INVESTIGATION REPORT:

NIAGARA REHABILITATION AND NURSING CENTER
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EXECUTIVE SUMMARY

Disability Rights New York (“DRNY”) is the designated federal Protection and Advocacy System (“P&A”)\(^1\) for individuals with disabilities in New York State, as set forth in Executive Law §558(b). One of DRNY’s core functions is to investigate allegations of abuse and neglect of persons with disabilities. DRNY has authority under federal and state law to thoroughly investigate allegations of abuse or neglect occurring in any public or private entity that provides care, services, treatment or habilitation to individuals with disabilities. See 42 U.S.C. § 15043(a)(2) (B); 45 C.F.R. § 1386.27; N.Y. Exec. Law § 558(b) (ii)-(iii).\(^2\)

In November, 2016, DRNY received complaints about the poor conditions of the facility and the inferior care provided to residents at Niagara Rehabilitation and Nursing Center (“NRNC”). NRNC is a skilled nursing facility which is located in Niagara Falls, New York, and has approximately 160 beds. Pursuant to its statutory authority, DRNY commenced an investigation of allegations of abuse and neglect.\(^3\) DRNY has found that:

1. NRNC Failed to Provide a Clean and Safely Maintained Facility.
2. NRNC Neglected Residents in Need of Assistance and Physically and Verbally Abused a Resident Seeking Care.
3. NRNC Neglected Residents Requiring Medical Care.
4. NRNC Failed to Provide Adequate Meals and Did Not Meet the Nutrition Needs of Residents.
5. NRNC Failed to Provide Discharge and Transition Services to Residents Who Wanted to Live in the Community.
6. NRNC Interfered with DRNY’s Investigation.

SCOPE OF INVESTIGATION

DRNY’s investigation consisted of the following activities:

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\(^1\) DRNY is supported by the U.S. Department of Health and Human Services (HHS), Administration on Intellectual and Developmental Disabilities (AIDD), Center for Mental Health Services (CMHS), Substance Abuse & Mental Health Services Administration (SAMHSA); U.S. Department of Education (DOE), Rehabilitation Services Administration (RSA) and, the Social Security Administration (SSA) to implement the Developmental Disabilities Assistance and Bill of Rights Act of 2000. This Report and its content and conclusions are those of DRNY and does not represent the views, positions or policies of, or the endorsements by, any of these federal agencies.

\(^2\) Appendix A details DRNY’s authority under the relevant P&A statutes and regulations.

\(^3\) The definitions of abuse and neglect under the P&A system are set forth in Appendix B.
1. Interviews with complainants regarding care and treatment at NRNC.
2. Review of two Resident’s records.

REPORTED ALLEGATIONS OF ABUSE AND NEGLECT

In November 2016, DRNY received complaints from a resident (Resident A), who wanted to be discharged and who complained that NRNC was not assisting her in discharge. Resident A also complained of systemic neglect and abuse at NRNC, including the facility’s failure to serve regular or sufficient meals, and its lack of consistent nursing or aide services.

Resident A stated that her bedsheets had not been changed in months, and that staff usually only changed bedsheets when a resident soiled them. Resident A stated that she often received meals to which she was allergic and could not eat. Resident A said she was assaulted by a NRNC resident with dementia, and multiple personal belongings, including her power wheelchair, were permanently broken by other residents.

Resident A also identified a lack of appropriate medical care. She stated that a nurse practitioner had offered her anti-depressants without conducting an evaluation. She also stated that she had been waiting for an appointment with an urologist for over five months, and was living in constant pain as a result of not receiving specialist care. Resident A also complained that she was denied access to her physician despite repeated requests that an appointment be made.

Six other residents also complained of systemic neglect and abuse at NRNC. In separate interviews the six residents stated that NRNC does not assist residents who want to be discharged. The six residents complained of their own fruitless efforts to discharge from the facility and their inability to arrange for discharge independent of NRNC staff. Residents also complained of the urine stench in the halls, dirty linen in bins in hallways, loss of personal items to laundry services, and
inadequate clothes washing. Residents complained of disrespectful conduct by staff including aides kicking residents’ beds to wake them.

After its first visit on November 7, 2016, DRNY received additional complaints from a former resident and his/her family member, and two current residents. The former resident (Resident B) stated that she was forced to remain in her bed for days because staff was unwilling to transfer her to her wheelchair and were unresponsive to call bell requests for assistance. Resident B also stated that she was denied medical care related to her urostomy bag. Resident B’s family member also stated that she was forced to remain in her bed for days because staff were not assisting Resident B with transfer to her wheelchair. Resident B’s family member also stated that Resident B was denied medical care. Another resident (Resident C) stated that she was not receiving medical care from the nursing staff. A resident (Resident D) reported that NRNC refused to assist in his discharge to the community.

During investigative visits, staff interrupted DRNY’s private conversations with residents by repeatedly asking the residents if they were okay and willing to talk with DRNY. Whenever staff saw DRNY speaking with a resident, staff would approach and remain with the resident until DRNY ended the conversation.

**INVESTIGATION FINDINGS**

**Finding: NRNC Failed to Provide a Clean and Safely Maintained Facility**

NRNC failed to provide and maintain a sanitary, orderly, and comfortable residence for individuals in the facility, in violation of a nursing home resident’s “right to a safe, clean, comfortable and homelike environment” in accordance with federal law regulating long term care facilities. During DRNY’s visits to NRNC we were forced to maneuver around residents in wheelchairs who had been left in the middle or to the side of the hallways. These residents were asleep in their wheelchairs, or staring at the wall or ground without speaking or moving. The hallways were

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42 C.F.R. § 483.10(i).
blocked by housekeeping carts, by large bins for garbage or laundry, or by excess furniture and maintenance equipment. These bins prevented residents in wheelchairs from navigating the hallways. In addition, multiple carts of cleaning supplies and dirty laundry blocked the path to resident rooms. The entire residential area smelled of human waste.

DRNY also found all residential areas to have dirty floors and walls that were in disrepair or soiled. Many residents had not been provided clean sheets in several weeks.

**Finding:** NRNC Neglected Residents in Need of Assistance and Physically and Verbally Abused a Resident Seeking Care

Staff did not respond to or acknowledge residents who had requested assistance via their call lights. On multiple occasions DRNY saw staff sitting on the counters of the nursing stations talking to each other while residents in wheelchairs were lined up waiting for attention.

The Department of Health and Human Services Departmental Appeal Board requires facilities to respond to activated call bells within an appropriate time period to adequately address the need of the resident.5

At each visit, DRNY observed residents being ignored when they used the call bells for nurse or aide assistance. Resident A used her cell phone to record the sounds of other residents calling for help when their call bells were not answered, but when NRNC staff learned that she had done so, Resident A reports that NRNC staff forced her to erase the recordings.

Resident A further states she attempted to independently transfer from her wheelchair to the toilet after several hours of waiting for a nurse or aide to assist her. The grab bar in Resident A’s bathroom was broken, requiring her to crawl on the floor to transfer to and from her wheelchair when using the toilet. During one attempt to transfer, Resident A stated that she fell and cracked her tooth on the sink in the restroom.

Resident B said she was forced to remain in her bed for continuous days because the nursing staff told her that she was too difficult to move, and would not respond to her call bell requests to be moved. Resident B required two individuals to assist her with transferring with a Hoyer lift. Resident B was told by staff that they viewed this process as burdensome, so Resident B was unable to leave her bed during the day unless she was willing to remain in her wheelchair until late evening.

NRNC also violated federal regulations because it failed to provide assistance to residents who were unable to address their own basic needs. During its first visit on November 7, 2016, DRNY

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5 *Windsor Place v. U.S. Dep’t of Health & Human Servs.*, 649 F.3d 293, 299 (5th Cir. 2011).
observed nursing staff and social workers threaten to discharge Resident C if she continued to cry out for assistance. DRNY found Resident C disheveled in her soiled bed and repeatedly calling for a nurse to help her. When DRNY staff approached a nurse on duty she explained that she was aware of Resident C’s need but she did not attend to Resident C. DRNY also witnessed a staff member roughly push a resident in a wheelchair into the hallway from the rehabilitation room. The staff member then screamed at the resident that it was not her time to receive services, yelling that she should stay away from that area. DRNY filed a complaint with the New York State Department of Health (“DOH”), which conducted an investigation of NRNC based on DRNY and resident complaints. DOH concluded that NRNC failed to maintain the physical, mental and psycho-social well-being of residents. DOH also concluded that “[r]esidents [were] being left alone in their room on several occasions without the call light within reach.”

NRNC failed to provide the federal required level of care to each of the above residents.

**Finding: NRNC Neglected Residents Requiring Medical Care**

NRNC neglected a resident, who uses an urostomy bag, when she was in need of medical attention due to urine leaking from her genital area. Resident B stated that she repeatedly told staff that she was experiencing bladder leakage after her clothes and sheets were soaked through with excretions. Resident B stated nursing staff draped a rag over her lower body because the facility was out of urostomy bags, and her requests for medical care were dismissed by staff who said her bladder problems were her imagination. Resident B further said she repeatedly requested to see an outside doctor and even attempted to call emergency services for assistance, but that emergency services who responded to her 911 call were turned away by staff when they arrived at NRNC. When Resident B was eventually seen by a doctor, she states her bowels had become so impacted that surgical intervention was required.

NRNC also neglected a resident with pressure ulcers. Resident A repeatedly told nursing staff that she had pressure ulcers, but she received no treatment for the wounds. Resident A, due to her disabilities, was unable to determine how serious the pressure ulcers were by herself. NRNC violated federal regulations by failing to ensure that Resident A received the necessary care to prevent pressure ulcers, and when the pressure ulcer occurred failed to provide treatment to promote healing, prevent infection, and prevent new ulcers from forming. In January 2017, Resident A stated she was hospitalized for a surgical procedure not related to her pressure ulcers, and the hospital staff finally discovered the pressure ulcer she complained about to NRNC.

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6 Untreated pressure ulcers result in open skin wounds that may require surgery or can lead to death.

7 42 C.F.R. § 483.25(b)(i)-(b)(ii).
Resident A reported she then received several days of wound care in order to address the pressure ulcer that NRNC had denied existed.

**Finding: NRNC Failed to Provide Adequate Meals and Did Not Meet the Nutrition Needs of Residents**

On multiple occasions NRNC did not comply with federal regulations that require facilities to provide a well-balanced diet that meets a resident’s needs as well as considers their preferences. Residents are repeatedly given meals that do not meet their dietary needs, including meals that contain known resident allergens. DRNY also found that some residents consistently do not receive meals. Residents who do not receive meals when they are scheduled to are forced to either go to the kitchen to request a meal, or choose not to eat. Further, Resident A received meals containing seafood, to which she is allergic. Even after residents reported issues concerning meal services to the nutrition staff, they still failed to provide consistent and appropriate meals.

**Finding: NRNC Failed to Provide Discharge and Transition Services to Residents Who Wanted to Live in the Community**

NRNC prevented residents who wanted to return to the community from being discharged. On November 15, 2016, DRNY met with the Director of Social Work to discuss Resident A’s transition to the community. Resident A told staff almost every day that she wished to leave. Resident A was provided no discharge planning assistance until DRNY started this investigation. In violation of federal law, NRNC failed to develop and implement an effective discharge planning process that focused on the discharge goals of Resident A, as well as preparing Resident A for an effective transition to the community. NRNC staff stated that the facility was waiting for Resident A’s application for Social Security Disability benefits to be processed before assisting her in transitioning to the community. When DRNY inquired about applications for an Olmstead Housing Subsidy or the Nursing Home Transition and Diversion Medicaid waiver program, one NRNC social services staff member was entirely unfamiliar with the terms, and another staff member indicated that it had slipped her mind to pursue them. NRNC staff admitted that Resident A’s discharge planning was overlooked until DRNY’s investigation.

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8 42 C.F.R. § 483.60.

9 42 C.F.R. § 483.21.

10 The Olmstead Housing Subsidy (“OHS”) program is a program which provides rental subsidy and transitional housing support services for high-need Medicaid beneficiaries including those transitioning from nursing home settings or to prevent nursing home placement.

11 The Nursing Home Transition and Diversion (“NHTD”) Medicaid waiver program provides supports and services to assist individuals with disabilities and seniors, including those living in nursing facilities, toward living in the community.
NRNC also violated federal regulations when it obstructed Resident D’s attempts to be discharged into the community. Resident D stated that NRNC did not contact the Niagara County Independent Living Center or his private insurance provider. These contacts were necessary to assist Resident D with discharge planning.

**FINDING: NRNC INTERFERED WITH DRNY’S INVESTIGATION OF ABUSE & NEGLECT**

On November 15, 2016, DRNY was prevented from speaking with any residents of the facility, aside from Resident A, DRNY’s client.

On November 30, 2016, NRNC refused to allow any questioning of staff concerning the facility, policies, care planning, and programming, even after NRNC was provided with DRNY’s legal authority to do so.\(^{12}\) NRNC also prevented DRNY from distributing rights and services brochures to residents.\(^{13}\)

NRNC purposefully prevented residents from speaking to DRNY by ushering them away.\(^{14}\) DRNY could only speak with residents in the hallway or lobby despite the clear statutory authority to unaccompanied and private communications. NRNC did not allow DRNY to take any photographs even though DRNY is entitled to photograph all facility areas used by or accessible to individuals with disabilities.\(^{15}\) Consequently, the photographs included in this report were provided to DRNY by residents.

**SUMMARY OF FINDINGS**

DRNY finds that the care provided to residents by NRNC staff is alarmingly inadequate, and the facility is unsanitary. Residents are provided no meaningful assistance in discharging from the facility. Residents are generally unaware of their rights because NRNC staff actively prevent dissemination of educational materials, and are themselves uneducated about transition planning and resident rights. NRNC fails to educate its residents about their rights and options or offer even minimal transition and discharge planning. Consequently, many residents needlessly remain in the facility until the end of their lives.

NRNC provides substandard care to its residents, all of whom are individuals with disabilities. The substandard care also results in many of residents, who may be capable of living in a more

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\(^{12}\) 42 C.F.R. § 51.42(a); 45 C.F.R. § 1326.27(a); 42 C.F.R. § 51.42(b).


\(^{15}\) 42 C.F.R. § 51.42(c)(3); 45 C.F.R. § 1386.22(f); Equip for Equality, Inc., 329 F.Supp.2d at 1101.
independent environment, remaining institutionalized. Residents are not provided adequate daily living assistance or medical care by staff. Residents are verbally admonished when they attempt to self-assist and are prevented from seeking medical care outside the facility.

**CORRECTIVE ACTION**

NRNC must take immediate steps to address deficiencies in care and services for residents and address DRNY’s findings of abuse and neglect:

- The facility must be cleaned immediately and on a regularly scheduled ongoing basis. Each resident room must be inspected for any safety issues. Any broken furniture or dirty linens must be replaced. All assistive devices must be in working condition.

- NRNC must instruct staff to respond to call bells. NRNC should hire additional staff if the current staff are unable to respond to call bells to meet the care needs of its residents.

- NRNC must amend its resident medical care policy to adequately address medical complaints and concerns. The resident medical care policy must identify a contact person, for residents to report to if they believe a medical concern is not being adequately addressed. The policy must also include access to a physician specialist consultant to address resident-raised medical complaints and concerns.

- NRNC must develop or immediately review policies for the prevention, discovery, and treatment of pressure ulcers to meet federal standards of care.

- NRNC must amend its resident nutrition services policies and practices to ensure appropriate meal provisions for residents. The policy must include the documentation and action steps required when a resident reports they have received an unacceptable meal or no meal at all. NRNC should hire additional staff if the current staff are unable to meet the nutrition needs of its residents.

- NRNC must train staff on community resources, grant and waiver programs available to assist residents to live in more independent environments. NRNC must also provide sufficient resources and access to information so that staff may facilitate community transitions.

- All NRNC staff must be informed of their obligation to comply with DRNY’s federal mandate to monitor NRNC and investigate complaints of abuse and neglect.
APPENDIX A

DRNY’S AUTHORITY TO INVESTIGATE ALLEGATIONS OF ABUSE AND NEGLECT IN NURSING FACILITIES

Protection and Advocacy Systems ("P&A Systems") have the authority to pursue legal, administrative and other appropriate remedies to protect and advocate for individuals with disabilities. This authority includes the investigation of allegations of abuse or neglect when allegations of such incidents are reported to the P&A System, or there is probable cause to believe abuse or neglect has occurred.

In 1975, Congress enacted the Developmental Disabilities Assistance and Bill of Rights Act [DD Act] because of the concerns it had regarding instances of abuse of developmentally disabled persons. The DD Act established the P&A System “to protect the legal and human rights of individuals with developmental disabilities.” To accomplish this goal, Congress granted broad authority to “investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.”

In 1986 Congress enacted the Protection and Advocacy for Individuals with Mental Illness Act. Congress found that “[s]tate systems for monitoring compliance with respect to the rights of individuals with mental illness vary widely and are frequently inadequate.” Accordingly, Congress granted P&A Systems the same powers found under the DD Act: the power to “investigate incidents of abuse and neglect of persons with mental illness if the incidents are reported to the system or if there is probable cause to believe that incidents occurred.”

In order to conduct investigations, both the DD Act and the PAIMI Act provide a P&A System with broad authority including access to facilities at times when service recipients are present.

Moreover,

A P&A system shall have reasonable unaccompanied access to public and private service providers, programs in the State, and to all areas of the service provider’s premises that are used by individuals with developmental disabilities or are accessible to them. Such access shall be provided without advance notice and made available immediately upon

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request. This authority shall include the opportunity to interview any individual with development disability, staff, or other persons, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation. The P&A may not be required to provide the name or other identifying information regarding the individual with developmental disability or staff with whom it plans to meet; neither may the P&A be required to justify or explain its interaction with such persons.  

Finally, the Protection and Advocacy of Individual Rights Act [PAIR Act] provides services to individuals with disabilities that neither have developmental disabilities as defined by the DD Act nor are mentally ill as defined by PAIMI Act. 29 U.S.C. § 794e (a)(l)(B). P&A Systems providing services under PAIR enjoy the same general authorities as those set forth in the DD Act, and are similarly able to investigate incidents of abuse and neglect of individuals with disabilities if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.

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24 45 C.F.R. § 1386.27(b)(2).  
APPENDIX B

DEFINITIONS OF ABUSE AND NEGLECT UNDER FEDERAL LAW

Abuse and Neglect Under the P&A Acts

PADD Act regulations define abuse as

any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes but is not limited to such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations, or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue. In addition, the P&A may determine, in its discretion that a violation of an individual's legal rights amounts to abuse, such as if an individual is subject to significant financial exploitation.26

The regulations define neglect as

a negligent act or omission by an individual responsible for providing services, supports or other assistance which caused or may have caused injury or death to an individual with a developmental disability(ies) or which placed an individual with developmental disability(ies) at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; or provide a safe environment which also includes failure to maintain adequate numbers of trained staff or failure to take appropriate steps to prevent self–abuse, harassment, or assault by a peer.

Similarly, the PAIMI Act defines abuse as

any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as—

(A) the rape or sexual assault of an individual with mental illness;
(B) the striking of an individual with mental illness;
(C) the use of excessive force when placing an individual with mental illness in bodily restraints; and
(D) the use of bodily or chemical restraints on a individual with mental illness

The Act defines neglect as

a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

Under the PAIR Act, PADD regulations are cross-applicable

Abuse and Neglect under Medicaid Laws

Medicaid regulations on patient care define abuse as

the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Similarly, neglect is defined as “the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.”

Residents are also entitled to the protections of 42 C.F.R. § 483.10, which concerns the standards for quality of care at skilled nursing facilities. 42 C.F.R. § 483.10 does not define failure to meet these standards as neglect.

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27 42 U.S.C. § 10802(1).
28 42 U.S.C. § 10802(5).
29 42 C.F.R. § 488.301.
30 Id.