LONG TERM CARE
COMMUNITY COALITION

Advancing Quality, Dignity & Justice

Issue Brief

Animal Care Standards vs. Nursing Home Resident Experiences: Freedom from Restraints

The quality and safety of nursing homes are longstanding public concerns. Numerous studies over the years have identified widespread and significant deficiencies in care, including serious abuse and neglect. It is such cases of degrading and inhumane conditions that led us to question the extent to which the experiences of residents in nursing homes actually fall below the standards and expectations for treatment of animals in zoos and other settings.

This is one issue in a series of briefs that provide the results of our assessment of the extent to which conditions in nursing homes fail to meet the standards of care for animals. Each brief focuses on an issue which we have identified as important. These briefs, and the full report on our assessment, are available at https://nursinghome411.org/ltccc-report-animal-care-vs-nursing-home-care.

The point of this work is not to trivialize the experiences of either nursing home residents or animals but, rather, to illustrate how systemic failures to hold nursing homes accountable for abuse and neglect too often subject residents to conditions that not only fall below the federal nursing home standards of care, but also below accepted standards for the humane treatment of animals.

EXAMPLE OF ANIMAL CARE STANDARD VS. NURSING HOME RESIDENT EXPERIENCE

Nonhuman primates must not be maintained in restraint devices unless required for health reasons as determined by the attending veterinarian or by a research proposal approved by the Committee at research facilities. Maintenance under such restraint must be for the shortest period possible.
-*Animal Welfare Act, USDA*

A resident's death at a non-profit Massachusetts facility serves as a cautionary tale for the dangers of bed rails. Staff at the facility recalled that the resident's head was twisted sideways and stuck between the bottom of the bed rail and the bedframe.
-*Statement of Deficiencies, CMS*

STANDARDS FOR NURSING HOME CARE

Under federal requirements, every resident in a certified nursing home has the "right to be treated with respect and dignity, including. . .[t]he right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." LTCCC's **Learning Center** has fact sheets and other resources with information and tips on reducing the use of both physical and chemical restraints.

RELEVANT NURSING HOME STATISTICS

- **Bed rails.** The use of bed rails is linked with heightened risk of preventable harm and death for nursing home residents. Residents may harm themselves when attempting to climb over, under, through, or around bed rails. Without a proper assessment, bed rails may place residents in immediate risk of serious injury or death.
- **Deaths from restraints.** About 550 bed rail-related deaths occurred from 1995 through 2012, according to a *New York Times* review of FDA data, lawsuits, state nursing home inspection reports, and interviews.
- **Inappropriate drugging**. Approximately 20 percent of nursing home residents are administered powerful and dangerous antipsychotic drugs, despite a US FDA "black-box" warning not to use these drugs on elderly individuals with dementia.
- **Chemical restraints.** A Human Rights Watch report, *They Want Docile*, states that in a typical week, "nursing facilities in the United States administer antipsychotic drugs to over 179,000 people who do not have diagnoses for which the drugs are approved." As detailed in the report, many of these residents have Alzheimer's disease or another form of dementia and are administered antipsychotic drugs as a form of chemical restraint, in place of appropriate care and services.

NEWS AND REPORTS

Death by bed rail

The Statement of Deficiencies (SoD) for Julian J. Levitt Family Nursing Home (MA) identified two residents who were entrapped in their bed rails. Care staff reported that, for one resident, the resident's body appeared "to be outside the bed with his/her head on the bed with the bottom of the side rail across his/her neck and [the resident] just hanging there, looked terrified. . . ." In respect to the second resident, staff told surveyors that the resident's head was twisted sideways and stuck between the bottom of the bed rail and the bedframe. His/her "face was observed to be swollen and his/her lips were cyanotic (a bluish discoloration of the skin due to low levels of oxygen in the blood). . . ." The resident "was determined to be deceased."

The website of **the nursing home states: "You can take comfort in knowing that your loved one is in good hands**. . . ." [Emphasis added.]

Why are nursing homes drugging dementia patients without their consent?

A 2018 *Washington Post* op-ed discussed how "[t]he use of antipsychotic drugs as chemical restraints — for staff convenience or to "discipline" a resident — has a long history in nursing homes."