Resident-to-resident incidents are a hidden source of harm in nursing homes. They shouldn't be

Dwayne E. Walls was a Korean War Veteran and an investigative reporter at the Charlotte Observer. Throughout his distinguished career, he wrote stories on social justice issues from the inner circles of the Ku Klux Klan and the homes of poor Black farmers; about voter fraud and the dysfunctions of the coroner system. His best stories were about vulnerable populations. Little did he know he would one day become part of one.

Walls developed Alzheimer's disease. When he declined and his wife, Judy Hand, could no longer care for him at home, she moved him to a nursing home in South Carolina.

One evening, Walls walked into another resident's bedroom and climbed into the empty bed. Moments later, the resident who lived in the room, an 88-year-old man with dementia, beat Walls with his cane. Walls was found severely injured, bleeding, and unconscious in a fetal position on the floor. He died a week later.

The phenomenon of resident-to-resident incidents in nursing homes is more common than most people think. A large Cornell University study found that one in five nursing home residents had been involved in such incidents in a single month. These incidents can be injurious, and even deadly.

Yet due to a series of factors — insufficient research and barriers to conducting it, residents' advanced dementia limiting their ability to recall and report incidents, and nursing homes' reluctance to participate in studies due to fear of adverse publicity — no one really knows just how often these incidents occur.

Resident-to-resident incidents are defined as "negative, aggressive, and intrusive verbal, physical, material, and sexual interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm in the recipient."

These incidents often occur when nursing home residents with dementia invade the personal space of other residents. It may be something like walking into their bedrooms or bathrooms, or taking food or other belongings from them. Conflicts between roommates is another common scenario.

The unmet needs of residents underlie the majority of these episodes. In the context of residents with dementia, this is typically a story of neglect. Low staffing levels, lack of staff training, inadequate supervision, and poor risk assessment and care planning are common factors that contribute to resident-to-resident incidents.

I have focused on addressing this phenomenon in various ways for more than a decade: conducting the first U.S. study on fatal resident-to-resident incidents, training staff members, presenting in conferences, publishing journal articles and an editorial, and it has even gotten me involved in documentary filmmaking and book writing.

One important issue I've focused on over the years — and continue to focus on because it has not yet been fixed — is the dearth of reporting on resident-to-resident incidents. The Minimum Data Set (MDS) 3.0, the largest federally mandated clinical dataset used by nursing homes to conduct comprehensive clinical assessment and care planning for individual residents, does not report these incidents. The Centers for Medicare and Medicaid Services (CMS), the federal agency overseeing approximately U.S. 15,000 nursing homes, also fails to track the phenomenon in its state survey deficiency citation (F-Tag) system.

In 2019, the federal Government Accountability Office published "Nursing Homes: Improved Oversight is Needed to Better Protect Residents from Abuse." One of its priority recommendations was for CMS to require that "abuse and perpetrator type be submitted by the state survey agencies in CMS's databases for deficiency, complaint, and facility-reported incident data, and that CMS systematically assess trends in these data." The Department of Health and Human Services (HHS) concurred with this recommendation. Yet more than two years later, CMS — which is an agency within HHS — has yet to implement it.

Tracking abuse "perpetrator type" at the national level is of utmost importance. Nursing home residents and their families, care advocates, researchers, and policy makers need to know if harmful incidents are due to staff-to-resident abuse or resident-to-resident episodes. These are two fundamentally different sources of harm with unique causes and contributing factors.

Each year, state agencies complete thousands of standard inspections and investigate complaints in which deficiency citations (F-Tags) are issued for violations. Currently, citations issued for staff-to-resident abuse and resident-to-resident incidents tend to be aggregated under the same F-Tag (F600 "Abuse"), and there's limited ability to readily distinguish between the two sources of harm. The lack of unique F-Tags to

distinguish between staff-to-resident abuse and resident-to-resident incidents represents a major missed opportunity for learning and prevention.

By instituting a mechanism for tracking each of these two sources of harm, CMS could maintain a centralized dataset of standard inspection and complaint investigation reports for each separately. This, in turn, would allow CMS to compile these invaluable reports and make them more readily accessible to the public, researchers, and care advocates such as on CMS's Care Compare website and through Freedom of Information Act requests.

When a common and harmful phenomenon such as resident-to-resident incidents is not being tracked, it remains hidden for all practical purposes. And by remaining hidden, it poses a threat to vulnerable and frail elders across the country and their loved ones who believe nursing homes are safe havens.

In May 2021, 83-year-old Lloyd Godfrey, who was living in a nursing home in the Bronx, died after an 87-year-old man beat him. Both were reported to have dementia. The two men were arguing shortly before the attack after the resident went into Godfrey's room. He then repeatedly smashed Godfrey's head on the concrete floor.

Tragedies such as this have happened before in New York and elsewhere but, as in the case of Dwayne E. Walls in 2008, unless they are reported by the media, they are invisible.

I am inclined to think that government agencies would not continue to remain indifferent if these traumatic but preventable injuries and devastating deaths occurred in childcare settings.

We all expect to remain safe in our homes. Elders living in nursing homes should expect the same.

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