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# Arizona fails to protect nursing home residents

## State is slow to investigate and act on abuse, neglect

**By Rhonda Bodfield and Enric Volante**

Anita McEvoy put her 92-year-old mother in a Tucson nursing home so she wouldn't get hurt as Alzheimer's disease took its toll. Instead, her mother shivered in bed while nursing aides took no notice. She died of hypothermia complications.

Another elderly woman, who couldn't see well and trusted nursing aides to bathe her, did not know they used a cell phone camera to photograph her in the shower, then went to the nursing station to show the photos and laugh about them with others.

And in a third local nursing home, a nursing aide assigned to feed a confused, 84-pound woman withheld a drink and demanded that the woman say "please" and "thank you," laughing while the woman kept asking: "What do you want? Who the hell are you?"

These cases and others over the past three years have this in common: State regulators did nothing about them.

Until Friday — when investigators reopened one of the cases as a direct result of the Star's questions.

### Lax enforcement leaves patients vulnerable

The inspectors who license Tucson-area nursing homes showed a consistent pattern of weak enforcement, an Arizona Daily Star investigation finds.

Only 15 percent of the time did they substantiate allegations of abuse, neglect or other problems in how the homes cared for some of our most vulnerable people.

The Star reviewed nearly 1,000 citations for safety problems and more than 1,100 complaints of poor care to the Arizona Department of Health Services in Pima County's 22 nursing homes in the three years ending in 2007. The county's hundreds of assisted-living homes are licensed separately and are not covered by the review.

The review mirrors what federal auditors have found nationally: State inspectors miss violations, underrate the severity of the offenses, and allow homes to yo-yo in and out of compliance.

The Star's investigation also reveals:

● The state blew its own investigation deadlines in three out of every four cases, often compromising the findings because patients and staff members are no longer around. The median case is 72 days late.

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**Before you decide: Consider your needs.**

o Do you need full-time nursing care now? Or do you want a home that offers assisted living but can graduate to a nursing home setting when it becomes necessary? Some homes offer both.

o Does the nursing home offer an organized activity program to keep you engaged?

o Do you require special medical services, and can the nursing home meet that need? Some homes won't take patients on ventilators, for example.

o Does the home allow pets?

o Are religious services available?

**Visit.**

o How do the staff members interact with residents and each other?

o Are there any unpleasant odors or other signs that the home is not kept clean?

o Is the dignity of residents being respected? Are they well-groomed and appropriately dressed, or are they wearing pajamas all day?

o Do you see that residents have a choice of meals? Can you live with

● Although Gov. Janet Napolitano has said families need more information to choose nursing homes, the state doesn't give you enough information to determine whether a home is giving consistently good care. The public can't see the patient's side of any given complaint. You can't see reports the nursing homes make when a patient is harmed. And the only snapshot of how a home is performing is up to 18 months old in some cases.

● The state fined poorly performing homes only 24 times in three years, even though it wrote 958 citations. Until recently, the fines were typically so small that even your next-door neighbor could pay them — usually not much more than $1,000.

● Unlike other states that have set precise staffing standards, Arizona adheres to a vague requirement of "sufficient" staffing. That standard, set by the federal government 20 years ago, is notoriously difficult to assess.

● Unlike doctors, nursing homes don't have to disclose if they've paid out judgments or settlements. Dozens of cases have been settled secretly. It could become even harder to learn about improper care, because homes are getting patients to promise not to sue if something goes wrong.

● Because the state rarely substantiates complaints, sometimes staffers who are fired at one nursing home after being accused of abuse or neglect can be hired right away at another.

Consumers need more protection and information because America is at the beginning of an elder-care crisis that promises to get worse, said Brad Astrowsky, a former prosecutor who now sues nursing homes.

"You can do research until your fingers bleed about what kind of car you should buy, but there's not a whole lot of stuff that will help you decide where to put your mother," he said. "Our priorities are messed up."

**Even with autopsy, neglect hard to prove**

Anita McEvoy's 92-year-old mother, Zora Fishik, went to bed on a cold November night at Devon Gables Health Care Center. She was too frail to get in and out of bed or a wheelchair and could not open or close the window by herself.

At breakfast the next morning, a nursing aide reported Fishik was leaning to the side and spitting up her food. Her pulse was so hard to detect that a nurse had to resort to a wrist monitor to get a reading. The old woman slurred her words and couldn't be understood. Staff members took her back to bed and covered her with a blanket.

When paramedics arrived minutes later, they noted Fishik's room was "very cool" and that she was "cool to touch." Her nail beds were blue, and her temperature was a severely low 85 degrees.

Her temperature rose to 99.5 degrees, but doctors gave her family little hope.

While at the hospital, paramedics told her family that the window to the room was open to the outside, where it was 33 degrees on that 2005 morning. That made sense to them. On occasion during their regular visits, they had seen nurses open patient windows to take a

the menu? Are snacks available? Does the staff assist residents who need help eating?

o Drop in without an appointment on different days and at different times of day. Do you still like what you see?

**Ask.**

o How many nurses are on staff during any given shift, and how many residents are assigned to them?

o How many residents does each nursing assistant care for? Can residents expect to work with the same staff members on most days of the week to ensure continuity?

o How often can residents expect a visit from the staff physician? Will the home drive you or help arrange visits to your personal physician?

o What is the staff turnover, and how are administrators addressing it? How long has the management team been in place?

o How is the home administrator addressing any deficiencies found in previous inspections?

o How are roommates assigned?

**Review public records**

Nursing homes should make their latest state inspection survey readily available to visitors. You also can check citations at the state's Web site, www.azdhs.gov/als/ltc/index.htm. Pull the public file of complaints on any home you are considering at the state's long-term-care licensing office at 400 W. Congress St. Even though the overwhelming majority are not substantiated, they offer clues to concerns residents may have.

**The reporters on this special report:**

Rhonda Bodfield is a longtime reporter now covering family issues. Enric Volante is a senior reporter and database specialist.

smoking break.

Fishik died the next day.

An autopsy found she died of complications of hypothermia, with other health problems "likely secondary to the prolonged exposure to the cold." The medical examiner pronounced it an accident.

During the state investigation, a nurse and nursing assistant insisted the woman was just fine when the aide dressed her for breakfast and that her room was not cold or hot and the window was not open.

Even armed with the autopsy — and the fact that residents are not supposed to be dying of the cold in facilities that care for them — inspectors determined they lacked evidence to cite the nursing home for neglect.

Together they have worked on award-winning Arizona Daily Star investigative projects involving campaign finance, workplace safety, medical malpractice, child abuse and gaps in firearms law.

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Fishik lived a long life. Family members have memories of her making delicious applesauce cupcakes and sewing an elaborate wedding gown for her granddaughter's Barbie doll, but that gives them little consolation.

"That's not a way for somebody to die," said granddaughter Amy Hellenberg, 29, a human-resources director and a nursing student.

Heather Friebus, who has been at the helm of Devon Gables for just over a year, said she could not comment on Fishik's case. "My No. 1 priority is to provide quality care for residents," Friebus said.

Sylvia Balistreri, the state's long-term-care licensing program manager, pledged Friday to reopen the Fishik case. After reviewing the Star's findings, she said the earlier investigation "reflects a different philosophy" than the one in place under her leadership.

State inspectors substantiated only 171 of the 1,146 complaints against Pima County nursing homes in the three years ending in 2007, according to the state's database.

Balistreri said the department has taken an "aggressive stance with nursing homes and will continue to do that."

She said the state is doing an effective job. In 2006, the department issued 31 citations when nursing homes actually harmed patients — that number was down to seven last year. That's evidence, she said, that nursing homes understand the state is watching and are more vigilant about patient care.

The burden of proof seems unreasonably high to attorney Brad Astrowsky.

"From an outside perspective," he said, "it seems you need a confession, a videotape or DNA evidence to get a complaint substantiated."

**Low staffing delays state investigations**

Midtown resident Edith Drinkwater, 69, said she was furious when a nurse at ManorCare insisted her 88-year-old mother was lying when she said she waited 45 minutes for help to go to the bathroom.

Drinkwater said her mother may have had Alzheimer's, but as her in-home caretaker for nine years until her death, she knew her mother could tell time and do math just fine. Said Drinkwater: "She never lied once in her life."

After Drinkwater complained to the state, she said, she called three or four times to check and kept hearing that the staff was overloaded but working on it. "Finally, I just stopped calling."

Although the state gave itself three months to investigate, records show no one investigated until 10 months after that deadline. The state did not substantiate her complaint. If state workers had come out earlier, Drinkwater said, they might have found others to back up her version of events. "I was shocked at the outcome," she said.

Because so many patients suffer from memory loss, delays compromise investigations. In another case, inspectors took eight months to look into a claim of verbal abuse at ManorCare. By then, the staff member

accused of being rude and having a short temper was gone. The patient no longer could remember her complaint, which inspectors could not substantiate for lack of evidence.

The Star found that the state did respond quickly to critical complaints involving egregious abuse and immediate health risks.

"We know that we're behind on complaints," said Sylvia Balistreri, the state's licensing program manager for long-term care. "Most of the time it's because we don't have enough staff to get out there and do the investigations."

The 31 inspectors assigned to oversee the state's 140 nursing homes do on-site visits at least once every 15 months or when serious complaints require more immediate attention.

Turnover remains a problem. It's especially hard to find nurses to staff the survey teams — a necessity given the complex medical issues they examine. "It's an area we have to deal with constantly," Balistreri said.

Six of the positions were vacant at the end of March.

The pool of workers available for complaints is even smaller. Only 10 inspectors have worked there more than four years. It takes about a year for new surveyors to investigate complaints on their own, and even then, they need a lot of support, Balistreri said.

**Poor care of loved ones leaves families frustrated, heartbroken**

Charlotte Sweeney, 73, raised four children with her husband of 52 years.

When he spent three weeks at La Colina Care Center on the South Side in early 2007, Sweeney began keeping a log of complaints: The staff didn't properly clean bathroom equipment, delayed rehabilitation and didn't treat her husband's leg injuries.

State investigators didn't substantiate her complaints.

"It felt like they were calling me a liar," said Sweeney, who said she believes that they didn't take a close look.

State auditors struggle nationally with consistency. The federal Office of Inspector General in 2003 found wide swings among states in how they apply federal rules. In Virginia, for example, a third of nursing homes were doing so well on inspections that they had not a single deficiency, while in Nevada, no homes achieved perfection. In Pima County, about 11 percent of survey and complaint investigations found no problems.

The U.S. Government Accountability Office concluded in 2005 that 8 percent to 33 percent of state investigations missed significant care problems at nursing homes.

Researchers at the University of Colorado Health Sciences Center wondered what's really happening in the field. In 2007 they tagged along with survey teams in four other states and found a trend: Investigators often minimized what was happening in nursing homes, either by dropping citations or downplaying their severity. Researchers watched new staff members argue vehemently to cite a home, only to meet resistance from higher-ups, resulting in a "socialization of trainees to make lenient decisions."

Sylvia Balistreri, who has been in charge of Arizona licensing for 2 1/2 years, said she is familiar with federal studies showing that inspectors do not feel comfortable issuing a lot of citations. That's not the message she sends her inspectors, she said. "We are very careful to let surveyors know that when there is a deficient practice, they are to cite it.

"I know how difficult the care is, but I do feel very passionately that we need to protect health and safety," she said.

The nursing home staff at Tucson's Waverly Park Healthcare Center in July 2005 began to document inappropriate sexual behavior for one man struggling with dementia and depression. The man was observed touching a woman's arm and then went to touch her breast.

In mid-August, a staff member saw the man in the activity room with his hand up the dress of a female resident.

During the next four months, the staff documented seven episodes of his sexual misbehavior involving women, some of whom "appeared scared" or screamed at his touch.

Finally, in January 2006, a staff member saw the man sitting in the hall fondling a woman. It appeared "his fingers were in her vagina."

Despite the sexually inappropriate behavior that spanned at least six months, a review of the resident's care plans showed the home did not start planning how to actively address the sexual behaviors until January.

Inspectors issued a mild citation for failing to care for the man's needs, and they neither fined the home nor made an issue of the failure to protect the women from molestation.

Balistreri said the office was hamstrung by federal guidelines until recently that required willful intent to show abuse — a problem with dementia.

Facilities also catch a break if surveyors find a problem but the facility already was cited for similar offenses or its staff already was attempting to fix it.

Records show that in August 2006, when a patient had fallen $12,000 behind due to a delay in getting his long-term-care benefits, an administrator at Waverly Park put him in a car and dropped him at his brother's home in a trailer park. The brother called the family's caseworker in a panic, saying he could not care for him and wasn't told he was coming. Among other problems, the patient was unable to climb the five steps to the trailer and had no way to get to dialysis treatments.

After the caseworker complained, the Waverly staff member conceded the 30-day discharge notice wasn't given and agreed to readmit the man. The state did not cite the home.

Waverly Park administrator Theresa Linnane would not comment on specific incidents that occurred before she took over in February 2007.

Waverly's notoriety after it badly flunked a December 2006 inspection cost the home half its patients, demoralized workers and caused even some hospital staffers to warn families away, she acknowledged. But Linnane, the former leader of a state inspection team, increased staffing levels and repolished the home's tarnished reputation. Although surveyors cited 52 deficiencies in that 2006 inspection, the most recent check found just one deficiency.

The state also did not cite La Colina, even though state inspectors confirmed that the home hadn't appropriately cared for Bertha Gradillas. She arrived for a short stay in July 2005 after surgery to remove a malignant brain tumor.

A week later, family members reported they started seeing green drainage from her scalp incision. The nursing home started treating the infection, but it documented only eight of the 12 required treatments.

The infection became so bad that she needed a second surgery to remove part of her skull. Daughter Suzi Gradillas, 47, said her mother joked that the divot in her head was her "trapdoor." Of course, it wasn't funny. Vital radiation treatment had to be delayed until September while she recovered a second time. She died 10 months later, a week after her 65th birthday.

State inspectors substantiated the complaint. But they didn't write a citation. Inspectors said the facility had been cited in February 2006 for not providing appropriate medical services for a different resident, and the same problem could not be cited again.

La Colina's administrator did not respond to phone calls and a visit from reporters.

Suzi Gradillas said she had a bad feeling the first day her mother was there. It was hot, and the air conditioner wasn't working in her mother's room. She hated the smell. She said she once saw a man fall out of his wheelchair and cut his head. She said the staffers acted like she was bothering them when she went in search of help.

"Every day after I left there, I would sit in the car and cry," she said. "I just kept asking myself, 'How can she be in this place?' "

Suzi Gradillas quit her job to care for her mother until her death.

And she has promised her aging father he will never have to go to a nursing home.

**Homes cite turnover, funding as problems**

Eighty-year-old Sylvia Culpepper moved into ManorCare after being treated for sciatica pain at a nearby hospital. Her doctor prescribed morphine, and the nursing home staff began giving it to her. Two days later, she was dead of an overdose.

Her family's lawyers say the staff continued to give her the morphine "despite the fact that she was showing visible signs of a narcotic overdose."

They also alleged in a lawsuit that Culpepper was the victim of a profit scheme to skimp on staffing at the expense of patient safety.

A ManorCare registered nurse who quit her job a week after Culpepper's death testified in the lawsuit that as the only nurse assigned to the subacute-care unit, her workload was too heavy and unsafe — part of an "intolerable working environment."

The case was settled on undisclosed terms two weeks ago on the morning attorneys began picking the jury.

The company offered its "deepest sympathy to the family of Sylvia Culpepper" but stressed that it did not admit negligence and was not cited for low staffing.

"It can cost a defendant extraordinarily large sums of money to prove it was not negligent," the company said in a written statement. "It is our company policy to use our company's resources to provide quality of care to our residents."

Twenty years ago, Congress passed extensive nursing home reforms. The new law set a vague requirement to have enough staffing to "maintain the highest practicable well-being of each resident." It required a licensed nurse to be on staff at all times and at least one registered nurse for eight hours each day, no matter how big or small the home.

Some states have imposed higher standards, but Arizona has not.

"Arizona, of all places, with all the old people there, should be more concerned about quality," said Charlene Harrington, a national expert on nursing homes at the University of California, who said 71 research articles in the past five years have linked staffing to good care.

Quality suffers in nursing homes that do not provide at least 4.1 hours of total daily care to each resident, a federal study concluded in 2001. Only an estimated 5 percent of nursing homes meet that level today. Florida currently comes closest, mandating 3.9 hours. California requires 3.5 and caps the number of patients that nurses and other staffers may attend to.

An Arizona Daily Star analysis of staffing levels at Pima County nursing homes shows only two homes meet the 4.1 level. Those two are specialty facilities: Pima County's Posada del Sol has a large behavioral-health component, and the new Avalon Health and Rehabilitation Center provides only short stays for rehabilitation services.

"At the national level, we have an administration that doesn't believe in regulation," Harrington said. The states don't want to do it because it will eat into their budgets, since they share the cost of Medicaid with the federal government. Taxpayers already pay about $75 billion in nursing home care through programs such as Medicare and Medicaid.

Some lawmakers want to strengthen nursing home regulations. Sens. Chuck Grassley, R-Iowa, and Herb Kohl, D-Wis., have introduced the Nursing Home Transparency Act of 2008, which would require more consistent reporting of staff hours, disclose more about who owns the homes and increase fines.

Art Martin, administrator for the non-profit Handmaker, a Tucson nursing home with a solid record of compliance, disagreed that the nursing home industry is underregulated. "Outside of the nuclear industry, we're among the most regulated industries in America," Martin said.

Those sentiments were echoed by Kathleen Collins Pagels, executive director for the industry group, the Arizona Health Care Association. Mandating more staff members, she said, "would be an unrealistic and

unfunded mandate."

Instead, homes should be given adequate funding, she said. They lose nearly $14 a day for each Medicaid patient, she said, and the federal government is toying with flat-lining cost-of-living increases in Medicare's budget, which would cost homes millions.

"We think providers are doing an amazing job despite the fact they're not being paid the cost of care," Pagels said.

In truth, it's hard to find staff members already.

On any given day, the nation's nursing homes are short almost 100,000 positions, according to a 2005 report by the National Commission on Nursing Workforce for Long-Term Care. The turnover rate is just shy of 50 percent for registered nurses and 71 percent for nursing aides, who make a median hourly wage of $10.67, according to the Bureau of Labor Statistics.

Recruiting and training new workers costs roughly $250,000 per year for each nursing home in the country, the report says. New staffers mean a dip in productivity, Martin said: "Some staff will leave for 50-cents-an-hour wage increase, so we're constantly stealing from each other."

Administrators, too, depart in huge numbers. A 2001 study pegged turnover at 43 percent.

Although nursing homes report staffing levels to the federal government, those numbers are not audited. Even federal auditors have questioned their validity. Homes also don't have to report their turnover rates.

Mary Reskin, a 50-year-old local teacher, said she didn't believe the horror stories she'd heard about understaffed nursing homes. Then her 73-year-old father, a teacher and guidance counselor at Flowing Wells High School for 30 years, became ill and spent time in three nursing homes in 2006.

"I'm a teacher; I don't expect perfection. I went in trusting people to do the best they could," she said. Instead, she found staffers who were overworked and indifferent.

In general, she said, the homes didn't keep her father clean, didn't care for him well and pushed him out the door too soon.

As a teacher trained to work with kids who are at high risk of dropping out, she said, she is used to dealing with people in a calm way. "I felt like all of a sudden, I was in a battle.

"From the experience that I have had, I would not put my dog in a nursing home in this town."

**Residents sign away right to sue**

When state regulations fail, it is often the courts that provide a separate check on nursing homes.

Few cases, though, actually go to trial. Most settle. And they inevitably settle with confidentiality agreements that prevent the victims or their lawyers from talking about the case or disclosing how much the nursing homes paid out.

Across the nation, fewer patients are filing suits and plaintiffs are winning less money, in part because of caps on lawsuit awards. In Texas, the number and size of claims are down more than 60 percent from pre-tort-reform levels.

In Arizona, however, the industry is pinched by more numerous and severe lawsuits, according to a 2007 report for the industry's American Health Care Association. The report warns of "new and expanding crises" in such states such as Arizona, Tennessee and Arkansas. In Arizona, claims per 1,000 occupied beds doubled to 12 in the decade that ended in 2006. On average, plaintiffs here seek more than $350,000 per claim — more than twice the national average of $146,000.

The nursing home lobby won some changes at the Arizona Legislature four years ago, requiring a victim to promptly produce an expert witness detailing the alleged substandard care. Lawmakers hoped this would reduce the filing of frivolous lawsuits against health-care professionals. Attorneys counter that those concerns are overblown — medical cases are so costly to work up that they are very careful about screening cases.

Four years ago, the Tennessee-based law firm of Wilkes & McHugh, dubbed "the law firm nursing homes love to hate," opened in Arizona. In 2006, it won a $1.5 million award against a Phoenix nursing home. In December 2007, the firm got a $725,000 award against one in Globe.

To head off such judgments, some nursing homes are increasingly using "alternative dispute resolution" agreements. Often found in admission packets, the document states that residents will not sue the home if something goes wrong, but instead will mediate the dispute. If that fails, the case generally goes before an arbitrator, selected and paid for by the nursing home. That decision is binding.

Leighton Rockafellow, a local attorney who has handled some of these cases, said he hadn't heard of these agreements just a few years ago, but now it's the first question he asks potential clients, who often don't know what it is, let alone whether they signed it.

"It's damaging anytime you take away the right to a jury," he said, since the fate of the case hangs on the decision of one person made in secret with little meaningful review. "If you had something that was the most important thing in your life, would you rather trust the outcome to a group or to just one person?"

Kathleen Collins Pagels, executive director for the industry group, the Arizona Health Care Association, said she couldn't say how many nursing homes use the agreements but pointed out that courts have upheld their use. "Some facilities use them; others don't, but we clearly face predatory legal challenges. All you need to do is watch TV and you'll see plaintiff's attorneys trolling for cases." She said she'd like to see limits on punitive damages but is not pushing for new legislative measures currently.

Sen. Russell Feingold, D-Wis., introduced legislation last year saying these agreements have far surpassed their initial intent of solving disputes between commercial companies of similar sophistication and bargaining power — say, a lumber company negotiating with a big chain home-improvement store.

Because arbitration companies are beholden to the corporations for repeat business, there is strong financial incentive to rule in their favor, the consumer advocacy group Public Citizen reported last year. The group looked at mandatory arbitration by the credit card industry in California, which in 2003 became the only state to open some arbitration records to the public. In more than 19,000 cases, 94 percent of the decisions sided with business.

**Records may not tell whole story**

Phil Jacobs never even knew the state was looking into a complaint that Desert Life Rehabilitation and Care Center, on the Northwest Side, may have been so careless that his mother died.

Jacobs, a restaurant worker, reluctantly put his mother, 62-year-old Isabelle Jacobs, in the home because she no longer could swallow and was on a feeding tube. Despite doctors' orders that she take no food or liquid by mouth, her roommate reported that on June 10, 2006, she saw Jacobs choking after drinking from an open can of feeding formula that was left within reach on the bedside table. Three days later, Jacobs went to Northwest Medical Center and was found to have aspiration pneumonia with a lung abscess. She died within weeks, heavily sedated because of panic attacks.

"She'd look me in the eye, with tears in her eyes, and say, 'I don't want to die,' " her son recalled.

The clinical record at the nursing home said Jacobs did aspirate, or draw fluid into the lungs by inhaling, and the staff moved the cans to the top shelf of the closet. State inspectors determined they didn't have enough evidence to say conclusively that Jacobs aspirated on the formula, and they did not cite the nursing home.

Phil Jacobs, who had always assumed his mother aspirated on her saliva, said he was "outraged" that he never found out about the investigation until the Star discovered it and told him. He said he's not convinced that state workers did a thorough job.

If you look at the public file for Desert Life, all the investigative record will show is that his mother took fluid into her lungs and went to the hospital. It will not tell you about the witness, nor even that Jacobs died.

Desert Life's administration refused comment.

Arizona licensing chief Sylvia Balistreri acknowledged that the information available to the public in the Jacobs case does not give a good picture of what happened.

But she defended her decision to reduce the amount of information written up in findings. "It is very true now that we are consolidating the amount of information that we write, purposefully, so that we cannot spend as much time doing the writing as we do the investigating."

She said federal rules prevent her from disclosing more information on complaints.

Even so, the state provides more public information now than it did before 2002, when the Arizona Auditor General's Office criticized the health department for not providing enough information. The department then added more detailed information to its Web site when it cites nursing homes for shortcomings.

You can see, for example, that La Cañada Care Center failed to prevent falls for six residents at high risk already, including a woman who broke her hip twice.

At La Rosa Health Care Center, two nursing aides said they offered the required bedtime snacks, but when asked, it was news to 11 residents.

Catalina Health Care Center was cited for not protecting a man's dignity after a worker checked him for incontinence, then left to retrieve supplies, leaving him standing there in the presence of a roommate with his garments around his knees and feces on his skin.

Still, the citations alone give a woefully inadequate look at what's happening in the nursing homes.

The state doesn't share the documents that reveal the initial complaint and discloses only its findings, which often provide few details about what happened. Even though patients' names are removed from public files, the state also removes key medical details, especially those of a sexual nature. Also hidden: some cases where nursing homes reported, as required, when a patient was harmed.

Complaints aren't irrelevant. A 2006 Harvard University study found they are a good indicator of how many problems state inspectors will find — and how serious those problems are — when the homes have their next inspection.

The state releases complaints only when the investigation is completed, and since it often holds complaints for months until the next licensing inspection, there is no current snapshot of compliance.

What's a person to do?

Tucsonan Wendy Annis moved her 84-year-old mother from the East Coast to Tucson last year when it became clear that she would need more oversight as her memory loss grew more severe.

Annis went online, then hit the streets. "It was more about legwork and just appearing on a doorstep without any kind of warning. I didn't want to have people prepared for a visit," said Annis, 53, who ultimately chose Handmaker Jewish Services for the Aging.

**Fired staffers rehired elsewhere**

Nursing homes are required to check that all direct-care staff members have fingerprint clearance, and inspectors consistently make sure they do. But sometimes that's not enough to make sure that residents are safe.

Santa Rosa Care Center fired a nurse who twisted arms behind backs and placed patients in headlocks, but he promptly found a job at another home, La Colina. Within months, someone accused him of hitting an elderly man who had memory problems. By the time investigators got out to interview the alleged victim two months later, he didn't recall being hit by anyone. The allegation was not substantiated.

A year passed before the nursing board took disciplinary action last June in the earlier Santa Rosa case. The board issued a public letter of reprimand for physical abuse. The staffer's license remains active and in good standing.

In a case at Desert Life involving aides who photographed a woman in the shower, the home filed a complaint with the nursing board against the one who was state-certified, even though the state home regulators did not substantiate that anything was wrong. Nearly 18 months later, the nursing board still has not resolved the case, and the aide's license is in good standing.

In a third case, La Colina officials called the state to report that one of its male residents had bruises on the chin, upper arm, hip and face, and blamed the injuries on a nursing assistant. As the elderly man told his story to a nurse, the assistant walked in and touched his shoulder, and the injured man became fearful, reports show. He immediately identified the assistant as the man who hurt him.

The aide denied that any abuse took place. The home fired him. The state did not substantiate the complaint.

One day after he was fired, the aide was hired at another facility.

Five weeks later, the staff discovered an elderly woman on the ground. A family member arrived and reported she was "going into shock." Nurses who came in to check on her found her curled in a fetal position. The resident alleged that the aide had undressed her at 2 a.m., applied lotion to her body and molested her as she whispered to him to stop.

The complaint of abuse was not substantiated, in part because she refused to undergo a rape exam. Inspectors cited the home for hiring the aide without verifying his fingerprint clearance. The staffer's license has since expired.

State licensing manager Sylvia Balistreri said workers who have abused patients should not be working at other facilities. The state does provide information to help nursing homes verify backgrounds of their employees, she said.

Balistreri said she's sure, however, that there are nursing homes that don't do adequate background checks because they need workers.

**Fines often small, ineffective**

The state began issuing steeper fines last year, but on the whole, the penalties are still small in comparison to what investigators find.

Take Santa Rosa Care Center, a midsize facility with more abuse or neglect citations than any other Tucson nursing home. It ranks second for complaints dealing with how the staff treats residents.

Inspection records show that in early 2006, multiple residents told state investigators that they were scared. One aide pointed his middle finger at a confused resident and pretended he would poke the patient in the eye. Another, a male nurse, would twist arms and put patients in chokeholds or headlocks, according to the residents.

One woman began weeping and shaking when she told inspectors about an incident in the dining room. The nurse swatted a hat off an elderly man's head when he refused to take it off. Then, when the patient got up to leave the table in protest, the staff member twisted the man's arm behind his back to make him sit down again.

Nursing home workers told inspectors that they knew about the abuse, which they characterized as routine.

Asked why they didn't report it, they said they feared their car windows might be smashed or their tires flattened. They also said the nurse boasted that nurses were in such demand that administrators wouldn't believe lower-level employees. And, they added, he would buy them pizza and do them favors for not reporting what they saw.

The home, which has 144 beds, agreed to pay $3,500 in fines for not protecting patients from abuse.

Later that year, the home received two more citations for harming patients.

One patient didn't get her anti-anxiety medications in September and October, even though staffers documented ongoing episodes of the patient yelling, cursing, pacing and removing her clothes.

The home also was cited for failing to keep a resident, who came in with a history of falls, from falling again. The woman broke her right ankle in a March fall. In September, she fell in the shower, bruising her hand and tearing her skin. Four days later, she was sent to an emergency room, bleeding and bruised. The resident fell six more times within two weeks in October. The facility could not show that a plan was created to keep her safe.

Santa Rosa agreed to pay $1,500.

Administrator Kim Arndt, who took over the facility last April, would not comment.

Sylvia Balistreri, the state program manager for long-term-care licensing, acknowledged that the fines "can become a cost of doing business for them. Sometimes it gets their attention; sometimes it doesn't."

As a result, she said, the state tries to be more creative. If a home has a problem with residents wandering away, for example, inspectors can ask the home to install special alarms. If a home has a problem that can be addressed with better training, the state can require it.

"Sometimes just putting a hammer to a facility doesn't always work," she said, adding that it can be traumatic for patients to be forced to move to move to a new place. "We want to help the facilities have sustained compliance instead of yo-yoing back and forth."

That regulatory philosophy isn't fail-safe. In the period reviewed by the Star, state officials cited each of nine nursing homes on three separate inspections for the same ongoing problem. Three homes each had four citations for the same thing. For serious problems, state workers do visit the facility again to look for improvements, but repeat violations remain a frustration, Balistreri said.

**Fixes are slow to come**

Those who study the nursing home industry and lobby for reforms say their experiences back up the Star's findings.

University of California researcher Charlene Harrington said she has been pushing for changes since 1975 — and in that time, she has seen numerous federal studies finding the same ongoing problems with weak enforcement across states. "It's kind of discouraging, but I do think the baby boomers are going to get really fed up with this," she said. "I don't think states are going to keep getting away with doing what they're doing."

Janet Wells, director of public policy with the National Citizen's Coalition for Nursing Home Reform, agreed that the problems the Star found are "pretty common" across state survey agencies. The group has been lobbying for change for 33 years, and change is often slow, she said.

But fixing the system needs to be a focus. We're all at risk, she said.

Then there's the larger issue of how we protect those who can't protect themselves.

"This is how substantial numbers of people in this country are ending their lives," Wells said. "It's the final place many people live and the last living experience people know. If it's a bad environment and if they're neglected and suffering unnecessarily, it speaks very poorly for our society and where our values are."

**RELATED PDF**

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**Before you decide: Consider your needs.**

o Do you need full-time nursing care now? Or do you want a home that offers assisted living but can graduate to a nursing home setting when it becomes necessary? Some homes offer both.

o Does the nursing home offer an organized activity program to keep you engaged?

o Do you require special medical services, and can the nursing home meet that need? Some homes won't take patients on ventilators, for example.

o Does the home allow pets?

o Are religious services available?

**Visit.**

o How do the staff members interact with residents and each other?

o Are there any unpleasant odors or other signs that the home is not kept clean?

o Is the dignity of residents being respected? Are they well-groomed and appropriately dressed, or are they wearing pajamas all day?

o Do you see that residents have a choice of meals? Can you live with the menu? Are snacks available? Does the staff assist residents who need help eating?

o Drop in without an appointment on different days and at different times of day. Do you still like what you see?

**Ask.**

o How many nurses are on staff during any given shift, and how many residents are assigned to them?

o How many residents does each nursing assistant care for? Can residents expect to work with the same staff members on most days of the week to ensure continuity?

o How often can residents expect a visit from the staff physician? Will the home drive you or help arrange visits to your personal physician?

o What is the staff turnover, and how are administrators addressing it? How long has the management team been in place?

o How is the home administrator addressing any deficiencies found in previous inspections?

o How are roommates assigned?

**Review public records**

Nursing homes should make their latest state inspection survey readily available to visitors. You also can check citations at the state's Web site, www.azdhs.gov/als/ltc/index.htm. Pull the public file of complaints on any home you are considering at the state's long-term-care licensing office at 400 W. Congress St. Even though the overwhelming majority are not substantiated, they offer clues to concerns residents may have.

**The reporters on this special report:**

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