

[washingtonpost.com](http://washingtonpost.com)

## As Care Declines, Cost Can Be Injury, Death

Lapses by Home Operators, State Create Perilous Conditions

By David S. Fallis  
 Washington Post Staff Writer  
 Sunday, May 23, 2004; Page A01

*First of four articles*

When death came to Theresa Buford, she was cold and alone.

She was 75, the favorite "Aunt T" whose nieces and nephews had spent their holidays over turkey and sweet potato pies at her Richmond home. A large, robust woman who loved watching soap operas, she had worked for years as a nurse's aide and had volunteered with the Girl Scouts.

But after her schizophrenia was diagnosed, she no longer could live by herself. In 2000, her niece placed her in Forest Hill Manor, a deteriorating assisted living facility on Richmond's west side.

She had been there just seven weeks when emergency workers found her, clammy and listless on a bare mattress in Room 5. She was suffering from hypothermia, doctors later determined, her body temperature 15 degrees below normal. She arrived at the hospital in a coma, was placed on life support and died two weeks later.

When state social service officials visited the home to investigate in the weeks that followed, they found residents huddled in blankets and wearing hats, jackets and gloves, records show. Outside, temperatures had dipped into the 20s. Inside, heaters were broken, and some thermostats were locked in wooden boxes and they could not be adjusted by caretakers.

Buford's death is among thousands of incidents of harm at Virginia's assisted living facilities, 627 homes licensed by the state to care for more than 34,000 disabled residents. An 18-month investigation by The Washington Post found a troubled and worsening record of care at the homes, including avoidable injuries and deaths, and a system of state oversight that often failed to identify or correct problems.

In 51 deaths over the past eight years, records raise questions about the quality of care or show that the homes bore some responsibility for the death. In more than 135 other cases, residents suffered sexual assaults, physical abuse or serious injuries, including head wounds, broken bones, burns and life-threatening medication errors. About 4,400 residents have been victims of abuse, neglect or exploitation since 1995, records show.

"The assisted living industry has been used as a dumping ground and a cost dodge for 25 years," Carolynne Stevens, director of licensing for the state Department of Social Services, wrote last year in an e-mail to her colleagues. "It will be a dangerous place for vulnerable people until we stop kidding ourselves that this is a sane or moral approach."

Thousands of state licensing documents and computer records obtained under the Virginia Freedom of

▼ ADVERTISING



### INTRODUCING OUR STAY FOR BREAKFAST<sup>SM</sup> PACKAGE.

Our exclusive offer includes a hearty breakfast for up to two adults and children ages 12 and under.

[BOOK IT NOW! ▶](#)

IT'S THE MARRIOTT WAY.<sup>SM</sup>

[Click for details.](#)



Pay with your Visa<sup>®</sup> card and get a \$100 Bonus Bucks<sup>®</sup> coupon.

Information Act provide a detailed picture of the problems in the state's assisted living industry, which cares for the disabled -- many of them elderly and mentally ill -- who are not sick enough to require a nursing home. The state documents, as well as police and court files, were supplemented by visits to two dozen homes and more than 500 interviews with state officials, facility owners and staff members, residents, their families and advocates.

The records describe a patchwork of facilities stretching from affluent Northern Virginia to urban Richmond and Appalachia, mostly privately owned homes whose resources vary widely. They receive anywhere from \$900 monthly per resident to more than \$5,000 at the more exclusive homes. Those who live in the homes are often poor, without families and subsidized by the state. Others pay for their own care.

Records show that, across the state and in all types of homes, many disabled and vulnerable adults have been abandoned to poor care and failed supervision. The victims represent a range of backgrounds and afflictions:

- Phyllis Bunch, 63, who was mentally retarded and schizophrenic, choked on a banana in September 2002 at Alleghany Manor in Covington, a home in western Virginia. Staff workers called 911 and tried CPR but decided she was dead and telephoned a funeral home to pick up her body. The rescue crew arrived first and reported finding her facedown on the floor covered by a blanket. No one was performing CPR. Emergency workers revived Bunch, but she did not regain consciousness and died four days later. Through an attorney, the home's owner, Shridhar V. Bhat, disputed the accounts of emergency personnel and denied wrongdoing.
- Mary Boyd suffered uncontrolled seizures in November 2002 at Winthrop Hall, a former elementary school in Richmond, after staff workers failed to dispense her epilepsy medication for 25 days, inspectors found. At the hospital, doctors worked for two hours to stop the seizures and were forced to administer drugs to paralyze Boyd and put her on a ventilator, which saved her life. The owner of Winthrop Hall did not respond to requests for comment.
- Cornelia Sink, 79, an Alzheimer's patient whose husband visited her daily, burned to death in September at Care Givers in Henry County near the North Carolina line. The fire started at a laundry room electrical outlet and spread quickly through the one-story brick building, fire officials said. When firefighters arrived, they found her lying half inside a doorway, her hair and clothes on fire.

Three years earlier, the state had expressed concern to the fire marshal that one staff member would be unable to evacuate residents in an emergency and repeatedly had reprimanded Care Givers for not having two workers on duty at night. Care Givers' owner, Ginga Martin, said in an interview that the night Sink died, one worker had not shown up, leaving one employee to watch eight residents, several of them Alzheimer's patients and one bedridden.

In the year before Theresa Buford died, state officials issued violation notices to Forest Hill Manor for inadequate staffing, dirty and unkempt residents and heating problems. Four months before her death, an inspector recommended that the state not renew the license, records show. Instead, a supervisor renewed the permit after the owner promised to make changes. State officials said they believed the heating problems had been corrected.

When Buford was found unresponsive, six rooms at the facility had broken heating units, according to court records. Robert Cosby, a former nurse's aide at Forest Hill, testified in a deposition that it was so cold in the home that "you're shivering and your hands are cold and you're losing feeling in your fingers." The owner "just shook his head and said, 'Okay, I'll take care of it,'" Cosby said later in an interview.

Inspectors later determined that the home had neglected Buford and had failed to keep the facility warm. Two doctors who treated Buford at the hospital said in court depositions that she died of complications from

hypothermia caused by the cold.

The state decided to revoke Forest Hill's license, and Buford's family sued, alleging that the home allowed her to freeze to death. Lynne Jones Blain, the attorney for the home, would not comment but denied wrongdoing in court records, suggesting that Buford's health problems could explain the hypothermia. The case was settled, with Forest Hill's insurance company paying the family \$345,000, according to court records.

The home's owner, Nazir A. Chaudhary, declined repeated requests for comment.

"This place had so many violations I didn't know about," said Antoinette Byrdson, Buford's niece, who watched over her aging aunt in the years before her death. "Had I known . . . I would have never placed her over there."

### **Escalating Complaints**

Hundreds of assisted living facilities operate free of complaints for years. Families often praise the homes that care for their ailing relatives. And industry leaders said most homes are run by dedicated, well-intentioned people who work long hours for low pay.

"The payoff is knowing these people are taken care of," said Grant Goldman, past president of the Virginia Adult Home Association, a trade group representing about 120 operators. "You have people in facilities who have no family and no friends, and you are all they have. It's very satisfying from a human aspect that we are taking care of people who otherwise would not be taken care of."

As the industry has grown, however, so have complaints about care: The number of grievances lodged with Adult Protective Services, a division of the state Department of Social Services, has increased by two-thirds in the past eight years.

The problems in Virginia's facilities are common across the country, according to national studies. But Virginia is the only state in which all the homes were disqualified from a federal funding program after inspectors in 1999 found "medical and physical neglect" of residents.

And relative to other states, Virginia has less stringent regulation of its homes and weaker enforcement tools. Maryland officials, for example, can impose a \$10,000 fine when a home violates its standards, compared with a maximum fine of \$500 in Virginia. Resident deaths and injuries in Virginia have triggered dozens of lawsuits against facilities in the past decade, records show, leading to millions of dollars in jury verdicts and settlements.

In 2002, a Prince William County court awarded Margaret Noel and her family \$1.5 million after jurors agreed that employees at the Summerville assisted living facility in Woodbridge tried to cover up an incident in which Noel broke her hip. Staff dropped the 83-year-old dementia patient and then put her in bed without calling for medical help, the suit alleged. Noel, described by staff workers as a "feisty little lady," was found the next morning grabbing her swollen upper thigh and crying out in pain, according to court records.

The verdict was appealed and the case was settled confidentially. Summerville's executive director said the incident was an aberration and did not reflect the facility's "high quality of care and service." State inspectors never investigated, saying they learned about Noel only when her attorneys requested records.

The state's ignorance of the case was not unusual: Its system of collecting information about the homes is so fragmented that officials cannot say how many people have died or been seriously injured because of abuse

or negligence.

The Post brought to the attention of the state two dozen serious incidents outlined in public records that inspectors had no record of investigating. That included the amputation of a man's leg after he was neglected, the attack and rape of a woman, and the failure to detect a resident's bedsore before it led to a massive blood infection that contributed to his death.

Regulators also said they were unaware of a string of eight deaths in 19 months at one home, even though they were investigating allegations of neglect at the facility when the deaths occurred.

Stevens, the licensing director, said in an interview that only a small fraction of the state's facilities are chronically troubled and that the number is decreasing.

Despite limited funding and rapid changes in the industry, her office has done "reasonably well" regulating the homes, said Stevens, pointing to stepped-up enforcement and training for operators.

The state, she said, is caught in a balancing act between closing homes that have problems and finding facilities that would take those displaced residents, many of whom have challenging disabilities. "I'm not saying it should get factored in, but as a matter of practicality, it does get factored in," she said.

### **An Industry Emerges**

Virginia and many other states began three decades ago to move mentally retarded and mentally ill patients into smaller facilities and group homes, propelled by civil rights lawsuits and a national movement away from huge, government-run institutions.

For those who did not require the full-time medical care of a nursing home, the state turned to "adult homes," which for years had taken in the elderly. This new demand essentially triggered a new industry -- eventually known as assisted living -- that sprang up in various settings, including forgotten roadside motels, old boardinghouses and abandoned hospitals. The homes ranged from four-bed facilities in run-down tenement homes to sprawling, Victorian-style campuses operated by national chains. In Virginia, the largest chain is Sunrise Senior Living, which has 27 facilities across the state.

In two decades, the number of assisted living facilities grew from about 300, with 10,000 beds total, to nearly 700 facilities and more than 34,000 beds, surpassing Virginia's nursing home industry. Not only did the facilities fulfill the goal of getting people into more homelike settings, but they also were much cheaper: A state mental hospital costs the government roughly \$460 per patient a day, compared with the state subsidy of \$28 a day for assisted living.

Many of the homes have become a housing solution of last resort, a bed for those with nowhere else to go. Many homes mix disabled young adults and the elderly, brain-injury victims and Alzheimer's patients, the mentally ill and the mentally retarded, as well as the criminally insane, convicted murderers and sex offenders.

By law, the homes are not considered medical or mental health facilities and are viewed as housing only, with some assistance for daily living. They are prohibited from accepting residents who need round-the-clock nursing care.

Violations of state regulations are varied and widespread and have been found by inspectors in roughly half the homes since 1998. The failures are detailed in the language of bureaucratic state records, punctuated by horrific imagery.

"He was like a skeleton someone had draped a skin over," a doctor told an inspector, describing a resident from Brice's Villa in Mechanicsville. The patient was dehydrated, malnourished and suffering from two broken ribs, an injury of unknown origin. Other medical records show that the patient, who died two days after he was hospitalized, resembled "someone out of a concentration camp." The state acknowledged that the man had serious health problems but it also found that he had not received adequate care. The facility's owner did not respond to requests for comment.

The state has documented problems in small operations and the larger, chain-owned facilities -- in those that accept subsidized residents as well as those that charge \$5,000 a month or more. In many cases, homes repeatedly are cited for the same offense, records show.

Dorothy J. Compher, a frail 93-year-old who was extremely hard of hearing and who used a walker, was crushed to death in 2001 when an employee of Sunrise of Falls Church backed a van over her. She and nine other disabled residents had just been dropped off for lunch at the International House of Pancakes in Arlington. Inspectors said later that there were not enough workers to unload the van safely, contributing to her death. In the previous six months, the facility had been fined twice for insufficient staffing.

Sarah Evers, vice president of communications for Sunrise Senior Living, said that the company has corrected the staffing problems noted by the state and that staffing exceeds requirements "in most cases."

Across the state, the failures can be traced to a range of causes. Residents with a vast array of disabilities often live together in settings never designed for their needs. Owners have wide latitude to decide how many employees are needed, and medical professionals are not required on-site. Nothing prevents an employee from working at a fast-food restaurant one week and caring for disabled residents the next, training on the job.

Owners of assisted living homes -- ranging from corporate, multi-state chains to mom-and-pop operations with little or no experience in caretaking -- argue that the economics of running a facility are difficult: High turnover among minimum-wage workers means a constant challenge of having to train new aides.

The larger chains tend to accept mostly patients who are paying for their own care. But owners of smaller facilities that accept subsidized residents said the primary cause of their problems is that the state grants are too low.

"I am personally going in the hole because the state cannot pay more," said Lori Herring, who runs Stoney Creek, a 23-bed converted farmhouse in Edinburg in the Blue Ridge foothills. She said that if the state increased its subsidy, "the staff would improve, the quality of food would improve . . . and I wouldn't have to be scrubbing toilets."

Roughly one-fifth of assisted living residents are subsidized by the state, clustered in homes willing to accept them. The \$28-a-day reimbursement they receive is a fraction of the \$122 a day spent on average at the Sunrise Senior Living facilities that filed cost reports to the state. Most Sunrise residents pay their own way.

In its recent session, the Virginia General Assembly increased the subsidy by \$1 a day, to go into effect next year. But the subsidies will still rank in the bottom third nationally, estimates show.

"That is inadequate," said Maurice A. Jones, who was appointed commissioner of the Department of Social Services in 2002. He said, however, that he did not support higher subsidies to the homes unless the money was accompanied by tougher standards.

### **'Land of the Lost'**

Life in Virginia assisted living facilities is largely a closed world.

Many residents never are visited by family or friends. They might see inspectors only twice a year. Their mental impairments make them poor witnesses. Advocates and inspectors said the residents are often afraid to complain. And there is no requirement that case managers be assigned to monitor residents' care, advocates noted.

"If there isn't someone following you, you are in the land of the lost," said Caitlin Wright Binning, a patient advocate for Virginia's National Alliance for the Mentally Ill before her death last year.

State officials have been left in the dark about abuse and neglect because agency records are often incomplete. By policy, records are destroyed after five years. And in many cases, facilities do not report incidents to the state, records show.

Among the cases brought to the state's attention by The Post was Archie A. Nance, an 80-year-old retired welder from Danville living at Chesapeake Home for Adults. Nance, who suffered from dementia, died in 2002 after a massive infection raged in his body, the result of untreated bedsores, his family alleged in court. Although the home denied wrongdoing, an arbitrator agreed with Nance's family and ruled that the staff's negligence "hastened his death."

"We visited quite often. . . . He was always in soiled pants and tied to a wheelchair," said his daughter-in-law, Barbara Nance.

Inspectors also had no record of investigating the neglect of Dorsey Williamson, a retired farmer who was losing his eyesight. At Ashwood Home for Adults in Danville, where Williamson was known as "Mr. Dorsey," an aide ignored a wound on Williamson's foot in 1998 until it became infected with gangrene, according to state records.

Doctors had to amputate his leg. The current administrator had no comment, noting that the home had changed management.

"Every time I went to see him, they had him stuck in his room with his TV on," said his granddaughter, Judith Totten.

Inspectors also said they did not know about the death in 1997 of Irene M. Pipkin, 84. She had been living for nearly a year at Oakcrest Manor in Chesapeake when she became ill one morning. She vomited and called staff members for help, according to a lawsuit filed by her son and daughter. Employees left her on her back, never attempted CPR and delayed calling 911 for two hours, her children contended. She died from inhaling vomit, the family's attorney said. The facility denied wrongdoing and settled the suit for \$50,000.

The state's oversight system was designed to allow regulators to monitor facilities through a combination of inspections, complaints from the public and reports from the homes. By law, the facility must notify inspectors of "any major incident which has or could threaten the health, safety or welfare of the residents or staff." But the law allows the facility to interpret what qualifies as a "major incident." Training manuals instruct that "minor incidents need not be reported."

"I'm sure a lot of mistakes are buried," said Douglas Moore, a veteran Virginia inspector.

Some complaints fall through the cracks between divisions at the Department of Social Services.

Adult Protective Services, which investigates mistreatment of the disabled and elderly, verified about 4,400 instances of abuse, neglect or exploitation since 1995. Over the same period, the division of licensing, which

regulates the facilities, had on its books fewer than 900 violations, meaning that many incidents known to the state never are investigated by those with the power to order changes.

Deaths in assisted living homes usually are not reported to state licensing officials or a medical examiner. In contrast, all deaths and injuries in mental health group homes and institutions must be reported by law. All deaths in state hospitals and training centers for the mentally retarded are forwarded for review to the medical examiner.

Fewer than 100 of more than 8,800 deaths recorded in assisted living facilities since 1990 were referred to a medical examiner for review or autopsy, according to an analysis of state records.

Asked by The Post to examine 265 deaths in adult homes -- cases chosen because the cause of death raised questions about whether it could have been prevented -- Virginia's chief medical examiner, Marcella F. Fierro, said at least 77 should have been reviewed by her office. Those cases included deaths from fractures, unspecified "exposure" and choking. Without a review, Fierro said, it is impossible to know whether the deaths were natural or the result of neglect or abuse.

Adult-home owners said they get mixed messages about exactly what to report.

"If I called them every time I had an incident, I'd never get off the phone," said Sharon Bailey, administrator of Tri City Garden Villa in Petersburg. Bailey said she did not consider it necessary to inform the state in April 2002 when a mentally disabled resident set herself on fire while trying to smoke a cigarette and suffered burns that sent her to the hospital.

State officials said they were not notified by Cary Avenue Adult Home in Gloucester in March 2003 when a 19-year-old, 278-pound resident assaulted one female aide and attempted to rape a second. The ordeal, described by prosecutors in an interview and recorded on a frantic 911 call, ended when police arrived at the wood-frame building surrounded by trees on a dead-end road. The resident was convicted of misdemeanor assault and battery.

The home's owner, Benny Stokes, said he believed it had been reported. "I just can't imagine anything happening without the state getting involved," he said.

State inspectors contend in records that the failure of Cralle Manor to immediately report allegations of a sexual assault of a mentally retarded woman in 2000 by a male resident contributed to a second alleged rape of the woman.

In 2002, state inspectors learned through police that two residents of the home, which is southwest of Richmond in Kenbridge, died under questionable circumstances. When a mentally disabled man collapsed, a worker stopped giving CPR to use the telephone, according to state documents. In the other case, workers failed to perform CPR after that resident collapsed, inspectors said.

Ann Gordon, owner of Cralle Manor, claimed that the residents were very ill, that staff workers did nothing wrong and that inspectors had distorted the facts. "I haven't had any families say they wouldn't want to be in my homes," she said.

Sometimes it takes a funeral home to find the neglect.

Roger L. Davis, 57, who suffered from schizophrenia, was a familiar sight around the Northern Neck town of Kilmarnock, where he would wander the streets draped in a big coat. He'd spent years working on tobacco farms as a young man but ended up in a state hospital, and since 1989 had lived at the Floyd Clark Adult Home.

When Davis's health deteriorated, the home failed to have him reevaluated, records show. A reevaluation would have determined whether he should stay at the home or be moved to a hospital or nursing home to receive more care for his heart disease.

Diana Ross, who helped manage the home, which is now closed, said staff did nothing wrong: "None of our residents was neglected . . . including Roger."

In the days before Davis died in March 2003, he refused to eat or take medications and became disoriented and uncooperative. The night before he died of heart disease, he complained of feeling ill. Still, the home did not seek medical help.

During a 4 a.m. bed check, Davis didn't respond. The owner said she peeked in the door but didn't investigate because his radio was on. At 6 a.m., an employee wrote in the log: "He refused to [be] aroused."

At midmorning, staff members called the funeral home to have Davis's body picked up. Morticians found Davis stiff with rigor mortis, dead much longer than the facility had reported. His nose was mashed flat, and he was crusted with grime and dirt. The funeral home staff notified the state, which had been probing health code violations and financial troubles at the facility.

"We wouldn't have done it, unless it was awful bad," said John Welch, who owns the funeral home in Warsaw. "And it was awful bad, no question about it."

*Staff researcher Bobbye Pratt contributed to this report.*

© 2004 The Washington Post Company