Elder Mistreatment in Long-Term Care

This research brief synthesizes the latest available information and research relating to the mistreatment of residents in long-term care, with a focus on nursing homes. Nursing homes have been associated with deficient care, an ill-prepared and understaffed workforce, substandard infection protocols, and inadequate facility and regulatory oversight which have resulted in substandard care and resident mistreatment. The vast majority of residents experience multiple chronic medical conditions, cognitive impairment, and/or physical frailties. These vulnerabilities and related dependence on others for care expose residents to a heightened risk of harm. With institutionalized residents largely isolated, abuse and neglect have remained mostly hidden and under-detected. Recently, COVID-19 has exposed harms often prevalent in facilities and may serve as a catalyst for collective and comprehensive improvements in the quality of care, safety, and well-being of residents.

**Key Takeaways**

- The voices of residents and family members are integral to fostering person-centered, culturally sensitive, and high-quality care within facilities
- Physical and psychological mistreatment are the most common forms of elder mistreatment reported in nursing homes
- Greater facility oversight, management, and transparency is needed, including an investment in the direct care workforce, to ensure high-quality resident care and prevent mistreatment
- Robust research is necessary to identify evidence-based, best practice approaches to quality care delivery within nursing homes
- Future efforts to improve care and mitigate abuse require committed and concerted efforts among residents, families, and providers in partnership with federal, state, and local regulatory agencies

**Demographics**

More than **1.4 million** individuals live in over 15,500 Medicare and Medicaid-certified nursing homes in the U.S.¹ Nursing homes provide round-the-clock skilled nursing care for those with acute medical needs.²

- Almost **85%** are aged 65 and older
- About **6.4%** are aged 85 and older
- The majority are women (**63.3%**)³

49.1% are diagnosed with Alzheimer’s disease and related dementias, conditions that are most prevalent in nursing home residents compared to other long-term care settings such as assisted living facilities.⁴

With growing numbers of the aging population living with chronic infirmities, it is projected that approximately **70%** of older people will require institutional care.⁵

While facilities are home to many older adults, they are also a workplace to over **1.2 million** employees⁶ whose job-related duties, responsibilities, and performances inextricably intersect with the lives and well-being of residents reliant upon their daily care and competence.
Nursing home reforms contained in the Omnibus Budget Reconciliation Act of 1987 (The Nursing Home Reform Act) affirmed the right of facility residents to high quality care, “free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.” Federal regulations implementing the Act defined Abuse as “willful infliction of injury, unreasonable confinements, intimidation, or punishment with resulting physical harm, pain, or mental anguish,” and Neglect as the “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” Despite congressional efforts to remediate deficits and allay mistreatment since the Act’s enactment, significant shortfalls in quality care remain and deficiencies have resulted in consequential harm to residents.

**Prevalence of Mistreatment**

There is scant research on the prevalence of elder abuse and neglect in nursing homes, though anecdotal data suggests that abuse may be widespread. The few studies conducted to date have provided varying estimates of prevalence. According to a recent systematic review and meta-analysis, based on self-reported data from older residents, there is insufficient evidence to calculate the overall prevalence of abuse. As addressed below, abuse may be perpetrated by a range of people, including staff, family, visitors, or other residents. It appears from staff self-reports that 2 in 3 caregivers committed abuse in the prior year.

NOTE: Self-reported estimates of elder abuse in facilities should be interpreted with caution as they may provide only a partial understanding of the problem and do not reflect the overall prevalence of abuse.

The Centers for Medicare & Medicaid Services oversees and assures regulatory compliance in nursing homes. From 2013 to 2017, the number of CMS deficiency citations for serious mistreatment more than doubled, even though the total number of citations decreased.

According to the National Ombudsman Reporting System (NORS), which documents resident complaints as reported to ombudsmen, reports of abuse, gross neglect, and exploitation represented 10.5%, 10.7%, and 12.5% of total resident complaints for the years 2018 to 2020, respectively. The most frequently reported form of mistreatment during that period was physical abuse.

**Total number of annual NORS complaints and percentages attributable to abuse, neglect, and exploitation, 2018-2020:**

- 2018: 10.5% out of 194,516 total complaints
- 2019: 10.7% out of 198,502 total complaints
- 2020: 12.5% out of 153,324 total complaints

It is widely believed that prevalence estimates understate the actual occurrence of mistreatment. For every offense reported, five more remain undisclosed and undetected by authorities. Reporting systems do not capture unreported occurrences by residents too embarrassed to disclose harm, worried about retaliation, fearful they will be disbelieved, or afflicted with neurocognitive deficits and unable to report the abuse. Nor do they track less discernible, more insidious forms of maltreatment such as seclusion, over-medication, and under-treatment.
Forms of Abuse

Limited robust data is available to estimate the most commonly occurring types of abuse in nursing homes. A recent systematic review and meta-analysis of the literature found that older residents cited psychological and physical abuse as the most frequently experienced types of abuse in facilities, followed by financial abuse, neglect, and sexual abuse.\(^\text{18}\)

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Psychological abuse</td>
<td>33.4%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>14.1%</td>
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<tr>
<td>Financial abuse</td>
<td>13.8%</td>
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<tr>
<td>Neglect</td>
<td>11.6%</td>
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<tr>
<td>Sexual abuse</td>
<td>1.9%</td>
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From 2016 through 2017, CMS surveyors reported that mental/verbal abuse and physical abuse were the most frequently cited deficiencies in nursing homes.\(^\text{20}\)

Specific types of physical abuse that occur within facilities include physical or chemical restraints, forced feeding, hitting or beating.\(^\text{21}\) Abuse may manifest as the intentional provision of poor care or failure to provide necessary care. It may also include depriving residents of their dignity, liberty, and free choice, such as confining a resident to their room against their will.\(^\text{22}\) Neglect is often reflected in the failure to provide for resident care needs.\(^\text{23}\)

Offenders

Perpetrators typically include staffers and fellow residents.\(^\text{25}\) Abuse can occur in staff-resident, resident-resident, and resident-staff dyads. Resident-to-resident aggression (RRA) and resident-staff abuse, where the resident is the aggressor, most often occur when the residents are cognitively impaired.\(^\text{26}\) A recent study of RRA in Norway found that nearly 90% of staff reported observing at least one incident of RRA in the prior year, most commonly verbal aggression followed by physical aggression.\(^\text{27}\) Often, resident behavioral outbursts associated with dementia are predictors of retaliatory physical harm by staff.\(^\text{28}\)
Although abusive acts may be directly committed by staff or residents, the responsibility is shared by facility owners and operators. Nursing homes are required to provide a safe environment for residents, who have a right to live free from abuse, neglect, and exploitation.29 Yet, research suggests that for-profit nursing homes, in particular, are associated with poor quality of care and lower staffing levels, factors which are predictive of abuse. In addition, owner/operators’ failure to properly train staff to care for residents, especially those with dementia and mental health needs, is linked to an increased risk of mistreatment.

Nursing homes must screen staff for prior convictions of abuse, develop policies and protocols to prevent mistreatment, and assure adequate staffing and training to ensure the safety and well-being of residents.30 Beyond these essential steps, greater transparency and accountability regarding nursing home finances, operations, and corporate structure are necessary to enhance quality assurance and resident care.

### Risk Factors for Mistreatment

Factors correlated with an increased likelihood of resident mistreatment are many, varied, and embrace individual, relational, and institutional characteristics.31

<table>
<thead>
<tr>
<th>Resident-related Risk Factors32,33</th>
<th>Staff-related Risk Factors34</th>
<th>Institutional Risk Factors35,36,37</th>
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<tbody>
<tr>
<td>Female</td>
<td>Burden and exhaustion</td>
<td>Stressful or poor work environment</td>
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<tr>
<td>Cognitive impairment</td>
<td>Caregiving-related stress</td>
<td>Insufficient staff to meet residents’ needs</td>
</tr>
<tr>
<td>Physical disability</td>
<td>Job dissatisfaction</td>
<td>Dearth of appropriate policies and procedures</td>
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<tr>
<td>Chronic disease</td>
<td>Poor mental health/psychological stress</td>
<td>Lack of managerial support</td>
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<tr>
<td>Social isolation</td>
<td>Negative attitude towards people with dementia</td>
<td>Lack of administrative awareness and understanding of elder abuse</td>
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<tr>
<td>Increased dependency</td>
<td>Adverse childhood experience</td>
<td>Challenging behaviors/resident aggression</td>
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<tr>
<td>Functional deficits</td>
<td>Care-related conflicts</td>
<td>Limited activities of daily living</td>
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<tr>
<td>Challenging behaviors/resident aggression</td>
<td>Ageist attitudes</td>
<td></td>
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<tr>
<td>Limited activities of daily living</td>
<td>Lack of training and supportive resources</td>
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### The Role of Ownership and Financing

The majority of nursing homes in the U.S. are for-profit (approximately 69%), followed by non-profit (approximately 25%), and government owned (approximately 7%). Private equity firms own nearly 11% of the for-profit facilities.38 Privately owned facilities, on average, provide lower quality of care when compared to not for profit ownership, due to strategies for maximizing profits, including inadequate staffing.39 Low quality of care may not on its own constitute a civil offense or criminal elder abuse, but it may increase the risk of abuse occurrence.40,41,42 A critical challenge in remediating abuse in for-profit homes is that punitive fines for deficiency citations may be considered a “cost of doing business” by larger corporations.43

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Quality of care...

Lower in for-profit facilities

Higher in non-profit facilities
THE CENTERS FOR MEDICARE AND MEDICAID

CMS conducts both re-certification inspections and complaint-based investigations in nursing homes that receive Medicare or Medicaid reimbursement for services. Re-certification inspections, or “standard surveys,” of facilities are required every 9 to 15 months following initial certification to assure compliance with federal standards and monitor resident safety and care.\(^44\) Noncompliance results in the issuance of deficiency citations, based on in-person surveyor observations, which reflect the scope and severity of the violation. There are six deficiency citations related to mistreatment.

Unlike standard surveys, complaint investigations are initiated largely by residents and family members and are more likely conducted close in time to the alleged misconduct. Both standard surveys and complaint investigations are implemented by state survey agencies (SSA),\(^45\) which in most states are the entities designated as investigators of abuse in nursing homes. In some states, APS also responds to abuse in nursing homes. Pursuant to federal regulations, SSA are required to report, investigate, and notify law enforcement, and in certain cases CMS, of elder abuse in nursing homes.\(^46\)

LONG-TERM CARE OMBUDSMAN

Long-term Care Ombudsmen are resident advocates, charged with protecting the health, well-being, and rights of residents in care facilities. Launched in 1972, the Ombudsman program was authorized by the Older Americans Act,\(^47\) and is administered by every state, the District of Columbia, Puerto Rico and Guam.\(^48\) Ombudsmen investigate allegations of abuse at the behest or on behalf of residents. Service provision is confidential, consent-based, and rooted in the preservation of residents’ rights and autonomy.\(^49\) Studies have found that the presence of ombudsmen at facilities is associated with increased reports of mistreatment and better quality of resident care.\(^50\)

FACILITY REPORTS

All Medicare and/or Medicaid-certified nursing facilities are required to report allegations of abuse or neglect to SSA to ensure resident safety. If APS addresses nursing home abuse cases in a particular state, facilities must also report to APS. If there is suspicion that a crime has occurred, the facility must report the incident to law enforcement.\(^51\)

Ageism in Nursing Homes

Ageism is a significant concern in facilities that potentially impacts residents’ care, treatment, and health outcomes. The World Health Organization defines ageism as “[t]he stereotyping, prejudice, and discrimination against people on the basis of their age.”\(^52\) In facilities, age-bias may be observed in individual, relational, and institutional domains.\(^53\) Stereotypes may be evident in routine staff-resident interactions such as treating older adults as invisible or infantilizing them, which can deprive them of dignity, respect, and agency, potentially leading to neglect.\(^54\)

One study found that staff who perceived residents as children were more likely to perpetrate abuse.\(^55\) Another study found that staff with poor attitudes towards residents with dementia were more likely to commit abuse.\(^56\) Age-prejudice may also be associated with denied or deferred care or inaccurate diagnoses, potentially resulting in consequential harm and mistreatment. At the institutional level, facility protocols and practices that implicitly or explicitly diminish the personhood of residents may contribute to a culture that enables elder abuse and neglect.\(^57\)
**Disparities within Nursing Homes**

Adversity within facilities has been disproportionally borne by African American and other minority and marginalized residents. Diverse residents live in poorer quality nursing homes, are given access to fewer resources, and have been exposed to greater harms.58 This was evident early in the pandemic, as facilities with greater concentrations of African American and other minority residents were significantly more likely to have COVID cases59 and experience COVID-related deaths.60

Other marginalized communities have experienced similar health inequities. FACILITIES HOUSING MORE RESIDENTS WITH MENTAL HEALTH ISSUES WERE LIKELIER TO HAVE LOWER STAR RATINGS AND FEWER DIRECT CARE STAFF.61 LGBT residents have reported feeling the need to conceal their sexual orientation to avoid rejection, ostracization, and neglect.62 Transgender elders face mis-gendering, disrespectful treatment, isolation, neglect, and bias from staff and fellow residents.63 There is a critical need to ensure equitable access to high-quality, person-centered, and culturally sensitive care and resources, especially for communities long oppressed and mistreated.

**Direct Care Workforce**

Over 1.2 million health care and support workers perform a range of interdisciplinary tasks in nursing homes, including medical, nursing, social work, infection control, therapeutic, and recreational services.64 Among them, approximately 527,000 direct care staff provide primary and proximal care to residents.65 Most are women, racially diverse, and full-time employees. The direct care workforce is largely under-trained, overburdened, unsupported, low paid, and generally ill-equipped to manage the complex and increasing social and care needs of residents.66

Facilities are also often understaffed, a chronic problem which can lead to higher mortality rates, decreased physical functioning, increased antibiotic use, more pressure ulcers, catheterization, urinary tract infections, higher hospitalization rates, weight loss, and dehydration.67

Missed care has been found to be a predictor of poor care quality, increased adverse events, and decreased patient satisfaction.68 A study of registered nurses (RNs) (N = 687) employed across 540 nursing homes found that 1 in 5 RNs reported frequently being unable to complete necessary patient care. RNs with burnout were 5 times more likely to miss needed care than those without burnout.69 Certified nursing assistants in a Florida study described high levels of moral distress as they found themselves having to re-prioritize care and use “workaround” strategies to overcome a lack of resources, staffing, and time.70
These deficits are associated with poor quality resident care and a heightened risk of elder mistreatment. To mitigate injurious outcomes, advocates have recommended a number of measures, such as imposition of higher minimum staffing requirements, enhanced workforce education and training, and increased facility and regulatory oversight. The presence of full-time social workers, registered nurses, and infection control specialists may also ameliorate conditions. Additional suggestions to improve the retention and recruitment of qualified staff include competitive compensation and opportunities for career advancement.

**Impact**

The full scope of harms experienced by nursing home residents is unknown. Most residents experience cognitive deficits, behavioral challenges, and/or physical frailties which can impede their ability to report abuse. The fear of retaliation by care staff upon whom residents depend for essential needs further inhibits disclosure. Social isolation may also factor into under-reporting of abuse and neglect. Notwithstanding barriers to disclosure, all forms of mistreatment are observed in facilities, and increased morbidity and mortality are not uncommon.

Physical abuse may manifest as untreated pressure ulcers, physical or chemical restraints, bruises, and fractures. Psychological abuse in facilities includes intimidation and isolation. Malnutrition, dehydration, poor hygiene, and infection are common forms of neglect. Both sexual abuse and financial abuse or theft of resident possessions have been reported in facilities. Suboptimal environmental conditions, such as under-staffing, are also associated with mistreatment.

**Interventions**

Improving care conditions and eradicating abuse and neglect in nursing homes requires a concerted, comprehensive, and consistent commitment by all invested stakeholders including lawmakers, regulators, owners/operators, employees, residents, and family members. Below are promising efforts and novel recommendations for preventing elder mistreatment in facilities.

- The Center for Advocacy for the Rights and Interests of the Elderly (CARIE) created a five-module curriculum called “Competence with Compassion” and an accompanying film that depicts an abuse scenario from the different perspectives of the staff involved, the resident, and family members. The film highlights the complex, multilayered problems that influence every aspect of caregiving.

- Given the link between caregiver job stress, emotional dissonance, and abuse occurrence, one study suggested an approach rooted in the Job-Demands-Resources model to mitigate mistreatment. Researchers found that caregiver education combined with organizational support and quality relationships with fellow staffers and supervisors could potentially buffer causal workplace agitators associated with abuse and neglect.

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**THE IMPACT OF COVID-19**

Nearly one quarter of all COVID-19 deaths in the U.S. occurred among nursing home residents and staff. The pandemic exposed and exacerbated pervasive shortfalls in facilities such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and deficiencies, resulting in over 154,000 deaths and more than 1.1 million confirmed COVID cases as of this writing. In addition, restricted visitor, ombudsman, and SSA access during the pandemic contributed to unprecedented social isolation and overwhelming loneliness for many residents, with grave consequences. In the first 6 months of the lockdown, it is estimated that more than 40,000 deaths in nursing homes were attributable to despair and the lost will to live experienced by residents, rather than the virus itself.

In response to a survey issued by the National Consumer Voice for Quality Long-term Care following the lockdown, family members who resumed in-person contact reported significant physical, mental, and cognitive decline in their loved ones. Family noted that loved ones had been unkempt, un bathed, undernourished, and significantly depressed, even suicidal. In addition, resident personal possessions, from glasses and hearing aids to wedding rings and clothes, were reported missing.
PRACTICE

- Increase organizational, administrative, and staff accountability through oversight and transparency
- Build the capacity of interdisciplinary professionals working in facilities to deliver comprehensive, integrated high-quality care to residents
- Improve surveillance efforts to detect mistreatment
- Ensure health equity and eradicate disparities within facilities
- Adopt culturally sensitive, person-centered care practices
- Root out ageism and its effects in facilities by affirming elder autonomy, rights, respect, and dignity
- Offer direct care staffers competitive compensation, supportive workplaces, and opportunities for career growth

EDUCATION AND TRAINING

- Educate staff in caregiving, dementia care, and infection control protocols
- Train direct care staff to manage workforce challenges and frustrations
- Train staff to avoid ageist attitudes and assumptions and provide proficient, person-centered care
- Expand training and licensing requirements for facility administrators
- Include geriatric and long-term care courses and competencies in nursing programs

RESEARCH

- Conduct qualitative studies identifying goals and high-priority outcomes for residents, family members, concerned others, and service providers
- Collect data on the prevalence and nature of abuse
- Evaluate the health inequities and disparities within facilities and the impact on residents
- Assess the efficacy of interventions to prevent abuse and neglect in facilities
- Investigate the presence and impact of racism, ageism, heterosexism, ableism and other forms of prejudice in facilities
- Understand institutional safety culture, protocols, and practices in facilities

POLICY

- Legislate minimum staffing requirements and increased patient to registered nurse ratios
- Increase regulatory oversight of facilities, unannounced on-site surveys, and the capacity of regulatory personnel to detect and discipline abuse and neglect
- Increase state and federal funding to Long-Term Care Ombudsman programs
- Support the World Health Organization’s global Decade of Healthy Ageing initiative to improve the lives and well-being of older people, which includes access to high-quality long-term care
Research Highlight

For additional reading on improving the quality of care in nursing homes, please refer to the 2022 National Academies of Sciences, Engineering, and Medicine report referenced below.

REFERENCES

8 Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 (1987). https://www.congress.gov/bill/100th-congress/house-bill/3545?q=%7B%22search%3A%5B%22cite%3APL100-203%22%5D&s=1&r=1
Residents, Families, and Staff

Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff


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**Keck School of Medicine of USC**

For more information: [https://ncea.acl.gov](https://ncea.acl.gov)

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