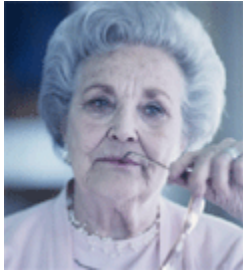


## Who Will Stop the Massacre?



By Martha Deaver\* President, Arkansas Advocates for Nursing Home Residents. [www.aanhr.org](http://www.aanhr.org)

My name is Martha Deaver. I would like to tell you about some of the abuses that occurred in 1999 to my mother, mother-in-law, and other residents in a Beverly Nursing Home, Riverview Manor, in Morrilton, AR.

In March of 2000 I had my mother and mother-in-law moved to St. Andrew's Place, a one-owner nursing facility located in Conway, Arkansas. This was an attempt to find better care for my loved ones. The Arkansas State Office of Long Term Care has investigated all of the abuses that I am going to tell you about. The background evidence, which are hundreds of documents, were obtained through the Freedom of Information (FOI) department, in order to prove this story.

My mother's name is Helen Steger. She was a Registered Nurse and the wife of an Air Force Colonel. She has four daughters. Her youngest child has Down-Syndrome. My mother cared for my sister, Mary Ann, at her home until the day of her accident. While taking Mary Ann out for a Sunday drive, my mother suffered a stroke.

For almost seven months, I took my mother to four different rehabilitation centers so she could receive therapy to try to bring her back physically and mentally. Some improvement was made. She was able to talk on the phone, to eat a normal diet, to move her arms and legs enough to be up all day in a wheel chair. I was finally told that there was no hope for any more improvement. It was a truth that I had already accepted since I was by her side every day and saw her struggles. I knew in my heart that nothing else could be done to improve her condition further. I then needed a place to help maintain her current condition.

Before my mother's stroke, my father had obtained a Long Term Care Policy in her name. The provision in the plan was that my mother must be admitted into a Long Term Care Facility. We would not be allowed to receive the coverage and care for her at home. It became clear to my family after only a few months that the facility we had chosen was not acting in my mother's best interest. I immediately obtained legal guardianship over my mother. This forced the nursing home to answer to me about her care. Due to poor staffing, I soon realized that I needed to be there with her daily. I also hired private sitters to come seven (7) days a week to be sure that someone was there if she needed anything.

My husband's mother lived in another Beverly facility in Morrilton, Arkansas. My husband and I decided it would be easier to care of them together in the same nursing home. We moved my mother-in-law to Riverview Manor, with my mother, and obtained Durable Power of Attorney to ensure decisions were made in her best interest, too.

Within three months, I was forced to start filing complaints on poor care to the Arkansas Office of Long Term Care. My repeated attempts to bring these complaints to the Administrator and Director of Nurses were being ignored by the facility and by Beverly Enterprises Corporate Office.

My mother, mother-in-law, and many other residents were not only neglected, but also abused. I have thousands of documents and taped conversations to prove the atrocities that happened against my loved ones. The abuses and neglect that occurred to my mother-in-law include, but are not limited to:

- She was found in bed with a washrag shoved in her rectum in order to stop her from having bowel movements because they were tired of changing her diaper.
- She was found with a fist-sized bruise in the middle of her chest after being abused. The pictures are shocking!
- They were cited for overdosing my mother-in-law on psychotropic drugs. These drugs are considered a chemical restraint. They require less care in the psychotropic drugged condition. This happens in many nursing homes across the country. This is done regularly to keep the nursing home from having to hire more employees.
- My mother-in-law is a diabetic, the doctor ordered her blood sugar level to be taken monthly, and the nursing home was cited for going four (4) months without following the doctor's order. This also happened to other residents.
- My mother-in-law was left up in her wheel chair for five (5) hours, unattended. This neglect caused her to have a level four (4) bed sore [a level four (4) bed sore is the worst level of bedsores “ the lesion goes all the way to the bone]. The doctor's orders stated that she should be in her wheel-chair no more than thirty(30) minutes.
- My mother-in-law was verbally abused by a worker who had been turned in repeatedly by other residents and their families in the facility for physical and verbal abuse.
- My mother-in-law was infested with head lice two times within a four month period.
- My mother-in-law received numerous unexplained cuts and bruises. My mother also suffered many abuses in this facility that include but not limited to:
  - She had a red alert strip on the front of her chart to show a drug she was seriously allergic to. She was given the drug anyway in spite of what was on her chart. The reaction put her in ICU for two weeks where she almost died.
- My mother's narcotics were found missing twelve (12) times. The facility was aware that this was attributed to one nurse.

- They were cited for failure to investigate the missing narcotics, and they were cited for failure to stop it from continuing.
- My mother was found with a baseball-sized bruise on her leg that no nursing home employees could explain.
- The nursing home was cited for failure to notify my mother's physician when she became severely ill.

The following are some of the abuses that happened to other residents: • A resident was given a shot of insulin that was meant for his roommate. This man was not even a diabetic!

- The nursing home was cited for failure to notify the residents' doctors when they became severely ill.
- A resident was given the wrong dosage of medication twenty-three (23) times in a one-month period.
- The nursing home was cited for falsifying documents pertaining to injured residents.
- An employee was turned in for hitting a man who was dying with cancer. The nursing home was cited for failure to investigate this employee about prior reports of abuse. These abuses were reported by family members and coworkers . The nursing home was also cited for failure to protect this man from abuse!
- The state investigator also stated in her report, "The facility failed to investigate and report and protect the residents seven (7) times.
- Nurses were told to ignore complaints about abuse on employees because of short staffing.
- They were cited by the state officials for failure to protect the residents from abuse, failure to report the abuse that occurred to family members or authorities, failure to protect the residents from further abuse, and failure to investigate allegations of abuse when family members and employees were reporting abuse.

The state investigator told me that through her investigation she was sure that my mother would be retaliated against for my role in the investigation. She suggested putting private sitters on the midnight shift, too. I took her suggestion. She will confirm this entire story. Beverly Enterprises spokesperson, Dan Springer, stated in an Arkansas Democrat Gazette interview that these abuses were simple things that needed to be worked on.

I realized I could no longer trust that my mother and mother-in-law would be safe in a Beverly Enterprise facility after the state investigator told me she felt like my family members would be in danger of retaliation. This forced me to have to move my loved ones. I searched [www.medicare.gov](http://www.medicare.gov) website and thought I had found a nursing home that would better care for my two family members. The website showed nothing that alarmed me.

Upon entering St. Andrews Place in Conway, in March 2000, my mother's condition had deteriorated greatly. She was totally paralyzed, only able to blink her eyes, and was completely fed through a tube in her stomach.

Within approximately two to three months, my mother began to mysteriously have one seizure after another. These were the first seizures since her stroke. No one could explain why she was suddenly having them. In August, 2000, two nurses informed me they had failed to give my mother her anti-seizure medication. I knew this probably had not been the first time her medications had been administered incorrectly. I went straight to the administrator and informed him that I would be filing a complaint with the Arkansas Office of Long Term Care. He told me that he did not consider this situation to be neither abuse nor neglect, and he put this statement in writing! I have this document.

As administrator and head of the facility, I expected him to ensure that my mother's medications were given properly and I told him this in no uncertain terms.

On August 5, 2000, I filed a complaint with the Arkansas Office of Long Term Care informing them that my mother's vital medications were not being given, and that I had the nurses on tape admitting it. My complaint was not investigated until October 2, 2000. After the state investigators finally showed up, they discovered that the nursing home had no system in place to document what medications the residents received, or if the residents of the facility had received any medication. This endangered every resident in the nursing home. The facility received a fifteen thousand dollar (\$15,000.00) fine, as the state and federal documents show. The nursing home was cited for putting its residents in the highest degree of danger that a nursing home can be guilty of by state and federal law, Immediate Widespread Jeopardy (This meant that every resident was endanger of serious harm or death).

Other citations in the October 4, 2000 state survey were, but are not limited to: • Leaving a rubber tourniquet and needle in the arm of my mother-in-law causing her hand and arm to turn black. • Being responsible for a woman receiving hundreds of ant bites while she slept. The pictures I have are shocking! • The nursing home was cited for not investigating a nurse after a family member reported her for shoving their mother down in her wheel chair. • My mother in laws leg was ripped open while she was being transferred from her wheel chair to her bed. They were cited for transferring her with two employees instead of three as her doctor had ordered. • They were cited for leaving my mother-in-law up in her wheel chair for eight (8) hours unattended causing a bed sore. • They were cited for failure to give my mother her vital anti-seizure medication. • It was also discovered that my mother's vital ant-seizure medication was being measured incorrectly when it was being given. 50mg of her Valporic Acid was being left out four times a day. This explained her multiple seizures.

The nursing home was infuriated with me. They knew I was responsible for the \$15,000.00 fine they received. They were very aware I was an advocate that knew state and federal regulations. I also had assisted other family members that were not aware of their rights on how to file complaints when their loved ones were abused in this nursing home.

When I realized that so many families were unaware of their rights, I started advertising "Free Residents Rights" in the local newspapers. The nursing home not only hated me, but they also feared me. On October 18, 2000, they became aware of who filed the complaints, and by October 23, 2000, they placed temporary restraining orders on my husband, my son, and me. They claimed that I was a danger to the residents, that I was placing the facility in danger of losing its Medicare funding, and several other bizarre allegations (Refer to restraining order).

On January 15, 2000, while under a restraining order, I was called at four (4:00am) and told, by a nurse, that my mother had a high temperature and was vomiting large amounts. The nurse had diagnosed my mother with a urinary tract infection. The doctor's order was to obtain a urine sample in the morning and do not send to the emergency room. After hearing of my mother's condition, I told the nurse to immediately go to my mother's room and re-assess her to see if her lungs were clear. The nurse assured me that her lungs were clear, but that she would check them again and call me back. Thirty minutes later, I received a phone call stating that they were immediately transferring her to the emergency room (I have tapes of both conversations with this nurse).

My mother's diagnosis in the emergency room was respiratory failure from vomit in the lungs. I was informed that she would not survive. I insisted on her being transferred to see her specialist in Little Rock, where she stayed in ICU on life support, for almost two months. The specialist said that my mother had to have lain there choking on her vomit for four to six (4-6) hours in order to develop such a fatal infection.

It took these two months to finally get a court date, but it was too late for my mother. The restraining orders were dropped when they were appealed in front of a chancery court judge. The saddest part of this miscarriage of justice is while I was waiting for the court date, my mother died in ICU from the abuse. She died on March 12, 2001. I postponed her funeral by one day to meet the court date. I wanted my mother to have her day in court!

The facilities administrator admitted to the judge that he did not have one eyewitness to any of the accusations on the restraining orders he had obtained against my son, my husband, or me. Keep in mind, the administrator signed under oath that all the accusations in the restraining order could be proven. He brought to court no proof! The Director of the Complaints Department with the Office of Long Term Care cited St. Andrew's Place for not allowing visitation with our two family members pertaining to the restraining orders. They still would not allow us to visit and got away with not allowing us to visit until it was ordered by the the judge after the death of my mother!

I have obtained thousands of documents to prove this story to be factual and true. In my research on this nursing home, I found ten more abuse surveys in a one year period that are shocking. One bazaar finding was that after being fined \$15,000.00 in October, the next month they were cited in another abuse survey for failure to do criminal background checks on 11 employees and failure to do tuberculosis tests on five employees. They have also been cited for more medication errors.

There has been no justice and because I have yet to get any criminal charges filed against either nursing home, I have been forced to file civil law suits against both nursing homes. Someone has

to hold them accountable! This massacre has to be stopped!

These are the abuses in two different nursing homes to my family members. There are thousands of abuses occurring daily all over the United States! The hundreds of news reports and the governments own studies prove this. The public has to be made aware that these abuses are going on. Maybe then, serious changes can be made in the care of our precious elderly. They deserve to live their last days out in peace and comfort! \*ABOUT THE AUTHOR Martha Deaver began her work as an advocate for the rights of nursing home residents in the late 1980's when her grandmother was a resident of an Arkansas nursing home. She joined The Arkansas Advocates for Nursing Home Residents in 1998 and became a member of the board of directors in 2001. In January of 2008 Martha was elected President of The Arkansas Advocates for Nursing Home Residents.

Martha's mother and mother-in-law where victims of nursing home abuse. Martha Deaver began her work as an advocate for the rights of nursing home residents in the late 1980's when her grandmother was a resident of an Arkansas nursing home. She joined The Arkansas Advocates for Nursing Home Residents in 1998 and became a member of the board of directors in 2001. In January of 2008 Martha was elected President of The Arkansas Advocates for Nursing Home Residents. Martha's mother and mother-in-law where victims of nursing home abuse.

In 2005 Martha Deaver was honored by NCCNHR for her long-term commitment to protect the rights of nursing home residents. She was presented with the Janet Tulloch Memorial Award in Washington, DC. Governor Mike Beebe wrote a letter of recommendation.

In June, 2006, Martha Deaver's tragic experiences with two Arkansas nursing homes was featured in "Ladies Home Journal" in a report titled, "It Broke My Heart That I Couldn't Protect My Mom." The journalist of this report, Michael J. Weiss, won a journalism award in Washington, DC from NCCNHR after the report was published.

Martha Deaver has worked with the Government Accountability Office by providing information and data to assist in the production of several GAO reports. After supplying numerous complaint surveys to the GAO, Martha was asked to be the spokes person for the announcement of complaint survey data being added to the government nursing home compare web-sight.

Martha Deaver worked for three years supplying information and data to Trudy Leiberman, the director of the Consumer Union dealing with health issues for Consumer Reports. After the three years, Martha hosted Trudy in Arkansas for one week while traveling the state to meet with nursing home owners, nursing home residents and their families, reporters, long-term care agency directors, and the Arkansas Attorney General. This culminated in one of Consumer Reports most in-depth outlooks on America's Nursing homes that was released in 2006. The article was titled, "The Crisis in America's Nursing Homes."