshall, D–Wilmington West, and Rep. William A. Oberle Jr., R–Beechers Lot, reviews the performance of state agencies and programs to determine if changes are needed or if the agency or program is no longer needed.

The Division of Long Term Care Residents Protection was created to protect residents of the 47 nursing homes and 289 other long–term–care facilities, which have a total of 7,693 beds. It inspects nursing homes, issues licenses, conducts criminal background checks and enforces regulations.

It was created after a state panel investigated conditions in Delaware nursing homes in the late 1990s. The Adult Abuse Registry also was created and now includes the names of 250 people against whom substantiated allegations of abuse have been made, with 28 others pending appeal, the report said.

Complaints and incidents regarding quality of care increased by more than 100 in 2004, with 552, compared with 417 in 2003. Of those, sanctions were imposed for 21 complaints, compared with 14 in 2003. The division can impose fines, appoint temporary management, ban admissions and refuse to pay for new Medicare/Medicaid admissions.

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BY THE NUMBERS

Division of Long Term Care Residents Protection (2004)

Investigations of abuse, neglect, mistreatment, financial exploitation

21,771 Complaints received

1,990 Incidents/complaints investigated

894 Incidents/complaints verified

108 Referrals to adult abuse registry

52 Referrals to Attorney General's Office

Quality care surveys

552 Complaints/incidents reported

518 Complaints investigated

528 Citations issued

475 Complaints forwarded to Centers for Medicare and Medicaid Services

21 Complaints resulting in sanctions