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SAFEGUARDING OUR SENIORS: PROTECTING THE ELDERLY FROM PHYSICAL AND SEXUAL ABUSE IN NURSING HOMES

HEARING

BEFORE THE

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MONDAY, MARCH 4, 2002

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1:32 p.m., in room SD–628, Dirksen Senate Office Building, Hon. John Breaux (chairman of the committee) presiding.

Present: Senators Breaux, Kohl, Wyden and Lincoln.

OPENING STATEMENT OF SENATOR JOHN BREAUX, CHAIRMAN

The CHAIRMAN. The committee will please come to order. Good afternoon to everyone. We thank all of our guests for being with us. I also want to acknowledge our colleagues who are here for what I consider to be a very important hearing this afternoon. I thank all of our guests in the audience and particularly thank the witnesses, who we will introduce in just a moment, for their testimony.

Today, we will examine a subject that is difficult for most of us to fathom, and that is physical and sexual abuse of individuals who reside in nursing homes. It is a subject that really should not exist. I genuinely wish that there was no issue of physical and sexual abuse in nursing homes to investigate at all.

Sadly, this investigation is another chapter in a long history for too long of abuses and problems in nursing homes. We as a nation must not tolerate abuse of our senior citizens in any form nor in any place. The Special Committee on Aging spent 14 years from way back in 1963 to 1977 investigating nursing home care. Other chairmen of this Special Committee on Aging and other committees in the Congress focused their attention on this particular problem after 1977.

We continue the work that began in 1998. Now, in the year 2002, 40 years have passed without a clear determination on the conditions of nursing homes as far as safety for our senior citizens.

Let me say up front and at the beginning that this hearing is not an indictment in any way of the entire nursing home industry. I recognize, this committee recognizes, the Congress recognizes, that there are many very fine nursing home facilities in this country that provide critical quality health care that is needed and nec-

essary, and that also provides those quality care provisions in a very safe manner.

However, the prevalence of abuse highlighted by this investigation has forced me to come to grips with the fact that our nation's public policy has been unable to adequately ensure the safety of our seniors in nursing homes.

This prompts me once again to look toward promoting and supporting other long-term care alternatives to nursing home care. This becomes all the more critical as the baby boom generation draws closer to senior citizen status. Today, the focus is on the response of law enforcement and other agencies to physical and sexual abuse in nursing homes.

Our committee asked the General Accounting Office, the investigative arm of the Congress, to investigate and determine how law enforcement responds to these crimes after we received complaints of confusion about where to make these complaints of abuse and complaints about which agency was responsible for investigating these allegations of abuse.

The General Accounting Office will share its findings in the report that I am releasing today. GAO's report not only addresses law enforcement's response to reports of physical and sexual abuse, but also finds the problem is even greater, that there is a pervasive lack of coordination among all the agencies that are charged with the responsibilities of protecting our seniors. By this, I mean law enforcement, social services, and also government.

To illustrate this point, I had a chart prepared that reflects the myriad of agencies involved in responding to the claims of physical and sexual abuse in nursing homes.

Immediately it becomes very clear, in my opinion, that while many agencies have jurisdiction, all too often no agency has the ultimate responsibility to investigate the allegations of physical and sexual abuse in nursing homes.

When everyone is in charge, it is clear that no one is in charge. We need to know that seniors in nursing homes are treated like everyone else when a crime does occur. We need to know that trained criminal investigators are notified immediately and can provide the evidence required for any necessary prosecutions.

We cannot continue to provide a system that discriminates against seniors with a bureaucratic reporting system that leaves abusive crime scenes stale and incapable of forensic investigation. A crime is a crime no matter where it is committed. Whether it is on a street corner in an urban city, or whether it is in a nursing home, it matters not. There is a crime and somewhere there is a criminal.

One last point I would like to make relates to the International Association of Chiefs of Police. This committee made repeated attempts to invite this association to represent the interests of police officers and detectives throughout the Nation with regard to how nursing home crimes are addressed.

I recognize that there are strong elder abuse units in police departments throughout the Nation that are doing outstanding work in this area. My own State of Louisiana is represented by Sheriff Charlie Fuselier, who is doing a great job in this particular area and will tell the committee about it.

However, I would like to read into the record a portion of the letter that I received from the International Association of Chiefs of Police declining this committee's invitation to participate in the hearing today, and it states the following:

"The IACP membership has not yet taken a formal policy position on the issue. Let me assure you that this is not an indication of the level of importance it believes this issue merits."

That is simply, to me, unacceptable for the national association representing the police chiefs in their law enforcement responsibilities. I believe the letter concisely makes the point of this hearing: too many police departments do not have abuse of seniors in nursing homes anywhere on their radar screen. Out of sight, out of mind is not acceptable. I think it is clear that we have much work to do to ensure that they are better trained and sensitized to the crimes against seniors that occur in institutions.

Moreover, it is essential that they not be treated differently from anyone else outside institutions or treated differently because of their age.

Before we introduce our first panel of witnesses, I'd like to recognize our colleagues on the Aging Committee. First, Senator Ron Wyden.

[The prepared statements of Senator Breaux, Senator Craig, Senator Reid, Senator Stabenow, and Senator Hutchinson follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

Good morning. I would like to thank all of you, especially my fellow members, for attending today's investigative hearing. I would also like to thank the Committee's Ranking Member, Senator Larry Craig, for his support throughout this investigation. Finally, and most importantly, I would like to thank the witnesses for being here today. Your testimony will assist the Committee greatly in determining how best to address the vital issues raised today.

Today, we will examine a subject that is difficult for any of us to fathom - physical and sexual abuse in nursing homes. It's a subject that should not exist, and I genuinely wish that there was no issue of physical and sexual abuse in nursing homes to investigate at all today. Sadly, this investigation is but another chapter in a long history - far too long - of abuses and problems in nursing homes. We as a country must not tolerate abuse of our senior citizens in any form.

The Special Committee on Aging spent 14 years from 1963 to 1977 investigating nursing home care. Other Chairmen of the Special Committee on Aging and other committees focused attention on the problems after 1977. Senator Grassley and I continued that work beginning in 1998. Now, in 2002, 40 years have passed without a determination that nursing homes are safe for seniors.

Let me say upfront that this hearing is not an indictment of the entire nursing home industry. I recognize there are many fine nursing homes in this country that provide quality care that is safe from abuse. However, the prevalence of abuse highlighted by this investigation has forced me to come to grips with the fact that our nation's public policy has been unable to insure the safety of our seniors in nursing homes. This prompts me once again to look toward promoting and supporting other long-term care alternatives to nursing home care. This becomes all the more critical as the Baby Boomers draw closer to senior citizen status.

Today, the focus is on the response of law enforcement and other agencies to physical and sexual abuse in nursing homes. The Committee asked the Government Accounting Office to investigate and determine how law enforcement responds to these crimes after we received complaints of confusion about where to make complaints of abuse and complaints about which agency was responsible for investigating abuse. GAO will share its findings in the report I am releasing today.

GAO's report not only addresses law enforcement's response to reports of physical and sexual abuse in nursing homes but also finds the problem is even greater - there is a pervasive lack of coordination among all the agencies charged with responsibilities of protecting our seniors - by this I mean, law enforcement, social services and government. To illustrate this point, I had a chart prepared that reflects

the myriad of agencies involved in responding to claims of physical and sexual abuse in nursing homes. Immediately, it becomes clear that while many agencies have jurisdiction, all too often, no agency has ultimate responsibility to investigate allegations of physical and sexual abuse in nursing homes.

We need to know that seniors in nursing homes are treated like anyone else when a crime does occur. We need to know that trained criminal investigators are notified immediately and can provide the evidence required for any necessary prosecutions. We cannot continue to provide a system that discriminates against seniors with a bureaucratic reporting system that leaves abuse scenes stale and incapable of forensic investigation.

One last point that I'd like to make relates to the International Association of Chiefs of Police. This Committee made repeated attempts to invite this association to represent the interests of police officers and detectives throughout the nation with regard to how nursing home crimes are addressed. I recognize that there are strong elder abuse units in police departments throughout the nation that are doing exemplary work in this area. However, I would like to read into the record a portion of the letter I received from the national association, declining the Committee's invitation to participate in the hearing today. It states the following:

...the IACP membership has not yet taken a formal policy position on the issue. Let me assure you that this is not an indication of the level of importance the IACP believes this issue merits....

I believe this letter concisely makes the point of this hearing. Too many police departments do not have abuse of seniors in nursing homes anywhere on their radar screen. I think it is clear that we have much work to do to ensure that they are better trained and sensitized to the crimes against seniors in institutions. Moreover, it is essential that they not be treated differently from anyone else outside institutions or treated differently because of their age.

Before introducing the witnesses, I would like to recognize other Senators for any opening remarks.

PREPARED STATEMENT OF SENATOR LARRY CRAIG

We are here this morning to examine the serious and growing problem of physical abuses of our nation's most vulnerable citizens. I want to begin by thanking Senator Breaux for convening this very important investigative hearing. We began this committee's investigation on Elder Abuse last year, including a discussion of abuses that happen in the elder's own home. I am pleased to see that this committee is continuing to explore different aspects of the problem, including instances of abuse that occur in nursing homes.

The challenges we face in remedying nursing home abuse are formidable. Employees of nursing homes with the legal duty to report suspected occurrences of abuse often fail to report to appropriate state and local agencies, including law enforcement. When cases are reported, there is often a long delay. Evidence is allowed to perish. When prosecutors finally get these cases, they have trouble acquiring reliable testimony from victims and other witnesses.

I'm hoping to hear today how existing state and local efforts to combat abuse in nursing homes might be enhanced by more collaborative approaches. In the state of Idaho, we have interagency protocols related to elder abuse responses both at the state and local level that have been quite effective. These formal protocols have the signatures of top officials in Adult Protection, the Ombudsman program, survey agencies, law enforcement, and prosecutors, demonstrating their commitment to work together on these cases. The protocols require specific reporting, facilitate collaborative investigations, and allow the exchange of client information between professionals acting on behalf of victims.

Additionally, existing federal resources should be better targeted to provide technical training in the identification, investigation, and prosecution of crimes perpetrated against the elderly in nursing homes and in the community. A high level of competence and expertise is necessary to effectively take on these very difficult cases.

I look forward to hearing the testimony today.

PREPARED STATEMENT OF SENATOR HARRY REID

Good afternoon Chairman Breaux and Ranking Member Craig.

The physical and sexual abuse of seniors is an unpleasant issue—but we cannot afford to look the other way and pretend that this problem does not exist. However unthinkable such crimes against vulnerable seniors are, they really do occur. They

are not isolated incidents—and the number of victims will only continue to increase as our population ages—unless we take effective steps to prevent abuse.

Certainly we must make sure that crimes against the elderly are reported and those responsible are prosecuted. Even more importantly, we need to do everything we can to prevent abuse before it happens.

For the past several years, Senator Kohl and I have focused our efforts on protecting our most frail and vulnerable seniors from workers with criminal backgrounds and known histories of abuse. We are the sponsors of the Patient Abuse Prevention Act, legislation that would require all long-term care facilities to conduct criminal background checks on potential employees. The Patient Abuse Prevention Act would also create a national registry of abusive workers. This registry would give long-term care facilities the ability to weed out workers who are known abusers. We need a national registry so offenders cannot continue to cross state lines and find employment in new facilities where they may continue to prey on the elderly.

Our bill is a culmination of several years of work on this issue, including numerous hearings in this committee. It is an inexpensive, common-sense proposal that we are confident will prevent many cases of abuse. In fact, a report by the Department of Justice revealed that 7 percent of FBI background checks on potential long-term care workers uncovered serious criminal convictions—including assault, rape and kidnapping. Our bill would help nursing homes identify these dangerous workers applying for jobs.

I understand that abuse of seniors is a complex problem and our legislation is only part of the solution. But as you listen to the stories today, I am sure you will agree that if our bill could prevent only one incident of abuse, it would be worth it. I urge my colleagues to join Senator Kohl and me in supporting the Patient Abuse Prevention Act, and I look forward to learning about other ways to protect our nation's seniors.

PREPARED STATEMENT OF SENATOR DEBBIE STABENOW

Chairman Breaux, thank you for convening a hearing today on the topic of abuse in nursing homes. While it is difficult for us to imagine that anyone would abuse a patient in a nursing home, the sad reality is that this abuse does occur. Today's hearing will help shed light on this critical issue and perhaps help find solutions.

The General Accounting Office (GAO) study conducted for this committee on abuse in nursing homes discovered that it is difficult for families to even discuss this issue. GAO estimates that much abuse is under-reported. Combine that with GAO's findings that there are many barriers to reporting abuse, and that many cases are not adequately investigated nor prosecuted, and we clearly have a problem. GAO's final recommendation is that the Center for Medicare and Medicaid Services should work to facilitate the reporting, investigation, and prevention of abuse to ensure protection of nursing home residents.

While this is a difficult issue for families to discuss, I think it is very important that this committee be an open forum so that we can consider the recommendations made by GAO. I also look forward to hearing from the other witnesses who will provide valuable information. I am strongly committed to ending abuse and neglect in nursing homes and I am pleased that our committee is taking on this issue that is so important for seniors and families.

PREPARED STATEMENT OF SENATOR TIM HUTCHINSON

Mr. Chairman, thank you for holding this critically important hearing today. Physical and sexual abuse of any kind is abhorrent and intolerable, but it is especially so in nursing homes, where vulnerable, unknowing, elderly patients are the victims.

I know that some of the testimony we will hear today tells of abuse that is incomprehensible. While these are difficult truths to fathom, we must be aware of what is happening and work together to convict bad actors and prevent further abuse.

In my home State of Arkansas, long-term care facilities have operated for many years under several state laws aimed at reducing the incidence of abuse and improving the quality of care. The Adult Abuse Act of 1983, for example, requires incident reporting of suspected abuse or neglect of residents. The Staffing Requirements for Nursing Facilities and Nursing Homes Act of 1999 has enabled Arkansas nursing homes to achieve minimum staffing levels of direct care workers that exceed the requirements of Arkansas' bordering state neighbors. Furthermore, and directly related to today's hearing topic, Arkansas nursing homes conduct criminal background

checks of their direct care staff in compliance with the Mandatory Criminal Records Checks for Applicants, Elder Choices Providers and Employees Act of 1997.

As Mark Malcolm, the Pulaski County Coroner, will mention in his testimony today, Arkansas also enacted legislation in 1999 to require all resident deaths to be reported to their county coroners. This legislation was strongly supported by the nursing home industry and patient groups throughout Arkansas.

Arkansas nursing homes and legislators have taken steps to address this deplorable crime against the elderly. We must continue to be vigilant, however, both in Arkansas and nationwide, to prevent such abuse.

I look forward to hearing our witnesses today and thank all of them in advance for their testimony.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you very much, Mr. Chairman, and let me commend you for holding this hearing. This gives us a chance to come back to an issue that must not be shunted aside and thank you for all of your leadership.

Mr. Chairman and colleagues, having been involved in this issue now for over 20 years, dating back to my days as co-director of the Oregon Gray Panthers, I can say without a doubt that there is a real pattern to how these issues unfold.

First, there is a government report like the one that is being released today that outlines a serious pattern of abuses.

Second, there are promises made by government and industry to clean house and all sides pledge that it is going to be different.

Finally, there is backsliding 6 months or so later and going back to something resembling business as usual. Mr. Chairman, I think it is so important that this time it be different. With your leadership we have that opportunity because I believe that a country that does not get this right, a county that does not protect the most vulnerable people in our nursing homes, is a country that has lost its moral compass and that cannot be tolerated.

Now, for just a moment, I want to talk about what I think are the central challenges in front of us as we go forward and put in place a reform package, and I want to note, Mr. Chairman, that I think the legislation that you are looking at—increasing reporting of senior abuse, enforcement of the laws—is absolutely critical and it seems to me any reform effort has to start with those and other patient protections.

I would add to it that I would like to see us strengthen the so-called watch lists. There is already an effort underway that I think is totally inadequate to watchdog the most deficient facilities, and I think that watch list ought to be strengthened.

Second, the idea that the Federal Government does not require the reporting of instances when there is suspicion of a crime, a brutal crime against a senior, is unacceptable. I know that there are discussions underway to speed notification of that, but I think those at a minimum ought to be part of a package of patient protection.

Third, it seems to me we have to continue to ensure that there are the funds necessary to carry out these changes. Perhaps the best measure of the short shrift that seniors in nursing homes get in our society are the inadequate reimbursements in Medicaid facilities, particularly in states like mine, that have held costs down, and that has to change as well.

Finally, I would hope that we would also put a focus on building up the advocacy networks of friends and relatives and ombudsmen, because you can pass laws, Mr. Chairman, by the crate full. We can pass one law after another, and if we do not have the friends and the relatives and the ombudsmen mobilized at the grassroots level, if we do not have that army of citizen advocates, all the laws in the world do not ensure that the older people in these facilities get the protections they deserve.

Mr. Chairman, it seems to me this time there is a chance to break that pattern, the pattern that you and I have seen on this committee for years and years. It is a pattern of indifference. It goes back to what I have seen since my days as Director of the Gray Panthers, and I am determined to work with you and our colleagues on a bipartisan basis so this time it really is different. Thank you.

The CHAIRMAN. Thank you very much, Senator Wyden. Next, we will hear from Senator Herb Kohl. Senator Kohl.

STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Thank you, Mr. Chairman. We appreciate your leadership on this committee, and while we also appreciate your holding this hearing, it is really sad that it is still necessary. Everyone knows, Mr. Chairman, that you have done everything in this committee's power to bring this sad situation to light and to try to change it.

This committee has held many, many hearings on problems in nursing homes. We have heard stories of people suffering from severe malnutrition and dehydration and life-threatening bed sores. As we will hear today, in addition to neglect and substandard care, our elderly and disabled also have to worry about being beaten and even sexually abused.

Unfortunately, this is not new. Over the past several years, we have continued to hear accounts of abuse and neglect in nursing homes. When we talk about nursing home residents, we're not just talking about nameless faceless people. These are our parents and our grandparents, our aunts and our uncles. They are sick and disabled, and they depend on nursing home staff to protect them and care for them.

It is important to emphasize that the vast majority of nursing home employees work hard and do their best to provide the highest quality care. But, as we know, it only takes a few abusive staff to terrorize patients and to unfairly portray the entire nursing home industry in a negative light.

As some of you know, I have introduced legislation, co-sponsored by Senators Breaux and Reid, that would take a major step toward addressing this problem. The Patient Abuse Prevention Act would create a national registry of abusive long-term care workers which will prevent abusers from moving from state to state and continuing to find work with vulnerable patients. This legislation would also require an FBI criminal background check to prevent people with serious criminal convictions from working with patients.

I am pleased that the American Health Care Association and the American Association of Homes and Services for the Aging, which represent nursing homes and other long-term care providers all

across the country, are now strong supporters of this bill. They recognize that background checks will benefit their industry and have worked with my office over the past few years to refine the bill. Their suggestions improved the bill and demonstrate their commitment to protecting their nursing home residents.

During the past 5 years, this committee has heard from the HHS Inspector General's Office, the GAO, local prosecutors, state inspectors, and auditors and now the nursing home industry. They all recommend establishing a national background check system.

I hope this hearing provides the final boost to pass this legislation. It is past time to act to protect our nation's seniors and disabled patients, and so again I thank you, Mr. Chairman, for cosponsoring the bill and for once again bringing this important issue to light.

The CHAIRMAN. Thank you, Senator Kohl. Next we will hear from an outstanding member of our committee, Senator Lincoln, from Arkansas.

STATEMENT OF SENATOR BLANCHE LINCOLN

Senator LINCOLN. Thank you, Mr. Chairman, and thank you for calling this very important hearing today, and to all of our witnesses and panelists that will be here today, we appreciate your concern and your willingness to come before us today and tell some very trying stories.

Most of us assume that our elderly and disabled citizens living in nursing homes are safe and cared for properly. While this is very often true, we will be hearing some very shocking stories today of how cruelly some of our most vulnerable citizens have been abused in nursing homes, and as Senator Kohl mentioned, it is disturbing enough just to think that we still require a hearing on this issue.

I was surprised to find out about the gaps in security and the lack of coordination between various sectors charged with protecting elderly and disabled people in nursing homes, and I was also concerned to learn that law enforcement agencies often treat crimes in nursing homes differently than crimes committed outside of nursing homes.

Some of you all may remember one of our former senators from Arkansas, Senator David Pryor, who also served on this committee. Years ago, Senator Pryor went undercover to work in a nursing home and to reveal some of the difficulties and some of the challenges that we were facing in our nation's nursing homes, and today I am going to be proud to introduce Mark Malcolm, who is our Pulaski County, Arkansas coroner, who has done tremendous amount of work in trying to improve the quality of care in nursing homes as well as point out what some of those difficulties and challenges are.

I will talk more about Mr. Malcolm later when I introduce him, but one thing that is very important is that in 1999, Mr. Malcolm helped to introduce legislation in the Arkansas legislature to require that all deaths of nursing home patients be reported to the county coroner for investigation regardless of the cause of death, and it has uncovered a great deal for us in Arkansas to better understand how we can provide greater care for our aging constituents in our communities.

With the growing elderly population and a growing likelihood that our parents and even we ourselves will spend some portion of our aging years in a nursing home, ensuring the safety and the quality of care of nursing residents becomes even more important to all of us. I am confident that we can develop solutions to close these gaps and to better protect these vulnerable citizens.

So I look forward to the testimony today and I thank you again, Mr. Chairman, for as always bringing about some incredibly important issues to the constituents that we serve.

The CHAIRMAN. Thank you very much, Senator Lincoln, and thank all the members for their commitment to this committee and the work that we are trying to do and for your involvement.

We would like to welcome now our first panel. This is a special panel. It is not easy when you are talking about a mother-in-law or a mother and some very bad things that happen. But I only thank you by also saying the obvious, that your testimony can help future generations from never having to experience some of the problems that your families have experienced, and in that sense, your testimony here is incredibly important for future generations.

We would like to introduce Mr. Michael Peters. He is from the State of Florida. He is an attorney for a person who will be known as Ms. Jane Doe, who suffered a rape in a nursing home.

We will have Ms. Barbara Becker, who is the daughter-in-law of a person who was attacked by a resident in a nursing home.

Our first witness will be Mr. Bruce Love. Mr. Love is the son of Ms. Helen Love, who died after her neck was broken in an incident in a nursing home by an employee of that nursing home. Fortunately, before she passed away, a short time before she passed away, two days, there was a taped deposition of what happened in her own words, which I think is very graphic and very, very helpful, and we would like, Mr. Love, if it would be all right to show that before you give us your statement, and if we could have that interview. It is about 3 minutes.

Mr. Love, I know that this could not be very easy for you, but again, as I said earlier, your appearance here today helps to make sure that it never happens again.

Mr. Love. That is correct, sir.

The CHAIRMAN. We would be pleased to hear from you.

STATEMENT OF BRUCE LOVE, SON OF PHYSICAL ABUSE VICTIM HELEN LOVE, MILL CREEK, CA

Mr. LOVE. Thank you for having me here, Mr. Chairman, and members of the committee. Obviously, I am Bruce Love, and that was my mother, and you just saw the film clip. I will just tell the story, and this is basically in her own words in the beginning of this deposition.

On Thursday evening, July 30, that was when I saw her for the first time lying on a gurney, waiting for treatment after she had been assaulted Tuesday evening at Valley Skilled Nursing Home.

My mother's own words are: "I was in good spirits Tuesday evening, watching TV. I had a bout of diarrhea and had the urge to go. I asked the attendant on duty for Imodium AD pills but got no response. When I leaked some diarrhea into my diaper, I called to be changed. It was sometime later when the attendant showed

up and was quite upset that my diaper was dirty, because he had changed me earlier in his shift."

"He called me names and was very rough and abusive in changing me. I told him to stop or I would yell for help. He said, 'Here is something for you to yell about,' and used an alcohol water swab through my vagina and my raw rectum."

I would like to add one more thing to the list. I did not know what Class II open sores were. I do now.

"I was on fire and yelled for help. I tried to sit up and grab the right side of the bed rail. He punched me with the flat of his hand, covered my mouth to stop my scream, and chopped me in the back of the neck with his other hand. With his left hand, he dug his fingernails into my wrist to break my grip on the side rail. With his right hand over my mouth, and his left hand squeezing my wrist, he pushed me down into my bed."

"I heard a second aide come to the door of my room to see about the commotion. When she saw him choking me, I kicked at my feet to get her attention, but she just laughed and went away. Then I knew no one was going to help me. I could not resist his strength and weight, and I could not breathe with his forcing my head down on to my chest. My deep inner fear told me to stop resisting him or he would kill me. I was afraid of dying this way, so I relaxed and went limp, playing dead. Finally, he let up his grip and stopped pushing me down. I just lay there trying not to breathe too loudly."

"Finally he walked toward the door. My roommate Shirley, who had remained quiet during the assault and watched through the curtain, spoke up and said, 'I saw what you did to Helen, so you'll have to kill me, too.' My assailant left the room. After a time of silence, I called to Shirley, and she was overjoyed to hear my voice. She thought I was dead. We stayed quiet all night in fear that he would be back. When daylight came, I thanked God I was still alive and I knew something was very wrong with my neck because it hurt terribly."

"All my life I have feared being neglected in a nursing home, and now I know what it is like. I was so close to death and somehow survived the attack. I don't want anyone else to suffer like this. Please, son, would you tell someone who can help."

I am here today to fulfill my mother's request and I mean that. After my father's death, my mother could no longer live by herself and came to live with me and my family first in California and then Nevada. My brother and I both happen to live out here. When I moved back to a remote area of California, my mother moved to Sacramento to live with my brother and his family.

In 1998, she was in U.C. Davis Hospital for some health evaluations. She suffered a broken finger when in a hospital bed she was negligently pushed against a steel door frame. The hospital assumed responsibility and moved my mother to Valley Skilled Nursing Home for physical rehabilitation, and that was her only reason to be there was to get this done.

Wednesday, January 29, I called the nursing home to speak with the RN to arrange for him to bring my mother up to where I live for a visit. During this call, I was informed that my mother had been roughed up a little bit. He informed me that one of the aides

of the previous evening shift had an altercation with my mother and used physical force against her.

He told me her sheets had been changed this morning because there were blood stains on them. At that point, he was interrupted. When he came back on the phone, he told me there was an individual there who wished to speak with me, at which time he handed the phone to someone else.

I did not know who this person was, and I had to question him to find out that he was the Administrator of Valley Skilled Nursing Home. He told me that the problem was taken care of and that the employee would no longer be tending my mother.

In addition, the administrator told me that the Department of Health Services had been notified. He also told me that the nursing home doctor would evaluate my mother for possible injuries, and if any were found, she would be taken across the street to U.C. Davis Medical Center. This ended our conversation.

I was very upset, so I immediately telephoned my brother and I could not reach him at work. Then I called a friend who was a local deputy sheriff. He advised me to speak with his sergeant and also the district attorney's office in the county that I live in.

Both officers advised me to get my mother away from the nursing home and to a hospital as soon as possible. They also suggested that I have a family member transport my mother to ensure that she would be cared for in a humane and loving manner.

I was finally able to reach my brother at home about 4 p.m. He immediately went to the nursing home to see our mother and called me from there. He was alarmed at my mother's condition. Her neck was very sore and painful. She had bruises on her chin and chest and lacerations on her right wrist.

She told Gary that she had been hit very hard on her chin and on the back of her neck. My brother telephoned our mother's personal physician and recommended Gary take our mother to the hospital as soon as possible. Gary had to go home and get my mother's wheelchair because he was not receiving any cooperation from the nursing home in moving her to the hospital.

When he returned, my brother was told by the nursing home's evening shift supervisor he could not take my mother out of the nursing home, at which time he called me for help. I spoke with his supervisor and informed him that we indeed were taking my mother to the hospital regardless of his protests.

Ironically we were informed by the nursing home official that it was not medically advisable to move our mother to the hospital. My brother had to use force to overcome the protest of the nursing home to get my mother out of the nursing home. This took an additional hour.

During this time, my brother called the Sacramento Police Department and explained what happened. They sent an officer to Valley Skilled Nursing Center, and they also sent a photographer to the hospital to be there when my mother arrived.

After extensive evaluation at the hospital, it was determined that my mother had indeed suffered grave injuries to her neck, and in fact her neck was broken. Vertebra 3, 4 and 5 were displaced leaving my mother's head hanging to the side.

She was unable to hold up her head. In the hospital's attempted emergency surgery—I want to clarify one point. She was given anesthesia to see if she could tolerate this and she expired. However, due to my mother's health condition and sensitivity to anesthesia, she expired on the table and had to be revived. The only remaining treatment for this injury was the installation of a halo, which had to be screwed into my mother's skull with metal bolts and rigidly attached to her upper torso.

In addition, a soft cast had to be applied to her right arm where the offender had grasped her wrist so hard that it was cracked. My mother lived in great pain and severe restriction of movement for the rest of her life, which was less than 60 days. She died on September 24, 1998, 2 days after this deposition tape that you saw, and she had requested removal of the halo due to severe pain just prior to expiration.

Prior to my mother's death, the offender had pleaded not guilty to the charge of assault and elder abuse. After my mother's death, he immediately changed his plea to guilty of elder abuse in order to avoid the manslaughter charges.

If I could add another point where I was very frustrated with this was his people beat us to the district attorney's office and they had a plea bargain before we could even get the rest of our information there. So the district attorney's office did not help us.

He spent one year in the Sacramento County Jail. As for Valley Skilled Nursing Center, they hired this individual to care for the elderly; they failed to perform an adequate background check before hiring this person. After investigation, my attorney learned that he had been dismissed from two prior nursing home positions for aggressive behavior toward residents.

The nursing home also failed to recognize the extent of my mother's injuries and to take her to the hospital immediately. If my brother and I had not stepped in and intervened, my mother might never have received any medical attention for the broken neck and broken wrist after being assaulted by this employee. Moreover, this man might still be caring for the elderly today.

Since the focus of this hearing is to hear about the response of law enforcement and other agencies to the physical and sexual abuse in nursing homes, I would like to share my experiences in this regard. We got no assistance from the social services agencies that we contacted. The ombudsman who was very good to us had no authority to do more than conduct a cursory interview and write up his observations.

A state agency surveyor in the building where my mother's neck was broken was there to investigate another spot or another matter. No one from that nursing home reported to her, and she was in the very next morning while my mother was still there.

Prosecutors did their best to prosecute the assailant, but much of the information was provided by our attorney. That is where the initiative came from to go after this guy was through my attorney's office.

Finally, the judge seemed unsure about the trial and what to do with the nursing home aides who abuse the elderly. After prompting from the attorneys, the assailant's license was revoked, and he was ordered not to have contact with the elderly in future work.

However, in spite of his actions that contributed to my mother's death or the charge of elder abuse, he only spent 6 months of a total of a year in the county jail.

There are no words to describe how devastating his experience is to me and my family. We entrusted my mother's care to institutions that failed us in every respect. My only hope is that somehow telling my mother's story, I can prevent this from happening to anyone else's mother in the future. I urge this committee to take action to ensure our senior citizens are protected at home, and after hearing what you had to say, I thank you, I thank you very much for your commitment to do this. Thank you for inviting me here today.

[The prepared statement of Mr. Love follows:]

STATEMENT OF BRUCE LOVE

Good morning, Mr. Chairman and Members of the Committee. I am Bruce Love, son of Helen Love, the woman you just saw in the film clip. I am here today to tell her story as told to me Thursday evening, July 30, 1998, at UC Davis Hospital Emergency Room while she was lying on a gurney awaiting treatment after being assaulted by an aide on Tuesday evening at Valley Skilled Nursing Home:

"I was in good spirits on Tuesday evening, watching TV. I had a bout of diarrhea and had the urge to go. I asked the attendant on duty for Imodium AD pills but got no response. When I leaked some diarrhea into my diaper, I called to be changed. It was sometime later when the attendant showed up and was quite upset that my diaper was dirty because he had changed me earlier in his shift. He called me names and was very rough and abusive in changing me. I told him to stop or I would yell for help. He said, "Here is something for you to yell about" and used an alcohol/water swab thru my vagina and my raw rectum. I was on fire and yelled for help. I tried to sit up and grabbed the right side rail of my bed. He punched me with his flat hand, covered my mouth to stop my scream, and chopped me in the back of the neck with his other hand. With his left hand he dug his fingernails into my wrist to break my grip on the side rail. With his right hand over my mouth and his left hand squeezing my right wrist, he pushed me down into my bed.

I heard a second aide come to the door to my room to see about the commotion. When she saw him choking me, I kicked my feet up to get her attention, but she just laughed and went away. Then I knew no one was going to help me. I could not resist his strength and weight and I couldn't breath with his forcing my head down onto my chest. My deep inner fear told me to stop resisting him or he would kill me. I was afraid of dying this way so I relaxed and went limp, playing dead. Finally he let up his grip and stopped pushing me down. I just lay there trying not to breath too loudly.

He finally walked toward the door. My roommate Shirley, who had remained quiet during the assault and watched through the curtain, spoke up and said, "I saw what you did to Helen so you will have to kill me too." My assailant left the room. After a time of silence, I called to Shirley, and she was overjoyed to hear my voice. She told me she thought I was dead. We stayed quiet all night in fear that he would be back. When daylight finally came, I thanked God that I was still alive, but I knew something was very wrong with my neck because it hurt terribly.

All my life I have feared being neglected in a nursing home, and now I know what it is like. I was so close to death and somehow survived that attack. I don't want anyone else to suffer like this. Please, Son, tell someone who can help."

I am here today to fulfill my mother's request.

After my father's death, my mother could no longer care for herself and came to live with me and my family, first in California and then in Nevada. When I moved back to a remote area of California, my mother moved to Sacramento to live with my brother and his family. In 1998,

she was at U.C. Davis Hospital for some health evaluations. She suffered a broken finger when the hospital bed she was in was negligently pushed against a steel doorframe. The hospital assumed responsibility and moved my mother to Valley Skilled Nursing Home for physical rehabilitation.

On Wednesday, July 29, 1998, I called the nursing home to speak with an RN to arrange for him to bring my mother to visit me. During this call, I was informed that my mother had been "roughed up a little bit." He informed me that one of the aides on the previous evening's shift had an altercation with my mother and had used physical force against her. He told me her sheets had been changed that morning because there were bloodstains on them. At that point, he was interrupted. When he came back on the phone he told me there was an individual there who wished to speak to me, at which time he handed the phone to someone else. I did not know who this person was and had to question him to find out that he was the Administrator of Valley Skilled Nursing Home. He told me that the problem was being taken care of and that the employee would no longer be tending my mother.

In addition, the Administrator told me that the Department of Health Services had been notified. He also told me that the Nursing Home's doctor would evaluate my mother for possible injuries and if any were found, she would be taken across the street to U.C. Davis Medical Center for treatment. This ended our conversation.

I was very upset so I immediately tried to telephone my brother Gary but could not reach him at work. Then I called a friend who was our local Deputy Sheriff. He advised me to call and speak with his Sergeant and also the local District Attorney's office. Both offices advised me to get my mother away from the Nursing Home and to a hospital as soon as possible. They also suggested that I have a family member transport my mother to insure that she was cared for in a humane and loving manner.

I finally was able to reach my brother at home around 4 p.m. He immediately went to the nursing home to see our mother and called me from there. He was very alarmed at our mother's condition. Her neck was very sore and painful. She had bruises on her chin and chest, and there were lacerations on her right wrist. She told Gary that she had been hit very hard on her chin and on the back of her neck. My brother telephoned our mother's personal physician, who recommended Gary take our mother to the hospital as soon as possible. Gary had to go home to get my mother's wheel chair, because he was not receiving any cooperation from the Nursing Home in moving her to the hospital. When he returned, my brother was told by the Nursing Home's evening shift supervisor, that he could not take mother out of the nursing home, at which time he called me for help. I spoke with the supervisor and informed him that we were indeed taking my mother to the hospital regardless of his protest. Ironically, we were informed by the Nursing Home official that it was not medically advisable to move our mother to the hospital. My brother had to use force against the protests of the Nursing Home to get our mother out of the Nursing Home and to the hospital. This took an additional hour. During this time, my brother called the Sacramento Police Department and explained what had happened. They sent an officer to Valley Skilled Nursing Home, and they also sent a photographer to the hospital to be there when my mother arrived.

After extensive evaluation at the hospital, it was determined that my mother had indeed suffered grave injuries to her neck - in fact, my mother's neck was broken. Vertebra 3, 4, and 5 were displaced, leaving my mother's head hanging to the side. She was unable to hold up her head. The hospital attempted emergency surgery. However, due to my mother's health condition, age, and sensitivity to anesthesia, she expired on the operating table and had to be revived. The only remaining treatment for the injury was the installation of a "halo," which had to be screwed into my mother's skull with metal bolts and rigidly attached to her upper torso. In addition, a soft cast had to be applied to her right arm where the offender had grasped her wrist so hard that it was cracked. My mother lived with great pain and severe restriction of movement for the rest of her life (less than 60 days). She died on September 24, 1998, two days after the deposition you just saw on video tape and after she requested the removal of the "halo" due to the severe pain it caused her.

Prior to my mother's death the offender pleaded "not guilty" to the charge of assault and elder abuse. After my mother's death he immediately changed his plea to "guilty" of "elder abuse" in order to avoid manslaughter charges, spending only one year in the Sacramento County Jail. As for Valley Skilled Nursing Home that hired this individual to care for the elderly, they failed to perform an adequate background check before hiring this person. After investigation, my attorney learned that he had been dismissed from two prior nursing home positions for aggressive behavior toward residents. The Nursing Home also failed to recognize the extent of my mother's injuries and to take her to the hospital immediately. If my brother and I hadn't stepped in and intervened, my mother might never have received any medical attention for a broken neck and a broken wrist after being assaulted by this employee. Moreover, this man might still be caring for the elderly today.

Since the focus of this hearing is also about the response of law enforcement and other agencies to complaints of physical and sexual abuse in nursing homes, I would like to share my experiences in this regard. We got no assistance from social services agencies that we contacted. The Ombudsman had no authority to do any more than conduct a cursory investigation and write up his observations. There was a state agency surveyor in the building when my mother's neck was broken who could have investigated the matter on the spot, but no one reported it to her. The prosecutors did their best to prosecute the assailant but had much information supplied by our attorney. Finally, the judge seemed unsure throughout the trial about what to do with nursing aides who abuse the elderly. With prompting from the attorneys, the assailant's license was revoked and he was ordered not to have any contact with the elderly in future work. However, in spite of his actions that contributed to my mother's death, he only spent 6 months in a county jail for "elder abuse."

There are no words to describe how devastating this experience has been to me and to my family. We entrusted my mother's care to institutions that failed us in every respect. My only hope is that somehow by telling my mother's story today I can prevent this from happening to anyone else's mother in the future. I urge this Committee to take actions to ensure that our senior citizens are protected from abuse. Thank you for inviting me here today.

The CHAIRMAN. Mr. Love, thank you so very much for what I know has been a very difficult time that you have been through. We certainly apologize for you having to go through it, but your statement here today is extremely important, and we thank you for being with us.

Next, we will hear from Ms. Barbara Becker. Ms. Becker.

STATEMENT OF BARBARA BECKER, DAUGHTER-IN-LAW OF PHYSICAL ABUSE VICTIM HELEN STRAUKAMP, EVANSVILLE, IN

Ms. BECKER. Mr. Chairman, members of the committee, thank you very much for allowing me to represent my mother-in-law Helen Straukamp, a homicide victim.

According to the facility, Helen had been injured. The hospital was informed that she suffered a fall, but an employee later told us of the actual assault. An eyewitness reported that Helen was picked up by the arms from a standing position, lifted off the floor and slammed into a wall and handrail, falling to the floor unconscious.

Helen was never even able to stand again and died 22 days later. The coroner ruled her death a homicide. The picture on the left is the way she was prior to the assault. I discovered on my own in Louisville that the perpetrator of this assault was a male mental patient with a decades long violent history, which included four shootings, SWAT teams, prison time, et cetera. None of this was ever mentioned in the investigations.

I found documents signed by the nursing home showing that they knew of his history. After the assault on Helen, this resident was soon given his usual access to the entire population of the facility. He threatened to castrate a wheelchair-bound resident while a surveyor was in the facility.

He attempted to assault yet another elderly female resident, and the administration of the facility did nothing. I notified a detective and the prosecutor's office. A judge issued an order for an involuntary removal to a psychiatric unit where he had to be placed in total lockdown and charged with involuntary manslaughter pending a competency hearing.

My experiences with regulatory agencies, law enforcement, et cetera, are as follows: Due to my dogged determination for accountability, I contacted elected representatives including the Governor, the State and U.S. attorneys, HCFA, HHS, and the GAO. It required four investigations to reveal 42 pages covering 6 years of previously undiscovered violations from the date of this man's admission.

No immediate jeopardy level was imposed due to Helen's death. HCFA overrode the state's flat fine, and imposed a $1,000 per day fine, but the scope and severity level remained unchanged. Still out of compliance on a revisit, the civil money penalty continued and total fines amounted to $60,800. But by not appealing, they were granted an automatic 35 percent discount on the Federal fine regardless of a homicide.

To this day, the facility's record on the CMS web site appears very favorable. The entire experience with the state regulatory agency was adversarial from the very first meeting. There was ab-

solutely no doubt to me who was being protected and it was not the residents.

In my first meeting with the department of health official I was personally told, "Well, this was not like a beating." You can tell for yourself. The former assistant commissioner of the Department of Health refused to discuss the case with me.

Law enforcement investigated but only the perpetrator. I contacted Adult Protective Services three times, only to be told that they do not handle nursing home cases. They are actually barred from investigating nursing home cases in my state without orders from the Department of Health. Department of Health rarely uses this resource.

I contacted our Peer Review Organization, and received only a letter and a brochure declining to even investigate. The Medicaid Fraud Unit completed a very thorough investigation and validated every piece of evidence that I had provided.

I pushed the completed case through the AG's office, who took no action, and on to my local prosecutors. They declined to investigate or prosecute. There has yet to be any justice for a homicide.

All I hear from the industry are labels of "isolated incidents," which must by now number in the hundreds of thousands. Frivolous lawsuits, no matter how horrific the case. I hear whining for more money, less regulation, and what I refer to as tort "de-form." The system leaves no alternatives for victims.

I could have provided reams of evidence today until I realized that countless victims and family members like me have stood here before you evidence in hand. Countless congressional reports, GAO reports and studies have been presented to Congress for years, as you know. The evidence is already in. Those with the power to stop these atrocities no exactly what is happening.

You have seen thousands of certificates of unnatural deaths, thousands of pictures of the bodies of victims of our system. At least 15 of the 25 largest chains have been accused, found guilty, or have admitted to Medicare fraud of multi-millions. To my knowledge, not one owner or operator has gone to prison. They are not even required to pay back all the defrauded funds.

Negligent homicide and elder abuse within my home or the community is treated as criminal, not so inside a nursing home. It is just a regulatory offense with no criminal accountability.

I am from a long line of patriots and veterans from World War I through Desert Storm, yet veterans referred to as the "greatest generation" are enduring these same nursing home atrocities and treated as those least deserving of our country's respect. Yet, there is considerable concern for the Afghan detainees in Cuba, and it is a felony to euthanize a mockingbird in Washington.

Helen's homicide was included in Congressman Waxman's report to Congress July 30, 2001 on reported abuse in one-third of our nursing homes and has received nationwide media attention.

It is long past time to restore the civil and constitutional rights of nursing home residents. Thousands are waiting to hear the results of today's hearings.

They would like to know when we will have justice, and with all due respect, what will I be able to tell everyone across the country when I go home? Thank you.

[The prepared statement of Ms. Becker follows:]

STATEMENT OF BARBARA BECKER

SPECIAL COMMITTEE ON AGING

March 4, 2002

Mr. Chairman, Members of the Committee, I am Barbara Becker from Indiana. Thank you for allowing me to represent my mother-in-law, 83-year-old Helen Becker Straukamp, homicide victim.

According to the facility, Helen had been "injured"; the hospital was informed that she suffered a "fall", but an employee later told us of the assault. An eyewitness reported that Helen was picked up by her arms from a standing position, lifted off the floor and slammed into a wall and handrail, falling to the floor unconscious.

Helen was never even able to stand again and died 22 days later. The coroner ruled her death a homicide.

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I found documents signed by the nursing home showing that they knew of his history. After the assault on Helen, this resident was soon given his usual access to the entire population of the facility. He threatened to castrate a wheelchair-bound resident while a surveyor was in the facility. He attempted to assault yet another elderly female resident, and the administration of the facility did nothing. I notified a detective and the prosecutor. A judge issued an order for involuntary removal to a psychiatric unit where he had to be placed in total lockdown and charged with involuntary manslaughter, pending a competency hearing.

My experiences with regulatory agencies, law enforcement, etc., are as follows:

Due to my dogged determination for accountability, I contacted elected representatives including the Governor, the state and U.S. attorneys, HCFA, HHS, and the GAO. Four investigations resulted in 42 pages covering six years of previously 'undiscovered' violations from the date of this man's admission. No immediate jeopardy level was imposed due to Helen's death. HCFA overrode the state's flat fine and imposed a $1,000/day fine, but the scope and severity level was unchanged. Still out of compliance on a revisit, the CMP continued and total fines amounted to $60,800; by not appealing, they were granted an automatic 35% federal discount to $39,520, regardless of the homicide. To this day, the facility's record on the CMS website appears very favorable. The entire experience with the state regulatory agency was adversarial from the first meeting. There was absolutely no doubt who was being protected, and it wasn't the residents. In my first meeting with a IDOH official, I was personally told "well, this wasn't like a beating"; the former assistant commissioner refused to discuss the case with me.

Law enforcement investigated, but only the perpetrator.

I contacted Adult Protective Services three times, only to be told that they don't handle nursing home cases. They are barred from investigating nursing home cases without orders from the DOH; DOH rarely uses this resource.

I contacted the Peer Review Organization, Health Care Excel and received only a letter and brochure, declining to even investigate.

The Medicaid Fraud Unit completed a very thorough investigation and validated every piece of evidence I had provided. I pushed the completed case through the AG's office (who took no action) and on to my local prosecutors. They declined to investigate or prosecute. There has yet to be any justice for a homicide.

All I hear from the industry are labels of "isolated incidents", which must by now number in the hundreds of thousands; "frivolous lawsuits", no matter how horrific the case; I hear whining for "more money", "less regulation" and what I refer to as tort 'DE-form'. The 'system' leaves no alternative for victims.

I could have provided reams of evidence today, until I realized that countless victims and family members like me have stood here before you, evidence in hand. Countless Congressional Reports, GAO Reports and studies have been presented to Congress for years. The evidence is already in....those with the power to stop these atrocities know exactly what is happening. You have seen thousands of certificates of unnatural deaths, thousands of pictures of the bodies of victims of our 'system'.

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It's long past time to restore the Civil and Constitutional Rights of nursing home residents.

Thousands are waiting to hear the results of today's hearings.

When will we have justice?

With all due respect, what will I be able to tell everyone across the country when I return home?

The CHAIRMAN. Ms. Becker, thank you very much for your contribution as well. I know also that it is not easy to talk about these matters, but it is incredibly important that we receive the information, and we thank you for doing so.

So, Michael Peters.

STATEMENT OF MICHAEL PETERS, ESQ., COUNSEL FOR RAPE VICTIM JANE DOE, ORLANDO, FL

Mr. PETERS. Thank you, chairman. Thank you for inviting me here today. I am a trial lawyer in Orlando, FL. I have made this trip today because this, indeed, is an important issue that your committee has chosen to address.

I am here today because I believe our national treasure, our elderly population, is at risk on a daily basis in nursing homes across the country. I salute Mr. Love and Mrs. Becker. I am humbled in their presence, because although I have heard many tales of horror such as theirs in the course of my work, I have never experienced it firsthand. I can only imagine the pain that their family has gone through, and I salute them for being here today to relive that before this committee, hoping that something will be done.

The past 4 years of my law practice have been devoted exclusively to the representation of nursing home victims, victims of abuse and neglect. I have seen things I never thought imaginable. I have a case where a man in Tennessee was completely helpless lying in bed, and a certified nursing assistant crawled up on top of him and beat him repeatedly about the head, and he ultimately was sent to the hospital and died from these blows.

A woman in Florida, 90-year-old woman, helpless again, lying in bed, and was beaten in the head with an aluminum can because she dribbled some of the formula in the can out of her mouth. She too died.

I have seen bed sores the size of footballs where you can see all the way down to a person's bone, but nothing that I have come across is more shocking than the case, the facts of the case that I came here today to tell you about, and that is a case where a 36-year-old woman who had suffered a massive stroke. As a result of this stroke, she was completely paralyzed on the left side of her body, she was not only physically disabled, but significantly mentally disabled as a result of the brain injury from this stroke. After hospitalization, she was sent to a nursing home because she could not care for herself. She needed 24-hour skilled nursing care, and she would probably for the rest of her life.

All of the things that we take for granted, she had to have somebody do for her. Get out of bed in the morning, brush your teeth, comb your hair, dress yourself, she needed assistance eating. If she needed to go to the bathroom, she needed assistance. Everything, like I said, that you and I take for granted, she had to have help with, and she was there for 2½ years, and this was being done.

As you can imagine over that period of time, she developed a level of trust and confidence in those people that saw her in a very intimate way every single day of her life. That trust and confidence was shattered sometime in April of 2000. Sadly, my client did not even know that that trust and confidence had been shattered. It was not until January 13, late at night, that she began to have ex-

cruciating stomach pains. The fact of the matter is she was in labor.

On January 14, in the wee hours of the morning, a nursing assistant came in to change her diaper, her adult diaper, only to find a baby lying in feces in her diaper with the umbilical cord still attached. You see my client had been raped. She had no knowledge of this incident. She had no knowledge that she was even pregnant. She carried this baby full term, 9 to 10 months, and nobody from the nursing home ever figured it out, the people that were bathing her everyday, that saw her naked, they did not figure it out. It was not until they came in and found the baby lying there.

She delivered that baby in that room by herself in the dark feeling excruciating pain with no anesthesia, with no medical help, with nobody. The nursing home did not call the authorities. They did send her out to the hospital or she was sent out to the hospital, and miraculously that baby lived. The baby is alive today and is being raised by her cousin in Orlando, FL.

I can only say that I spent an hour sitting in my office when this case came into my office, trying to figure out how something like this could have happened. I have yet to figure that out. There are many questions that have been raised by this situation, and none of those questions in my mind have been answered yet. But I promise you that I am going to find out the answers if I can.

The good news is that in this particular case, local law enforcement was able through DNA match to identify a suspect, make an arrest. That person has been arraigned and will stand trial in Orlando, FL for this heinous crime.

I certainly would like to answer any questions that this Senate committee has regarding this issue. I think that in other cases, the case in Tennessee where the man was beaten to death, there was not a good response by law enforcement. They never did make an arrest. From what I can tell from the paperwork, they never made any reasonable investigation of the matter. The state agencies and local agencies likewise chose to slide this under the rug, and they still have not identified the man that beat him to death. I think there is a very important issue here, and I appreciate your devotion, the commitment that you have made to address the issue. Thank you.

The CHAIRMAN. Thank you, Mr. Peters, and thank you, Mr. Love, and Ms. Becker, for your presentations. You know that in the almost 30 years I have been in Congress, this is probably the most disturbing testimony that I have ever experienced on any committee either in the House or in the Senate.

You know we have special laws that protect crimes against juveniles and children in this country, as we should, because they are a vulnerable population, but certainly seniors, particularly in institutions of care, nursing homes and what have you, are also particularly vulnerable and maybe even more so than a child, because they are outside of a family setting, many times without seeing any relatives or loved ones over a relatively long period of time.

So, while it is important that we give that attention to juveniles, it is equally important, if not more so, to make sure that we give that same degree of attention to problems when crimes are commit-

ted against seniors. I mean it just goes without saying that for every crime, there is a criminal somewhere.

What you are telling this committee, I think, is that law enforcement is not really involved sufficiently to take care of that. While it is tragic that these things happen, it is equally as tragic if nothing is ever done about it, because that would only allow it to occur again in the future.

Mr. Love, your testimony about your mother is just very important and very difficult to give. How did you find out about what happened? How did you first learn that your mother had had her neck broken?

Mr. LOVE. I saw my mother——

The CHAIRMAN. Get close to that mike, please.

Mr. LOVE. Excuse me. On Thursday when I went down to see my mother, I found out this through the evaluation of the hospital emergency room. The very next morning, I went over to Valley Skilled, and what was ironic was her charts were still being filled out that Helen was awake, spontaneous, and she had left the facility Wednesday night.

The CHAIRMAN. How many days was it from the time it happened?

Mr. LOVE. This was 2 days later. Her charts were still being filled out on a Friday that she was, you know, alive, you know, was responsive, that kind of stuff, and my mother had been removed Wednesday night.

The CHAIRMAN. Did anybody from the facility call the family to tell them that something bad had happened?

Mr. LOVE. Until I had called, she was, like I said, beaten on a Tuesday night, this was Wednesday morning—I was only advised from the shift supervisor—not the shift supervisor—the RN that was taking charge of what had happened to my mother. Otherwise, there was no call the night before, and——

The CHAIRMAN. Who was the first to call the law enforcement officials? Was it the nursing home?

Mr. LOVE. No, they did nothing. My brother took the initiative to call the nursing home—not—excuse me—the nursing home—called Sacramento Police Department to make sure there was an officer that would help him respond to, you know, ease and facilitate getting my mother, you know, over to the emergency room, and the law enforcement responded with also a photographer, who came in the middle of the night and took the police photographs to substantiate what her injuries were.

The CHAIRMAN. Did the nursing home ever call law enforcement?

Mr. LOVE. No.

The CHAIRMAN. What you also say, in effect, is that the nursing home really hired a criminal?

Mr. LOVE. That is what I understood. Our attorney did some investigative work into this gentleman's background, and it was not a very good background.

The CHAIRMAN. The person who did this to your mother had actually been dismissed from two prior nursing homes for aggressive behavior toward residents.

Mr. LOVE. Yes, and my attorney has more detail, but that kept it brief so we could portray this.

The CHAIRMAN. You mentioned that there was a survey, a state agency surveyor, in the building when your mother's neck was broken. Can you elaborate on what, not who it was by name, but what was that person's position? Was he a state official in the nursing home of some sort?

Mr. LOVE. She was from Health and Human Services and this is for the Aging, and they also take care of the same—the ombudsmen turn their reports into these people, and this lady was in Wednesday morning on another incident, but was never notified while she walked right down the hallway past my mother's bed, but was never notified that there was an incident at all as of Wednesday morning, and the lady was there, and I had talked with that woman.

The CHAIRMAN. So you have a situation here where the nursing home personnel, which knew about what happened, neither notified law enforcement nor did they notify the state agency that regulates nursing homes?

Mr. LOVE. That is correct. Also no other evaluation was done on her by anyone outside of the nursing home, so that led us to believe we were very fortunate to discover my mother's injuries at that particular time, because I do not know if she would have ever received anything, since the only people that had looked at her at all were internal.

With my mother's neck broken, one of her complaints was they tried to have her doing range of motion movement to see if she could function and what was going on, and everyone I have ever talked to said with a severe neck injury, you would never do something like that, and the person that did this was the director of nursing.

The CHAIRMAN. You certainly do not do that with a broken neck.

Mr. LOVE. I would not think so, sir.

The CHAIRMAN. Ms. Becker, again, thank you for what I know is difficult, but I also want to assure you that these hearings will not be forgotten after you leave. You said that the facility had said that your mother-in-law had been injured in a fall. Is that how they characterize what had happened to her?

Ms. BECKER. What they left on our answering machine was just simply that she had been injured. The documents that they sent with her to the hospital indicated that she fell.

The CHAIRMAN. So the family was notified how? By a call left on an answering machine from the nursing home?

Ms. BECKER. Yes.

The CHAIRMAN. They indicated that your mother-in-law had been injured.

Ms. BECKER. Injured.

The CHAIRMAN. But did not elaborate how?

Ms. BECKER. No.

The CHAIRMAN. What did you do after that? Did you call the nursing home and say what do you mean, how is she, or did you call and find out more about it, and what did they say?

Ms. BECKER. Initially I called. She had fallen before, so I assumed injured, she had fallen. We called to find out whether she was still at the nursing home or at the hospital, and she was already back at the nursing home because the hospital was not told.

So we went directly there as soon as we made contact with them, but there was no mention of the assault until an employee came forward in secrecy and——

The CHAIRMAN. How long after the incident happened did you find out what really happened, the fact that your mother-in-law had been picked up from a standing position, slammed into a wall and a handrail, and fallen unconscious. How long after it happened did you actually find out what really happened?

Ms. BECKER. We had been gone for the day. I would say we had been at the nursing home for maybe 45 minutes when this person came forward.

The CHAIRMAN. Do you know if the nursing home ever called law enforcement after it happened?

Ms. BECKER. No, sir, they did not.

The CHAIRMAN. Do you have any knowledge as to whether they reported what actually happened to the state authorities that regulate the nursing home?

Ms. BECKER. I do not think so. I reported it.

The CHAIRMAN. You yourself had called the state and all these other agencies that you called as well?

Ms. BECKER. Law enforcement, yes.

The CHAIRMAN. You said that you did not get much help from the regulatory agencies at all?

Ms. BECKER. Right.

The CHAIRMAN. How about from law enforcement?

Ms. BECKER. They did a very good job up to the point of investigating this male mental patient, but once he passed away, there was nothing further done.

The CHAIRMAN. Do you think that from your knowledge, had the nursing home done a background check on employee—this was a mental patient in there?

Ms. BECKER. Resident, yes.

The CHAIRMAN. I am sorry. That is for Michael. The person that did this to your mother-in-law was actually a patient in the facility?

Ms. BECKER. Correct.

The CHAIRMAN. Right. But that patient had a long history of rather violent mental problems?

Ms. BECKER. Yes.

The CHAIRMAN. Mr. Peters, another absolutely horrifying story. I mean it is just almost unimaginable. On your situation, did the nursing home call law enforcement?

Mr. PETERS. Not to my knowledge, chairman. Like I said, she was sent to the hospital pretty soon after that, but I have not been able to see anywhere in the records so far that the nursing home called the family. The family ended up finding out when the hospital called.

The CHAIRMAN. So the family found out not from the nursing home where it happened, but actually from the hospital where she was admitted after the baby was discovered, I take it?

Mr. PETERS. That is what I understand so far.

The CHAIRMAN. When was the family first involved with law enforcement officials about what happened?

Mr. PETERS. It was within a couple of weeks.

The CHAIRMAN. A couple of weeks?

Mr. PETERS. A couple of weeks within her being admitted to the hospital.

The CHAIRMAN. But obviously the situation here is even more separated from the time of the actual crime, which was the rape, and not being discovered until the lady had the actual baby in the nursing home 9 months later.

Mr. PETERS. That is correct.

The CHAIRMAN. Tell me about the employee who perpetrated the crime. I mean this was a criminal. Was there any reason to suspect that this person had any kind of tendencies in his past record to be involved in this type of activity?

Mr. PETERS. None that I can find so far, but the case in terms of the civil case is still ongoing, and for that reason I cannot speak a whole lot, but I can say that I will be doing discovery on that very issue. I do know that he was a 9-year employee of the nursing home. What I do not know is what his actions were during that 9 year period. I have not gotten his records.

The CHAIRMAN. Can you tell us how and who found out who was responsible?

Mr. PETERS. Yes. There was an anonymous call from a woman who evidently worked at the nursing home, but she never identified herself. She called the police officers.

The CHAIRMAN. I take it that the evidence indicated either through DNA or some other manner of gathering evidence that this person was, in fact, responsible?

Mr. PETERS. Yeah. What was bothersome to me is getting into this the nursing home originally tried to say that my client had been taken out of the facility during the time that she would have become pregnant. Well, the records show that is clearly not the case and a couple of witnesses came forward to try to trump up a story to that effect, and it has all been disproved. Believe it or not, this man originally claimed that this was a consensual sexual relationship, and that is why—and he voluntarily gave his DNA, and then they matched up, and, of course, anybody that spends 2 minutes with my client knows that the notion that this was consensual is absurd.

The CHAIRMAN. Can you tell—my last question—can you tell us how the law enforcement officials got involved in this case? I know there is civil litigation going on, but from a law enforcement standpoint, how did they become involved in this case?

Mr. PETERS. They were called likewise by the hospital, because what I have found in these——

The CHAIRMAN. Not by the nursing home?

Mr. PETERS. Not by the nursing home. What I was going to say what I found in these cases is that when a hospital gets a patient that has obviously been the victim of some kind of incident in the nursing home, they are pretty quick to get on the phone and call the police because they do not want any of that responsibility falling into their lap.

The CHAIRMAN. Thank you, Mr. Peters, and thank all of you for very powerful testimony. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. Your excellent questioning highlights, it seems to me, how the safety net that is sup-

posed to protect vulnerable seniors is just full of holes. Mr. Love, I was particularly struck by the last page of your testimony—basically the entire system broke down—the social service agencies, the ombudsman did not have the necessary authority, the state surveyors, the prosecutors, the judge. I mean at every step of the way the system that is supposed to be there for seniors as a safety net, there was not any there.

What I would like to do for just a couple of moments is have you trade places with all of us who are sitting on this side of the dias. We want to make sure that we do not have witnesses here in another 18 months saying exactly the same thing. I think, Ms. Becker, you put it very well. The question is what do we say when we go home? What do we say about it being different?

The question will be what is it like in 2 years when the press has gone away and some of the attention is not there? Will we have exactly the same system that exploits and rips these people off? So what I would like to do for a few minutes is just have each of you put yourself in our shoes. We want to make it different this time. Give us a couple of priorities. Each one of you, start with you, Mr. Love, then you Ms. Becker, and then you, Mr. Peters. You have got the election certificate today and tell the U.S. Senate what you think ought to be done. Mr. Love.

Mr. LOVE. It is ironic. I tried to do something like this to help you along with just some ideas. A few of the recommendations are—when you were leading into when we started this, someone said this, like put a face on the problem. You are not going to forget it, and I am just going to use Polly Klaus' father keeps things alive, keeps things stirred, and when you do this, the interest is there. I do not know of too many people that do not know the Polly Klaus story.

From my situation, the other part was I feel some of the laws are there, and all they have to do is enforce them. But they have to take that initiative. I have no complaint with the Sacramento PD, so if I was listening to this—they did what they could, but the detective told me once it is turned over to the DA, I cannot do anymore.

There is one thing I am going to try and say with this in some way or another, we have to with some aid promote Health and Human Services enforcement, but get them free of limitations by supervisory pressure not to go after offenders. I cannot say too much specifically on sources, but we had an individual come to us and say that she was too efficient and she needed to tone it down, and if she did not do that, it was going to cost her her job.

Senator WYDEN. What level of involvement did this come from? Was this a governmental person?

Mr. LOVE. This was a governmental person, and like I said——

Senator WYDEN. Somebody in government said you are doing too much to protect seniors?

Mr. LOVE. This was a supervisory level, you know, and this woman did not like it, she would not have a position, and she had to say that off the record for keeping her job.

The other thing is I know a little bit about, you know, the IRS and a few other things, but in the IRS, if you are in a corporation, and you are one of the officers, and shall we say money is lost, and

you are an executive in that position, they can go after you personally to make sure that the government is reimbursed for what should have been paid in the first place.

So one of the things I would consider is can you hold owners or managers of a corporation criminally responsible? All I am saying is my experience has been there has been a number of cases that I have had a chance to see or know about where the people are fined, the insurance companies pay the fine, and business goes on as usual.

Senator WYDEN. Is business going on as usual at the facility where your mom was?

Mr. LOVE. I cannot speak recently on that. But what I am saying is there were other litigations that came in after our case and that was going to be substantially damaging to them, and the insurance company no longer wanted to insure them. They had lost their insurance after our case is what my understanding was.

The biggest thing what I am saying was is if someone would be held criminally responsible, and I will use the terms that I have written right here, for continued abuse in the conduct of the operations of a nursing home, and there is no corrective measures, are we to believe that there is no consequences for, shall we say, continuing bad business when—all I am saying if I was a member of a corporation, and my corporation did not pay it, if I am the one that has got the assets, they could go after me and take them back. I just wonder whether something along that line.

I will make one last statement, and I will be brief. After contacting my attorney to make sure I was correct with this, collect the fines and penalties assessed by the state agencies for nursing home violations. In California, this would help you get the needed funds for enforcement, and the money just is not gone after or it is appealed and appealed and appealed and reduced quite substantially.

But with her passing on to me the knowledge that there is millions of dollars that have not been gone after to be collected that have been assessed for Class A, which is the most serious violations, I do not know what to say. They had been fined. Nothing is being done.

Senator WYDEN. Good recommendations. Ms. Becker.

Ms. BECKER. I believe I said something like that in my testimony. We have regulations, probably more than we need. They are not worth the paper they are written on if they are not enforced. To me the biggest insult of the whole experience has been that had this happened in my home, there is no question I would have been investigated, I would have been prosecuted, and I probably would have been put in prison. That is why I cannot let it go. I think that would change a tremendous amount of things down the ladder.

Senator WYDEN. Sends a powerful message. Mr. Peters.

Mr. PETERS. Yes. The first thing I would do, and I am certainly no expert on what can be done on the Federal level versus the state level, but I would suggest having Federal imposed regulations in law across the board for nursing homes in the United States that require mandatory criminal background checks, mandatory investigation into their background for whatever facilities they worked at previous, because the nature of the nursing home business is people move around a lot, and they get lost in the shuffle.

They need to have their background investigated going back probably, you know, 5 to 10 years. Then I would impose Federal, stiff Federal penalties, when nursing homes have cases of unreported abuse or it is discovered after the fact that there was abuse and they knew about it and they did not do anything about it.

Then if you can discover that they violated these Federal regulations on hiring, the penalties need to be stiff and maybe include license revocation.

The third thing I want to talk about real briefly, if I can, has nothing to do with we are talking about the response. I think one of the big things in looking at nursing home care going forward in this country is prevention, and again I do not know if this can be done on a Federal level, but security cameras in rooms, affectionately known as "granny cams," if the residents and their families want them, they can agree to it, you can put them in there, and I am telling you people do not do things when they know the camera is watching. It may not eliminate all the bad apples that get in, but it will certainly limit the bad behavior.

Senator WYDEN. Mr. Chairman, my time is up, but I think because you and I are on the committee involved in communications issues, that is an area we ought to follow up with Mr. Peters on, because he has, in effect, said let us look at a tool that would empower the patients and families. In other words, you are not forcing it on them. You are saying let us look at something that empowers them to have this added tier of protection.

Senator Breaux and I are both on the committee that deals with these issues, and we will have the chance to follow that up as well. Thank you, Mr. Chairman.

The CHAIRMAN. Well, we got cameras catching people running red lights, for God's sakes. I mean you think if you can use cameras with something as insignificant as that, something like this is something that should be considered.

Senator KOHL.

Senator KOHL. Thank you very much, Mr. Chairman, and I would like to say I can guarantee that your coming here and testifying is not going to be in vain, and if I guaranteed that, I am sure you would look at it with some degree of question, but I do believe that this hearing is going to result in improvement in the kind of care and the kind of oversight that we give to our elderly who are in nursing homes.

Just to talk about this bill that we have been trying to get passed now for 5 years, this national registry of abusive long-term caregivers, the bill also would require that the FBI conduct criminal background checks to see if there are any serious violations in the history of a potential employee, of a health care facility, which I think you indicated, Mr. Love, was on the record of the abuser of your family member. There was a record of a criminal violation.

Mr. LOVE. That is correct, Senator. My attorney was dogged enough to go back and find, you know, what had happened with this previous individual. We were not given that information. My attorney found out.

Senator KOHL. Would the three of you be at least minimally satisfied if we could pass that bill? That is to say establish a national registry of those people who have abusive backgrounds, and also

require that the FBI conduct a criminal background check on any people who apply for employment? Ms. Becker.

Ms. BECKER. May I ask a question?

Senator KOHL. Yes.

Ms. BECKER. Would it be mandatory that if a facility just does not report, say they have an employee who abuses one of their residents, and if they do not report that and let that person move from place to place, which happens a lot, would there be stiff penalties for doing so?

Senator KOHL. So you are suggesting we add that provision to the bill?

Ms. BECKER. Yes, sir.

Senator KOHL. OK.

Mr. LOVE. They found out in California that you are supposed to turn in any violations, so the nursing home is supposed to do that. What they found is instead of turning in the paperwork, there is a habit of, shall we say, you go down the road and we will keep our mouth shut, get lost. That is why homework had to do be done in reverse to find out what this individual was about.

Senator KOHL. Just to get at this question about reporting it, presumably the reason that a facility would not report it is because it would reflect badly on them?

Mr. LOVE. That is correct.

Senator KOHL. But if, in fact, there was no public declaration other than this person is listed as an abuser, then the facility would have no compunction about reporting that person as an abuser to be listed on a registry; right?

Mr. LOVE. I would agree with that. That was the reason in California, again, the background checks are supposed to be performed to put the responsibility on the new hiring agency, and shall we say some are not diligent in that aspect?

Mr. PETERS. Senator Kohl, I think the national registry idea would be a great starting place, which would allow nursing homes to, in fact, investigate their employees on a nationwide level. Therefore, if you have a CNA, a certified nursing assistant, that has worked in Arizona, and had problems and moved to Florida to work, it would be required by the new nursing home to check the national registry. If that person is on it, they would be precluded from hiring that person. You are going to eliminate some of the bad apples. I think it is a real good place to start.

Senator KOHL. OK. Well, as I said, we cannot guarantee that we can get this bill passed, but we have been trying for 5 years to get it passed, but I believe our chances are better than they have ever been before, and I believe your presence here today, your testimony, the record that you are establishing, will have a lot to do with providing the impetus to get the bill passed, and I think it is going to be done. So we all appreciate your coming.

The CHAIRMAN. Thank you, Senator Kohl. I would just make an observation. Back in 1998, Congress passed an appropriations bill that allowed the states in that legislation to request FBI criminal background checks for nursing home employees. It is cheap, relatively simple. FBI does the work, gives you a report. I think there are probably only two states that availed themselves of that oppor-

tunity now. They can do it right now. The FBI will do the work for them, but they are not doing it. Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman, and once again thanks for your leadership in this issue on behalf of our seniors, but also on behalf of aging Americans. When I was a staffer here in Washington before I was elected, I can remember calling home to my mother, and she did not have time to talk to me on the phone because she was going over to the elementary school. She was a room mother, and I made the comment to her, I said I am the youngest of your four children, you have not had a child in the public schools in almost 25 years now, and I said why are you going over? She said because those kids need a room mother, they need a valentine cookie, they need a bean bag toss at Halloween, and in jest she said, she said I want those children to grow up as well adjusted as possible. She said you never know. They may be the ones running the nursing home you put me in one day.

So it is not just these atrocities and these tragic stories that you have shared with us today, but it is the fear in our aging population of what they may be subjected to, because of the stories you have shared with us. I do not have any questions for you. I just want to tell you how grateful I am that you were willing to bring these stories to light, to bring these stories to us, in hopes that we can work with those in states who have gone a little bit further, who have pushed the envelope.

There are some things in our State in Arkansas where we have seen some terrible things happen, and we have worked with our coroner, who will be testifying in the next panel, but certainly so many things that we could be doing, and hopefully in conjunction with Senator Kohl and Senator Breaux and Senator Wyden and myself, we can continue to bring to light to our colleagues and move forward in some areas, particularly in legislation. It will be of great assistance, not only to ensure that the tragic stories you have told us today do not occur again, but that we can help to eliminate any fear of those aging constituents out there who are fearful of where they might be themselves one day.

So thank you very much for coming. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Lincoln. I want to thank the panel again. This is obviously very powerful testimony, and shame on us if we do not follow up and get something done as a result of it. I assure you that we intend to and intend to do it aggressively, and this panel would be excused, and hope to continue to work with you.

I would also note for the record, I mean I think the testimony we have heard is not typical of nursing homes in this country. I mean the fact that it ever happens is one incident too many.

The CHAIRMAN. Let us welcome up the second panel. Ms. Leslie Aronovitz with the General Accounting Office who did the report for us; Mr. Mark Malcolm who is the coroner from Little Rock, who maybe Senator Lincoln will say something about; Ms. Delta Holloway, who is with the American Health Care Association, representing the nursing home industry; Mr. Henry Blanco, the National Association of Adult Protective Service Administrators; and from my home State of Louisiana, Sheriff Charlie Fuselier, on behalf of the National Sheriffs' Association.

I told everyone that for Sheriff Fuselier, as he testifies, I will engage in simultaneous translation so that everybody can understand us. [Laughter.]

But Charlie, we are very happy that you are here with us. Let us take Ms. Aronovitz, again with the General Accounting Office, to give us her testimony from GAO. Thank her very much for what has been a very long effort on the part of GAO in looking at this issue, and on abuse in nursing homes, and I think they did a terrific job.

Ms. Aronovitz.

STATEMENT OF LESLIE ARONOVITZ, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH EDUCATION AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Ms. ARONOVITZ. Thank you, Chairman Breaux, and committee members. I am deeply saddened but unfortunately not shocked by the testimony we have heard on the first panel. The fact is we cannot overstate the vulnerability of nursing home residents who are physically and mentally abused and impaired.

The Federal and state oversight agencies and the nursing homes themselves are fully aware of the heightened risk these fragile residents face. In fact, these entities have policies and procedures in place intended to protect residents from abuse. Nevertheless, our work in three states confirms that significant gaps in these protections leave residents at considerable risk. I say this fully acknowledging that even the best of safeguards cannot prevent every incident of abuse.

The ambiguous and hidden nature of abuse in nursing homes makes the prevalence of this offense difficult to determine. For reasons such as fear of recrimination of adverse publicity, as was mentioned, we found that family members, nursing home staff and even management do not always report allegations of abuse timely enough for it to be fully investigated or at all.

We were also concerned that some states do not interpret and apply the definition of abuse in the way that the Centers for Medicare and Medicaid Service's officials believe that the definition should be applied. In Federal nursing home regulations, CMS defines abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

The states we visited maintain their own definitions that are consistent with this one, but their application of the definition varies. For example, Georgia survey agency officials were less likely to determine that an aide had been abusive if the aide's behavior appeared to be spontaneous or the result of a reflex response.

Pennsylvania officials were not likely to cite an aide for abuse unless the aide caused the resident serious injury or obvious pain. So, for example, of someone took a hairbrush and struck the back of a resident's head and no injury appeared, they might be less likely to decide that that was, in fact, abuse.

The Illinois survey agency considered any nonaccidental injury to be abuse and cited aides even when residents were combative or had not suffered serious injury. In discussing the states' different

approaches, CMS officials contended that an aide who slaps a resident, regardless of whether it was a reflexive response, should be considered abusive.

In light of these different perspectives, we have recommended that CMS clarify the definition of abuse to ensure that states cite abuse consistently and appropriately.

Another problem we identified consistent with the testimony you just heard is that existing protections are not adequate to keep a person with a history of abuse from getting a job in a nursing home. For instance, when hiring nurse aides who are the primary caregivers in nursing homes, facilities are required to check a state registry for information on these perspective employees.

However, the registry is limited to information about an aide's employment in nursing homes within the state. Even when an aide has been cited for abuse within the state, there may be a considerable time lag between before that information gets entered into the state registry.

We believe that such a serious citation warrants due process, but currently there is no time limit on the beginning of the process and on the end, not in the middle where due process occurs that needs to be fixed.

For instance, there is no time limit on states completing the investigation that could lead a nurse aide to be cited nor in a decision being rendered after a hearing has taken place.

That just extends the time period that a name would actually go on the registry if, in fact, a nurse aide was determined to be abusive. At the states we visited, it took 5 to 7 months on average between the initial finding of abuse and its entry in the registry, and several cases took over 2 years.

During this time, a nursing home employer consulting the registry would have found clean records for these aides. There can be other cracks in employment screening. For instance, in the case of certain employees such as laundry aides or maintenance workers, there is no registry or licensing entity for a nursing home employer to consult.

These individuals would have to have a criminal conviction which would be found in law enforcement records before an abuse history would show up on a background check. Furthermore, some states allow individuals to begin working before facilities complete their background checks. In Illinois, a new employee can work for 3 months before the criminal background check is complete, while in Pennsylvania, an aide can work for 1 month under these circumstances.

In Georgia, on the other hand, criminal background checks must be completed within 3 days of the request and nurse aides cannot start work before then.

Overall, we believe that existing safeguards need to be strengthened and we are making five recommendations for CMS to address the systemic problems discussed in our report.

However, state officials and nursing homes must also practice unflagging vigilance. The extreme vulnerability of the nursing home population calls for nothing less. Mr. Chairman, this concludes my prepared remarks, and I will be glad to answer any questions any of you may have.

[The prepared statement of Ms. Aronovitz follows:]

United States General Accounting Office

GAO

Testimony

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NURSING HOMES

Many Shortcomings Exist in Efforts to Protect Residents from Abuse

Statement of Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

GAO-02-448T

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss the issue of abuse in nursing homes. The 1.5 million elderly and disabled individuals residing in U.S. nursing homes constitute a population that is highly vulnerable because of their physical and cognitive impairments. Residents typically require extensive assistance in the basic activities of daily living, such as dressing, feeding, and bathing, and many require skilled nursing or rehabilitative care. Residents with dementia may be irrational and combative. This combination of impairments heighters the residents' vulnerability to abuse and impedes efforts to substantiate allegations and build cases for prosecution.

Our work for this committee on nursing home care quality has found that oversight by federal and state authorities has increased in recent years.[1] During these years, however, the number of homes cited for deficiencies involving actual harm to residents or placing them at risk of death or serious injury remained unacceptably high—30 percent of the nation's 17,000 nursing homes. Concerns exist that too many nursing home residents are subjected to abuse—such as pushing, slapping, beating, and sexual assault—by the individuals entrusted with their care. You therefore asked us to examine efforts by nursing home oversight authorities to protect residents against physical and sexual abuse. My remarks today will focus on (1) inherent difficulties in measuring the extent of the abuse problem, (2) gaps in efforts to prevent and deter resident abuse, and (3) the limited role of law enforcement in abuse investigations. My comments reflect the findings of a report we are issuing today. The report is based on our visits to three states with relatively large nursing home populations and discussions with officials at the Centers for Medicare and Medicaid Services (CMS)—the federal agency charged with oversight of states' compliance with federal nursing home standards.[2]

In brief, the ambiguous and hidden nature of abuse in nursing homes makes the prevalence of this offense difficult to determine. CMS defines abuse in its nursing home regulations and the states we visited maintain definition consistent with the CMS definition. However, the states vary in

[1]U.S. General Accounting Office, *Nursing Homes: Sustained Efforts Are Essential to Realize Potential of the Quality Initiatives*, GAO/HEHS-00-197 (Washington, D.C.: 2000).

[2]U.S. General Accounting Office, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312 (Washington, D.C.: 2002).

their interpretation and application of the definitions. For example, nurse aides in two of the states we visited who struck residents were not considered abusive by state survey agency officials under certain circumstances, whereas the third state's nurse aides under similar circumstances were consistently cited for this offense. Incidents of abuse often remain hidden, moreover, because victims, witnesses, and others, including family members, are unable to file complaints or are reluctant for several reasons, including fear of reprisal. When complaints and incidents are reported, they are often not reported immediately, thus harming efforts to investigate cases and obtain necessary evidence.

Despite certain measures in place at various levels to prevent or deter resident abuse, certain gaps undermine these protections. For instance, states use a registry to keep records on nurse aides within the state, but these state registries do not include information about offenses committed by nurse aides in other states. Unlicensed or uncertified personnel, such as laundry aides and maintenance workers, are not listed with a registry or with a licensing or certification body, allowing those with a history of abuse to be employed without detection, unless they have an established criminal record. In addition, in the states we visited, nursing homes often did not notify state authorities immediately of abuse allegations. Moreover, states' efforts to inform consumers about available protections appeared limited, as the government agency pages in telephone books of several major cities we visited lacked explicitly designated phone numbers for filing nursing home complaints with the state.

Local and state enforcement authorities have played a limited role in addressing incidents of abuse. Several local police departments we interviewed had little knowledge of the state survey agencies' investigation activities at nursing homes in their communities. Some noted that, by the time the police are called, others may have begun investigations, hampering police efforts to collect evidence. Even the involvement of Medicaid Fraud Control Units (MFCU)—the state law enforcement agencies with explicit responsibility for investigating allegations of patient neglect and abuse in nursing homes—is not automatic. MFCUs get involved in resident abuse cases through referrals from state survey agencies. However, as demonstrated in the states we visited, the extent to which a state's MFCU investigates cases varies according to the referral policies at each state's survey agency. Our review of alleged abuse cases suggests that the early involvement of the state MFCU can be productive in obtaining criminal convictions.

In its federal oversight role, CMS could do more to ensure that nursing home residents are protected from abuse. Requirements for screening and hiring prospective employees, involving local law enforcement promptly when incidents of abuse are alleged, and ensuring the public's access to designated telephone numbers are among the protections that CMS could strengthen. Our report makes recommendations addressing these requirements.

Background

To help ensure that nursing homes provide proper care to their residents, a combination of federal, state, and local oversight agencies and requirements is in place. At the heart of nursing home oversight activities are state survey agencies, which, under contract with the federal government, perform detailed inspections of nursing homes participating in the Medicare and Medicaid programs. The purpose of the inspections is to ensure that nursing homes comply with Medicare and Medicaid standards. CMS, in the Department of Health and Human Services (HHS), is the federal agency with which the states contract and is responsible for oversight of states' facility inspections and other nursing-home-related activities.[3] By law, CMS sets the standards for nursing homes' participation in Medicare and Medicaid.

State survey agencies also investigate complaints of inadequate care, including allegations of physical or sexual abuse. Once aware of an abuse allegation, nursing homes are required by CMS to notify the state survey agency immediately. They must also conduct their own investigations and submit their findings in written reports to the state survey agency, which determines whether to investigate further.

Certain federal and state requirements focus on the screening of prospective nursing home employees. CMS requires nursing homes to establish policies prohibiting employment of individuals convicted of abusing nursing home residents. Although this requirement does not include offenses committed outside the nursing home, the three states we visited—Georgia, Illinois, and Pennsylvania—do not limit offenses to those committed in the nursing home setting and have broadened the list of disqualifying offenses to include kidnapping, murder, assault, battery, or forgery.

[3]CMS was formerly the Health Care Financing Administration (HCFA) and was renamed in June 2001.

As another protective measure, federal law requires states to maintain a registry of nurse aides—specifically, all individuals who have satisfactorily completed an approved nurse aide training and competency evaluation program.[4] This requirement is consistent with the fact that nurse aides are the primary caregivers in these facilities. Before employing an aide, nursing homes are required to check the registry to verify that the aide has passed a competency evaluation.[5] Aides whose names are not included in a state's registry may work at a nursing home for up to 4 months to complete their training and pass a state-administered competency evaluation. CMS' nursing home regulations require states to add to the registry any findings of abuse, neglect, or theft of a resident's property that have been established against an individual. The inclusion of such a finding on a nurse aide's record constitutes a lifetime ban on nursing home employment, as CMS regulations prohibit homes from hiring individuals with these offenses. As a matter of due process, nurse aides have a right to request a hearing to rebut the allegations against them, be represented by an attorney, and appeal an unfavorable outcome. Other nursing home professionals who are suspected of abuse and who are licensed by the state, such as registered nurses, are referred to their respective state licensing boards for review and possible disciplinary action.

Among the local and state law enforcement agencies that may investigate nursing home abuse cases are the MFCUs. MFCUs are state agencies charged with conducting criminal investigations related to Medicare and Medicaid. Generally, MFCUs are located in the state attorney general's office, although they can be located in another state agency, such as the state police. Part of their mission is to investigate patient abuse in nursing homes. MFCUs typically receive abuse cases from referrals by state survey agencies. If criminal charges are brought, prosecuting attorneys within the MFCU or attorneys representing the locality take charge of the case.

[4]In certain instances, some individuals would be exempt from this training, such as student nurses or nurses trained in another country.

[5]Nursing homes in the states we visited have several means of checking the nurse aide registries to determine whether aides are in good standing and eligible for employment. Homes receive quarterly bulletins listing all disqualified aides in their state. In addition, they may obtain this information from the survey agency's website or by calling the survey agency.

Ambiguous and Hidden Nature of Nursing Home Abuse Makes Extent of Problem Difficult to Measure

The problem of nursing home abuse is difficult to quantify and is likely understated for several reasons. First, states differ in what they consider abuse, with the result that some states do not count incidents that CMS or other states would count as abuse. Second, powerful incentives exist for victims, their families, and witnesses to keep silent or delay the reporting of abuse allegations. Third, some research focuses on citations of nursing homes for abuse-related violations, which are maintained in a CMS database, but these data reflect only the extent to which facilities fail to comply with federal or state regulations. Abuse incidents that nursing homes handle properly are not counted, because no violation has been committed that warrants a citation.

States Do Not Share Common View of Resident Abuse

Some states may not be citing nurse aides for incidents that other states would consider abuse. Based on the definition of abuse in the Older Americans Act of 1965,[6] CMS defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."[7] States maintain their own definitions that are consistent with the CMS definition. Our review of case files showed that states interpret and apply these definitions differently.

For example, on the basis of the abuse cases reviewed, we noted that Georgia survey agency officials were less likely to determine that an aide had been abusive if the aide's behavior appeared to be spontaneous or the result of a "reflex" response. The Georgia officials told us that, to cite an aide for abuse, they must find that the individual's actions were intentional. They said they would view an instance in which an aide struck a combative resident in retaliation after being slapped by the resident as an unfortunate reflex response rather than an act of abuse. Among the Georgia case files we reviewed, we found 5 cases in which the aides struck back after residents hit them or otherwise made physical contact. In all five cases, Georgia officials had determined that the aides' behavior was not abusive because the residents were combative and the aides did not intend to hurt the residents.

In Pennsylvania, officials emphasized other factors to determine a finding of abuse. They said that establishing intention was important, but they

[6] 42 U.S.C. § 2002 (1994).

[7] 42 C.F.R. § 488.301 (2001).

would be unlikely to cite an aide for abuse unless the aide caused serious injury or obvious pain. Our review of Pennsylvania files indicated that most of the aides that were found to have been abusive had, in fact, clearly injured residents or caused them obvious pain. In several cases reviewed in which residents were bumped or slapped and reported being in pain as the result of aides' actions, the survey agency officials decided not to take action against the aides because, in their view, the residents had no apparent physical injuries.

In contrast, the Illinois survey agency considers any nonaccidental injury to be abuse. Thus, incidents not considered abusive in Georgia and Pennsylvania—reflex actions and incidents not involving serious injury or obvious pain—could be considered abusive in Illinois. In the 17 Illinois case files we reviewed involving either combative residents or residents who did not suffer serious injury, officials found that aides had been abusive. When Illinois handled a case similar to a Georgia case in which a nursing home employee witnessed a nurse aide strike a combative resident, the state not only included this information in the individual's nurse aide registry file, it also referred the matter to the state's MFCU, resulting in a criminal conviction.[8]

CMS officials indicated that states may use different definitions of abuse, as long as the definitions are at least as inclusive as the CMS definition. The officials agreed that intent is a key factor in assessing whether an aide abused a resident but argued that intent can be formed in an instant. In their view, an aide who slaps a resident, regardless of whether it was a reflexive response, should be considered abusive. In light of these different perspectives, we have recommended that CMS clarify the definition of abuse to ensure that states cite abuse consistently and appropriately.

People May Be Unable or Reluctant to Report Abuse Allegations

The physical and mental impairments typical of the nursing home population handicap residents' ability to respond to abuse. Some residents lack the ability to communicate or even realize that they have been abused, while others are reluctant to report abuse because they fear reprisal. For these reasons, elder abuse in nursing homes is likely

[8]As a result, the aide was sentenced to 2 years probation, directed to complete 100 hours of community service, and prohibited from employment that would involve contact with the elderly or people with disabilities.

underreported or often not reported immediately. In some cases, residents are unable to complain about what was done to them. In other cases, family members may hesitate to report their suspicions because they fear retribution or that, if reported, the resident will be asked to leave the home. In still other cases, facility staff fear losing their jobs or recrimination from coworkers, while facility management may not want to risk adverse publicity or sanctions from the state. In our file reviews, we saw evidence that family members, staff, and management did not immediately report allegations of abuse. (See figure.)

Figure: Examples of Allegations Not Immediately Reported

- A resident reported to a licensed practical nurse that she had been raped. Although the nurse recorded this information in the resident's chart, she did not notify the facility's management. The nurse also allegedly discouraged the resident from telling anyone else. About 2 months later, the resident was admitted to the hospital for unrelated reasons and told hospital officials she had been raped. Once hospital officials notified the police, an investigation was conducted and revealed that the resident had also informed her daughter of the incident, but the daughter dismissed it. The resident later told police that she did not report the incident to other staff because she did not want to cause trouble. The case was closed because the resident could not describe the alleged perpetrator. However, the nurse was counseled about the need to immediately report such incidents.
- An aide, angry with a resident for soiling his bed, threw a pitcher of cold water on him and refused to clean him. Another aide witnessed the incident. Instead of informing management, the witness confided in a third employee, who reported the incident to the nursing home administrator 5 days after the abuse took place. The aide who threw the water on the resident was fired and was cited for resident abuse in the state's nurse aide registry.
- Nursing home management failed to promptly notify the state survey agency of an incident in which an aide slapped a resident and visibly bruised the victim's face. Although the home investigated the situation and took appropriate action by quickly suspending and ultimately firing the aide, it did not notify the state survey agency until 11 days after the abuse took place.

Source: Case files from state survey agencies in Georgia and Pennsylvania.

Data on States' Nursing Home Citations Provide Little Information About Resident Abuse

Data from states' annual inspections of nursing homes, while a source of information about facility compliance with nursing home standards, provide little precision about the extent of care problems, of which resident abuse-related problems are a subset. Abuse-related violations committed by nursing homes include failure to protect residents from sexual, physical, or verbal abuse; failure to properly investigate allegations of resident abuse or to ensure that nursing home staff have been properly screened before employment; and failure to develop and implement written policies prohibiting abuse.

In 2000, we reported on the wide variation across states in surveyors' identification and classification of serious deficiencies—conditions under which residents were harmed or were in immediate jeopardy of harm or

death.[9] The extent to which abuse-related violations are counted as serious deficiencies depends on how the surveyor classifies the severity of the deficiency identified. In our analysis, the problem of "interrater reliability"—that is, individual differences among surveyors in citing homes for serious deficiencies—was one of several factors contributing to the difference of roughly 48 percentage points across states in the proportion of homes cited in 1999 and 2000 for serious deficiencies. The variation ranged from about 1 in 10 homes cited in one state to more than 1 in 2 homes cited in another.

We also found that one state's tally of nursing homes with serious deficiencies would have been highly misleading as an indicator of serious care problems. Of the homes the state surveyed during the 1999-2000 period, it found 84 to be "deficiency free." However, when we cross-checked the annual inspection results for these homes with the homes' history of complaint allegations, we found that these deficiency-free homes had received 605 complaints and that significant numbers of these complaints were substantiated when investigated. This discrepancy illustrates the difficulty of estimating the extent of resident abuse using nursing home inspection data.

Gaps Exist in Efforts to Prevent or Deter Resident Abuse

Nursing home residents' inability to protect themselves accentuates the need for strong preventive measures to be in place in both nursing homes and the agencies overseeing them. Although certain measures are in place, we found them to be, in some cases, incomplete or insufficient. In the states we visited, efforts to screen employees and achieve prompt reporting fell short of creating a net sufficiently tight to protect residents from potential offenders.

Sources Used to Screen Prospective Employees Do Not Contain Complete or Up-to-Date Information

Nursing homes have available three main tools to screen prospective employees: criminal background checks conducted by local law enforcement agencies, criminal background checks conducted by the Federal Bureau of Investigation (FBI), and state registries listing information on nursing home aides, including any findings of abuse committed in the state's facilities. The information included in these sources, however, is often not complete or up to date.

[9] GAO/HEHS-00-197.

State and local law enforcement officials in the three states we visited conduct background checks on prospective nursing home employees, but these checks are made only state wide. Consequently, individuals who have committed disqualifying crimes—including kidnapping, murder, assault, battery, and forgery—may be able to pass muster for employment by crossing state lines. On request, the FBI will conduct background checks outside the prospective employee's state of residence, but in some states these requests are rarely made, according to an FBI official.

Some states allow individuals to begin working before facilities complete their background checks. Pennsylvania permits new employees to work for 30 days and Illinois, for 3 months, before criminal background checks are completed. In contrast, Georgia requires that background checks be completed within 3 days of the request and interprets this requirement to mean that the checks must be completed before prospective employees may assume their duties.

Of the three states we visited, only Illinois requires that the results of criminal background checks on prospective nurse aides be reported to the state survey agency, which enters the information in the registry. A 1998 survey conducted by HHS' Office of Inspector General reported that Illinois was the only state with this requirement.[10] Nursing homes in Illinois checking the state registry are able to determine if an aide has a disqualifying conviction well before an offer of employment is made and a criminal background check is initiated. Alternatively, the survey agencies in states without this requirement do not have the information necessary to warn their respective nursing home communities about inappropriate individuals seeking employment.

Nurse aide registries, designed to maintain background information on nursing home aides, also contain information gaps that can undermine screening efforts. To cite an individual in the state's registry for a finding of abuse, authorities must first establish a finding, notify the individual of the intent to "annotate" the registry, and if the individual requests, hold a hearing to consider whether the finding is warranted. Specifically, the individual must be notified in writing of the state's intent to annotate the registry and be given 30 days from the date of the state's notice to make a written request for a hearing. Because the hearing may not be completed

[10]HHS Office of Inspector General, *Safeguarding Long-Term Care Residents*, A-12-97-00003 (Washington, D.C.: Sept. 14, 1998).

for several months after it is requested and decisions may not be rendered immediately, additional time may elapse. As with background checks, state registries do not track an aide's offenses committed at nursing homes in other states.

Our analysis of nurse aide records from 1999 indicated that hearings to reconsider an abuse finding added, on average, 5 to 7 months to the process of annotating an individual's record in the state registry. During this time, residents of other nursing homes were at risk because, even if an aide was terminated from one home, the individual could find new employment in other homes before the state's registry included information on the individual's offense. Thus, because of the amount of time that can elapse between the date a finding is established and the date it is published, the use of nurse aide registries as a screening tool alone is inadequate.

Facilities can screen licensed personnel, such as nurses and therapists, by checking the records of licensing boards for disciplinary actions, but screening other facility employees, such as laundry aides, security guards, and maintenance workers, is limited to criminal background checks. Unless such employees are convicted of an offense, problems with their prior behavior will not be detected. No centralized source contains a record of substantiated abuse allegations involving these individuals. Even when abuse violations identified through nursing home inspections are cited, they result in sanctions against the homes and not the employees. We identified 10 uncertified and unlicensed employees in the 158 cases we reviewed who allegedly committed abuse. One of the 10 pled guilty in court, thus establishing a criminal record. However, the disposition of five of these cases left no way to track the individuals through routine screening channels. Three of the nine—all of whom were dismissed from their positions—were investigated by law enforcement but were not prosecuted. Two others were also terminated by their nursing home employers but were not the subject of criminal investigations. (In these cases, physical abuse was alleged but the residents did not sustain apparent injuries.) The remaining four cases involved instances in which the allegations proved unfounded or the evidence was inconsistent; the individuals were thus not tracked, as appropriate.

In 1998, the HHS Office of the Inspector General recommended developing a national abuse registry and expanding state registries to include not only

aides but all other nursing home employees cited for abuse offenses.[11] A firm that CMS (then the Health Care Financing Administration) contracted with in September 2000 is currently conducting a feasibility study regarding the development of a national registry that would centralize nurse aide registry information and include information on all nursing home employees. The contractor intends to report its findings in March 2002.

Efforts to Alert Authorities of Abuse Incidents and Allegations Lack Sufficient Rigor

Enlisting the help of the facilities and the public to report incidents and allegations of abuse can supplement other efforts to protect nursing home residents. However, in the states we visited, nursing homes' performance in notifying the survey agencies promptly was well below par. In addition, access to information on phone numbers the public could use for filing complaints was limited.

In the three states we visited, nursing homes are required to notify their state survey agencies of abuse allegations immediately, which the agencies define as the day the facility becomes aware of the incident or the next day. Using this standard, we examined 111 abuse allegations filed by the three states' nursing homes. We found that, for these allegations, the homes in Pennsylvania notified the state late 60 percent of the time; in Illinois, late almost half of the time; and in Georgia, late about 40 percent of the time. Each state had several cases for which homes notified the state a week or more late and in each state at least one home notified the state more than 2 weeks late. Such time lags delay efforts by the survey agencies to conduct their own prompt investigations and ensure that nursing homes are taking appropriate steps to protect residents. In these situations, residents remain vulnerable to additional abuse until corrective action is taken.

As a nursing home resident's family and friends are another essential resource for reporting abuse to the state authorities, increasing public awareness of the state's phone number for filing complaints should be a high priority. CMS requires nursing homes to post phone numbers for making complaints to the state. However, in major cities of the states we visited, phone numbers specifically for lodging complaints to the state survey agency were not listed in the telephone book. This was the case in

[11] HHS Office of Inspector General, A-12-97-00003.

Chicago and Peoria, Illinois; in Athens and Augusta, Georgia; and in Philadelphia and Pittsburgh, Pennsylvania.

At the same time, the telephone books we examined listed numbers in the government agency pages for organizations that appeared to be appropriate for reporting abuse allegations but did not have authority to take action. In the telephone books of selected cities in the three states we visited, we identified listings for 42 such entities that were not affiliated with the state survey agencies. Of these, six entities said they were capable of accepting and acting on abuse allegations. These included long-term care ombudsmen and adult protective services offices. The other 36 either could not be reached or could not accept complaints, despite having listings such as the "Senior Helpline" or the "Fraud and Abuse Line." Sometimes these entities attempted to refer us to an appropriate organization to report abuse, with mixed success. For example, calls we made in Georgia resulted in four correct referrals to the state survey agency's designated complaint intake line but also led to five incorrect referrals. Five entities offered us no referrals.

Law Enforcement's Involvement in Protecting Residents Is Limited

The involvement of law enforcement in protecting nursing home residents has generally been limited. Owing to the nature of the nursing home population, developing adequate evidence to investigate and prosecute abuse cases and achieve convictions is difficult. The states we visited had different policies for referring cases to law enforcement agencies.

Residents' Impairments Weaken Law Enforcement's Efforts to Develop Cases

Critical evidence is often missing in elder abuse cases, precluding prosecution. Our review of states' case files included instances in which residents sustained black eyes, lacerations, and fractures but were unable or unwilling to describe what had happened. However, despite what appeared to be signs of abuse, investigators could neither rule out accidental injuries nor identify a perpetrator.

The cases that are prosecuted are often weakened by the time lapse between the incident and the trial. Law enforcement officials and prosecutors indicated that the amount of time that elapses between an incident and a trial can ruin an otherwise successful case, because witnesses cannot always retain essential details of the incident. For example, in one case we reviewed, a victim's roommate witnessed an incident of abuse and positively identified the abuser during the investigation. By the time of the trial nearly 5 months later, however, the

witness could no longer identify the suspect in the courtroom, prompting the judge to dismiss the charges. Law enforcement officials told us that, without testimony from either a victim or witness, conviction is unlikely. Similarly, resident victims may not survive long enough to participate in a trial. A recent study of 20 sexually abused nursing home residents revealed that 11 died within 1 year of the abuse.[12]

Local Law Enforcement Authorities in States Visited Not Frequently Involved With Nursing Home Abuse Incidents

In the states we visited, local law enforcement authorities did not have much involvement in nursing home abuse cases. Our discussions with officials from 19 local law enforcement agencies indicate that police are rarely summoned to nursing homes to investigate allegations of abuse. Of those 19 agencies, 15 indicated that they had little or no contact with their state's survey agency regarding abuse of nursing home residents in the past year. In fact, several police departments we interviewed were unaware of the role state survey agencies play in investigating instances of resident abuse. Several of the police officials we met with noted that, even when the police are called, other entities may have begun investigating, hampering further evidence collection.

Involving law enforcement authorities does not appear to be common for abuse incidents occurring in nursing homes. Facility residents and family members may report allegations directly to the facility. There is no federal requirement compelling nursing homes that receive such complaints to contact local law enforcement, although some states, including Pennsylvania, have instituted such requirements.

MFCUs Not as Involved as Their Mission Would Suggest

The involvement of MFCUs—the state law enforcement agencies whose mission is to, among other things, investigate allegations of patient neglect and abuse in nursing homes—is not automatic. MFCUs get involved in resident abuse cases through referrals from state survey agencies. Each of the states we visited had a different referral policy. In Pennsylvania, by agreement, the state's MFCU typically investigates nursing home neglect matters, while local law enforcement agencies investigate nursing home abuse. In contrast, the survey agencies in Illinois and Georgia both refer allegations of resident abuse to their states' MFCUs, but these two states' referral policies also differ from one another.

[12] Ann W. Burgess, Elizabeth B. Dowdell, and Robert A. Prentky, "Sexual Abuse of Nursing Home Residents," *Journal of Psychosocial Nursing*, Volume 38, No. 6, June 2000.

Of the cases we reviewed in Illinois, the survey agency consistently referred all reports of physical and sexual abuse to the state's MFCU, regardless of whether the source of the report was an individual or a nursing facility. The Illinois MFCU, in turn, determined whether the cases warranted opening an investigation. The Georgia survey agency, on the other hand, screened its allegations before referring cases to the state's MFCU, basing its assessment of a case's merit on the severity of the harm done and the potential for the MFCU to obtain a criminal conviction.

Our review of case files from Illinois and Georgia suggests that the more the state's MFCU is involved in resident abuse investigations, the greater the potential to convict offenders.[13] (This case file review consisted of only those cases that were opened in 1999 and closed at the time of our review.) The Illinois MFCU obtained 18 convictions from 50 unscreened referrals. In Georgia, however, where the survey agency tried to avoid referring weak cases to the state's MFCU, 14 of 52 cases were referred and 3 resulted in convictions. The state's small number of convictions from the cases opened in 1999 was not consistent with the expectation that prescreened cases would have greater potential for successful prosecution.[14]

In 2000, the Georgia survey agency substantially changed its MFCU referral policy, leading to a four-fold increase in the state's total number of referrals from the previous year. The policy change followed a meeting between survey agency and MFCU officials, at which the MFCU indicated a willingness to investigate instances that the survey agency had previously assumed the MFCU would have dismissed—such as incidents involving nursing home employees slapping residents.

The timeliness of referrals made to the MFCU may also play a role in achieving favorable results. Of the 64 cases referred in the two states, we determined that the Illinois survey agency referred its cases to the MFCU earlier than did Georgia's. Illinois referred its cases, on average, within 3 days after receiving a report of abuse, whereas Georgia referred its cases, on average, 15 days after learning about an allegation.

[13]Because of Pennsylvania's referral policy, its MFCU files, with a few exceptions, did not include resident abuse cases.

[14]Georgia's conviction results are lower than might be expected also given the state survey agency's practice of disregarding abuse allegations in which patient provocation is a factor.

Concluding Observations

The problem of resident abuse in nursing homes is serious but of unknown magnitude, with certain limitations in the adequacy of protections in the states we visited. Nurse aide registries provide information on only one type of employee, are difficult to keep current, and do not capture offenses committed in other states. At the same time, local law enforcement authorities are seldom involved in nursing home abuse cases and therefore are not in a position to help protect this at-risk population. MFCUs, which are likely to have expertise in investigating nursing home abuse cases, must rely on the state survey agencies to refer such cases. When a state's referral policy is overly restrictive, the MFCU is precluded from capitalizing on its potential to bring offenders to justice.

Several opportunities exist for CMS to establish new safeguards and strengthen those now in place. Our report includes recommendations for CMS to, among other things, clarify what is included in CMS' definition of abuse and increase the involvement of MFCUs in examining abuse allegations. Without such improvements, vulnerable nursing home residents remain considerably ill-protected.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or the committee members may have.

Contact and Acknowledgments

For further information regarding this testimony, please contact me or Geraldine Redican-Bigott, Assistant Director, at (312) 220-7600. Sari Bloom, Hannah Fein, and Lynn Filla-Clark made contributions to this statement.

(290164)

The CHAIRMAN. Thank you very much, Ms. Aronovitz, for the good work that GAO has done for this committee.

Senator Lincoln, do you want to introduce Mark Malcolm?

Senator LINCOLN. I would be honored to. Thank you, Mr. Chairman. We are extremely honored in Arkansas to have Mark Malcolm who was appointed as coroner of Pulaski County on January 1, 1995 by the Pulaski County judge and serves as the only full-time county coroner in our State of Arkansas.

He served as the Chief Deputy Coroner for 8 years prior to being appointed as coroner. He also serves, however, as instructor for the University of Arkansas Criminal Justice Institute, the University of Arkansas at Little Rock, and the University of Arkansas for Medical Sciences. He also founded the Pulaski County Coroner's Office of Professional Education Program which provides death investigation training to law enforcement officers, prosecutors and coroners throughout our State.

He also holds the fellow status with the American Board of Medi-Legal Death Investigation and is one of 26 board certified death investigators in the United States.

So, Mr. Chairman, I think you will agree along with that criteria and background, and also the fact that he helped to introduce legislation in our legislature, our state legislature, to require that all deaths of nursing home patients be reported to the county coroner for investigation regardless of the cause of death, and certainly without this law, many cases of abuse resulting in the death of nursing home residents would have gone and would continue to go unreported.

So we are extremely honored and privileged to have such an individual in our state who cares so much about making sure that in point in fact these laws are adhered to and what is on the books is actually practiced. We appreciate very much the service you give to the people of Arkansas, Mr. Malcolm, and we welcome you to the committee.

Mr. MALCOLM. Thank you.

The CHAIRMAN. Mr. Malcolm, with that powerful introduction, you are on.

STATEMENT OF MARK MALCOLM, CORONER, LITTLE ROCK, AR

Mr. MALCOLM. Thank you, Mr. Chairman, and members of the committee. Thank you for the opportunity to be here, and certainly I am grateful for Senator Lincoln's introduction.

In January 1994, my office began fielding the first inquiries regarding deaths of nursing home patients. The questions came primarily to us from family members and were generally centered on the level of care or lack thereof provided by the facility. More specifically, did the level of care contribute to or cause the death?

The initial investigations consisted primarily of nursing home medical and hospital record reviews, study of physician orders, physician interviews, interviews of both current and former nursing home staff members, and in most cases we found that the level of care was adequate and did, in fact, not contribute to the cause of death.

Some cases, however, warranted further scrutiny. From 1994 until 1998, my office conducted six exhumations of nursing home

patients. After a full post-mortem examination, all six were determined to have been unnatural deaths. Two cases were ruled as medication errors and four were asphyxial deaths.

The case that drew the most attention was that of a 78-year-old man who died on the evening of July 28, 1998. He had been improperly placed in a vest restraint and was discovered wedged between his mattress and bed rail. He was so tightly compressed in the position that four staff members had to work to free him. He was dead by the time he was extricated.

Despite the circumstances of the death and a large injury to his upper chest that was evident at the time of his removal, the administrator of the home notified the family that the decedent had died naturally and in his sleep. An audit by the Arkansas Department of Human Services Office of Long-Term Care brought that death to my attention and an investigation began. Following exhumation and autopsy, the death was ruled as positional asphyxia.

Under existing Arkansas law, this death and other cases of unnatural death in nursing homes should have been reported to the coroner and to law enforcement, and despite the existing statutory requirement to report the deaths, nursing home administrators chose to release the decedents to funeral homes preventing that legally required investigation.

Whatever the motive, it was clear that a law directed specifically to long-term care patients was necessary. In January 1999, I began working with the counsel for the Office of long Term Care. We authored a bill, submitted it to the state legislature. That bill was passed and signed into law as included in your packet of information today.

Essentially what the law requires is that all deaths of nursing home patients in Arkansas be reported to the county coroner regardless of the cause of death. The law further requires that if a person is transferred to a hospital from the nursing home, and they die within their first 5 days of admission, that case also must be reported to the coroner.

Every nursing home patient who dies in Pulaski County, Arkansas is examined by me or a member of my staff. In addition to the physical examination, there are complete reviews of medical records, interviews with physicians, facility staff and family. We compare the pharmacy records to the doctors' prescriptions. We match that against the nurses' notes to ensure that medications are properly administered.

Since July 1, 1999, my office has conducted approximately 2,400 nursing home investigations. The majority of these cases we have found the level of care to be adequate. In 56 of these death investigations, we have uncovered a much different story. We have dinner-plate sized bed sores with infected, necrotic, dying tissue, infected feeding tubes, rapid and unexplained weight loss, dehydration, improperly administered medications, and medication errors that have resulted in death.

We have found basic needs such as general hygiene and dental care neglected, urine and fecal matter dried on bed linens and in diapers that have been left unchanged for what is most assuredly hours. We have seen a patient whose care had been so poor that

a mucous growth formed on the roof of her mouth. It was left untreated. It eventually sloughed off and she asphyxiated and died.

When my staff and I arrived to examine this woman and conduct our investigation, there were ants on her body and in her bed.

Without this law in place, in my State, these cases would go unreported and unnoticed and the decedents would simply be released to funeral homes and the families would be left none the wiser.

In 16 years at the coroner's office in Pulaski County, I have been active at my state legislature on a variety of different issues, but I can tell you, members of this committee, none more important than Act 499 of 1999. The intention of the legislation was solely for the protection of the long-term care patient. However, independent oversight such as that provided by my office can also provide a modicum of protection to respectable, responsible facilities against frivolous accusations and unwarranted claims.

Facilities that are staffed by competent, conscientious health care professionals welcome an independent confirmation of their good care in the currently litigious atmosphere of their industry.

Mr. Chairman, that concludes my prepared remarks. Be happy to answer any questions.

[The prepared statement of Mr. Malcolm and related information follow:]

Pulaski County

CORONER

ADMINISTRATION BUILDING
201 SOUTH BROADWAY
LITTLE ROCK, ARKANSAS 72201
501-340-8355
501-340-8358 FAX

CITIES

ALEXANDER

CAMMACK VILLAGE

JACKSONVILLE

LITTLE ROCK

MAUMELLE

NORTH LITTLE ROCK

SHERWOOD

WRIGHTSVILLE

UNINCORPORATED AREA

600 SQUARE MILES

MILITARY BASES

LRAFB

CAMP ROBINSON

Testimony of Mark Malcolm
Coroner of Pulaski County, Arkansas
March 4, 2002

In January of 1994 my office began fielding the first inquiries regarding deaths of nursing home patients. The questions came to us primarily from family members and were generally regarding the level of care or lack thereof, provided by the nursing home facility, or more specifically, did the level of care contribute to or cause the death?

The initial investigations consisted primarily of nursing home and hospital medical record reviews, study of physician' orders, physician interviews, and interviews with both current and former nursing home staff members. In most cases we found that the level of care was adequate and did not contribute to the death. Some cases, however, warranted further scrutiny. From 1994 to 1998 my office conducted six exhumations of nursing home patients. After a full post-mortem examination, all six were determined to have died unnatural deaths. Two cases were ruled and medication errors and four were deaths caused by asphyxia.

The case that drew the most attention was that of a 78 year old man who died on the evening of July 28, 1998. He had been improperly placed in a vest restraint and was discovered

wedged between his mattress and bed rail. He was so tightly compressed in this position that four staff members had to work to free him. He was dead by the time he was finally extricated. Despite the circumstances of the death and a large area of injury to the upper chest, the administrator of the nursing home notified the family of the decedent that he had died naturally in his sleep. An audit by the Arkansas DHS Office of Long Term Care in October of 1998 brought the death to my attention and an investigation began. Following exhumation and autopsy, the death was ruled as positional asphyxia.

Under existing Arkansas law this death and any other case of unnatural death in nursing homes should have been reported to the coroner and law enforcement. Despite the existing statutory requirement to report these deaths, nursing home administrators chose to release the decedents to funeral homes preventing the legally required investigation. Whatever the motive, it was clear that a law directed specifically to long term care patients was necessary.

In January of 1999 I began working with the counsel for the Office of Long Term Care and we authored a bill for consideration by the State Legislature. The bill was passed and signed into law and is included in your packet of information.

Essentially, the law requires that all deaths of nursing home patients be reported to the county coroner for investigation regardless of the cause of death. The law further requires that the death of a nursing home patient who is transferred to a hospital and dies within five days of admission also be reported to the coroner.

Every nursing home patient who dies in Pulaski County, Arkansas, is examined by me of a member of my staff. In addition to the physical examination there are complete reviews of medical records, interviews with physicians, facility staff, and family. We compare pharmacy records to doctors' prescriptions and match that information to nurses' notes to ensure that medications are properly administered.

Since July 1, 1999 my office conducted approximately 2400 nursing home investigations. In the majority of these cases we have found the level of care provided to be adequate. In 56 death investigations we have uncovered a much different story. We have seen dinner plate-sized bed sores with infected and dying tissue, infected feeding tubes, rapid and unexplained weight loss, dehydration, improperly administered medications, and medication errors that resulted in death. We have found basic needs such as general hygiene and dental care neglected, urine and fecal matter dried on bed linens and in diapers left unchanged for hours. We have seen a patient whose care had been so poor that a mucous growth formed on the roof of her mouth and when it finally sloughed off, she asphyxiated and died. When we arrived at the facility to examine this woman, ants were crawling on her bed and body.

Without this law in place, these cases would go unreported and unnoticed, and the decedents would simply be released to funeral homes with families left none the wiser. In sixteen years at the Coroner's Office, I have been active at my State legislature on a variety of issues but none more important that Act 499 of 1999. The intention of the legislation was solely for the protection of the long term care patient. However, independent oversight such as that provided by my office can also provide a modicum of protection to respectable, responsible facilities against frivolous accusations and unwarranted claims. Facilities staffed by competent, conscientious professionals welcome an independent confirmation of good care in the currently litigious atmosphere of their industry.

PULASKI COUNTY CORONER'S OFFICE
GENERAL ORDER

INVESTIGATIONS INTO THE DEATH OF LONG TERM CARE PATIENTS

General Order: G.O. 108

Purpose

A. This General Order establishes the policy and procedures of the Pulaski County Coroner's Office as it pertains to investigations into the deaths of long term care facility residents. The General Order is established in accordance with Act 499 of 1999 and becomes effective June 30, 1999.

Policy

A. It shall be the policy of the Pulaski County Coroner's Office to conduct thorough and efficient investigations into the deaths of those who die in long term care facilities and those who die in hospitals after being transported from a long term care facility.

B. Long-term care investigations shall be carried out in the same manner as any other death investigation conducted by the Pulaski County Coroner's Office.

Protocol

A. When a long term care facility death is reported to the Pulaski County Coroner's Office the deputy coroner on-call shall respond immediately to the notifying facility or appropriate hospital. The on-call deputy shall also contact the supervisor on-call. The supervisor on-call shall respond as well.

B. Upon arrival the deputy coroner shall contact the reporting party from the long term care facility or hospital. The name of the reporting party and the time the deputy arrived at the facility shall be recorded. The deputy coroner shall inquire as to the circumstances leading to the death and obtain pedigree information of the decedent.

C. The deputy coroner shall observe the decedent and conduct an examination of the decedent to include the following:

1. Photographs of the decedent and the room or area where the death occurred.
2. General cleanliness of room and facility and hygienic observations.
3. Position of decedent (in bed, chair, on floor, face down, face up).
4. Restraints (posey vest, buddy belt, arms, legs).
5. Clothing description.
6. Medical paraphernalia description.
7. Body temperature, rigor mortis, and livor mortis.
8. Hair color.
9. Eye color.
10. Eye condition (dry, glazed, bloodshot, petechial hemorrhage).
11. Dental condition (natural teeth, dentures, gums).
12. Nutrition (malnourished, emaciated, well nourished).
13. Bed sores, ulcers (non-bandaged, bandaged, last time dressing changed).
14. Location of bedsores or ulcers.
15. Severity of bedsores or ulcers (minor, deep tissue exposure, bone exposure).
16. Bruising (document location, severity, age of bruise, when and how occurred, report made by staff). The deputy coroner must obtain a copy of the incident report. Bruises must also be inspected for any pattern that may be present. Restraints, hands, fingers, fists, or other blunt objects may cause pattern bruises. The Coroner must be notified immediately if a pattern bruise is suspected.
17. Broken bones (document location, severity, type of fracture, when and how occurred, report made by staff). The deputy coroner must obtain a copy of the incident report.
18. Document any insect and rodent bites or infestation. The Coroner must be notified immediately if insect or rodent bites are suspected.
19. Other cuts, lacerations, abrasions, and contusions.

20. Completion of body chart and additional photography to document the condition of the decedent.

D. The deputy coroner shall conduct interviews with the staff to determine the following;

1. Admitting physician and diagnosis including contact number for the physician. The deputy coroner must contact the treating physician.
2. Current diagnosis if different from admission including any recent hospitalizations or treatments.
3. Medications. A copy of the medication list must be obtained by the deputy coroner as well as the last medications taken and the time given by staff.
4. Whether CPR performed?
5. Whether the patient was DNR?
6. Last time seen alive, by whom, and what time.
7. When death occurred. Was the death witnessed and if so by whom? Was the death discovered and if so by whom and what time?
8. Last visitation by family or others.
9. Whether the decedent ever "walked away" or attempted to leave the facility without authorized escort or family member? If so, the number of attempts must be obtained as well as dates and times.
10. Whether the patient was under the care of adult protective services?
11. Whether any abuse or neglect reports had ever been made regarding the decedent? If so, each incident report must be obtained by deputy coroner as well as dates and times, and who committed or was suspected of the abuse. The deputy coroner must also contact the appropriate law enforcement agency to determine if the long-term care facility contacted police to report suspected abuse or neglect. The Coroner must be notified immediately if an abuse or neglect complaint or report is on file regarding the decedent.

12. Whether any complaint visit reports or deficiency reports from DHS are on file? If so, a copy of the report must be obtained by the deputy coroner. The Coroner must also be notified immediately. DHS must be contacted by the deputy coroner to determine if there are any complaints regarding the decedent. When the death occurs after business hours, DHS shall be contacted immediately upon the beginning of the next business day.
13. Funeral home information.

E. Upon completion of the initial investigation by the deputy coroner a decision on disposition of the decedent must be made. The deputy coroner shall consult the on-call supervisor to determine the following;

1. There is no reason to suspect abuse or neglect of the decedent and the death is of natural causes. If the death is of natural causes the on-call supervisor may release the body to the funeral home.
2. The presence of abuse or neglect cannot be ruled out without additional information. If the presence of abuse or neglect cannot be ruled out the Coroner must be immediately notified. The Coroner or on-call supervisor shall notify the appropriate law enforcement agency. In addition to the coroner's investigation, coroner's office personnel shall assist the law enforcement agency in whatever way is requested. The Coroner and supervising law enforcement officer shall determine the need for medical examiner notification.
3. There is reason to suspect abuse, neglect, or foul play in the death. The Coroner and appropriate law enforcement agency must be notified immediately. In addition to the coroner's investigation, coroner's office personnel shall assist the law enforcement agency in any way requested. The decedent shall be transported to the medical examiner.

F. If there is no reason to suspect abuse or neglect and the death is determined to be of natural causes the Coroner shall notify the long-term care facility in writing.

G. If abuse, neglect, or foul play is suspected and the decedent is transported to the medical examiner the Coroner shall notify DHS and the decedent's family.

Stricken language would be deleted from and underlined language would be added to law as it existed prior to the 82nd General Assembly.

State of Arkansas
82nd General Assembly
Regular Session, 1999

As Engrossed: S2/9/99 S2/11/99

A Bill

ACT 499 of 1999

SENATE BILL 222

By: Senator Brown
By: Representative Salmon

For An Act To Be Entitled

"AN ACT TO AMEND ARKANSAS CODE 5-28-204 TO REQUIRE THAT ALL NURSING HOME RESIDENT DEATHS BE REPORTED TO THE COUNTY CORONER; AND FOR OTHER PURPOSES."

Subtitle

"TO AMEND ARKANSAS CODE 5-28-204 TO REQUIRE THAT ALL NURSING HOME RESIDENT DEATHS BE REPORTED TO THE COUNTY CORONER."

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code 5-28-204 is hereby amended to read as follows:

"5-28-204. Persons required to report abuse.

(a) Any person or official who is required to report cases of suspected abuse of adults under the provisions of this chapter, who has reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, shall report that fact to the appropriate medical examiner or coroner. In all cases of death of a long-term care facility resident, the long-term care facility shall immediately report the death to the appropriate coroner. The report is required regardless of whether the facility believes the death to be from natural causes or the result of abuse, sexual abuse, or negligence, or any other cause. In all cases of death of an individual in a hospital who was a resident of a long-term care facility within five (5) days of entering the hospital, the hospital shall immediately report the death to the appropriate coroner. The report is required regardless of whether the facility believes the death to be from natural cause or the result of abuse

1 sexual abuse, negligence, or any other cause.
2 (b) The medical examiner or coroner shall accept the report for
3 *investigation and upon finding reasonable cause to suspect that an adult has*
4 *died as a result of abuse, sexual abuse, or negligence shall report his*
5 *findings to the police, and the appropriate prosecuting attorney. ~~and, if~~ If*
6 *the institution making the report is a hospital, or nursing home, the coroner*
7 *shall report his findings to the hospital or nursing home unless the findings*
8 *are part of a pending or ongoing law enforcement investigation.*"
9
10 SECTION 2. All provisions of this act of a general and permanent nature
11 are amendatory to the Arkansas Code of 1987 Annotated and the Arkansas Code
12 Revision Commission shall incorporate the same in the Code.
13
14 SECTION 3. If any provision of this act or the application thereof to
15 any person or circumstance is held invalid, such invalidity shall not affect
16 other provisions or applications of the act which can be given effect without
17 the invalid provision or application, and to this end the provisions of this
18 act are declared to be severable.
19
20 SECTION 4. All laws and parts of laws in conflict with this act are
21 hereby repealed.
22 */s/ Brown*
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3-9-99
APPROVED
GOVERNOR

PRESIDENT SENATE

Speaker of the House

The CHAIRMAN. Thank you very much, Mr. Malcolm, for your testimony. Next from Louisiana Sheriff Charlie Fuselier. Charlie, thank you for coming up. We really appreciate it.

STATEMENT OF CHARLES FUSELIER, SHERIFF, ST. MARTIN VILLE, LA, ON BEHALF OF THE NATIONAL SHERIFFS' ASSOCIATION

Mr. FUSELIER. I would like to thank you, Senator Breaux, and the members of the Special Committee on Aging.

The CHAIRMAN. Pull that mike a little closer, if you can, a little bit closer.

Mr. FUSELIER. Thanks for inviting me to testify as to law enforcement efforts to address nursing home abuse at this hearing on crimes against the elderly in nursing homes. It is my hope that this testimony will help to improve the quality of life for older adults residing not only in nursing homes but in any type of residential care facility which includes group homes, assisted living facilities, and mental retardation facilities.

By initiating the first Triad Program in the Nation on August 30, 1989, the St. Martin Parish Sheriff's Office has an established and long-standing record of commitment to older adults that is recognized as extending beyond my jurisdiction in St. Martin Parish, LA.

The Triad Program has proved to be a successful crime prevention program aimed at older adults. Currently, there are some 834 Triad Programs in 47 states. Additionally, England, Canada, and Australia have expressed interest in utilizing the concept in their countries. In 1990, the St. Martin Parish Sheriff's Office instituted the statewide Elderly Crime Victim Assistance Program through grant funding from the Louisiana Commission on Law Enforcement and the Administration of Criminal Justice.

In 1992, the Elderly Protective Services Program was initiated in the State of Louisiana. These two programs served to heighten our understanding of the severe vulnerability of infirm older adults especially when they are in the care of those persons they know and trust.

During the 1994 legislative session in Louisiana, legislation was enacted creating the Committee for Law Enforcement Services to the Elderly. This committee was formed in response to the growing concern of crimes against the elderly to include abuse, neglect and exploitation of the elderly residing independently in their homes as well as those in residential care facilities.

Representation on this committee includes members from the Louisiana Commission on Law Enforcement, the Louisiana Sheriffs' Association, the Louisiana Municipal Chiefs of Police, the State of Louisiana Justice Department, the Governor's Office of Elderly Affairs, the Councils on Aging and the American Association of Retired Persons and the Louisiana District Attorneys Association.

Early on members of this committee recognized and expressed a concern about law enforcement's response to crimes in residential care facilities. The concern grew that there was an apparent lack of continuity in the response by law enforcement from jurisdiction to jurisdiction to crimes committed in residential care facilities.

As a result of the committee's concern, a Crime in Residential Care Facilities Conference was held in Baton Rouge, LA on November 12, 1997. The agenda included a legal session, investigating crimes in residential care facilities, physical and behavioral indicators of abuse, neglect, and the role and responsibilities of the various investigating agencies.

The roles and responsibility section of that conference included a panel of representatives from the Department of Health and Hospitals, the State of Louisiana Justice Department, Elderly Protective Services, the Louisiana Nursing Home Association, state long-term care ombudsman, the police supervisor of Baton Rouge Crimes Against the Elderly and a sheriff. In Louisiana, this conference was the impetus for the underlying questions about local law enforcement's response to crimes in residential care facilities.

In 1999, the legislation was enacted forming the Aged Law Enforcement Response Team, the ALERT officer. The ALERT program established a 40-hour elderly service officer certification through the Peace Officers Standard and Training Council. Law enforcement officers successfully completing the course lectures and written tests were certified as elderly service officers.

The objectives of the ALERT program are: to create a statewide network of law enforcement officers with specialized training in working with the elderly to ensure uniformity in the delivery of high quality law enforcement services to elderly citizens; to have the ALERT ESO officer serve as the primary point of contact when elderly victims are involved; and to provide training within their agency and others in the parish on effectively assisting older adults.

These objectives pertain to all elderly in Louisiana whether residing independently or residing in residential care facilities. The 40 hour curriculum includes 19 hours of instructions on identification of abuse, neglect and exploitation; the role of the long-term care ombudsman in nursing homes; investigating crimes in residential care facilities; criminal statutes dealing with the cruelty, exploitation and sexual battery of the infirm; and the United States Attorney's Office role in nursing home abuse.

Plans are currently being drafted for 2003 to include having at least one ALERT trained assistant district attorney in each judicial district.

In conclusion, there is a general assumption that because the infirm elderly are residing in residential care facilities, that government will assure that they are in a safe environment. The reality is that because of their confinement, in some instances, the infirmed elderly can be trapped in a situation of abuse and have no one to turn to for protection.

Certainly, physical and sexual abuse in residential care facilities are a strong priority that needs to be addressed by law enforcement with the same type of responses given to crimes committed to other citizens living independently outside a facility.

Law enforcement's general perception is that they are treated the same as everyone. The reality is that without specialized training such as offered by the ESO ALERT program, law enforcement generally does not have the skills to properly evaluate such a complex situation.

Twenty-five years ago, there were very few juvenile officers. Now, they are a significant part of the law enforcement community. As we the baby boomer arrive and outnumber our nation's youth in the next 10 to 15 years, the ESO ALERT officer will be an essential part of the law enforcement community, much like the juvenile officers are today.

Chairman Breaux, and members of the Special Committee on Aging, I submit that providing for expanded training for law enforcement officers to address the growing needs of a rapidly aging population is clearly necessary to address the growing problem of physical and sexual abuse in residential care facilities.

I look forward to working with you and I stand ready to take your questions.

[The prepared statement of Mr. Fuselier and related material follow:]

United States Special Committee on Aging

"Crimes Against the Elderly in Nursing Homes"

Testimony of:

Charles A. Fuselier, Sheriff

St. Martin Parish, Louisiana

Special Committee on Aging
Crimes Against the Elderly in Nursing Homes

DATE: March 4, 2002

TIME: 1:30 p.m.

PLACE: Senate Special Committee on Aging
SDG-31 Dirksen Senate Office Building
Washington D.C. 20510

WITNESS: Sheriff Charles A. Fuselier
Post Office Box 247
St. Martinville, Louisiana 70582
337-394-3071

STATEMENT:

I would like to thank Chairman Senator John Breaux and the members of the Special Committee on Aging for inviting me to testify as to law enforcement's efforts to address nursing home abuse at this hearing on "Crimes Against the Elderly in Nursing Homes." It is my hope that this testimony will help to improve the "quality of life" for older adults residing not only in nursing homes but in any type of residential care facility which includes Nursing Homes, Group Homes, Assisted Living Facilities, and Mental Retardation Facilities.

By initiating the first Triad Program (Exhibit 1: Triad Program Overview), in the nation on August 30, 1989, the St. Martin Parish Sheriff's Office has an established and longstanding record of commitment to older adults that is recognized as extending beyond the boundaries of my jurisdiction in St. Martin Parish, Louisiana. The Triad Program has proven to be a successful crime prevention program aimed at older adults. Currently, there are some 834 Triad Programs in 47 states. Additionally, England, Canada and Australia have expressed interest in utilizing the concept in their countries. The strength

and success of Triad comes from the combined efforts of both law enforcement (as the deliverer of police services) and senior citizens (with their vast wealth of knowledge and experience) who provide support to law enforcement in an advisory capacity and as volunteers. In St. Martin parish and in many other areas throughout our country, this has proven to be a winning combination.

In Louisiana, the Triad program caused us to take a deeper look at the multi-faceted issues of crime and the elderly. We began to understand that older persons were more likely to be victimized by someone they know and trust rather than by strangers. Examples of this include the large number of cases of abuse/neglect/exploitation of the elderly by their caregivers in the home setting. In our concern to respond to these issues, the St. Martin Parish Sheriff's Office expanded beyond traditional law enforcement type services to become involved in two programs. The first one serving elderly victims of violent crimes. The second program serving suspected victims of abuse/neglect/exploitation.

In 1990 the St. Martin Parish Sheriff's Office initiated the state-wide Elderly Crime Victim Assistance (ECVA) Program (Exhibit 2: Louisiana Map of ECVA Program Headquarter and Satellite Programs and Exhibit 3: ECVA Brochure) through grant funding from the Louisiana Commission on Law Enforcement and Administration of Criminal Justice. In 1992 the Elderly Protective Services (EPS) Program was initiated in the state of Louisiana. The St. Martin Parish Sheriff's Office was awarded the contract by the Governor's Office of Elderly Affairs to provide these services in Region III, which currently encompasses 10 parishes in the Acadiana Region (Exhibit 4: Louisiana Map of EPS Region III Service Area and Exhibit 5: EPS Program Brochure). These two

programs served to heighten our understanding of the severe vulnerability of infirmed older adults, especially when they are in the care of those persons they know and trust.

During the 1994 legislative session in Louisiana, legislation was enacted creating the "Committee for Law Enforcement Services to the Elderly" (Exhibit 6: Chapter 8-A Victimization of Senior Citizens - LA. R. S. 1231-1236). This committee was formed in response to the growing concern of crime against the elderly to include abuse/neglect/exploitation of the elderly residing independently in their homes as well as those in residential care facilities. Appointment to this committee is subject to gubernatorial approval with jurisdiction established within the Louisiana Commission on Law Enforcement and Administration of Criminal Justice. Representation on this committee includes members from: the Louisiana Commission on Law Enforcement, the Louisiana Sheriffs' Association, the Louisiana Municipal Chiefs of Police Association, the State of Louisiana Justice Department, the Governor's Office of Elderly Affairs, parish volunteer Councils on Aging, American Association of Retired Persons, and the Louisiana Association of District Attorneys. I have the honor of serving as chairperson of that committee since its inception in 1995.

A brief description of the committee's duties and responsibilities include: 1) Studying and evaluating programs; 2) Consulting with experts, service providers and representative organizations; and 3) Recommending policies and programs.

Early on the members of the committee recognized and expressed a concern about law enforcement's response to crimes in residential care facilities. The concern grew that there was an apparent lack of continuity in response by law enforcement from jurisdiction to jurisdiction to crimes committed in residential care facilities.

As a result of the committee's concern, a "Crime in Residential Care Facilities Conference" was held in Baton Rouge on November 12, 1997 (Exhibit 7: Conference Brochure). The agenda included: Legal Session, Investigating Crimes in Residential Care Facilities, Physical and Behavioral Indicators of Abuse/Neglect, and the Role and Responsibilities of the Various Investigating Agencies.

The "Role and Responsibilities" segment of that conference included a panel of representatives from the Department of Health and Hospitals, State of Louisiana Justice Department, Elderly Protective Services, Louisiana Nursing Home Association, State Long Term Care Ombudsman, the Police Supervisor of the Baton Rouge Crimes Against the Elderly (CATE) Unit, and a sheriff. This was the first time members of these agencies, whose responsibility it is to identify and/or investigate crimes against the elderly, came together in the same room. Discussion centered on their individual agency's role and responsibilities, as well as what situations would necessitate several agencies working together. In Louisiana, this conference was the initial impetus for the underlying questions about local law enforcement's response to crimes in the residential care facilities. The members of the committee knew that although the conference was successful in breaking ground in identifying the problems of "crimes in residential care facilities," more work would have to be done to educate sheriffs and chiefs throughout Louisiana.

In 1999, legislation (Exhibit 8: LA R.S. 1237 ALERT Program) was enacted forming the ALERT (Aged Law Enforcement Response Team) Program. The ALERT Program (Exhibit 9: ESO/ALERT Program Particulars) established a forty (40) hour Elderly Services Officer (ESO) certification (using the Illinois State Elderly Services Officer Model) through the Peace Officers Standards and Training (POST) Council. Law enforcement

officers successfully completing the course lectures and written test were certified as Elderly Services Officers. Those officers meeting the specified criteria (Exhibit 10: ALERT Criteria) received an additional distinction as a member of the state-wide Aged Law Enforcement Response Team (Exhibit 11: ESO/ALERT Critical Tasks).

The objectives of the ALERT Program are 1) To create a state-wide network of law enforcement officers with specialized training in working with elderly citizens; 2) To ensure uniformity in the delivery of high quality law enforcement services to elderly citizens; 3) To have the ESO/ALERT officers serve as the primary point of contact; and 4) To provide training within their agency and others in the parish on effectively assisting older adults. These objectives pertain to all elderly in Louisiana whether residing independently in their homes or residing in residential care facilities.

The forty (40) hour curriculum (Exhibit 12: ESO/ALERT Curriculum) includes 19 hours of instruction on Identification of Abuse/Neglect/Exploitation, the Role of the Long-Term Care Ombusman in Nursing Homes, Investigating Crimes in Residential Care Facilities, Criminal Statutes dealing with Cruelty/Exploitation/Sexual Battery of the Infirmed, United States Attorney's Office role in Nursing Home Abuse, and Elderly Protective Services. An Advanced Training is offered annually and provides information to officers on new services as well as new information to keep them abreast of the ever changing services and needs of seniors.

The goal of the ALERT Program is to have at least one (1) ALERT and/or ESO in every parish in Louisiana. There are currently 90 Certified ALERT Officers and 33 Elderly Services Officers totaling 123 in 51 of the 64 parishes in Louisiana (Exhibit 13: Map of Louisiana and Exhibit 14: Listing of Certified ALERT/ESO Officers in Louisiana

and Exhibit 15: Recruitment Letter for ESO/ALERT Certification). Four (4) of the fifty-one parishes have ESO's only.

Some limitations to the program include manpower and budgetary constraints within local police departments and sheriff's offices that may affect the amount of time the ESO/ALERT officer can devote to their extra duties. There are some officers who can

devote their entire work day to elderly services. However, many have other duties and responsibilities and the ESO/ALERT work is an extra duty.

Also worth mentioning is that plans are currently being drafted for 2003 to include having at least one ALERT trained Assistant District Attorney in each judicial district. Training initiatives such as this can assist in promoting a full partnership between sheriffs and District Attorneys in the investigation and prosecution of the perpetrators of crime against the elderly.

CONCLUSION: There is a general assumption that because the infirm elderly are residing in residential care facilities, "the government" will assure that they are in a safe environment. The reality is that because of their confinement in some instances, the infirm elderly can be trapped in a situation of abuse and have no one to turn to for protection.

Certainly, physical abuse and sexual abuse in residential care facilities are a strong priority that needs to be addressed by law enforcement with the same type of response as given to crimes committed to other citizens living independently outside a facility. Law enforcement's general perception is that they are treated the same as everyone. The reality is that without specialized training such as that offered by the ESO/ALERT Program, Law enforcement generally does not have the skills to properly evaluate such a complex

situation.

Twenty-five years ago there were very few juvenile officers. Now, they are a significant part of the law enforcement community. As we, the baby boomers arrive, and outnumber our nation's youth in the next ten to fifteen years, the ESO/ALERT officer will be an essential part of the law enforcement community much like the juvenile officers are today. To Chairman Senator Breaux and members of the Special Committee on Aging, I submit that providing for expanded training for law enforcement officers to address the growing needs of a rapidly aging population is clearly necessary to address the growing problem of physical abuse and sexual abuse in residential care facilities.

I look forward to working with you. I stand ready to take questions.

Exhibit 1

THE FACTS ABOUT TRIAD

What is a Triad?

A Triad consists of a three-way effort among

- a sheriff,
- the police chief(s) in the county, and
- AARP or older/retired leadership in the area

who agree to work together. Their primary goals are to reduce the criminal victimization of older citizens and enhance the delivery of law enforcement services to this population. Triad provides the opportunity for an exchange of information between law enforcement and senior citizens. It focuses on reducing unwarranted fear of crime and improving the quality of life for seniors. A Triad is tailored to meet the needs of each community and is guided by a senior advisory council (S.A.L.T.). Triad is an integral part of community policing.

Why is Triad Necessary?

Older Americans comprise the most rapidly growing segment of the population. One in every eight Americans is already age 65 or older, a total of more than 33.6 million. Increased life expectancy is leading to new issues and problems for the criminal justice system as most communities experience a dramatic increase in the number of older persons. Calls for service, crimes, victims - all are changing.

How Did Triad Get Started?

The American Association of Retired Persons (AARP), the International Association of Chiefs of Police (IACP), and the National Sheriffs' Association (NSA) signed a cooperative agreement in 1988 to work together to reduce both criminal victimization and unwarranted fear of crime affecting older persons.

The three national organizations agreed that police chiefs, sheriffs, older leaders, and those who work with seniors, working together, could devise better ways to reduce crimes against the elderly and enhance law enforcement services to older citizens. This, they believe, is true community policing, providing better service to a population which appreciates, respects, and supports law enforcement.

Who Carries Out Triad Activities?

The engine that drives Triad is the S.A.L.T. Council (Seniors And Lawmen Together). Triad is a concept - three organizations - chiefs of police, seniors and sheriffs working together for the benefit of seniors. Here the representatives of seniors, sheriff's offices and police departments combine their talents to create and implement programs tailored to the needs of their community. SALT Councils typically include representatives of the police departments, the sheriff's office, AARP and other senior organizations, RSVP, social service agencies, hospitals, the business community, clergy, and other agencies involved in, or interested in, helping the elderly. The SALT Council assesses and addresses the needs of the elderly in the community by finding out what the needs really are and **collaboratively** developing ways in which to meet those needs. Triad is the concept, the SALT Council is the application of that concept.

What Can Triad Do?

A Triad assesses the needs of a particular community. Areas with serious crime problems may focus on crime prevention and victim assistance. Where older persons are not often targets of crime, the SALT Council may decide to concentrate on reassurance programs, training for law enforcement, and involving volunteers within the law enforcement agencies.

The S.A.L.T. advisory council plans activities and programs to involve and benefit both law enforcement and seniors. Triad sponsored activities include:

- Information for older persons on:
  - How to avoid criminal victimization
  - How to expand involvement in Neighborhood Watch
  - Home security information and inspections
  - Knowledge of current frauds and scams
  - Ideas for coping with telephone solicitations and door-to-door salesmen
  - Elder abuse prevention, recognition and reporting information

- Training for deputies and officers in communicating with and assisting older persons
- Telephone reassurance programs for older citizens
- Adopt-a-senior visits for shut-ins
- Intergenerational projects beneficial to seniors and youth
- Emergency preparedness plans by and for seniors
- Senior walks at parks or malls - with crime prevention component
- Victim assistance by and for seniors
- Courtwatch activities
- Refrigerator cards with emergency medical information
- Mature volunteers within law enforcement agencies
- Citizen Police Academy to educate the community
- Speakers bureau available to the community
- Information tables at senior centers and malls

Triads across the country choose activities which the S.A.L.T. Council agrees will be beneficial to citizens in that area.

Triad Plan of Action

I. Chief and sheriff meet to discuss
   A. Crimes against seniors
   B. Possible areas of Triad involvement
   C. Composition of senior council (S.A.L.T. group)
   D. Selection of S.A.L.T. chairman

II. S.A.L.T. group is chosen
   A. Topics for discussion for S.A.L.T. Council:
      1. Demographics of aging
      2. Countywide senior statistics
         a. Numbers of older persons
         b. Crimes against seniors
         c. Problems faced by seniors
         d. Fears of older persons
      3. Method of surveying senior population
      4. Programs currently available
      5. Possible unmet needs

B. Subcommittees assigned, such as
   1. Survey: fears, concerns, needs, interest of older citizens determined and Triad volunteers identified
   2. Crime Prevention
   3. Volunteers
   4. Speakers/publicity
   5. Law enforcement training

III. Crime prevention education launched
   A. Senior events such as sponsored breakfast, senior fair
   B. Programs for and by seniors at
      1. Senior housing
      2. Neighborhood Watch groups
      3. Senior centers
      4. Churches
      5. Mall walks
   C. Topics
      1. Update on current crimes affecting older persons
      2. Facts to combat unwarranted fear of crime
      3. Programs on fraud, scams, home security, marking of valuable property, etc.

IV. Victim assistance program, initiated or expanded
   A. Volunteers to work with senior victims
   B. Tactics to increase victim reporting

V. Training for law enforcement officers
   A. Concerns of elderly citizens
   B. Effective communicting with older persons
   C. Combination of professionals and older persons conducting training

VI. Expansion
   A. Evaluating activities and success periodically
   B. Volunteer leadership and responsibilities increase

For more information on Triad, call 800-424-7827.

Exhibit 2

Elderly Crime Victim Assistance (ECVA) Coverage

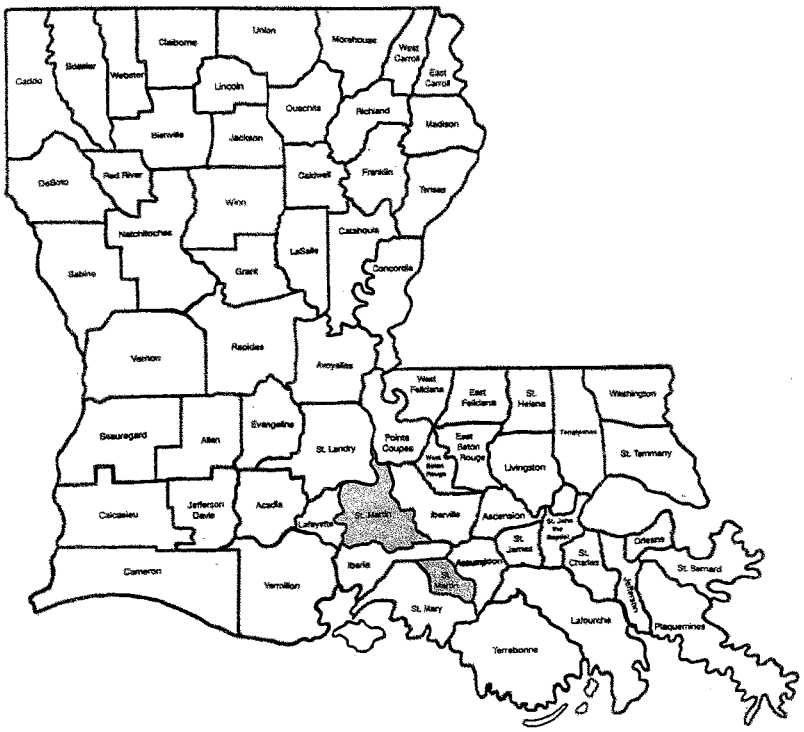


Exhibit 3

HOW TO RECEIVE SERVICES

Information on Services available through this program may be obtained by contacting:

ELDERLY CRIME VICTIM ASSISTANCE PROGRAM SUBGRANTEE:
St. Martin Parish Sheriff's Office
Post Office Box 247
St. Martinville, LA 70582

Executive Director - Sheriff Charles A. Fuselier
Program Director - Captain Audrey Thibodeaux
337-394-2133
1-800-738-3071 (TOLL FREE HOT LINE)

or
for information
Contact The Satellite Program Nearest You

Baton Rouge Police Department
1-225-389-8648

Caddo Parish Sheriff's Office
1-318-226-6794

Calcasieu Parish Sheriff's Office
1-337-491-3718

Lafayette Parish Sheriff's Office
1-337-236-5615

Ouachita Parish Sheriff's Office
1-318-329-1200

Rapides Parish Sheriff's Office
1-318-473-6759

St. Bernard Parish Sheriff's Office
1-504-278-7634

Tangipahoa Parish Sheriff's Office
1-985-345-6150

Winn Parish District Attorney
1-800-256-3517

This brochure was printed using Crime Victim Assistance funds administered by the Louisiana commission on law Enforcement under subgrant number **G-99-0-002**

HELP is available for

ELDERLY VICTIMS OF CRIME

Elderly Crime Victim Assistance Program

1-800-738-3071

For more information
See Inside ➤

VICTIMS OF CRIME ACT OF 1984

The Victims of Crime Act was passed by Congress in 1984 to provide for direct services to victims of violent crimes. Funding for this program is generated entirely by fines, penalty assessments and forfeited appearance and bail bonds collected by the federal government. The Louisiana Commission on Law Enforcement is the state agency designated by the Governor to administer the program in Louisiana. Through approval by the Victim Services Advisory Board and the Louisiana Commission on Law Enforcement, the St. Martin Parish Sheriff's Office was awarded federal funds to establish the Seniors and Lawmen Together - Elderly Crime Victim Assistance (SALT- ECVA) Program to provide direct services to elderly victims.

The Information in this pamphlet applies to the Act as amended, 42 U.S.C. 10601.

ELIGIBILITY FOR SERVICES

A person 60 years or older who believes (s)he is a victim of crime in the State of Louisiana which involved the **use of force** or **threat of force** which resulted in emotional and/or physical trauma,
and/or
which involved the **Abuse of Vulnerable Adults** to include "the mistreatment of older persons through physical, sexual, or psychological violence, neglect, or economic exploitation and fraud.

THOSE NOT ELIGIBLE FOR SERVICES

1. The offender and/or an accomplice
2. A victim whose own misconduct either caused or contributed to the criminal attack depending on the degree of such misconduct.

SERVICES PROVIDED

Direct services provided to elderly victims of crime and to older persons who are victims of mistreament through physical, sexual, or psychological violence, neglect, or economic exploitation and fraud will include, but is not limited to:

1. **CRISIS COUNSELING/INTERVENTION** to in-person crisis intervention, emotional support and guidance and counseling provided by advocates, counselors, mental health professionals, or peers.
2. **FOLLOW-UP SERVICES** To offer emotional support, empathetic listening and guidance for other-than crisis reactions after victimizations.
3. **CRIMINAL JUSTICE/SUPPORT/ADVOCACY** refers to support, assistance, and advocacy providec to victims at any stage of the criminal justice process, to include post-sentencing services and support.
4. **REFERRAL TO CRIME VICTIM REPARATION PROGRAM** includes making the victim aware of the availability of crime victim compensation, assisting the victim in completing the required forms, gathering the needed documentation, etc. It also may include follow-up contact with the victim compensation agency on behalf of the victim.
5. **FORENSIC INTERVIEW** refers to fact-finding interviews of victims for the purpose of information gathering or furthering services.
6. **EMERGENCY LEGAL ADVOCACY** ing temporary restraining orders, injunctions, other orders and elder abuse petitions.
7. **INFORMATION AND REFERRAL SERVICE** through telephone or in-person contacts with victim to identify services offered and support availabie by **SALT-ECVA** Program and other community agencies.
8. **PERSONAL ADVOCACY** refers to assisting victims in securing rights, remedies and services from other agencies, locating emergency financial assistance, intervening with employers, creditors and others on behalf of the victim, assisting in filing for losses covered by public and private insurance programs including workman's compensation, unemployment benefits, welfare, etc., accompanying victim to the hospital, etc.
9. **SAFETY MEASURES/PLAN** refers to emergencies that are intended to restore the victim's sense of security. This includes services which offer an immediate measure of safety to crime victims such as boarding up broken windows and replacing or repairing locks.
10. **FINANCIAL EXPLOITATION** Although VOCA funded programs cannot restore the financial losses suffered by victims of fraud, victims are eligible for support services.
11. **EMERGENCY FINANCIAL ASSISTANCE** An emergency award is made when it appears that undue hardship will result if no relief is provided. Victim Emergency Funds may be awarded for:

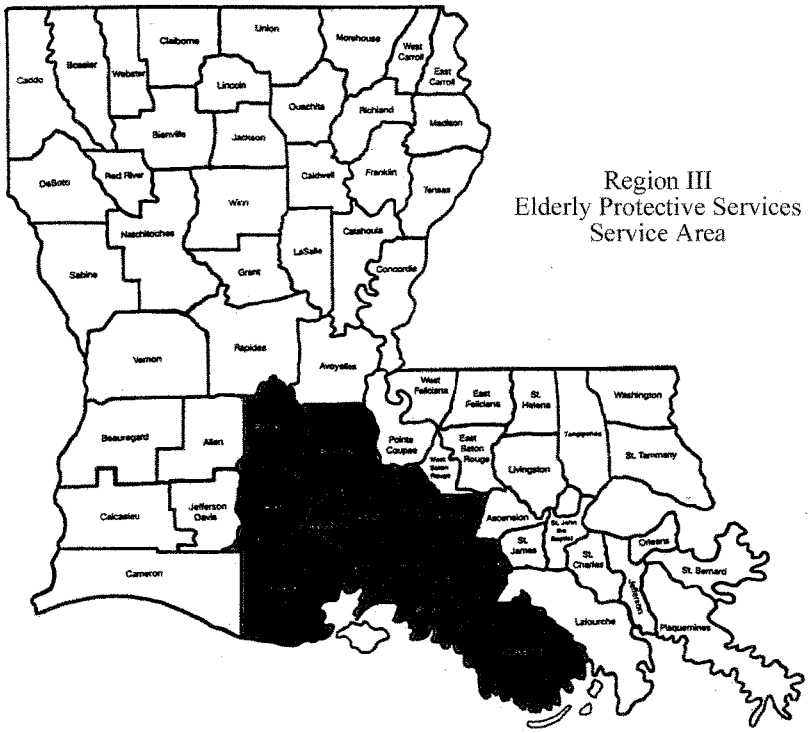
    Temporary Shelter for crime victims who cannot safely remain in their current lodgings.

    Offer measures such as repair locks or boarding-up of windows to prevent the immediate reburglarization of a home or an apartment.

    Provide crime victims with petty cash for meeting immediate needs related to:

    Transportation
    Food
    Shelter
    Other Necessities

Exhibit 4



Region III
Elderly Protective Services
Service Area

Exhibit 5

ELDERLY PROTECTIVE SERVICES

ACADIANA SERVICE AREA

Parishes Included:

- ★ ACADIA
- ★ ASSUMPTION
- ★ EVANGELINE
- ★ IBERIA
- ★ LAFAYETTE
- ★ ST. LANDRY
- ★ ST. MARTIN
- ★ ST. MARY
- ★ TERREBONNE
- ★ VERMILION

EXECUTIVE DIRECTOR:
SHERIFF CHARLES A. FUSELIER

EPS PROGRAM DIRECTOR-SUPERVISOR
CAPTAIN NEWMAN BRAUD

437 W. MILLS AVENUE
BREAUX BRIDGE, LA 70517

TELEPHONES
(337) 332-3344
1-800-738-3071
FAX
(337) 332-3351

To:

ST. MARTIN PARISH SHERIFF'S
ELDERLY PROTECTIVE SERVICES
437 WEST MILLS AVENUE
BREAUX BRIDGE, LA 70517

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
AND
ST. MARTIN PARISH SHERIFF'S OFFICE

ELDERLY PROTECTIVE SERVICES

ABUSE NEGLECT and EXPLOITATION

of the ELDERLY
are

CRIMES

HELP ELIMINATE THEM!!

PROTECTING THE ELDERLY

ABUSE, NEGLECT, EXPLOITATION

These are not pleasant words, however, they are reality for many elderly persons living alone,with their families, in nursing homes, or other institutions.

No clear picture of elderly abuse, neglect, or exploitation, has yet emerged. They can be kept secret for years if the victim is neither able nor allowed to go out. Studies of such cases have revealed that over seventy-five percent (75%) of the victims are women, and further, that over fifty percent (50%) are 75 years of age or older.

The admission that such problems can and in fact do exist, is all the more difficult because society; the abused, neglected, exploited victims themselves, as well as the caregivers who fail them, choose not to recognize problems that exist.

ABUSE - can be physical, such as infliction of pain or injury, or psychological such as being frightened, intimidated, threatened, or isolated.

NEGLECT - can involve withholding of food or health services by a caregiver, or, self-neglect by the elderly themselves who fail to eat, go to the doctor, or take medications properly.

EXPLOITATION - involves the improper or illegal use of funds, property, or other resources.

ABUSE, NEGLECT, AND EXPLOITATION OF THE ELDERLY ARE CRIMES . . . REPORT THEM!!

Reports shall be made to any elderly protection agency or local, parish, district or state law enforcement agencies.

WHAT TO REPORT

SUSPECTED

- PHYSICAL ABUSE
- CAREGIVER NEGLECT
- SELF-NEGLECT
- FINANCIAL EXPLOITATION
- EXTORTION
- MENTAL ABUSE
- SEXUAL PROBLEMS
- PROPERTY THEFT

Any person having cause to believe or suspect that an elderly person's physical or mental health is being abused, neglected, or exploited, by any means, is required by law to report it.

The person making the report, may remain anonymous by requesting anonymity. ALL reports will be handled professionally and with strictest confidence.

WHAT CAN YOU DO?

You can begin by recognizing and admitting that abuse, neglect, and exploitation of the elderly is a reality and does exist.

You can learn about the resources available in your community which can either help prevent or stop the problem.

You can relieve the strain of a care-giving family by volunteering relief and assistance.

You can visit, listen, and help when and where there is a need.

You can assist an elderly person who is living alone, to be more comfortable and secure in his or her environment.

****

EVEN MORE

You can be more aware of what's happening in your neighborhood or in your family. Report any suspected problems.

****

LOUISIANA HAS A LAW THAT REQUIRES ALL CITIZENS TO REPORT CASES OF NEGLECT OR ABUSE OF THE ELDERLY. THE LAW GRANTS CIVIL AND CRIMINAL IMMUNITY TO ANY CITIZEN REPORTING IN GOOD FAITH.

Exhibit 6

CHAPTER 8-A. VICTIMIZATION OF SENIOR CITIZENS

§1231. Short title

R.S. 15:1231 through 1237 may be cited as the "Committee on Law Enforcement Services for the Elderly".

Acts 1994, 3rd Ex. Sess., No. 19,§ 1; Acts 1999, No. 841,§ 1, eff. July 2, 1999.

§1232. Legislative findings and declaration

A. The legislature hereby finds and declares that there are many efforts currently under way that work to coordinate criminal justice and social services partnerships to deal with the victimization of senior citizens. The Triad Program, sponsored by the National Sheriff's Association, hereafter referred to as "N.S.A.", the International Association of Chiefs of Police, hereafter referred to as "I.A.C.P.", and the American Association of Retired Persons, hereafter referred to as "A.A.R.P.", is one such effort. This program was replicated in Louisiana by the Louisiana Sheriff's Association, hereafter known as "L.S.A.", the Louisiana Association of Chiefs of Police, hereafter known as "L.A.C.P.", and the state A.A.R.P., with Louisiana being the first state to initiate such an agreement. This effort recognizes that senior citizens have the same fundamental desire as other members of society to live freely, without fear or restriction due to the criminal element, and that the state should seek to expand efforts to reduce crime against this growing and uniquely vulnerable segment of its population.

B. It is the intent of the legislature, therefore, to promote a coordinated effort among law enforcement and social services agencies to stem the tide of violence against senior citizens and support media and other strategies aimed at increasing both public understanding of the problem and the senior citizens' skills in preventing crime against themselves and their property. Further, it is the intent of the legislature to address the problem of crime against senior citizens in a systematic and effective manner by promoting and expanding collaborative crime prevention programs, such as the Triad model, that assist law enforcement agencies and senior citizens in implementing specific strategies for crime prevention, victim assistance, citizen involvement, and public education.

Acts 1994, 3rd Ex. Sess., No. 19,§ 1.

§1233. Establishment of the committee

There is hereby established within the jurisdiction of the Louisiana Commission on Law Enforcement and Administration of Criminal Justice, the Committee on Law Enforcement Services for the Elderly, hereafter referred to as the "committee".

Acts 1994, 3rd Ex. Sess., No. 19,§ 1; Acts 1999, No. 841,§ 1, eff. July 2, 1999.

§1234. Membership of committee; public office; compensation; meetings; quorum

A. The committee shall consist of the following people:

(1) A representative of the Department of Public Safety and Corrections, office of state police, to be appointed by the deputy secretary of public safety services.

(2) Two representatives of the Louisiana Sheriff's Association, to be appointed by its president.

(3) Two representatives of the Louisiana Municipal Chiefs of Police Association, to be appointed by its president.

(4) One representative of the governor's Office of Elderly Affairs, to be appointed by its executive director.

(5) Two representatives from parish volunteer councils on aging, to be appointed by the executive director of the governor's Office of Elderly Affairs.

(6) One representative from the Louisiana Commission on Law Enforcement and Administration of Criminal Justice, to be appointed by its executive director.

(7) Two representatives from the American Association of Retired Persons, to be appointed by the president of the state American Association of Retired Persons.

(8) One representative from the Department of Justice, executive office of the attorney general, to be appointed by the attorney general.

(9) One representative from the Louisiana Association of District Attorneys, to be appointed by the Louisiana Association of District Attorneys.

B. In the performance of its functions, the committee shall, to the extent possible, solicit the participation and involvement of retired law enforcement personnel.

C. The committee shall elect a chairperson by a majority vote of the membership.

D. Members of the committee shall serve until the appropriately designated person in each representative organization selects another representative, and all persons on the committee shall be subject to the approval of the governor.

E. Membership on the committee shall not constitute the holding of a public office, and members of the committee shall not be required to take and file oaths of office before serving on the committee.

F. The members of the committee shall receive no compensation for their services as members.

G. No member of the committee shall be disqualified from holding any public office or employment, nor shall any member forfeit any employment or office by reason of his or her membership on the committee.

H. The committee shall meet as often as deemed necessary, but in no event less than four times annually. The chairman shall call the first meeting of the committee no later than January 1, 1995. A

majority of the membership shall constitute a quorum for conducting business.

Acts 1994, 3rd Ex. Sess., No. 19,§ 1; Acts 2001, No. 858,§ 1.

§1235. Duties and responsibilities

A. The committee shall advise the office of state police, sheriffs of the parishes in the state, and other local law enforcement agencies, senior advocates chosen in consultation with the governor's Office of Elderly Affairs and the parish volunteer councils on aging, and A.A.R.P. representatives in the study and evaluation of "Triad Programs" as an effective response to the problems of crime against elderly persons.

B. The committee may also consult with experts, service providers, and representative organizations engaged in the protection of the elderly and may recommend the development of "Triad Programs" in the state of Louisiana to assist the elderly to avoid criminal victimization through the coordinated efforts of state, parish, and local law enforcement agencies and organizations which provide services for the elderly.

C. The committee may also recommend policies and programs to assist law enforcement agencies to implement "Triad Programs", including training and crime prevention standards and technical assistance. Such recommendations may include the following:

(1) The establishment of a statewide central clearinghouse for information and education materials.

(2) The development of innovative community police programs for the elderly.

(3) The provision of assistance by the committee to the council on peace officers standards and training for the development and delivery of training to law enforcement professionals involved in the "Triad Programs", including but not limited to the following subjects:

(a) Crimes against the elderly and the protection of elderly persons.

(b) Police sensitivity to the needs of elderly persons as victims, witnesses, or victims of "vicarious victimization", which impairs their quality of life.

(c) Availability of social and human services.

(4) The provision of assistance to state and local law enforcement officials and to nonprofit corporations and organizations with respect to effective policies and responses to crimes against elderly persons.

(5) The promotion and facilitation of cooperation among state agencies and local government.

(6) The promotion of effective advocacy services to protect and assist elderly persons and elderly victims of crime.

(7) The evaluation of the relationship between crimes against elderly persons and other problems confronting elderly persons, and the making of recommendations for effective policy response.

(8) The collection of statistical data and research.

(9) The establishment of rules and regulations necessary to carry out the purposes of R.S. 15:1231 through 1236.

Acts 1994, 3rd Ex. Sess., No. 19,§ 1.

§1236. "Triad Program" defined

A. As used in R.S. 15:1231 through 1236, the "Triad Program" means the triad cooperative model developed by the American Association of Retired Persons, the National Sheriff's Association, and the International Association of Chiefs of Police, which calls for the participation of the sheriff, at least one police chief, and a representative of at least one senior citizens' organization within a parish and may include participation by coalitions of law enforcement, victims' services, and senior citizen advocate organizations.

B. If there is not both a sheriff and a police chief in a parish or if the sheriff or a police chief does not participate, a Triad Program may include in the place of the sheriff or police chief another member of the criminal justice system.

Acts 1994, 3rd Ex. Sess., No. 19,§ 1.

Exhibit 7

Who Should Attend?

Police Officers

Deputy Sheriffs

State Police Officers

Nursing Home Adm. Personnel & Staff

Assisted Living Adm. Personnel & Staff

Group Home Adm. Personnel & Staff

Home Care Adm. Personnel & Staff

Developmentally Disabled Facility's Adm. Personnel & Staff

Ombudsman

Elderly Protective Service Staff

Council on Aging Staff

Continuing Education

Continuing Education Unit (CEU) have been applied for through the Louisiana Board of Examiners for Nursing Facility Administrators.

Conference On:

Crime in Residential Care Facilities

Working Together to Identify & Investigate Crime in Residential Care Facilities

Wednesday
November 12, 1997

Holiday Inn South
9940 Airline Highway
Baton Rouge, LA 70818

Vorking Together to Identify & Inv. ligate Crime in Residential Care Facilities

(Nursing Homes, Group Homes, Assisted Living, Developmentally Disabled Facilities)

Agenda

8:00 ***Legal Session*** *Overview of Louisiana Laws Relating to Abuse/Neglect*
Glen Petersen, State of Louisiana, Justice Dept.

9:30 ***Investigating Crimes in Residential Care Facilities***
George Campagna, Criminal Investigator Attorney General's Office

10:15 ***Break***

10:30 ***Investigating Crimes in Residential Care Facilities (Continued)***

11:15 ***Physical and Behavorial Indicators of Abuse/Neglect***
Dr. Henry Rothschild

12:15 ***LUNCH***

1:30 ***Role and Responsibilities of the Various Investigating Agencies***
Panel Speakers:
Lorena Landry, Dept. Of Health & Hospitals
Glen Petersen, State of Louisiana, Justice Dept.
Robert J. Seeman, GOEA, Elderly Protective Services
Sister Michael Sibille, LA Nursing Home Assoc.
Linda Sadden, GOEA, State Long Term Care Ombudsman
Maj. Walter Smith, Crime Against the Elderly Baton Rouge Police Department
Larry C. Deen, Sheriff, Bossier Parish, Louisiana
Roger Breedlove, Asst. DA, 9th Judicial District

3:15 ***Break***

3:30 ***Question and Answer Session with Panel Members***

4:00 ***General Wrap Up: Where Are We Going?***

Conference Registration Fee $50.00

Conference Hotel

Holiday Inn South
9940 Airline Highway
Baton Rouge, LA 70816

To Make Reservations call:
1-888-814-9602

Mention the "Crime Conference". Have your credit card ready to guarantee your reservation for a room rate of $65.00 a night until October 26th.

Conference is Sponsored By

Louisiana Commission on Law Enforcement

Committee for the Coordination of Police Services to the Elderly

Crime in Residential Care Facilities Conference - Baton Rouge, Louisiana
Wednesday, November 12, 1997

Registration is limited to the first 100 Registered

WORKING TOGETHER TO IDENTIFY & INVESTIGATE CRIME IN RESIDENTIAL CARE FACILITIES

CONFERENCE REGISTRATION FORM
Registration Fee $50.00
Wednesday, November 12, 1997

NAME: _____

AGENCY : _____

ADDRESS: _____

PHONE #: _____ FAX #: _____

Please fill out registration form and mail or fax to:
St. Martin Parish Sheriff's Office
437 W. Mills Avenue
Breaux Bridge, LA 70517
Phone #: 318-332-2131
Fax #: 318-332-3411

Exhibit 8

§1237. Creation of the Aged and Law Enforcement Response Team

A. The Aged and Law Enforcement Response Team Program hereinafter known as "ALERT" is hereby established within the Louisiana Commission on Law Enforcement and Administration of Criminal Justice. ALERT shall augment the state and local Triad Program, as provided in R.S. 15:1236, by creating a supportive implementation and training program.

B. ALERT shall accomplish the following objectives:

(1) Creation of a statewide network of law enforcement officers hereinafter known as "Elderly Services Officers" with specialized training in working with elderly citizens and the crime problems specific to the elderly.

(2) Creation of a statewide network of assistant district attorneys with specialized training in working with elderly victims, witnesses and defendants and criminal justice issues specific to the elderly.

(3) Uniformity in the delivery of high quality law enforcement services to the state's elderly citizens through training and certification.

(4) Accountability and accessibility of services through parish level boards composed of law enforcement officials and seniors, thus making the program more responsive to the local needs of elders.

C.(1) The Aged and Law Enforcement Response Team Board hereinafter known as the "board" shall be comprised of the committee as provided for in R.S. 15:1231 et seq.

(2) The board shall retain all of the duties and responsibilities of the committee and will additionally exercise the following:

(a) Oversight and monitoring of the Elderly Services Officers program.

(b) Review all grants under the program, from either state or federal sources, and make recommendations relative to funding, program structure or special conditions to the Louisiana Commission on Law Enforcement and the Administration of Criminal Justice.

(c) Assist the Louisiana Peace Officer Standards and Training Council hereinafter known as "POST", relative to the design of the training program and the certification of Elderly Services Officers.

(d) Provide a comprehensive clearinghouse for materials relative to the elderly services which will be made available to the Elderly Services Officers statewide.

(e) Receive information from Elderly Services Officers in each parish relative to the law enforcement and service needs of elderly citizens in their parishes.

(f) Prepare an annual report to the governor and the legislature relative to emerging crime problems as they effect the elderly.

D.(1) The Aged and Law Enforcement Council hereinafter known as the "council" shall be established in each parish and shall be composed of the sheriff, district attorney, chiefs of police, seniors and representatives from the primary elderly services organization. The chairman of the council shall be a criminal justice official with parish wide authority and selected by the council members.

(2) The council shall be charged with the following duties and responsibilities:

(a) Coordination of service delivery among the various agencies involved with the law enforcement related services for the elderly.

(b) Monitoring local crime conditions and alerting the state board, local criminal justice agencies, and the seniors of emerging crime problems.

(c) Monitoring the Elderly Service Officer program in the parish.

(d) Cooperating with all agencies involved in the delivery of law enforcement services to the elderly to identify gaps in the service delivery system and seek ways to fill those needs.

(e) Receive the annual report prepared by the Elderly Services Officer which sets forth the law enforcement service needs of the elderly citizens in the parish, the corresponding response of the Elderly Services Officer Program, and potential crime problems affecting the elderly.

E.(1) ALERT may provide funding for one Elderly Services Officer in each parish during the first year of the program, subject to availability of funding and prioritization by the committee and the Louisiana Commission on Law Enforcement and the Administration of Criminal Justice. The individual will be selected by the local agency receiving the grant, in accordance with the selection process outlined in the Elderly Services Officer training program. The Elderly Services Officer shall be a POST certified peace officer, meeting all experience criteria established by the committee and shall complete POST certification as an Elderly Services Officer prior to assuming his duties. Funding for Elderly Services Officers under the ALERT program shall be contingent upon the individual officer receiving certification as an Elderly Services Officer. The program may fund the cost for one certified Elderly Services Officer per parish for the initial phase of the program operation and all costs associated with training subject to availability of funding and prioritization by the committee and the Louisiana Commission on Law Enforcement and the Administration of Criminal Justice.

(2)(a) The Elderly Services Officers shall serve as the primary point of contact between the law enforcement community and the elderly.

(b) The Elderly Services Officers duties shall include the following:

(i) Establishment of educational programs in crime prevention, crime reporting, and referral for senior citizen groups in the community.

(ii) Assistance to all law enforcement agencies in the parish with training and, when necessary, case services in matters pertaining to senior citizens.

(iii) Serve as a referral agent for senior citizens with needs for which the citizen has been unable to determine the appropriate agency for assistance.

(iv) Develop community awareness programs relative to fraud and scam operations, elder abuse, and other crime problems which primarily affect the elderly.

(v) Identify crime trends which affect the elderly, as well as other needs of the elderly in the community, and make an annual report of such matters to the board and the council.

(vi) Assist in cases involving elderly victims or witnesses which are under investigation or processed by the Elderly Services Officer's agency or other law enforcement agency in the parish when requested.

F.(1) The district attorney in each judicial district shall designate an assistant district attorney to serve as the elderly services assistant district attorney.

(2) ALERT may provide funding for one elderly services assistant district attorney in each judicial district beginning the second year of the program subject to funding availability and prioritization by the committee and the Louisiana Commission on Law Enforcement and Administration of Criminal Justice. Funding shall be contingent upon certification of the assistant district attorney.

G.(1) The Elderly Services Officer training and certification program may be developed by POST with advice from the board. ALERT shall fund the cost of developing and conducting the training.

(2) The criteria and process for the screening of applicants shall be developed by POST in consultation with the board and a physician in the practice of geriatric medicine recommended by the Louisiana State University Medical School. All persons nominated by local law enforcement agencies to receive the Elderly Services Officers training program shall be approved through the screening process before they may attend the training or receive certification.

H.(1) Upon completion of the training program, all candidates for Elderly Services Officers shall be required to pass a certification examination developed by the POST council with advice from the board.

(2) Each certified Elderly Services Officer shall be required to complete an annual training course.

Acts 1999, No. 841,§ 1, eff. July 2, 1999.

Exhibit 9

ESO/ALERT PROGRAM PARTICULARS

The ESO is considered a generalist not a specialist. The ESO usually has a regular assignment, however, when needed to assist an elderly client, the trained ESO "expert"will be available within your agency to be of assistance.

The ESO will be trained to assist elderly victims of crime and may benefit from the help of the Elderly Crime Victim Assistance Program which can include limited emergency funds for food, shelter, and to make the home safe from immediate re-victimization.

The ESO will be trained to assist the Elderly Protective Services (EPS) Program whose responsibility is to investigate reported cases of abuse/neglect/exploitation. When EPS requires law enforcement assistance within a parish, the ESO is their contact person who either directly assists or arranges for assistance from the proper officer.

The ESO will be considered the expert who can provide training within your agency as well as officers from other agencies in your parish on how to assist elderly persons, such as victims/witnesses of crimes, etc.

The ESO is expected to either help establish or become an active participant in the Triad/SALT Program within their parish.

Exhibit 10

ALERT CANDIDATE MINIMUM QUALIFICATIONS

Be a full-time certified law enforcement officer, meeting the minimum standards of the POST Council and have completed a minimum of two years as a certified law enforcement line officer.

> EXCEPTIONS: Persons having previously received Elderly Services Officer Certification from another state may be accepted for Louisiana certification if all other criteria is met.

Have earned at least an associate (two year) degree or have earned 60 hours of instruction from an accredited institution of higher learning.

> EXCEPTIONS: Persons with five (5) years active law enforcement experience can be substituted for 60 hours of college credit.

Have no current history of drug/alcohol use or abuse.

No history of mental or psychological condition that may adversely impact the ESO duties of the ALERT Program.

Exhibit 11

ESO/ALERT CRITICAL TASKS

Once ESO Certification/Training is completed, the ESO/ALERT Officer is expected to return to their jurisdiction to perform, at a minimum, at least the following critical tasks:

Providing educational programs in crime prevention, crime reporting (to law enforcement), and information/referral (where to go for help) for senior citizen groups in the community.

Assisting all law enforcement agencies in the parish with training and, when necessary, case services in matters pertaining to senior citizens.

Serving as a referral agent for senior citizens with needs for which the citizen has been unable to determine the appropriate agency for assistance.

Developing community awareness programs relative to fraud and scam operations, elder abuse, and other crime problems which primarily effect the elderly.

Identification of crime trends which effect the elderly, as well as the needs of the elderly in the community, and making an annual report of such matters to the ALERT Board and the Parish SALT Council (ALERT Sub-Committee).

Assisting in cases involving elderly victims or witnesses which are under investigation or processing by the Elderly Services Officer's agency or other law enforcement agency in the parish when so requested, as appropriate.

Replicate the Triad/SALT Program.

Exhibit 12

ELDERLY SERVICES OFFICE[illegible] (SO) CERTIFICATION COURSE
Baton Rouge, LA

March 7, 2001

March 19 - 23, 2001 Class #1

Monday March 19th	Tuesday March 20th	Wednesday March 21st	Thursday March 22nd	Friday March 23rd
7:30 am - 8:00 am **Administrative** *Charles Baxley* LSU Staff	7:45 am - 8:00 am **Administrative** *Charles Baxley* LSU Staff	7:45 am - 8:00 am **Administrative**	7:45 am - 8:00 am **Administrative**	7:45 am - 8:00 am **Administrative**
		8:00 am - 9:00 am **Long Term Care Ombudsman** *Linda Saddin*	8:00 am -10:00 am **Alzheimer's / Safe Return** Chapter of LA Alzheimer's Association	8:00 am - 11:00 am **Elderly Protective Services** *Robert Seemann, LCSW* Governor's Office of Elderly Affairs
8:00 am - 9:00 am **Elderly Crime Victim Orientation** *Audrey Thibodeaux* St. Martin S.O.	8:00 am - 12:00 pm **Con-Artists, Scams, Financial, Consumer, Medical & Repair Frauds** *Bruce Walstad* Street Smart Seminars Franklin Park, IL	9:00 am - 12:00 am **Interdiction / Power of Attorney / Wills / Trusts** **Mental Health Laws** *Kevin Robshaw, JD*		
9:00 am - 12:00 pm **Victimization of the Elderly** *Trudy Gregorie* Director of Victim Services & Program Development Arlington, VA			10:00 am - 12:00 pm **Crime Victim Reparation** *Robert Wertz* LA Commission on Law Enforcement	11:00 am - 12:00 pm **Test / Evaluation** *Charles Baxley* LSU Staff
12:00 pm - 1:00 pm **LUNCH**	12:00 pm - 1:00 pm **LUNCH**	12:00 pm - 1:00 pm **LUNCH**	12:00 pm - 1:00 pm **LUNCH**	12:00 pm - 1:00 pm **LUNCH**
1:00 pm - 5:00 pm **Victimization of the Elderly** *Trudy Gregorie* Director of Victim Services & Program Development Arlington, VA	1:00 pm - 5:00 pm **Con-Artists, Scams, Financial, Consumer, Medical & Repair Frauds** *Bruce Walstad* Street Smart Seminars Franklin Park, IL	1:00 pm - 2:00 pm **Mental Health Advocate** *Kathy Cook*	1:00 pm - 2:00 pm **Crime in Residential Facilities** *George Campagana*	1:00 pm - 3:00 pm **Discussion of Triad & Alert Program** *Michael Ranatza* Executive Director LA Commission on Law Enforcement *Charles A. Fuselier* Sheriff *Capt. Audrey Thibodeaux* St. Martin Parish S.O.
		2:00 pm - 5:00 pm **Law Enforcement & Older Persons** *Audrey Thibodeaux* **St. Martin Parish S.O.**	2:00 pm - 3:00 pm **Criminal Statutes** *J. Jeter, JD* 3:00 pm - 4:00 pm **US Attorney's Office Role** *G. Peterson, JD* 4:00 pm - 5:00 pm **Panel** *G. Peterson, G. Campagna* *J.Jeter, L. Saddin, K. Robshaw*	3:00 pm - 4:00 pm **Graduation**

Exhibit 13

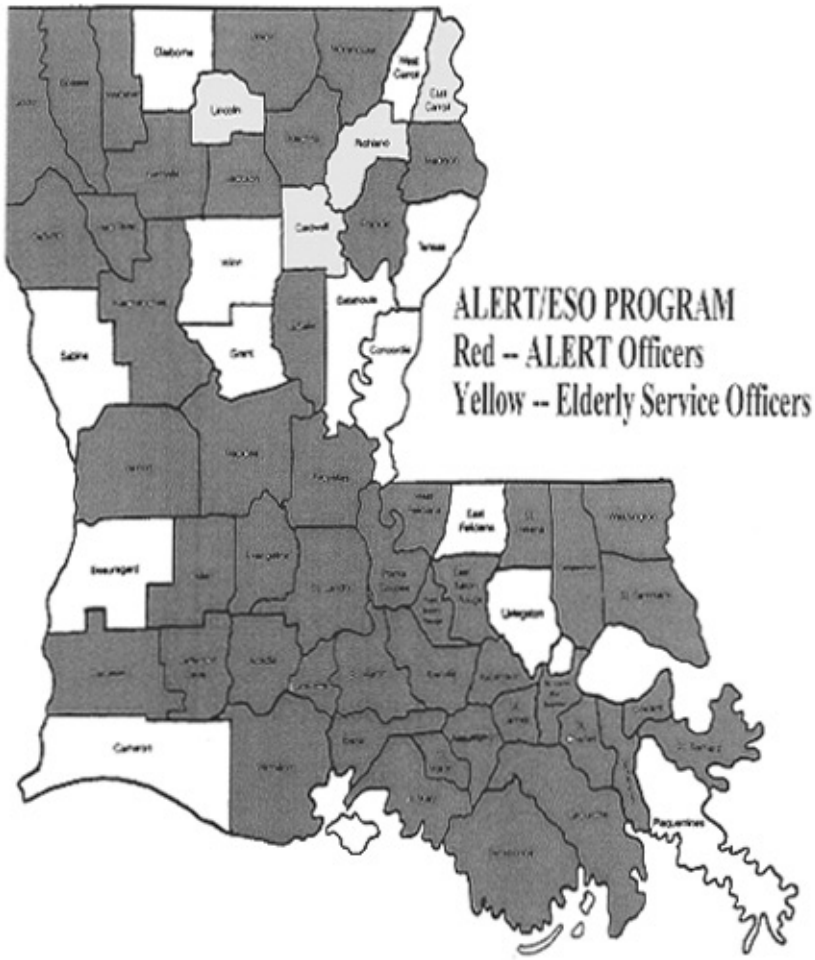

ALERT/ESO PROGRAM
Red -- ALERT Officers
Yellow -- Elderly Service Officers

Exhibit 14

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
1	David C. Addison	Livonia Police Dept.	P.O. Box 307 Livonia, LA 70755	225-637-2520 225-637-3189 fax
2	Phillip W. Aleshire	St. Tammany Parish S.O.	P.O. Box 1120 Covington, LA 70433	985-875-2102 985-875-2195 fax
3	Dianne R. Alpough	St. Landry Parish SO	P.O. Box 390 Opelousas, LA 70571	337-948-6516
4	Evelyn Armatta	New Iberia City Police	457 E. Main Street New Iberia, LA 70560	337-369-2310 337-369-2327 Fax
5	Wardell Ballentine	Rapides Parish S. O.	P.O. Box 1510 Alexandria, LA 71301	318-473-6700
6	Barbara Gail Bartlett	Calcasieu Parish SO	5400 E. Broad Lake Charles, LA 70611	337-491-3718
7	David Wayne Batiste	St. Martin Parish SO Elderly Protective Svs.	437 West Mills Ave Breaux Bridge, LA 70517	337-332-3344 337-332-3351 Fax
8	Ashley A. Baudoin	St. Mary Parish SO	P.O. Box 571 Franklin, LA 70538	337-828-6960 337-828-6972 Fax
9	Charles E. Baxley	LSU - LETP	276 Pleasant Hall Baton Rouge, LA 70803	225- 578-5115 225-578-4781 Fax
10	David Coy Beavers	Rapides Parish S.O.	P.O. Box 1510 Alexandria, LA 71301	318-473-6700
11	Preston Lee Billiot	Jeanerette Police Dept.	1437 Main Street Jeanerette, LA 70544	337-276-6324
12	Felisa R. Blake	Grambling Police Dept.	P.O. Box 108 Grambling, LA 71245	318-247-3771 318-247-0760 fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
13	Karen L. Blake	Elderly Protective Services	902 C.M. Fagan, Suite F Hammond, LA	985-543-4036 985-543-4038 Fax
14	Randell Bordelon	Rapides Parish S.O.	P.O. Box 1510 Alexandria, LA 71309	318-473-6700 318-449-5455 Fax
15	Charles W. Borchers	St. Bernard Parish S. O.	P.O. Box 168 Chalmette, LA 70043	504-271-2504 504-278-7799 fax
16	Quentin L. Boudreaux	Jefferson Parish SO	3300 Metairie Road Metairie, LA 70001	504-832-2400
17	Rhonda K. Brannon	Madison Parish S. O.	100 North Cedar Tallulah, LA 71282	318-574-1833 318-574-5368 Fax
18	Newman S. Braud	St. Martin Par. SO, ESO	437 West Mills Avenue Breaux Bridge, LA 70517	337-332-3344 337-332-3351 Fax
19	Wendy B. Breath	St. Martin Parish S.O. / E.P.S.	437 West Mills Avenue Breaux Bridge, LA 70517	337-332-3344 337-332-3351 fax
20	James C. Brown	Terrebonne Parish SO	P.O. Box 1670 Houma, LA 70361	504-876-2500
21	Verna M. Brown	New Orleans Police Dept.	801 Rosedale Drive New Orleans, LA 70122	504-483-2030 504-483-2570 fax
22	Robin L. Brunke	Gonzales Police Dept.	120 S. Irma Blvd. Gonzales, LA 70737	225-647-7511 225-647-9544 Fax
23	Kathryn Cambre	Tangipahoa Parish S.O.	P.O. Box 727 Amite, LA 70422	985-345-6150
24	Gwen Chretien-Olivier	Calcasieu Parish SO	5400 E. Broad Street Lake Charles, LA 70601	337-491-3717
25	Debra W. Cook	New Orleans Police Dept.	10101 Dwyer Blvd. New Orleans, LA 70127	504-244-4600 504-243-3120 fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
26	John Brett Cooper	DeSoto Parish S.O.	205 Franklin Street Mansfield, LA 71052	318-872-3956
27	Tara Lorio Core	Elderly Protective Services	902 C.M. Fagan, Suite F Hammond, LA	985-543-4036 985-543-4038 Fax
28	Christine Cortopassi	Lafourche Parish S.O.	751 Goode Street Thibodaux, LA 70301	985-449-4480
29	Michael Couvillon	Vermilion Parish SO	P.O. Box 307 Abbeville, LA 70510	318-898-4403
30	Brenda Cummings	Webster Parish S.O.	P.O. Box 877 Minden, LA 71055	318-377-1515
31	Glen D. Dartez	Lafayette Police Dept.	P.O. Box 4308 Lafayette, LA 70502	337-291-5670 337-291-5665 Fax
32	Charles H. Davis	Natchitoches Par. SO	200 Church Street Natchitoches, LA 71458	318-352-6432 318-357-2249 Fax
33	Ernest Desselle, Jr.	Avoyelles Parish S.O.	675 Government Street Marksville, LA 71351	318-253-4000 318-253-8085 Fax
34	Alma O. Douglas	Lafourche Parish SO	P.O. Box 5608 Thibodeaux, LA 70302	504-448-2111 504-447-1854 Fax
35	Gene C. Duhon	Calcasieu Parish SO	5400 East Broad Lake Charles, LA 70601	337-491-3700
36	Ronald L. Durand	Iberia Parish S.O.	300 Iberia Street; Ste. 120 New Iberia, LA 70560	337-369-3714 337-367-0725 fax
37	Eloise D. Edwards	East Carroll SO	400 First Street Lake Providence, LA 71254	318-559-2800

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
38	Emily Ruth Ervin	Madison Parish S.O.	100 North Cedar Street Tallulah, LA 71282	318-574-1831 318-574-5368 Fax
39	Clara R. Farley	Ofc. of Elderly Affairs	1525 Fairfield Ave, Room 538 Shreveport, LA 71101-4388	318-676-5200 318-676-5212 Fax
40	Tommy P. Favaron	Iberville Parish SO	P.O. Box 231 Plaquemine, LA 70764	225-687-5100 225-687-5295 Fax
41	Judy R. Fielder	St. Charles Parish SO	P.O. Box 426 Hahnville, LA 70057	985-783-6237 985-783-1195
42	Bradford Fontenot	Ville Platte Police Dept.	P.O. Box 477 Ville Platte, LA 70586	337-363-1313 337-363-0351 fax
43	Roy Dale Freeman	Washington Parish SO	1002 Main Street Franklin, LA 70438	504-839-3434
44	Charlene D. Frosch	Mandeville Police Dept.	1870 Hwy 190 Mandeville, LA 70448	985-626-9711 985-624-3125 fax
45	James Randall Fuller	Union Parish SO	100 E. Bayou Street Suite 101 Farmerville, LA 71241	
46	Pamela S. Gaines	Ascension Parish SO	828 S. Irma Blvd. Gonzales, LA 70737	225-621-8300
47	Farrell C. Gros	Assumption Parish S. O.	P.O. Box 69 Napoleonville, LA 70390	504-369-7281
48	Drew F. Gushlaw	Oakdale Police Dept.	118 N. 10th Street Oakdale, LA 71463	318-335-0290 318-335-0620 fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
49	Katherine M. Guye	Red River Parish S.O.	P.O. Box 375 Coushatta, LA 71019	318-932-4221
50	Bart Leonard Habetz	Acadia Parish SO	P.O. Box 289 Crowley, LA 70526	337-788-8700
51	Riley Harbor III	Baton Rouge City PD	704 Mayflower Street Baton Rouge, LA 70821	225-389-4801
52	Velma L. Harrison	Richland Parish SO	708 Julia Street Rayville, LA 71269	318-728-2071 318-728-6454 Fax
53	Virginia Ann Higgins	St. Martin Parish SO	437 West Mills Ave. Breaux Bridge, LA 70517	337-332-3344 337-332-3351 Fax
54	Arnold B. Hodges	St. Helena Parish SO		225-222-4413 225-222-6908 Fax
55	Nancy L. Iguess	Office of Elderly Affairs - Elderly Protective Services	805 Bayou Pines West, Suite A-1 Lake Charles, LA 70601	337-491-2619 337-491-2752 Fax
56	Larry Ingargiola	St. Bernard Parish SO	P.O. Box 168 Chalmette, LA 70043	504-278-7634
57	Lifford D. Jackson	Caddo Parish SO	501 Texas Street #101 Shreveport, LA 71101	318-226-6678 318-226-6886
58	Sharon W. Jackson	Elderly Protective Services	200 Third Street Baton Rouge, LA 70801	225-387-4277 225-706-0004 Fax
59	Earnest L. James	W. Feliciana Parish S.O.	P.O. Box 1844 St. Francisville, LA 70775	225-635-3241 225-635-6947 Fax
60	Michael T. Janise	Jennings Police Dept.	110 North Broadway Jennings, LA 70546	337-824-0423 337-821-5538 Fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
61	Vicki F. Johnson	Bienville Parish SO	P.O. Box 328 Arcadia, LA 71001	318-263-2215 318-263-7418 fax
62	Elizabeth Lea Jones	Ouachita Parish S.O.	400 St. John Street West Monroe, LA 71210	318-329-1216 331-322-4375 Fax
63	Melody M. Karamanis	Ouachita Parish SO	P.O. Box 1803 Monroe, LA 71210-1803	318-327-1330 318-322-4375 fax
64	Jeffrey R. Keenum	Lake Charles Police Dept.	830 Enterprise Blvd. Lake Charles, LA 70601	337-491-1311 337-491-1580 Fax
65	Gufielle Keller	St. James Parish SO	P.O. Box 83 Convent, LA 70723	225-562-2200
66	Mary Kennedy	Morehouse Parish S.O.	351 S. Franklin Bastrop, LA 71220	318-281-4141 318-283-1773 Fax
67	Donnie Ray Knox	Jackson Parish SO	Room 100 Jonesboro, LA 71225	318-259-9021
68	Kevin K. Knudsen	Jefferson Parish SO	3300 Metairie Road Metairie, LA 70001	504-832-2400
69	S. Jane Kuperstock	Washington Parish SO	916 Pearl Street Franklinton, LA 70438	504-839-7836 504-839-7839 Fax
70	Dwayne LaGrange	St. Charles Parish SO	P.O. Box 426 Hahnville, LA 70057	504-783-1355 504-783-1195 Fax
71	"B.J." Landry	Lafayette Parish SO	P.O. Drawer 3508 Lafayette, LA 70506	337-236-5611 337-236-3967 Fax
72	Dobie D. Landry	Lafourche Parish SO	P.O. Box 5608 Thibodaux, LA 70301	504-448-2111 504-447-1854 Fax
73	Drew C. Lehmann	St. Tammany Parish SO	P.O. Box 1120 Covington, LA 70434	504-875-2633

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
74	Charles Joseph Mabile	Assumption Parish SO	P.O. Box 69 Napoleonville, LA 70390	985-369-7281 985-369-1395 fax
75	Mary Twickler Mann	Baton Rouge Police Dept.	P.O. Box 2406 Baton Rouge, LA 70821	225-389-8648
76	Fernest J. Martin	Jeanerette Police Dept.	1437 Main Street Jeanerette, LA 70544	337-276-6323 337-276-9527 fax
77	Greg K. Maurin	St. John Parish SO	P.O. Box 1600 LaPlace, LA 70069-1600	504-652-7058
78	Nelda Jean May	Caldwell Parish SO	P.O. Box 60 Columbia, LA 71418	318-649-2345 318-649-5226 fax
79	Lutricia B. McDonald	Lake Charles EPS	805 Bayou Pines West Lake Charles, LA 70601	1-888-491-2619 337-491-2219 337-491-2752 fax
80	Emma McNeal-Williams	Lincoln Parish TRIAD	1011 Cornell Drive Ruston, LA 71270	318-251-5119 318-251-8601 Fax
81	Greta F. Melancon	St. James Parish SO	P.O. Box 83 Convent, LA 70723	225-562-2200 225-562-2380 fax
82	Francis W. Naquin	Lecompte Police Dept.	P.O. Drawer 128 Lecompte, LA 71346	318-776-9211 318-776-0154 fax
83	Karla S. Naquin	Lafourche SO	751 Goode Street Thibodaux, LA 70301	985-449-4486 985-449-4488 fax
84	Kenneth D. Noble	Vernon Parish SO	203 South 3rd Street Leesville, LA 71446	337-238-1311
85	Davie C. Oakes	Oakdale Police Dept.	118 N. 10th Street Oakdale, LA 71463	318-335-0290 318-335-0620 fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
86	Gerald Palmer	Hodge Police Dept.	P.O. Box 280 Hodge, LA 71247	318-259-4704 318-259-6670 Fax
87	Helen H. Parker	Caldwell Parish SO - TRIAD	P.O. Box 60 Columbia, LA 71418	318-649-2345 318-649-5226 fax
88	John B. Parker	Alexandria Police Dept.	1000 Bolton Avenue Alexandria, LA 71301	318-441-6485
89	Joe E. Phillips	LaSalle Parish SO	P.O. Box 70 Jena, LA 71342	318-992-2151
90	Joan L. Pickup	Elderly Protective SVS	3939 Causeway #101 Metairie, LA 70002	504-832-1644
91	James C. Pontiff	Lafayette Police Dept.	900 E. University Lafayette, LA 70502	337-291-5022 337-291-5023 fax
92	Denise M. Pothier	Elderly Protective Services	902 C.M. Fagan, Ste F Hammond, LA	1-800-533-1297 985-543-4038 Fax
93	Percy Reed	New Orleans Police Dept.	715 South Broad Street New Orleans, LA 70119	504-826-1585 504-826-5157 fax
94	James S. Ritchie, Jr.	W. Feliciana Parish S.O.	P.O. Box 1844 St. Francisville, LA 70775	225-635-3241 225-635-6947 Fax
95	Evelyn B. Robinson	Monroe Police Dept.	P.O. Box 1581 Monroe, LA 71210	318-329-2600 318-329-2610 Fax
96	Edward R. Rozell	W. Baton Rouge SO	P.O. Box 129 Port Allen, LA 70767	225-343-9234
97	Vincent J. Russo, Jr.	Pointe Coupee Parish SO	P.O. Box 248 New Roads, LA 70760	225-638-5400
98	Thomas Joseph Scott	Leesville Police Dept	101 East Lee Street Leesville, LA 71446	318-238-0331 318-239-7792 Fax
99	Robert J. Seemann	Office of Elderly Services	412 N. Fourth Street Baton Rouge, LA 70803	225-342-9722 225-342-7144 fax
100	Donny R. Smith	Elderly Protection	806 N. 31st, Suite A Monroe, LA 71201	318-362-4280 318-362-4295 Fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
101	Jo Ann Stampley	Alexandria EPS	900 Murray Street, Suite 100-A Alexandria, LA 71301	1-800-256-7007 318-484-2219 318-484-2236 fax
102	Thomas J. Staten	Monroe Police Dept	700 Wood Street Monroe, LA 71203	318-329-2600 318-329-2610 fax
103	Norma M. Steib	St. James Parish SO	4800 Highway 44 Convent, LA 70763	225-562-2000
104	Jeffery Lynn Stewart	Acadia Parish SO	P.O. Box 289 Crowley, LA 70526	337-788-8700
105	Doris D. Swift	Caddo Parish SO	501 Texas, Room 101 Shreveport, LA 71101	318-226-6794 318-226-6977 Fax
106	Donn M. Tarter	EPS	900 Murray Alexandria, LA 71301	318-484-2219
107	Jerry L. Taylor	Union Parish SO	107 E. Bayou Farmerville, LA 71241	318-368-3124
108	Myra Ann Theriot	Breaux Bridge City Police	101 Berard Street Breaux Bridge, LA 70517	337-332-2186 337-332-3069 fax
109	Audrey Thibodeaux	St. Martin Parish SO	437 West Mills Avenue Breaux Bridge, LA 70517	337-332-2131 337-332-3411 Fax
110	Eddie Thibodeaux	St. Landry Parish S.O.	P.O. Box 390 Opelousas, LA 70570	337-948-6516 337-942-9729 Fax
111	Clifford W. Thomas	Thomas Consulting & Management	304 Nevada Drive Monroe, LA 71202	318-340-9996 Ofc. & Fax
112	Marcelette Thompson	Franklin Parish SO	6556 Main Street Winnsboro, LA 71295	318-435-4505 318-435-6762 Fax

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
113	Mark Alan Toloso	Bossier Parish SO	2510 Viking Drive Bossier City, LA 71111	318-747-8600
114	Kevin P. Trahan	Acadia Parish SO	P.O. Box 289 Crowley, LA 70526	337-788-8700
115	Rory Vaughn, Sr.	Iberville Parish SO	P.O. Box 231 Plaquemine, LA 70764	225-687-3553
116	Bruce P. Vige`	Eunice Police Department	300 South 2nd Eunice, LA 70535	337-457-2626 337-457-6589 Fax
117	Jackie R. Vitatoe	Calcasieu Parish SO	5400 East Broad Street Lake Charles, LA 70601	337-491-3626
118	Barbara F. Vittitoe	Westwego Police Dept.	417 Avenue A Westwego, LA 70094	504-341-5428 504-341-0301 fax
119	Vicki Lynn Watson	Red River Parish SO	P.O. Box 375 Coushatta, LA 71019	318-932-4221
120	Joseph Allen Way	St. Tammany Parish SO	P.O. Box 1120 Covington, LA 70433	985-875-2105 985-875-2195 fax
121	Joseph P. Williams	Calcasieu Parish SO	5400 E. Broad Street Lake Charles, LA 70615	337-494-4561 337-491-3700
122	Rena Mae Williams	St. Martin Parish SO	437 W. Mills Avenue Breaux Bridge, LA 70517	337-332-2131
123	S."Carlene" Willis	Bossier Parish SO	P.O. Box 850 Benton, LA 71006	318-965-2203

ESO Graduate Master List

#	Name	Agency	Agency Address	Telephone/Fax
124	Earnestine L. Yokum	Calcasieu Parish SO	2112 Moeling Street Lake Charles, LA 70601	337-491-3700

Exhibit 15

Sheriff

Charles A. Fuselier

PARISH OF ST. MARTIN
P. O. BOX 247
ST. MARTINVILLE, LA 70582
TELEPHONE (337) 394-3012 • FAX (337) 394-5705

Dear Sheriff/Chief/or Designee:

We are currently accepting applications for the 2002 ESO/ALERT (Elderly Services Office/Aged law Enforcement Response Team) POST (Peace Officers Standards and Training) Certification to be held at Louisiana State University in Baton Rouge. Our initial goal was to have an ESO/ALERT Officer in each parish, and after our first five certifications, we are please to have 123 ESO/ALERT Officers in 45 parishes in Louisiana. There is no charge for the training.

There are two complete (40) hour certification sessions scheduled for 2002 so your agency's candidate(s) may choose to atend either the April or June session. The following are specifics about the training:

TRAINING SESSION:	**April 8 - 12, 2002**
APPLICATION DEADLINE:	**April 1, 2002**
TRAINING SESSION:	**June 10 - 14, 2002**
APPLICATION DEADLINE:	**June 3, 2002**

TRAINING COST: NO CHARGE

MATERIAL COST: All classroom supplies are furnished at no charge

LODGING: If Attendee lives beyond a 30 mile radius of LSU they will be reimbursed for meals according to State Travel Regulations. Reimbursement will be mailed approximately 3 weeks after graduation.

MILEAGE: Attendees living within a 30 mile radius of LSU they cannot be reimbursed for milage. Attendees using their personal vehicles will be reimbursed for one time travel to and from training at $.28 a mile round trip according to State Travel Regulations. If traveling in an Official Unit, mileage cannot be reimbursed. Reimbursement will be mailed approximately 3 weeks after graduation.

ATTIRE: You may dress comfortably for class. No shorts or cutoffs allowed. Dress nice on the Friday for a class graduation picture.

"ON PARLE DEUX LANGUES ICI"
Equal Opportunity Employer

Enclosed are the following:

Particulars About the Program - Attachment 1
Worker Characteristics - Attachment 2
Minimum Qualifications - Attachment 3
Critical Tasks (Sample Job Description) - Attachment 4
Application - Attachment 5

If you are unable to send someone meeting the minimum qualifications, but would like to send someone to the training, we can provide Elderly Services Officer Certification for those not meeting minimum standards. Please contact Captain Audrey Thibodeaux at 337-394-2133, if you have any questions or need assistance. Thanking you in advance for your consideration in this matter, I remain,

Sincerely,

Charles A. Fuselier, Sheriff
St. Martin Parish, Louisiana

CAF:tal

Attachments

St. Martin Parish Sheriff's Office
Captain Audrey Thibodeaux
Post Office Box 247
St. Martinville, LA 70582
(337) 394-2133
(337) 394-5705 (Fax)

The CHAIRMAN. Sheriff Fuselier, thank you for a really terrific statement and a very good story.

Mr. Blanco, Henry Blanco, we are pleased to receive your testimony.

STATEMENT OF HENRY BLANCO, BOARD MEMBER, NATIONAL ASSOCIATION OF ADULT PROTECTIVE SERVICES ADMINISTRATORS, PHOENIX, AZ

Mr. BLANCO. Mr. Chairman, members of the committee, I would like to extend congratulations to you and the committee for providing a forum to discuss this serious issue. I am the Program Administrator for the Aging and Adult Administration within the Arizona Department of Economic Security. We are also the designated unit on aging under the Older Americans Act.

The CHAIRMAN. Mr. Blanco, speak up a little bit and get that mike a little bit closer. It does not pick it up too well. Maybe push it down a little bit. I think it is a little too high. There you go.

Mr. BLANCO. However, today I am testifying before you as representative of the National Association of Adult Protective Service Administrators, or NAAPSA.

The association represents Adult Protective Services, APS, programs nationwide by providing advocacy, training, research and innovation in the field of APS. All states in our union have identified APS programs. However, there is no Federal law that provides direction for APS. As a result, program parameters are entirely up to each state.

Some APS programs are not involved in investigating allegations of abuse in long-term care facilities. Adult Protect Services are those services provided to elderly and disabled adults who are in danger of abuse, neglect or exploitation, and who are unable to protect themselves and have no one to assist them.

It is estimated in the United States, two million older persons and persons with disability are abused, neglected or financially exploited each year. Most experts believe this number may be only the tip of the iceberg since many victims are unable to report their abuse and have no one to do so for them.

According to the most recent figures from the National Center for Health Statistics, there are currently 16,700 nursing homes in the United States with 1.8 million beds serving 1.6 million residents. Of these homes, 95.6 percent of them are certified for Medicaid and/or Medicare participation.

Without question, the physical and sexual abuse of our elders in long-term care facilities must be highlighted and addressed with all possible resources. I would like to provide you an example of three cases that APS is involved in, and I have further examples in my written testimony.

The first case was an 64-year-old woman who was placed in a long-term care facility. The client was to have a diagnostic test, a barium enema; the doctor had ordered one tap water enema to be given the night before. The client, however, was not an easy person to get along with, often demanding and belligerent. Two LPNs decided to get even with the client because of her behavior and gave her 15 enemas with approximately three feet of tubing completely inserted into her rectum.

None of this would have come to light if the client had not complained that the nurses had verbally abused her. The case took 3 years to get to court.

In a second case, an 85-year-old woman was raped at a local nursing home. She was alert, oriented and competent. The client said the male caregiver had raped her. A long-term care facility chose not to believe her. Instead gave her two Tylenols, told her to go bed, get a good night sleep and they would discuss it in the morning. Another source in the facility reported the incident to APS and to law enforcement.

The local law enforcement Sex Abuse Unit was able to retrieve the sheets. Semen was found on the sheets. She had been raped. The certified nurse's assistant was arrested, tried and sent to jail.

In a third case, a 74-year-old woman was raped by a CNA. Another staff person saw the CNA with his pants down around his ankles and asked what was going on? The CNA said he was "adjusting himself." The victim unfortunately was demented, unable to communicate. Rape could not be substantiated and charges were not filed.

These cases are complex and involve the necessary coordination of many different jurisdictions and agencies. Coordination between APS, law enforcement, regulatory agencies, professional licensing boards, long-term care ombudsman programs, Medicaid fraud units, to name a few, are critical in successfully addressing these issues.

There are several initiatives that we would recommend. My full statement includes additional recommendations. I would like to highlight a few of them. The first one as the congressional report indicates, salary and training for caregivers is a major issue. The issue of salaries, other benefits and working conditions and their relationship to quality must be addressed.

Second, many states have mandatory reporting laws. Some states provide protection from civil or criminal liability for the reporting source. Other states protect the reporting source and retribution by their employer for reporting to APS or law enforcement. These protections and requirements should be available nationwide.

Third, the Social Services Block Grant is the only fund source of Federal funding that provides special funds for the delivery of adult protective services. SSBG has been reduced over the past few years from 2.8 billion to 1.7 billion. Thirty-one states depend on these funds to provide protective services to victims like those I have described.

Although the president's budget for fiscal year 2003 holds SSBG at 1.7 billion, we are heartened by the recent news that the White House is supportive of Senator Lieberman's and Santorum's care legislation that would restore SSBG funding on a temporary basis. Their bill is Senate bill 1924.

Fourth recommendation, we recommend that we provide a dedicated funding source for the expansion, enhancement and development of services for a nationally funded APS program.

Fifth recommendation would be to strengthen the requirements for fingerprinting and background checks for all employees of long-term care facilities. A major obstacle in this area is the expense and the amount of time required for fingerprint clearances.

A sixth recommendation is to recognize that physical and sexual abuse occurs at all levels of care, and most be aggressively addressed regardless of where it occurs.

A seventh recommendation would be to review Federal regulations, both programmatic and funding, to ensure that obstacles to coordinating and cooperation are not created for the many state and Federal agencies involved in long-term care facilities.

One of the areas to review is the ability to share information, which may be essential but considered confidential. Adults served by Adult Protective Services are among this country's most vulnerable citizens. Those in our nation's long-term care facilities are often most isolated.

They need our help. They deserve your attention, and they have earned the right to be safe in their older years regardless of where they reside. Mr. Chairman, I would like to submit my full testimony for the record. Thank you.

The CHAIRMAN. Without objection, the whole statement, of course, will be made part of the record.

[The prepared remarks of Mr. Blanco follow:]

Senate Special Committee on Aging
Investigative Hearing on Elder Abuse, Neglect and Exploitation
Washington, DC
March 4, 2002
Testimony Provided by Henry Blanco
for the
National Association of Adult Protective Services Adminstrators

Mr. Chairman, members of the committee,

I would like to extend my congratulations to you and the committee for providing a forum to discuss this serious issue; the physical and sexual abuse of our most vulnerable population; elderly and vulnerable adults who are institutionalized. My name is Henry Blanco. I am the Program Administrator for the Aging and Adult Administration within the Arizona's Department of Economic Security. However, today I am testifying before you as a representative of the National Association of Adult Protective Services Administrators. The Association represents Adult Protective Services (APS) programs nationwide, by providing advocacy, training, research and innovation in the field of APS. All States in our Union have identified APS programs. However, there is no federal law, which provides direction for program requirements. As a result, program parameters are developed around State statue. Some APS programs are not involved in the investigating allegations of abuse in long term care facilities.

Adult Protective Services are those services provided to elderly and disabled adults who are in danger of abuse, neglect or exploitation; and who are unable to protect themselves, and have no one to assist them. Some of these services include: Investigation of reports of abuse, financial exploitation and neglect of vulnerable adults;

Although we have made great strides, we cannot possibly meet the increasing demand and complexity of needs facing our clients without federal leadership and resources. In Arizona, 18% of our APS investigations involve allegations from long term care facilities. According to the most recent figures from the National Center for Health Statistics, there are currently 16,700 nursing homes in the U.S. with 1.8 million beds, serving 1.6 million residents. Of these homes 95.6 % of them are certified for Medicaid and/or Medicare participation. Without question, the physical and sexual abuse of our elders in long term care facilities must be highlighted and addressed with all possible resources. I would like to provide you an example of five cases APS was involved with:

Case 1. A 64-year-old woman placed in a long term care facility. The client was to have a diagnostic test (barium enema) on Monday A.M. The doctor had ordered one tap water enema to be given the night before. The client however, was not an easy person to get along with, often demanding and belligerent. Two LPN's decided to get even with client because of her behaviors and gave her 15 enemas with approximately 3 feet of tubing completely pushed into her rectum. Along with the 15 enemas, she was also given mineral oil retention enemas and fleets enemas. The client cried out once that they were hurting her and the LPN's told her to shut up. The LPN's also gave her an injection of narcotic to keep her quiet while they perpetrated this atrocity. The LPN's lied on the narcotic sheet saying the drug had fallen and broken. The Registered Nurse in charge of the floor was aware of what was happening as well were the Certified Nurse

locked, the head of nursing let herself into the room with a key and found the maintenance man having sexual contact with the victim. He had been having sexual relations with her for several months, even though she was incapable of giving informed consent. It appeared that he had preyed on other residents over the years.

Case 5. In Wyoming a CNA pleaded no contest to one count of Battery and two counts of Elder Abuse/Neglect. The case was prosecuted by the Medicaid Fraud Control Unit of the Attorney Generals's Office.The Medicaid Fraud Control Unit worked in close cooperation with the Adult Protective Services Division of the Department of Family Services. The charges stem from allegations of physical and mental mal-treatment by the CNA upon a nursing home resident where she was employed. The CNA was sentenced to 150 days incarceration that was suspended, with the condition of one year probation. She was ordered to pay a $100.00 fine for the Battery count, $100.00 for each of the Elder Abuse/Neglect counts, $300.00 to Crime Victims Compensation and court costs and Public Defender fees. The CNA and the State agreed that she will not seek employment in the care and treatment of the elderly or disabled in the future and she will attend anger management classes.

These cases are complex and involve the necessary coordination of many different agencies and jurisdiction. Coordination between APS, law enforcement, regulatory

often are among the programs frequently cut. It is urgent that SSBG funds be restored to at least $2.8 billion. SSBG funds support APS services for approximately 650,000 older and disabled adults. 31 states depend on these funds to provide protective services to victims like I just described. In Texas, for example, eighty percent of the state's APS system is financed by SSBG. Although the President's budget for FY 2003 holds SSBG at $1.7 billion we are heartened by the recent news that the White House is supportive of Senators Lieberman and Santorum's CARE legislation that would restore SSBG funding on a temporary basis. Their bill, S 1924, the *Charity Aid, Recovery and Empowerment ("CARE") Act of 2002* would increase SSBG funding to $1.975 billion in FY '03 and then $2.8 billion in FY '04. Unfortunately the bill includes a provision that would return SSBG to the current $1.7 billion level in FY '05. The inclusion of their bill, S 1924, the *Charity Aid, Recovery and Empowerment ("CARE") Act of 2002* would increase SSBG funding to $1.975 billion in FY '03 and then $2.8 billion in FY '04. The provision even if only for two years reflects understanding of the importance of SSBG and that it helps states fund services for vulnerable populations much of which gets into the hands of social services agencies associated with faith-based organizations, such as Catholic Charities and Jewish Family Services. SSBG needs more than a temporary fix but the provisions in S 1924 would be a crucial step in the right direction.

4) Provide a dedicated fund source for expansion, enhancement and development of services for a nationally funded APS program. The Violence Against Women's Act

Adults served by Adult Protective Services programs are among this country's most vulnerable citizens. Those in our nations long term care facilities are often our most isolated. Most of these victims are unable to ask for our help. As we have seen in many of our cases, when it is asked for, it is often responded to with a hit, a slap, a pinch and in some cases, rape. Our current generation of older victims have raised their families, made numerous sacrifices, endured hardships and have done so much for America and others throughout the world. Now too many of them are being abused and deserve our immediate attention. They need our help, they deserve your attention, and they have earned the right to be safe in their older years, regardless of where they reside. The true measure of our society will be how we treat those who have spent their lives doing for others.

Thank you.

The CHAIRMAN. Mr. Blanco, if you would kind of pass that mike over to Ms. Holloway so she will be able to give us her testimony, we would appreciate it.

Ms. Holloway, thank you for being with us.

STATEMENT OF DELTA HOLLOWAY, RN, BOISE, ID, ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION

Ms. HOLLOWAY. Thank you. Good afternoon.

The CHAIRMAN. Same thing, these mikes. You got to really kind of get close to them to make them really work well.

Ms. HOLLOWAY. OK. We will try to do this. OK. Good afternoon, Senator Breaux and committee members. Thank you for inviting me this afternoon to testify before you. My name is Delta Holloway and I have worked with the elderly and the frail for the last 25 years. I am a registered nurse. I am a nursing home administrator. I have served my profession as the Director of Nursing and I currently am the President and Quality Assurance Officer for Western Health Care in Boise, ID.

I am testifying today on behalf of the American Health Care Association. AHCA represents over 12,000 long-term care facilities, but most importantly these facilities care for over one million patients.

First, I must say that the examples of abuse, the many cases of abuse that we have heard today, are utterly deplorable. Incidences like these just must be prevented. I want to say for the record on behalf of myself, AHCA and all of the caregivers, criminal acts while rare in nursing homes must be prosecuted to the fullest extent of the law.

It is important that we ensure the public is aware that these terrible situations are by far the exception and not the rule. The report released today by the General Accounting Office raises several serious issues and makes very many sound recommendations. We concur with each and every one of GAO's recommendations.

To be most effective, providers need two things. We need a clear definition and process for abuse, and we need partnership with law enforcement. Yes, it is important to recognize our residents have medical conditions that make some of the activities of daily living very difficult. Some medically necessary clinical procedures involve therapeutic contact and oftentimes that contact might cause pain.

But therapeutic contact is not abuse! A definition that distinguishes between appropriate, although uncomfortable, care and contact and abuse must be established.

For an example, I provided care to an elderly woman with significant dementia and difficult behavioral issues. My patient acted out and was abusive to her caregivers. She often refused meals and her care when she did not take her routine medications. When she was on the medications, she was much happier and she truly did enjoy a better quality of life.

On one occasion, one of my registered nurses attempted to force her mouth open to administer the medication. A certified nursing assistant witnessed this act and reported it to me immediately. I called the survey agency immediately and started my own investigation.

I suspended the nurse with pay until I could complete a further investigation. After our investigations, the facilities, the survey and certification agency, and in this case the state board of nursing, the state board did not revoke her license. However, I did terminate her.

Second, providers need to be acknowledged as full partners with state agencies and law enforcement in the abuse prevention, reporting and investigation process. A system that is not adversarial and views providers as a part of the solution would be far more effective and much more beneficial to what matters, and that is our patients.

Nursing homes are required to report all incidents of abuse, or suspected abuse, within 24 hours, to conduct an investigation and to give a written report to survey and certification agency within 5 days and other state agencies in some states.

Among the 50 states, there are many different reporting requirements that are probably in need of standardization. Streamlining and standardizing the process so that providers report an allegation of abuse to the state survey agency would eliminate confusion among consumers, patients, and providers. As I said, we wholeheartedly agree with the recommendations from the GAO report.

We do have several suggestions that might even strengthen those. First, there should be one single point of contact to make a report, preferably to the state survey agency. There would be one number listed.

Second, we believe that education and training of local law enforcement and Medicaid Fraud Control Units on the nursing home environment, on the patients that we serve, and on the staffing is highly needed.

Finally, we need a precise definition of what is abuse that will lead to a better understanding of the problem and more successful targeting and eventually the prosecution of those that are truly guilty.

AHCA has been working with Senator Kohl to develop a national criminal background system check. Any such system should act quickly, and it should include all health care settings. This should also be funded 100 percent so as to not take away the resources for our primary mission which is patient care. We support Senator Kohl's legislation and we will work toward passage of this bill.

Last, but certainly not least, government must be a partner in facilitating staffing of our homes. CMS just finished a report that documents the need of over 400,000 additional nursing staff right now. Unfortunately, government has not met its responsibility for funding this level of staff, nor has it helped to develop the needed workforce.

In summary, thank you for the invitation to testify and for treating providers as a part of the solution to protect residents, to prevent abuse, and to report the incidents. Mr. Chairman, we care for our patients all day everyday, both professionally and personally.

No one wants to prevent abuse or punish or remove perpetrators more than we do. We stand ready to work with Congress, the administration, local law enforcement, ombudsmen, adult protection, and any other entity that will allow us to be a part to protect the vulnerable seniors in our country.

Thank you for the opportunity to testify on this very critical topic.

[The prepared statement of Ms. Holloway follows:]

Testimony of

Delta Holloway

On behalf of the

American Health Care Association

Before the

Senate Special Committee on Aging

on

Efforts to Deter Physical and Sexual Abuse of Nursing Home Residents

March 4th, 2002

Good afternoon, Senator Breaux, Senator Craig and members of the Committee. Thank you for inviting me to testify before you today.

My name is Delta Holloway, and I have been caring for the elderly and disabled for 25 years. I am a Registered Nurse, a licensed nursing home administrator, have been a director of nursing, and am now the President and the quality assurance officer for Western Health Care in Boise, ID.

I'm testifying today on behalf of the American Health Care Association. AHCA represents some 12,000 long term care facilities, and more importantly, these facilities care for over one million patients.

First, I must say that the examples of abuse we've heard earlier today are utterly deplorable. Incidents like these must be prevented and can never be tolerated. I want to say for the record on behalf of myself, on behalf of AHCA and on behalf of all caregivers: Acts of criminality, while extremely rare in skilled nursing facilities, must be prosecuted to the fullest extent of the law. It's easy, I'm certain, for people to draw quick yet inaccurate conclusions about long-term care just by listening to what we heard earlier. It's important that we ensure the public is very well aware that these terrible situations are, by far, the exception – not the rule.

The providers entrusted to care for patients in nursing homes are the front lines of defense in abuse prevention. We strive first to prevent all incidents of abuse, in the rare instance when they do occur, we are the ones who report them, do a preliminary investigation and remove personnel if appropriate

The report released today by the General Accounting Office (GAO) raises several serious issues and makes many sound recommendations. We concur with each and every one of the GAO's recommendations.

To make the system better, providers need to:

- Ensure an efficient reporting system predicated on a clearly defined standard of abuse is established.

- Work as partners with all parties involved in the complaint and investigation process.

First, with regard to identifying abuse, this is not as simple as it may seem. However if the standard is clear, it will be easier to enforce. Every stakeholder in the system would benefit from a clearer definition.

Often our patients have medical conditions that make some daily living activities difficult. Some medically necessary clinical procedures involve therapeutic contact that is uncomfortable, and sometimes even painful. Changing pressure ulcer dressings from wet-to-dry is painful; physical therapy for contractures can hurt. It is not uncommon for providers to deal with allegations of abuse arising from this type of contact.

But, therapeutic contact in and of itself is not abuse, and a definition that distinguishes between appropriate, although uncomfortable, contact and true abuse must be established.

On the other hand, providers cannot assume that requiring a patient to accept medical treatments always is appropriate. For example, I provided care for an elderly woman with significant dementia and difficult behavioral problems. My patient acted out and was abusive of caregivers, refusing meals and care when not taking medication. On medication she was much happier, enjoyed a better quality of life and accepted her physician ordered and team-planned medical care.

On one occasion, a registered nurse who had been with me for years attempted to force this woman's mouth open to administer medication. A Certified Nurse Assistant (CNA) saw this and immediately reported the incident to me.

I called the survey agency, completed a report and suspended the nurse with pay until a thorough investigation could be done. The state licensing board reviewed the nurse's actions and decided her temperament was not well suited to working in long term care, so they encouraged her to leave the profession. Although the state licensing board did not revoke her license, I terminated her. After over three years of quality service, I let my nurse go.

This woman did not intend to hurt the resident. Was it abuse? I found that it was because the family had made its wishes known that the patient not be forced to take medicine, and the RN knew this. Should law enforcement have been called in? Would they have handled it better? I don't know. All I know is that I am responsible for ensuring all residents are cared for, protected and their wishes respected.

There are many gray areas to be grappled with when trying to identify abuse. An effective approach must separate abuse from neglect, from appropriate medical treatment and from unnecessarily harsh or disrespectful treatment. It is not an easy task.

Second, providers sincerely want to work with the community, local law enforcement and state survey agencies to protect residents, and as caregivers, we are by far the best equipped to do so. Providers need to be acknowledged as full partners with state agencies and law enforcement in the abuse prevention, reporting and investigation process.

Recently CMS developed seven key components to detect and prevent abuse. The components were incorporated into the survey inspection protocol, and surveyors were trained in their use. However, in some states, providers were not informed of the new abuse prevention protocol or trained to use them until well after the survey inspection process was underway.

Obviously, neglecting to inform or train providers severely undermines the benefits of having protocols in the first place. A system that is not adversarial and views providers as part of the solution would be far more effective and much more beneficial to what matters most: our patients. Because providers are the first line of defense for patients, they should be trained in conjunction with surveyors in any new abuse prevention methods.

One area where providers have been partners is the CMS abuse poster campaign mentioned in the report. AHCA has been working for years on this effort and is fully supportive of prominently posting awareness and reporting information in our homes.

With regard to reporting abuse, nursing homes are required to report all incidents of suspected abuse within 24 hours and conduct an investigation. A written report of investigation findings must be submitted to the state survey agency within five days. Additional agencies that must be notified vary according to state law.

Among the 50 states, there are many different reporting requirements in need of standardization. In Idaho, nursing homes must report a death or serious injury causing jeopardy to the life, health or safety of a resident to law enforcement within four hours. Knowing whom to report to and under what circumstances is a key issue that must be addressed.

Last month in my facility, a nurse aide was walking past a room and witnessed a person throwing towels and washcloths at a resident's face, and immediately reported it. I notified adult protective services and the state survey agency.

It turned out to be the resident's son who had been her caregiver for several years prior to her living with us. He was adamant that he be allowed to do this and that he brush her hair in an aggressive, painful manner. My administrator said no, that while she is entrusted to us for care, we must take responsibility to protect her – as is the law.

Adult protective services declined to intervene saying that as long as she was in our facility, her safety and well-being was under the jurisdiction of the state survey agency. To make matters worse, the son was so angered by our actions that he had his mother discharged from our facility. There is simply no clear reporting guidance in this area.

Streamlining and standardizing the process so that providers report all allegations of abuse to the state survey agencies would eliminate confusion among consumers, patients and providers. It would also simplify the process for the benefit of everyone involved.

We know the patients and the caregivers first hand, and are therefore most qualified to evaluate the situation. We stand ready to work with local law enforcement, the administration and Congress to continue to lower incidents of abuse and to improve reporting and prosecution for all concerned.

While incidents of abuse were cited in just 4.3% of nursing homes nationally, it's still too high. We must keep improving, and to do so it is imperative that we combat abuse with a more focused collaborative approach.

As I said, we have reviewed the GAO report, and we wholeheartedly agree with each and all of the recommendations. We do have several suggestions for taking them further and for refinements that would improve both prevention and reporting efforts.

Among those suggestions are:

First, there should be one single point of contact for anyone -- resident, facility, family, staff, ombudsperson, etc. -- to make a report, preferably to the survey agency. This would eliminate the multiple agency listings in directories, many of which are not equipped or authorized to take a report. This would also enable every facility to have an accurate phone number to post, and when changed, could be quickly revised and publicized. The agency should then be responsible for immediate notification of local law enforcement.

Second, when appropriate, we also believe that education and training of local law enforcement and the Medicaid Fraud Control Units (MFCUs) on the nursing home environment, on types of patients, and on staffing situations would enhance the ability to conduct investigations and make an appropriate finding.

This training would be critical to local law enforcement in helping them understand the differences between therapeutic contact, clinical necessities, dignity violations and actual abuse in the nursing home setting. The importance of this training cannot be over emphasized. We stand ready to work with CMS and law enforcement to develop and implement training programs, including on-site visits for law enforcement when appropriate.

Finally, we believe similar procedures should be put in place to protect vulnerable elderly and disabled citizens, regardless of the setting in which they reside or receive care.

We urge that a standard, clinically enlightened definition of abuse be adopted in consultation with government, providers, law enforcement, consumers and other stakeholders. We believe that a more precise definition of abuse will lead to a better understanding of the problem and more successful targeting and prosecution of offenders.

We agree with the GAO that timeframes for determination and inclusion of abuse findings in the state nurse aide registry should be shortened. We also agree that state

registries should be expanded into one national registry. A more efficient process cannot be achieved without expediting the adjudication process for complaints. Any changes designed to improve the timeliness of reporting must be implemented in a manner that does not compromise the due process rights of caregivers.

The American Health Care Association has, for years, been working with Senator Kohl to develop a national criminal background check system. Any such system should not be limited to nursing homes; rather it should include all health care settings where vulnerable patients receive care.

Due to the severe staffing shortage in long-term care, background check systems should produce quick results and not unnecessarily deter the hiring of care giving staff. Finally, background checks must be funded so as not to take resources away from our primary mission of patient care.

We support the concepts stated in Senator Kohl's legislation and will work towards prompt passage of his bill.

And last, but certainly not least, government must become a partner in facilitating adequate staffing of our homes. Abuse takes place when not enough people are involved in care, or when the wrong people are hired. CMS just finished a report that documents the need for over 400,000 additional nursing staff right now. Unfortunately, government has not met its responsibility for funding this level of staff, or developing the needed workforce.

In summary, thank you for the invitation to testify, and for treating providers as they should be – part of the solution to protect residents, prevent abuse and report incidents.

- Providers are the front lines of prevention of abuse and first reporter and investigator. We must be partners in this critical effort.
- Abuse must be clearly defined to be appropriately combated.
- We agree with all GAO recommendations and have additional suggestions to go further.
- We support the Kohl national criminal background check system and an expanded national nurse aide registry.
- Providers, residents, family and others need a single point of contact and process for reporting abuse.
- We must have enough dedicated staff to be able to prevent abuse more effectively.

Mr. Chairman, we care for our residents all day everyday – both professionally and personally. No one wants to prevent abuse, or punish and remove perpetrators more than we do. We stand ready to work with Congress, the administration and local law enforcement to prevent abuse and protect our patients.

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The CHAIRMAN. Thank you, Ms. Holloway, and thank all of our panel for a very enlightening, very informative, and I think very helpful testimony. Let me begin with Ms. Aronovitz on behalf of GAO.

As I take it, the study that GAO did for the committee involved surveys in Georgia, Pennsylvania and Illinois. Were those the three states?

Ms. ARONOVITZ. We looked at 158 cases of reported abuse in those three states. That is correct.

The CHAIRMAN. I take it those states were selected to try and give us an indication of how things would be on a national level?

Ms. ARONOVITZ. Absolutely. We had no intention of doing an evaluation of those particular three states. As a matter of fact, what we tried to do is use those states to learn about some of the systemic problems that occur nationwide.

The CHAIRMAN. You have helped us a great deal. In the three states that you all surveyed at GAO, were there found to be requirements in the law or by practice of a requirement that the nursing homes report abuse that occurred in the home that could be potentially criminal to law enforcement or was it a requirement to report to the health officials of the state or were there no requirements at all?

Ms. ARONOVITZ. There is actually no Federal requirement that nursing homes report abuse to local law enforcement or their Medicaid Fraud Control Units, who are the state prosecutory unit or agency.

The CHAIRMAN. That was in those three states or is that nationwide?

Ms. ARONOVITZ. No. Nationwide there is no Federal requirement. Now what we found in the three states that state law often requires this type of reporting, but we also found that it does not always happen in a timely way.

The CHAIRMAN. You mentioned the average time would be some 5 to 6 months in some cases to report an abuse case?

Ms. ARONOVITZ. That was the situation where a nursing home reported abuse to the state and the state decided to cite a nurse aid and put their name in the registry. We found cases where there was delayed reporting by the nursing home in about half the cases that we looked at where nursing homes were supposed to report to the state.

Nursing homes are supposed to report within 24 hours and that is defined as the day of or the day after the incident took place. But we found in about half of the cases that we looked at that reporting took place a week or 2 weeks later and actually we found eight cases where the nursing home reported the incident over 2 weeks late.

The CHAIRMAN. Obviously the longer the time between the incident and the reporting, it makes it much more difficult if not impossible to investigate.

Ms. ARONOVITZ. Also, it keeps residents who are subject to abuse vulnerable because no one is protecting them during that time.

The CHAIRMAN. One of the things I mentioned is the thing that we did—I mean the rule that we passed back in—when was this—1998, with regard to the attorney general, FBI being able to do

background checks on employees in these type of facilities. It actually says that the attorney general may charge a reasonable fee not to exceed $50 per request to any nursing facility or home health care agency requesting a search and exchange of records pursuant to this section, and do you find that this is being done by any of the facilities that you worked with?

Ms. ARONOVITZ. Actually, there is no Federal requirement that a nursing home do a background check. There are state requirements that that happen. The Federal requirement is that nursing homes do not hire employees with a criminal background that has a history of abusing nursing home residents.

The CHAIRMAN. But the information we have is that the states are not really availing—I mean the various institutions are not really taking advantage of this provision that would allow them to do these background checks?

Ms. ARONOVITZ. That is exactly right. We found in the three states that even though there are state laws requiring criminal background checks, they are usually done only at the state level, and when we talked to the FBI, 29 states do not really avail themselves of Federal FBI checks, nor do other states routinely.

The CHAIRMAN. So obviously, if a person was a criminal in one state and went to work in a second state, that state check would not disclose that they were, in fact, hiring a criminal?

Ms. ARONOVITZ. In most cases that is true. Once in awhile, the state would require the nursing home to go to another state if they know that in the last 2 years an applicant worked in a different state. But typically that would not be the case and the information about background, criminal background, in another state would not be reported.

The CHAIRMAN. OK. This investigation is very helpful, but an investigation without follow-up and recommendations and actions by Congress is not worth very much. Can you summarize for the committee the recommendations that GAO has presented to this committee?

Ms. ARONOVITZ. Absolutely. The first one is that there be a Federal requirement that the state survey agencies immediately contact local law enforcement or the MFCUs when there is a confirmed allegation of abuse.

The CHAIRMAN. That is—I do not want to interrupt you—but that is law enforcement as opposed to a social worker or the state health agency?

Ms. ARONOVITZ. That is correct. The nursing homes already have to report to the state survey agency. We think that there should be a requirement that this also be reported immediately to the local law enforcement of MFCU.

The second is that the Centers for Medicare and Medicaid Services need to convince states to make it much easier to know how to report abuse, and one suggestion, having one phone number would be very useful. We found in looking at phone books in nine cities in the three states that it was very common to get phone numbers that look like you could report abuse. For instance, numbers in the book that said "senior help line" or "fraud and abuse line," and in fact, those numbers had no jurisdiction or ability to take the calls at all or complaints.

The third one would be to clarify the definition of abuse so that all states would be applying that standard consistently and appropriately.

The fourth one would be to assure that nursing homes do not hire people with criminal backgrounds, and, in fact, CMS needs to study the prevalence of this and to try to figure out other options for convincing states to assure that nursing homes are not, in fact, hiring people with criminal backgrounds, and also we feel very strongly that we need to shorten the time period between the time a state survey agency decides to cite a nurse aide with abuse and the time it actually gets reported to the registry.

The opportunity there to not disturb due process would be at the beginning of the process. Right now there is no requirement that a state survey agency investigate the case and make a decision about whether to cite a nurse aid within any reasonable timeframe. In addition, at the end of the process, once the hearing takes place, there is no requirement that the hearing officer make a decision and report those findings immediately.

The CHAIRMAN. Thank you very much for that very good summary.

Ms. ARONOVITZ. You are welcome.

The CHAIRMAN. Sheriff Fuselier, I am really proud of your testimony. I think this is an indication of one example when our state has done a very credible job. You can be very proud of the leadership role that you have played in putting this process together, and I am just looking at the map you have here of where we have the ALERT officers. It covers almost the entire State of Louisiana, and where you have the elderly services officers in addition in some parts.

I mean can you tell me the Triad Program, I mean it is an association that was really put together through AARP and law enforcement officials and how does that structure work?

Mr. FUSELIER. Well, the Triad Program is a program with the sheriffs, the chiefs and the older American groups, generally AARP or the Council on Aging, where we come together and form a SALT council and get interested people who are interested in the prevention of the victimization of the elderly to actually sit down at a table and discuss the problems that we are having.

This may include people from the nursing homes, clergy, anybody who provides this service to the seniors, and this is one way to pass information across. I think it was probably the forerunner of community oriented policing, because this happened before that.

The CHAIRMAN. Ms. Aronovitz was talking in terms of there is a requirement that the nursing homes report abuse to the state health officials. You know there are several categories here and I think logic indicates, a common sense approach to this. You can have a nursing home that gives poor treatment. You can have a nursing home that the poor treatment becomes abuse. Then you can have a situation where the abuse is so clearly defined as a criminal act in the case of a person with a broken neck because they have been thrown against the wall, or a rape victim who suffered that indignity in a nursing home.

Do we get that in Louisiana in the sense of are we having people from nursing homes reporting to law enforcement when there is a

suspected case, not just of mistreatment, but I mean a criminal act that occurred? I mean there is a natural tendency for nursing homes to say, look, we are going to handle it internally. There is a natural tendency for police officers to say we have got enough problems controlling street crime. We do not have time to go into the nursing home. They will take care of it. How does it work in the real world?

Mr. FUSELIER. I do not think in Louisiana we have taken that position. I think our position is that we want to protect our elderly, and I think you can see from the testimony and the legislation that was enacted that we have taken steps to bring these people together to address the problem, exactly the problem that you have said, is that, you know, we want to make sure that the nursing homes are reporting, and I would say there are a number of cases probably that are not reported that should be.

What we have, I think, is there was testimony we need that one number, and they would get back to local law enforcement, because I think sometimes we do have some of these things fall through the cracks, and not necessarily anyone's fault.

The CHAIRMAN. Well, I am very proud of what you have done. I think the message that could come out from Louisiana, "Don't mess with the elderly." Mr. Fuselier. That is exactly right.

The CHAIRMAN. Ms. Holloway, in your testimony on behalf of the nursing home industry as well as your personal experiences, this is a difficult situation that needs to be addressed. I am very pleased that you have indicated the support of the industry for the recommendations from GAO, and I would say again that the vast majority of nursing home facilities provide very much needed service to people who sometimes are very seriously ill and need 24 hour a day, 7 day a week care.

There will always be bad actors in any business, in any profession anywhere in the country. Our responsibility, industry's responsibility, is to come as close as we possibly can to eliminating it. All of these suggestions or some of them are costly, and I know that many of the nursing homes are operating on very narrow margins, many of which have gone under financially.

You put cameras in nursing homes. That is going to be a huge expense. I would think that the background checks can be done at a minimum amount of cost, particularly with the FBI doing it. Nursing homes or anyone else in these type of situations dealing with vulnerable people should not hire people with criminal records in that area, and I am all for an individual's rights and responsibilities and everything else, but I do not want to see people who abuse people working in nursing homes. I mean that is just my common sense approach. I think the members of the committee would agree with.

What I guess I would ask among other things would the industry support a requirement that these cases when they are found out not only be reported to a social worker or the state health institution, but also be reported to law enforcement? Because I take it that that is not now a Federal requirement. What is your comment on that?

Ms. HOLLOWAY. I would support that, and I would think that if we had the one number and it did get reported to the licensure

agency, it would be good if that agency would call the local police department.

I will say that in my state in 1998, a law was passed that if there is a death or serious injury to an adult, a vulnerable adult, an elderly person, the nursing home, the physician, the family, whomever might be aware of that, needs to report to law enforcement within 4 hours.

The CHAIRMAN. Let me ask. This is the real question here. We can have all the reporting requirements we want. How do we assure that when a criminal act occurs in a nursing home facility, that, in fact, someone in that facility reports it to criminal law enforcement authorities? I know we can have the rule.

Ms. HOLLOWAY. Sure.

The CHAIRMAN. The CMS, Center for Medicare and Medicaid Services, can adopt a resolution that is saying, look, the Federal Government tax dollars are paying most of the cost of operating the facilities, and we have now a national requirement that these things be reported if they occur within 4 hours or within an hour, immediately, but if a nursing home decides we are going to handle this internally, it would be horribly embarrassing if we reported this.

I think the opposite. I mean these things are going to be found out. We have seen it today. I mean all of these incidents, they tried to cover them up and people find out about it. Eventually it comes to light, and I would dare say that a nursing home that has tried to cover it up is going to look much worse in the eyes of the public and their constituents if they did not report it and take prompt action than one who admits it happened and reported it promptly to law enforcement.

That is a better nursing home than one who does not report, but how do we do that? Do we have to have a policeman in every nursing home in this country?

Ms. HOLLOWAY. I hope not.

The CHAIRMAN. How do we do it?

Ms. HOLLOWAY. I am happy to say, I do not like this because it is labor intense, but I am liking it more and more. In our state, we are asked by survey and certification to complete an incident report. That is a whole different form that we have to fill out than the record.

First of all, if there is any resident to patient situation, abuse, or there is suspected abuse, we must call the survey and certification within 24 hours. I am proud to say that in our state we call them right away because we want them to be aware that there is a potential problem.

We also call ombudsmen. We do not call adult protection unless a family member is involved. We are to complete this form and it gives the specifics about how we found the resident, our investigation, and we must talk to all levels of staff, nursing assistants, nurses, social workers, activity people, anyone that may have been involved with that resident, we must develop a plan of action so that this will not to the best of our ability happen again.

The CHAIRMAN. I take it that in your state there is no legal requirement to report to law enforcement officials if the type of

things happen in that nursing home that we heard about here today? Is there a legal requirement to do that?

Ms. HOLLOWAY. If there is death or serious injury, we do.

The CHAIRMAN. If there is death or serious injury, there is a legal requirement to report not just to the health department but to law enforcement?

Ms. HOLLOWAY. In 4 hours.

The CHAIRMAN. Within 4 hours.

Ms. HOLLOWAY. Yes.

The CHAIRMAN. OK. Thank you. I want to assure you certainly this senator's intent is to try and work with the industry. This is an important industry. It provides important services to millions of senior citizens. We have to assure that it is being done to the high quality standards that you spoke about here today and we are going to work with you all to ensure that that happens.

It is like those first three people that came up indicated that we hear about this all the time and nothing gets done. Something will get done.

Ms. HOLLOWAY. Senator, I believe something should get done.

The CHAIRMAN. Thank you for that attitude.

Ms. HOLLOWAY. I need to say that when the survey agency visits our facility, they read charts, they look for incident reports, and if from our call, they feel that something does not sound right, they come to the facility, even before the 5 days when they have the full report. They call and see what kind of an effect has this situation had on the resident, and I will tell you that they will be out immediately if there has been an adverse reaction by the patient.

The CHAIRMAN. Thank you very much for your testimony again.

Ms. HOLLOWAY. OK.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman, and first let me tell you how much I appreciate your determination. As you know, this is not the first time this has come up. This is part of a pattern. We have talked about it now for several hours. Just as sure as the night follows the day, you have a report like this GAO report outlining the abuses, the industry and government pledge that there are going to be changes, and then a year or so later, there is going to be backsliding.

I mean that is the pattern on this issue. Ms. Aronovitz, would you disagree with that?

Ms. ARONOVITZ. No, I think it is very important that there be the types of fixes that will stick, and right now it is clear that there are a lot of administrative gaps and criminal protection gaps in the system, absolutely.

Senator WYDEN. I think we are going to have a bill and an ongoing effort led by our chairman that others of us are going to sponsor so that we can follow up. I want to ask some questions to sort of amplify on some of the points that you made, and I think your report is superb.

So here the country sits literally 20 years into this, the Federal Government having spent billions of dollars in Medicare and Medicaid, and the Federal Government does not require nursing homes to call police where there is a suspicion of a crime. Any sense how that could possibly have happened? Did the Federal Government

just miss it or did people sit around and say we cannot afford this rule? What did you find on this point with respect to how something like that which seems like such a glaring flaw, how did it happen?

Ms. ARONOVITZ. The Federal Government does require some administrative type procedures that ultimately might get at a problem in which a law enforcement entity ultimately gets involved, but there are too many steps and, in fact, it is too circuitous in terms of how that works. For example, a state agency could, in fact, immediately call law enforcement agency if it considers abuse that is reported to it by the nursing home to be severe enough, but it is not absolutely required.

The MFCU, the Medicaid Fraud Control Unit, in many states is responsible for prosecuting in a criminal sense abuse, but, in fact, the state survey agencies sometimes screen the allegations and only refer the ones that they think are the most severe or the most prosecutable.

There is an example in Illinois where every case of abuse that we are talking about at the severity we are talking about automatically goes to the Medicaid Fraud Control Unit and that unit with its professional prosecutors and criminal investigators review and screen those cases to decide which ones to pursue.

We found that there was a much higher conviction rate per capita in that state when that process was used. The one thing I should say is that different states have different laws that sometimes are pretty tough in terms of their requirements.

But they vary extensively across states in terms of what is required and what types of employees are included. For instance, in one state we found that nursing homes must report to the local law enforcement entities if it has to do with a criminal abuse from a caregiver. In other places, the law refers to all nursing home employees.

There is enough gaps in state law and enough that we do not know about those state laws where there should be some Federal consistent oversight.

Senator WYDEN. I think what I was after, is how in the world could the Federal Government have allowed this to happen? I mean I find it hard to believe somebody was sitting up there at CMS or its predecessor and said, you know, let us just be rotten to seniors today and ignore their needs, but maybe you can enlighten us as to how this could have happened?

Ms. ARONOVITZ. I think that CMS depends very much on the survey and certification agencies. As Ms. Holloway was describing, the surveys when they are conducted, either periodically or when a survey agency finds that there is serious abuse, goes out and does an investigation. When these surveyors go out, they look at the way nursing homes conduct their hiring practices and conduct their own investigations into these instances, and supposedly they will be checking to assure that nursing homes are following the administrative processes, and in cases where there were several allegations of criminal behavior, that those got reported. So I think the Federal Government's relying on these surveys to identify these cases does not always happen.

Senator WYDEN. Thank you. I think that addresses my concern. Let me ask you about some of your other findings, and again what I hope here is to just amplify a little bit so that we get a sense of why some of these problems are occurring. You cite the fact that patients and relatives are reluctant to report abuse and obviously there is fear of retribution, fear that patients who have nowhere else to go will be pushed out of the facilities.

What did you hear from the patients and the families on this point? Particularly did the patients and families tell your investigators we just do not think they are going to prosecute and we do not think they are going to enforce the laws, so that is why we are not speaking out?

Ms. ARONOVITZ. Actually, our investigation focused mostly at the overseers and the experts in the field, and we did talk to quite a few experts who look at this problem and also the Department of Justice which also believes that this is underreported, and one of the things that we find are that the bond or the relationship that builds between a family and the caregivers of a loved one is very, very strong.

Sometimes we heard that the family will not even believe or accept the fact that a caregiver could be abusive and sometimes when a loved one comes to the nursing home and sees that there is a bruise, there is a lot of mystery around how that bruise happened, and sometimes the nurse aides and other employees are given the benefit of the doubt.

As you mentioned, in other cases, the family is afraid that the loved one might be asked to leave the nursing home and another place will have to be found, and in some cases there are just very worried about accusing the nurse aide if, in fact, they do not have all the facts.

These type of instances usually occur in the privacy of a resident and a caregiver or another nursing home employee. There is not usually a lot of witnesses to this, so there is a lot of mystery around some of these abusive situations have taken place.

Senator WYDEN. Just a couple of other questions. What about the findings of GAO with respect to the role of the nursing home administrator? What I have found, because I was the public member, as a Gray Panther co-director before I was elected to the House, I was the public member on the Nursing Home Board of Examiners at home in Oregon, and I think that so much of what happens in a nursing home is set by the tone of the administrator.

I gather that you all made some findings that the nursing home managers are not exactly proactive on a lot of these matters as well. Can you amplify on that?

Ms. ARONOVITZ. Yeah, we cannot project or talk about the universe of all nursing homes, and it is very important that we understand that, because there are tremendous nursing homes and nursing home administrators——

Senator WYDEN. Absolutely.

Ms. ARONOVITZ [continuing.] Who have devoted their life to protecting residents. But in our sample, we looked at 158 cases, 111 of them were instances where a nursing home found out about an abuse situation, and we could determine the dates that that abuse situation occurred. In about half the cases, in 54 of those cases, the

nursing home administrator did not notify the state survey agency within the 24 hour required timeframe.

In 37 of those cases, the state survey agency was notified 2 to 7 days late. In nine instances, they were notified a week to 2 weeks late, and as I said earlier, in eight of those 54 cases, the nursing home administrator notified the state survey agency over 2 weeks late.

Senator WYDEN. It is an important point and one we will want to ask you more about as we move to trying to put together a reform effort, because clearly the tone starts at the top, and you have addressed some shortcomings there.

One question for you, Ms. Holloway, if I could. What would you say today are the most important self-policing efforts that the association has taken on to date? That is important because obviously you want to have as much self-policing as you can so that any Federal legislation is targeted to the areas where it is most needed. What would you say are the most important self-policing initiatives that the association has taken on to date?

Ms. HOLLOWAY. I just have to say one more time, we just cannot tolerate this abuse. I believe it an honest statement from us that we wish to work with the recommendations of the GAO report and do something about a national registry that would indicate that a staff member should or should not be hired. Right now that is only certified nursing assistants, and should be broadened to others.

The other very, very important issue is the criminal background check. I think that we have been policing ourselves in some states better than others perhaps. Some do do the Federal criminal background check. It costs about $50 an employee and you get the results in two to 3 weeks, where the state check costs $10 and you get it in five to 7 days.

Senator WYDEN. I want to ask one question for the sheriff if I could, and thank you for your excellent testimony and the service that you provide. I have always felt with law enforcement that at some level it comes down to a question of priorities.

Law enforcement people are incredibly busy, and everybody is sitting there every single day having to juggle all of these issues that are so important in terms of protecting the public health and safety.

What are your thoughts on how we make this issue, the elder abuse question, a higher priority in terms of law enforcement? Certainly, the dollars for training can help, but the end of the day, this is going to be about priorities and making this a major one.

Mr. FUSELIER. Well, Senator, this is one of the goals of the ESO officer, that we would have this person that would specialize in doing that. However, in all cases that is not necessarily his only responsibility, but it would be his, I guess, top priority, the same as we mentioned with juvenile officers. You have to take the time to do it. With our growing population, we are going to have no choice. We have to recognize the fact that servicing our elderly is a top priority.

Senator WYDEN. Mr. Chairman, thank you.

The CHAIRMAN. Well, thank you, Senator Wyden, for your involvement, your continued involvement. I want to thank this panel. You all have been extremely helpful. We have got some good ideas,

good suggestions, and thank the first panel once again. With those two panels, that will conclude this hearing. The committee will be adjourned.

[Whereupon, at 3:55 p.m., the committee was adjourned.]

APPENDIX

Dear Senator Breaux
and Mr. Cecil Swamidass,
Committee on Aging:

I am writing this letter to you in direct response to the NBC evening news report in late February on your committee's investigation into nursing home abuse. This was very important to me because I never knew there was a national agency or committee to report nursing home abuse to although I have asked many state agencies here in Alabama.

The report featured an elderly woman whose neck was broken by her male caregiver. The woman was able to tell the police who hurt her and he was arrested. Many times the elderly are not able to defend themselves or are they able to speak well enough to implicate their abusers. Also in the report was why these incidences of abuse are not often reported by the staff who witness them.

I would like to address this question in my letter to you. I strongly disagree with the lady who is chairman of the Nursing Home Association, when she stated these occurances are the exception and not the rule. As an employee of Beverly Healthcare in Fairhope, Alabama, I witnessed abuse on a daily basis.

I had taken my certified nursing assistant's course with the Red Cross.

We were encouraged constantly to report any abuse to the area ombudsman or we would be part of the abuse. However, upon my employment at Beverly, we were told never to report any abuse but to the charge nurse. This was a delima for me as the charge nurse was involved in the abuse. I worked the evening shift and could not ever get an appointment with the director of nursing, Martha Howell.

The list of abuses I documented in March and April of 1999 are included. Our facility received its state inspection in mid April, 1999. A state inspector asked me my name and position. She watched me as I helped a resident, Mrs Lily Coburn recieve her shower. She then asked me if I had witnessed any abuse. I reported to her some of the cursing and teasing and intimadation of residents done by charge nurse Pam Wicker. I also reported how CNA Terri Jones gave cold showers to resident Faye Bristridge and Jesse Howell when they soiled themselves. These ladies screams were heard by other CNA's and the charge nurse Pam Wicker and ignored. When I told them I would wash her, Terri Jones laughed and said Faye loved cold showers. She was shivering and crying. I also reported how male CNA's forced female residents to let them wash, change and bathe them.

This was done nightly on the 300 hall at Beverly Healthcare in Fairhope. I witnessed Hariet May force resident Avery Howard into having him change and dress her and other ladies behind closed doors with no female present. I do not understand why a physician cannot examine a woman without a nurse present and these male CNA's at Beverly with sometimes two weeks training can force an elderly lady into changing and washing her. I reported to the inspector about how resident weren't being fed in the dining room and how nurses and CNA's stole from the residents. She also asked me about two recent deaths at Beverly that were of a questionable nature.

I reported to the inspector that in the case of Moxine Nichols, I witnessed charge nurse Pam Wicker and CNA's Tiffany and Terri Jones intimidate Mrs. Nichols because she could not get up on her walker because she was too weak. They told her they would not drag her lazy ass to the bathroom. Ms Nichols was crying and asking for help. This was all done in front of her roommate. I asked them to leave and I would take her but they told me that she needed to retain her independance and that I needed to take care of my own residents. The next day when I

arrived on the evening shift, Mrs. Maxine was lying in her bed with a large baseball sized knot on her head. She did not respond even though I called her name several times. I then asked her roommate to tell me what had happened. She looked toward the door as if she were afraid to speak. She told me Maxine had pressed her button several times and called out but no one came. She tried to walk to the bathroom but fell on the floor hitting her head. I also reported that the staff at night frequently pull the call lights out of the panel. This prevents residents from calling for help. I went to ask if Mrs. Maxines' family had been notified. The charge nurse said she would be ok. That night Mrs. Maxine Nichols died. I don't think they even called the doctor.

The other death I was questioned about was Mr. John McKenzie who was found in his bed in a pool of blood on April 6, 1999. Our administrator told us not to speak about this to anyone as it would violate resident confidentiality laws. I think she also knew that our state inspection was about to take place. Mr McKenzie was said to have bled to death by a improperly inserted foley catheter. He was not checked on all night.

After our state inspection, the facility at Beverly received a poor substandard rating.

When I reported to work after the inspection on Saturday April 28, 1999, I met a girl

Lokey, I had never worked with. The regular week-end nurse, Marty, was not there. Marty often helped me with the residents and was a wonderful caring nurse. I was then met by Pam Wickel, charge nurse with our floor supervisor, Alexis. I was told by Alexis that Martha Hazell our director of nursing was on the floor going over residents charts due to the reporting of abuses.

I was then told by Pam and Alexis that Gracie, my partner would be pulled to another hall. I would have to care for the ladies on the main 500 hall myself. I told them this was impossible. I had never had anymore than eleven and never had to lift by myself. Alexis told me that if my duties were not done by ten o'clock, I would have to stay until they were finished. If I refused, I would be fired and if I left, I would be charged with abandonment which is a criminal offense. I then went to ask Pam for help because I had double the amount of the other CNAs. She told me I was a blabber-bitch and I needed thirty-five shitty residents, and that I had gotten everyone in trouble. I was very upset at this because I was told my interview was confidential.

Later in the evening, while trying to lift one of the residents Mrs. Eunice Ness, from her bed to her chair, I started to feel tight chest pains and was short of breath. I was not even provided with a gait belt to lift these ladies larger than me. This was unsafe for

my residents on the 500 Hall of Beverly Healthcare. Many were wet and soiled and sitting in the wheelchairs and beds. Some of the ladies were crying out for me to help them and I could not help but one at a time. About five call signals were going off at one time. I received no help.

I went to ask Tracie Nicholas, CNA if she would help me, I would help her. She could not believe how many residents I was responsible for. I told her I was not feeling well and I didn't think I could make it by myself. She agreed to help me. While we were taking all the residents back from the dining room, I started to feel very dizzy and weak. I had to lift all my residents from bed to wheelchairs, then transfer them in wheelchairs to the dining room two floors away. Tracie and I were the only ones assigned to dining room duty. It was impossible to transfer forty residents in two shifts, feed, and transfer that many residents. We of course did not have time to feed them. We then had to transfer them all to bed. After I pushed my last group out of the dining room, CNA Richard Hickman noticed that I was completely wet and crying. I told him I couldn't breath and I thought I was having a heart attack. He ran to get charge nurse Pam Wicker.

She wouldn't come. He then went to get the PRN nurse Audrey Moore to come and check me out.

Audrey informed me I was just having a panic attack, to take a few breaths and return to work because Martha Howell had told her if I left, I would be fired. I was very confused and upset, I did not know what to do, I could not even think clearly. I tried to call my husband but he didn't answer.

When I returned to the 500 hall, to put my residents to bed, I informed Pam Wicker I could not left anymore residents. I asked her if she would please take my vital signs, she refused and walked off. I am sure she thought I was trying to get out of work. Many of my residents were crying for me to put them to bed as it was getting late. Tracie finally arrived to help me. She was very short and was not able to help much with lifting. When I lifted Mrs. Faye Prestridge out of her wheelchair, I started to have severe chest pains. Tracie ran to get help, but no one would come.

Tracie then said I looked blue and she was taking me to the hospital down the street. She helped me out to her car and drove me to the emergency room. I was taken into the room and was placed under a cardiac code status. My heart rate was

280 and my blood pressure was very low. The doctor told my husband he was afraid that if he did not convert my heart rate, he was afraid I would go into cardiac arrest. I received two cardio-conversions, the second one started to correct my heart rythm. Dr Runnels then asked me wasn't there anyone that was licensed personnel at Beverly noticed what kind of shape I was in. My husband was angry and called the police. The doctor told me that Tracie had done the right thing and saved my life, However upon her return, to Beverly, after she finished her duties, she was fired. She was very upset, as she depended on her job until she took her RN exam and carried the insurance on her husband and two small children.

I stayed in the emergency room all night and was then transferred to the intensive care unit at Thomas Hospital for two days, then on the cardiac floor for three days. I could not even get out of bed without a serious arythmia drug. The cardiologist told me once I had this bad attack I would now always have problems and would have to take these heart medications for the rest of my life.

I was then referred to a heart specialist in Mobile, Alabama, Dr. Micheal O'Dowd. I told him what happened to me at Beverly. He told me he couldn't understand why any facility would ask a forty-five year old woman to body lift any one person, much less 20-25 total care

residents. He told me I should get a lawyer as my problems would be life-long and my medicine very expensive, usually about five hundred dollars a month. He also told me never to work at such a place again where lifting over twenty pounds is required. I also had to give up a small side business I had for five years doing construction cleaning. This was a major blow to my family and we had to take out a second mortgage twice on our home in order to afford my medicine.

After returning home from the hospital, my husband was very angry and called Cecilia Godfrey, our administrator. She promised to conduct a full investigation. Although I called twice, she never returned my calls. Beverly, of course refused to pay any of my medical bills. My hospital bill was ten thousand dollars!

Our attorney, Thomas Williams told me and my husband that we could not recover damages for employer abuse because in the State of Alabama; your employer can abuse you, curse you, intimidate and fire you and you cannot sue your employer. He also told me large chains like Beverly Healthcare know this and know they can get away with revenge to the employees for reporting abuse. Mr. Williams told me they are the worst offenders in the nation and are at the

worst in workmens compensation claims. They hire large law firms against these claims owing that an unemployed employee with medical bill can't affard long sustained legal assistance. Mr. Vernon Duke, a representative of the Alabama Industrial board says Beverly never helps it's hurt employee and will stall and postpone and appeal til you're dead. I agree with Mr. Duke as next month will be three years since my awful night at Beverly Healthcare. I have never had a trial yet. My court dates have been postponed three times.

Beverly Healthcare is very politically active. I don't know if the state legistators of our state of Alabama know that the laws of our state help protect unscrupulous employers like Beverly Healthcare abuse employees for reporting cases of abuse. There are many honest caring nurses and caregivers that feel guilt at not reporting some of the gross cases of neglect in all nursing homes and hospitals of Alabama, but when they report such incidences, we know we have no advocate. The laws in our state backs big business like Beverly who can continue to abuse for a profit.

I hope that you can do something for the elderly citizens of our country in your committee. I know I am resolved

never to put my parents in a nursing home here in Alabama. I can't believe the acts of abuse I witnessed occured in the United States and not in some remote third world country. I have heard of other cases similar to mine occurring at Beverly Healthcare in Fairhope and also at Beverly in Foley Alabama. I encouraged some of these people to fax your committee also with their own horror stories. I was once t[illegible] by medicare and state inspector, Sharon Martin, that unfortunately, Beverly Healthcare is rampant in our state.

I now work as a CNA part-time at the Thomas Hospital Skilled Nursing Facility. We abide by the same medicare rules as all nursing homes. We are never given more than five residents to care for. This is for the safety and care giving for the resident, we are strictly forbidden to lift anyone. I also can never imagine our charge nurse calling our residents "fat bitch or "lazy ass." Our administator, Sharon Kendrick strictly enforces an anti-abuse policy and never retaliated against any employee who did the right thing and reported.

Thank you, My Swamidass, for reading my rambling letter. I did not include all the abuse I documented in just the few months I was employed. I hope this helps your panel understand how care-givers are threatened for reporting abuse. I have sent copies to the Health and Human Services, Attorney General John Ashcroft and others you listed.

Sincerely,
Deborah Brady
Robertsdale, Alabama

March 4, 2002

Senator John Breaux
1900 North 18th Street
Monroe, LA 71201

RE: **Nursing Home Abuse**

Dear Senator Breaux:

Thank you SO much for checking into legislation protecting residents of nursing homes from abuse. In 1995, my grandmother was a resident of Ridgecrest Nursing Home in West Monroe. She was abused and nearly died from the abuse. We called the police department and were told there was nothing that could be criminally done to the nursing home, but that we had a "heck of a civil case." We weren't interested in money; we were interested in keeping this from happening to any other patients at the nursing home. I contacted the Attorney General's office in Baton Rouge. They opened and closed their investigation without ever speaking to one member of our family. I cornered Richard Ieyoub to ask him how his office could do such a thing. The end result from all of this was that they "found no wrong doing" on the nursing home's part–totally ludicrous!

At this time, we are going to trial in July on this case. Nearly seven years has passed since all of this happened. This nursing home had a man bathing patients who was on parole for sexual abuse of a minor. His parole officer knew he was working at the nursing home. This same man bathed my grandmother, and we'll never know what went on when he was bathing her. He shouldn't have been working for the nursing home at all.

Another thing we found was that the Department of Health and Hospitals does a survey once a year and it is supposed to be posted for families to view in the nursing home. Ridgecrest was cited for every violation we accused them of, yet we never saw that survey. They hid it from family members. This was a violation of the law in itself.

Something needs to be done to protect the elderly. They have paid their debts to society, and once they go into the nursing homes, they are forgotten about. In our case, we were at the nursing home EVERY SINGLE DAY and this still happened. What about the patients who don't have family members to check on them?

Page Two
March 4, 2002

This cannot wait another day. Someone needs to fight for our residents. My grandmother is now 98 years old and is still alive. She beat all odds and survived her abuse. She never regained her mental capacity after all of this, though, so we lost the last seven years with her. She'll basically be a vegetable for the rest of her life.

I would be glad to do anything necessary to help you get this legislation into effect. My phone number is (318) 330-9018.

Thank you so much for helping our elderly!

Sincerely,

Carol Brown

Carol Brown

P.S. My attorney will probably kill me for writing this letter, but it's not about money to me; it's about making changes. I would love to see a law passed in my grandmother's name to protect everyone after her who has to suffer at the hands of nursing homes.

STATEMENT OF W. GARRETT BOYD
McLEAN, VIRGINIA

As background, my father was a Southern Baptist Minister having spent much of his full time pastorate of over 40 years in Texas and New Mexico. My mother was his bride and helpmate of over 60 years.

Following my father's retirement, he and my mother moved to Memphis, Tennessee to be near my younger sister. My father died in Memphis at age 82 some three years ago.

My mother, also age 82, was ambulatory, drove herself and lived alone. Although we had engaged a part time caregiver to spend time with my mother, it was more companionship than physical need.

One morning when the caregiver arrived, she found that my mother had fallen out of bed and was somewhat disoriented. EMS was called and she was taken to Baptist Hospital where she was to be kept for 24 hours under observation. No tests were run to determine if she had suffered a mild stroke. The following day, although she continued to be disoriented, Baptist, having found no physical problems, was preparing to discharge her when they found her wandering the hall of the hospital. They took her to her room and restrained her as the caregiver who was to drive her had gone out to prepare for her return home. Obviously, she was not restrained properly as she managed to get herself out of the restraints, pick up her belongings, and as she was again in the hallway of the hospital, slipped and fell breaking her hip.

My eldest sister and I were called and immediately took the next flight to Memphis, arriving as she was in surgery. Again, no tests had been taken to determine if she had had what are called mini-strokes prior to putting her under a general anesthesia. According to our friends in the medical community, that was an absolute no, no and they were not surprised when it took her almost 24 hours to come out of the anesthesia.

As you are probably aware, a broken hip at age 82 is a life changing experience, which requires 24-hour care. The Baptist Memorial insisted that they had no responsibility in the event.

Mother was kept in Baptist Memorial for a few days to allow enough healing to take place for her to be transferred to their Germantown facility to further recoup and begin initial physical therapy.

Two days before she was to be released, a person she believed was an employee of the facility raped her. Although the rape crisis center verified the rape, the perpetrator was experienced enough to use a condom, strip the sheets and bed clothing from her bed, give her a shower and dress her in a clean gown. The rape took place between 11pm and 5am in a darkened room and the only description my mother was able to give was that he was a black man in what she described as a uniform of the hospital employees. Baptist Rehab continues to take no responsibility for the incident.

As you may imagine, it was very difficult for the wife of a man of God to talk about the incident. The police, with no DNA substance to use for matching, were not able to close the case.

My mother died 10 days later. The last day of her life, as I held her in my arms, the horror of her experience, though not verbalized, was etched on her face. Although one could never prove it in court, I am convinced that this heinous act, committed in a facility one would expect to be safe, significantly contributed to her demise.

This kind of neglect, though considered to be "not that unusual" by the rape crisis center, emphasizes the need for thorough investigation into both the people and the security measures employed at health care facilities in general and elder care facilities in particular.

I hope no member of this esteemed committee ever has to face the horrors generated through such an incident.

Thank you.

Senate Special Committee on Aging Hearing

WRITTEN ACCOUNT OF ABUSE OF MARY HELEN ROSENHOOVER TOLD BY HER DAUGHTER CATHY NEWMAN

I am writing on behalf of my mother, Mary Helen Rosenhoover. On July 7, 2000, Mary Helen Rosenhoover had a massive stroke while visiting with her sister in Pennsylvania. Just six months prior, Mary's husband died after a yearlong battle with cancer. Mary was a healthy, active and vibrant 80-year-old woman. Her stroke had devastating effects leaving her with left-side paralysis, cognitive dysfunction, a feeding tube and in a comatose state. I live in Maryland and could not stay in PA because I am a wife and mother of three boys. I made arrangements through a Mercy Medical Airlift group to have my mom flown to Maryland so that she could be near us. After consulting with several physical therapists, a decision was made to place my mom at Laurel Regional Hospital because they have a small acute rehabilitation center. She was admitted to Laurel on August 8, 2000. She had just begun to come out of her coma, which made it easier to assess her physical and cognitive abilities. Within one week, she began to respond to intensive physical therapy, started to talk and swallow soft foods. She was however still paralyzed and needed assistance with all personal functions. The team assigned to care for my mom, met with me on 8/15/00 for a conference on my mom's progress. All agreed, she made remarkable progress but still had a long road ahead.

Suddenly, my mom got violently ill, vomiting and not responding to anyone. For three days, my mom would not look at me and a cardiologist was assigned to determine if she had another stroke or possible heart attack. The tests revealed nothing, yet my mom failed to progress and I was given two days to find a different facility because they could no longer keep her under Medicare rules. On August 28, 2000 I moved mom to a sub-acute rehabilitation facility. Two days later my mom began to tell me what had happened to her at Laurel, which is why she had become so violently ill. A 23-year-old male employee of Laurel had started taking my mom for rides in her wheel chair. He told her, " I know your daughter is here everyday but when she's not, I will take care of you." He would wink at her and said he was her friend and she didn't need to tell anyone about their special relationship. He would take her to rooms where he would touch her breasts and suck on her nipples. Then he took her to the cafeteria when it was closed and stuck something into her vagina. It took my mom days to tell me what happened because communication was difficult due to her stroke. My mom felt she was somehow responsible. When I asked why she didn't tell me earlier, she said she was too afraid and she thought no one would believe her. She lived in a world where health care employees held a high position and could be trusted completely. She never dreamed an institution she held in such high esteem would betray her. Her world was falling apart. She pleaded with me to not make her talk about it anymore. She was humiliated and wanted to forget.

A short time later, a staff member at her new facility, noticed a vaginal discharge and they were in the process of ordering tests when my mom became so ill, that she went into a coma. It was determined that she had an infection that turned into septicemia. Because she failed to progress, I was told I must move her to a long-term care facility as Medicare

would no longer pay for her care. I brought my mom home with me and my husband, boys and I cared for her. All of the doctors and health care workers tried to discourage me from bringing her home because she needed 24 hour care. In good conscience, I could not put my mother in a situation where she would live in constant fear and felt my only option was to bring her home. When we finally got her home she said, "Now I feel safe." I knew we were doing the right thing. Over the next several months, she continued to get infections which she never recovered from and she died in my arms on July 7, 2001.

In May of that year, I went to see the president of Laurel Hospital and told him what had happened to my mom. I asked if they could help me with some of her expenses, as they were responsible. Please note that the person, who abused my mom, did so to at least five other women at that facility. The president of Laurel said he could do nothing, as it was not their fault. In a year, my mom lost her husband, her home, her way of life, her health and her dignity then finally her life.

Thank you for addressing this issue. My life is forever changed because of this tragedy. I would be happy to help as a volunteer so that maybe one elderly person is spared and my mom's death has meaning.

Statement of Bette Vidrine
Lafayette, LA

Comments: My mother, Hester Sobel, has been in Magnolia Estates Nursing Home here in Lafayette, Louisiana, since December 2000. On January 27, 2002, she was attacked by another nursing home resident. She is 84, frail, and an Alzheimer's patient. The man who beat her up is 67, strong, and has full mental capacity. I have attached a report on the attack.

Sunday, January 27, 2002

About 10:45 or 11 pm the phone rang, but I did not wake up and get to it before it hung up. It immediately rang again. It was Magnolia Estates Nursing Home saying that my mother had been beaten up and was injured. I immediately dressed and my husband and I went to the nursing home. Mother was in a wheelchair in the nurse's station. Her left eyeball was bloody and the eyebrow above this eye was cut and bleeding, and she was also bleeding from her right arm. The nurses told me another patient had hit her and kicked her. They had not called the ambulance because they could not reach a doctor. The staff told us that it was Curtis Romero, another patient, who had done it. The nurses had called the police and they had not arrived yet, so we decided to take mother immediately to the hospital. The police would go to Magnolia first, and then come to meet us at the hospital. The nurses on duty were Larry Barrier, Janice Smith, Shanica Smith and Frances Couvillion.

Mother's glasses had been damaged so she couldn't wear them. [The replacement value is $376.]

Mr. Romero's daughter was screaming that it was the nursing home's fault that her father had done this to my mother because his blood sugar was 329 and that made him violent. Larry Barrier, the nurse in charge, said that had nothing to do with it, that Mr. Romero knew that such aggressive and harmful violence was totally not acceptable since there were established procedures for patients to handle other patients going into their room by mistake. The fact is that 'Mr. Romero had followed Mrs. Sobel into the hallway where he struck her violently to the floor and then kicked her'. Mr. Barrier informed Mr. Romero's daughter that he had to leave the nursing home within 24 hours. In addition, Mr. Barrier and all the nurses said that Mr. Romero showed no remorse at all. In fact, he told the nurses "braggingly" that he had hit her and "would do it again". One of the nurses, Ms. Couvillion, helped me remove mother from the nurse's station so she wouldn't have to listen to Mr. Romero's daughter screaming.

My husband and I took mother to Southwest Medical Center in my car. Dr. M. Fruge saw her almost immediately. He did an examination and took x-rays. He told me mother had a broken rib, and that "from the angle of the break, it could not have been caused by anything other than a kick while she was on the floor". They did two stitches in her eyelid. They admitted her to the hospital for observation to see if she had a punctured lung or other internal injuries.

While Dr. Fruge was examining mother, it obviously hurt her as he was probing to see what was wrong, and she relived the attack, quivering and covering her face with her arms and saying, "Don't hit me. Don't kick me."

The police came. I spoke with Patrolman R. McFarland. I told him what had happened. He told me that Mr. Romero's daughter sent her apologies through him, that she was very sorry about what had happened, she was sorry she had screamed at us, and that her father had a history of violence against women.

Monday, January 28, 2002

I met the next morning with Ricky Bonin, Magnolia's Administrator, and Rhonda Darden, the Director of Nursing (DON). We went over the attack. When I told them that the police told me Mr. Romero had a history of violence against women, they acted like they were unaware of that. [On February 26th I received a report that Magnolia had submitted to the Department of Health and Hospitals which stated that this was not Mr. Romero's first incident, that he had slapped a Verdie Savoie two weeks before, on January 14th. I also later found out from other residents that Mr. Romero was always trying to pick fights.)

Mr. Bonin and Ms. Darden told me they were looking up the laws to see how they would go about removing Mr. Romero from the nursing home. They told me the attack had occurred at shift change, which was why no nurses were observing the monitor or the hallway at the time. They said they had videos in the halls, but had not seen the video of this attack yet. The Romero family had threatened the nursing home and our family with lawsuits, saying Magnolia should have prevented mother from going in his room, and she provoked the attack by going in his room.

I called my sister in Indiana and told her what had happened. I kept her constantly updated every day.

I then went to the hospital to see mother. She was sitting in bed, with pain in her side. She had flashbacks as to what had happened. They were going to do some more tests on her. Dr. Manuel was her doctor. Later that day they decided to keep her another night for further observation.

Tuesday, January 29, 2002

I took another day off work. The hospital called that they were ready to discharge mother. I called the nursing home to see if Mr. Romero were gone. They said he would be leaving within a half an hour. I was not going to bring mother there until he was gone. I did not want her to have to face him and chance another attack.

I went to the hospital and got mother, and brought her back to Magnolia. She was in pain while walking.

I met with Ricky Bonin again. He explained to me why it had taken so long to get rid of Mr. Romero, that he had to be sure to follow all the State's rules and regulations, and this had never happened in his life before, so he had to make sure it was all done correctly. He let me see the video of the attack. I saw mother go into Mr. Romero's room, and then leave about a minute later. His room is at the end of the hall on the left. Her room is near the end of another hall, on the left, and she often confuses the halls. About 10-15 minutes later, she went into his room again. She left again. Then he attacked her in the hall. The video was set for every few seconds. I saw him go for her, then I saw her rolling around on the floor like a wounded animal when a car hits it, then trying to get up and not able to. I saw Mr. Romero head for the nurses' station. He was a big strong looking man. I then went to see Mr. Romero's room, and saw that he was gone and it was being cleaned completely. I saw that the switch plate was broken.

Wednesday, January 30, 2002

I saw mother was still in pain while walking. I asked the nurse to see about getting her some medicine to help her sleep so she would sleep all night and be sure to get enough rest so she could heal better. Everyone in the nursing home was very upset about all this. Mother told Mrs. Perram all about the attack. (Mrs. Perram is another resident's wife who is at the nursing home with her husband nearly all the time.)

Thursday, January 31, 2002

I went to the nursing home late at night to talk to the night nurses. Janice Smith, the nurse on mother's hall, was the one who Mr. Romero came to the night of the attack. He told her, "I just hit her, and I'll do it again." She then ran to mother, and mother told her that he had kicked her also. The other nurses then came and helped her take care of mother. She told me the CNA's were not involved at all, because they were all at the time clock. No one was watching the monitors when it all happened because they were all at the time clock. Shift change is at 10:00 for the CNA's, and also at the same time, the nurses have to clock out and in again. So nobody was at the nurses' station during the attack.

The nurse told me that the doctor prescribed some Vistaril for mother to take to help the pain and to help her sleep. It seemed to be helping.

Friday, February 8, 2002

When I visited mother, I noticed her leaning very badly to the left and limping, dragging her left foot. She said she didn't hurt anywhere.

Saturday, February 9, 2002

Mother was still leaning and limping, dragging her foot. I asked the nurse, Rachel Gallien, to make a note of it so she could see the doctor on Monday. She also said that her back hurt, and showed me the upper back near where her rib was broken.

Monday, February 11, 2002

I brought mother to Dr. Dugal's office in Sunset. He x-rayed her hips and found no fracture. She was obviously tender, and he said she must have internal bruises from the fall, but there were no breaks or cracks. While he was examining her it hurt her, and she asked him if he were the man who hit her. He said no, he would never do anything like that.

Statement of Cassie Tracy
March 4, 2002

I am Cassie Tracy, daughter of Helen Malon. My sister, Pat Shultz and I have been caring for our mother for several years. My mother lived on her own after our father passed away in 1986. Our mother was fairly healthy then but later suffered with chronic back pain. She suffered a stroke 7 years ago. She tried to continue to live in her own home but could no longer take care of it. She sold her home and moved into an apartment. Her back pain became more severe causing her to be hospitalized quite often. Eventually she had to go to a nursing home where she lived for 1 year, then went to assisted living for 2 months. She then decided she could live on her own again. We rented an apartment for her, but her back pain increased and her hospital stays were more often and for longer periods. After one of her hospital stays the doctor recommended we put her in a nursing home for a short period to help her get stronger. At that nursing home she fell and broke her right pelvic and also hit her head causing her to have staples inserted to close the wound. This caused another hospital stay. The nursing home where this incident occurred took her back for 1 day and then sent her to another hospital for evaluation due to the injuries. She was stabilized and released from the hospital. The nursing home said they could not care for her.

We then took her to St. Sophia's nursing home where our niece was working as a nurse. We thought seeing someone from the family more often would help her. We told the staff of our mother's broken pelvis. They put her in physical therapy and would you believe had her x-rayed because she was not reacting to therapy and reported to us that she had a broken right pelvic. They had been treating her incorrectly. They then corrected this matter. Our mother had not walked for almost 2 years when she was severely injured at St. Sophia's.

At 4:00 AM on the morning of Friday, June 22, 2001 someone from the nursing home called my sister. Her 18 year old daughter answered the phone and they told her that our mother had fallen from her bed, but she was OK. They just had to report the incident to a family member. A short time later they called back again and told my sister that due to regulations they had to call the paramedics and they were going to transport her to the hospital just for a routine check. She was not injured and there was no need for a family member to be present. She would just be evaluated and returned to the nursing home.

My sister tried to contact the nursing home from 6:30 AM until 12 noon. She had been disconnected several times, put on hold, transferred and ignored. Finally around noon she was able to contact the nurse's station. She was then informed that our mother had not returned from the hospital. Pat questioned this and they told her that was not their responsibility. They told her that our mother was taken to DePaul hospital. Pat then contacted the emergency room and they told her that she was being admitted and was

scheduled to have surgery that same afternoon to repair multiple facial fractures. My sister then contacted my daughter and myself. When we arrived at the hospital we were in shock.

Our mother looked like she had been punched in the face. Her eye was swollen closed. The doctor could not even force the eye open to examine her to see if there was any damage done to the eye. The orbital bone was broken as well as her jaw and nose. She lost over 1 pint of blood from her broken nose. She was in distress and laid there all alone in fear because the nursing home lied to us. Had we known the extent of her injuries we would have been there immediately.

My sister called the nursing home from the hospital demanding someone come to the hospital to see what had been done to our mother. The administrator refused saying he was too busy. He finally agreed to send the director of nursing and assistant director to the hospital. All they kept saying was that they were investigating. They told us that they were unable to contact all of the employees on duty that night because some of them did not have phones. They also told us that our mother had climbed over the rail of her bed and fallen. Our mother had not walked for almost 2 years. She laid in a fetal position as her muscles had deteriorated from not using them. We found it hard to believe that she climbed over a bed rail.

We contacted our niece, Irene. She was not working that night and had no idea of the injury that her grandmother sustained. One of the workers told Irene that her grandmother was found behind the door to her room laying in a pool of blood. The nursing home administration told the staff that our mother was walking in her room and fell. The workers at the nursing home told my sister that they didn't know our mother could walk. Well, she couldn't.

The morning of Saturday, June 23, 2001 I called the Florissant police department. They had a detective call me at the hospital and he came over with his camera. He took several pictures and took a statement from each of us. The house doctor believed the nursing home and thought she fell over the side of the bed. He said it would take a sick person to do something like that. Apparently, he does not watch the news or read the paper. We questioned the doctor about the bruises on her neck. He just shrugged his shoulders. He couldn't explain them. We questioned this same doctor as to why our mother did not have any other injuries. She suffered from osteoporosis. Her hips were so weak they could fracture on their own. He could not answer this.

The police detective did his investigation and questioned some of the workers at the nursing home. No one seems to know what happened. He determined that their was no criminal assault and simply wrote a memo. He gave us the roll of film that he had taken. However, when it was developed, none of the pictures turned out. Fortunately, we had

taken our own pictures which I will send to you by mail. Our mother already suffered from dimensia and could not tell us what happened. This incident set her back even further. She would put her arms over her face and scream out "don't hit me, please stop, don't pull my hair." She was in shock. The nurses that cared for her at the hospital told us that her injuries were not from a fall. They felt that she had been punched in the face. We just couldn't get anyone to listen to us.

The division of aging was called. It took several months for them to do an investigation. At which time I learned that St. Sophia's had been cited for accidents, falls and improper transfers in April of 2001. They were visited again in June and found that nothing had been corrected and that St. Sophia's was receiving penalties for not having corrected what they had been cited for. Their investigation showed there were things that could have been done differently. Our mother was injured after the second visit from the Division of Aging.

I supplied the investigator with pictures, the police memo, the names and numbers of the paramedics that transported our mother that night as well as reports from the emergency room and hospital records. I also gave him the name and number of the doctor that was going to operate on her. To my knowledge, none of these people were contacted.

Our mother was in the hospital for 1 week. We worked with the social worker and found another nursing home that cared for her for the last 8 months of her life. Our mother passed away on February 18, 2002.

We have reviewed the other testimonies that were given on March 4, 2002, and we feel like the others do. This should have never happened and the criminals working in nursing homes should be treated like any other criminals on the street. They strike the weak and get away with the crime.

Our mother had stated several times that bad things happen in here to the people, but you can't say anything because it only makes it worse. We believe she was right.

Thank you for listening to our mother's story and we hope you have the power to correct the situations that exist.

ROBERT I. MARSHALL
Majority Whip
STATE SENATOR
Third District

SENATE
STATE OF DELAWARE
LEGISLATIVE HALL
DOVER, DELAWARE 19903

COMMITTEES
Labor & Industrial Relations, Chair
Revenue & Taxation, Chair
Children, Youth & Families
Combat Drug Abuse
Ethics

March 4, 2002

The Honorable U. S. Senator John Breaux
503 Hart Building
Washington, D. C. 20510

Dear Sen. Breaux:

Thank you for interest in the issue of nursing home abuse. In Delaware, we have enacted a package of nursing home reform legislation and provided funding to pay for the reforms. I am enclosing a brief summary of my legislative reform package with this letter.

Since the newly-released GAO study focuses on the issue of physical and sexual abuse, and identifies the failure or inability of states to get timely information on criminal backgrounds of nursing home employees, I am also forwarding to you a copy of my legislation mandating both state and federal (FBI) criminal background checks for prospective nursing home employees. The State provided funding for both criminal background checks.

The General Assembly also passed my bill requiring day care facilities and long-term care facilities to request "service letters" of previous employers in order to identify those employees who either quit or were fired due to issues of abuse or neglect that did not reach the level of criminality. Employers were provided civil immunity for making a good-faith effort to provide this information.

I would respectfully request that this letter and the enclosed information be made part of the public record of today's hearing.

I would also offer any assistance that I can in your efforts to protect our most vulnerable citizens from abuse, neglect and financial exploitation.

Sincerely,

Bob Marshall/SJA

Robert I. Marshall
Majority Whip
Delaware State Senate

601 South DuPont Street, Wilmington, DE 19805
Home: 302-656-7261 Senate Offices: Dover 302-744-4168 Wilmington 302-577-8744

PRINTED ON RECYCLED PAPER

The following bills have been passed and signed by the Governor:

From the 139th General Assembly:

a. SB 302-Creates the Division of Long-Term Care Consumer Protection to assume overall responsibility for oversight of long-term care services. Money was provided in the Budget Bill to help the new Division staff up.

b. SB 303-Requires criminal background checks and drug screening for those offered employment in nursing homes and similar facilities. Funding was provided by the State to pay for the criminal (FBI) background checks.

c. SB 304-Expanded the Patient's Bill of Rights to give patients and families greater say in patients' care. Also gave patients and residents greater access to specific information about the services they receive and about those providing the service.

d. SB 321-Strengthened abuse & neglect statute by tightening the State's investigative procedures to ensure timely investigations. Funding was also provided in Budget Bill to provide for more investigators and prosecutors for the Medicaid Fraud Unit.

e. SB 322- Completely rewrote nursing home licensing statute for the first time since 1953, and gave statute real teeth by strengthening civil penalties for violations.

f. HB 558-Created a hearsay exception to enable infirm patients to provide testimony in criminal abuse and neglect cases.

From the 140th General Assembly:

g. SB 20-Requires that CNA's receive at least 150 hours of training, 75 hours in the classroom and 75 hours hands on, and creates a voluntary career ladder to encourage nursing homes

to retain CNA's and to provide opportunity for advancement for motivated CNA's. Funding was provided for a pilot program to train CNA's.

h. SB 21-Lowers standard for prosecuting abuse and neglect cases for in-home care from "intentional" to "knowing or reckless".

i. SB 22-Creates a Nursing Home Residents Quality Assurance Commission to assist the Division in carrying out its mandate to ensure that Delaware's nursing home residents are safe and secure, are receiving quality care, and are free from abuse, neglect and financial exploitation.

j. SB 112-Lowers standard for prosecuting abuse and neglect cases in nursing homes from "intentional" to "knowing or reckless". It also adds the crime of financial exploitation to the Code.

k. SS 1 for SB 115-The key component of the entire package was finally enacted into law on September 8, 2000. This bill requires minimum direct care staffing by shift, provides funding for increased staffing, requires a nursing supervisor on duty 24 hours a day, and increases staffing for in-service education, activities, and dietetics and nutrition.

DELAWARE STATE SENATE

139TH GENERAL ASSEMBLY

SENATE BILL NO. 303

AS AMENDED BY

SENATE AMENDMENT NO. 3, AND
HOUSE AMENDMENT NO. 2

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO QUALITY IN HIRING OF EMPLOYEES OF NURSING HOMES AND SIMILAR FACILITIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code by redesignating the current "§1141" as "§1145."
Section 2. Amend Title 16 of the Delaware Code by adding a new §1141 in Subchapter III, Chapter II, Title 16, to read as follows:
"§1141. Criminal Background Checks.
(a) Definitions:
(1) 'Applicant' means any person applying for a position in a nursing home or other entity licensed pursuant to 16 Del. C. Ch. 11, that affords direct access to patients or individuals receiving care at such a facility, or a person applying for a license to operate such a facility or business.
(2) 'Direct Access' means the opportunity to approach children and/or adults without the presence of other adults during the course of one's assigned duties.
(b) No employer who operates a nursing home or other entity licensed pursuant to 16 Del. C. Ch. 11 may hire any applicant without obtaining a report of the person's entire criminal history record from the State Bureau of Identification and a report from the Department of Health and Social Services regarding its review of a report of the person's entire Federal criminal history record pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544.
No temporary agency may refer an applicant to a nursing home or other entity licensed pursuant to 16 Del. C. Chapter 11, without obtaining, at said agency's expense, a report of the person's entire criminal history record from The State Bureau of Identification and a written report from the Department of Health and Social Services regarding its review of the person's entire Federal criminal history record pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544. The State Bureau of Identification shall be the intermediary for the purposes of this section and the Department of Health and Social Services shall be the screening point for the receipt of said Federal criminal history records. The Department of Health and Social Services shall promulgate regulations regarding its review of the Federal criminal records, the criteria which constitute disqualifiying factors for employment in a nursing home or other facility licensed pursuant to 16 Del. C. Ch. 11, and a means for notifying employers of the results of the assessment.
(c) Notwithstanding the provisons of subsection (b), the employer may hire an applicant on a conditional basis when the employer receives evidence that the applicant has requested his or her State and federal criminal history record, and has been fingerprinted by the State Bureau of Investigation. 'Evidence' for purposes of this subsection shall be a verification from the State Bureau of Identification that the person

(d) Notwithstanding the provisions of subsection (b), when exigent circumstances exist, and an employer must fill a position in order to maintain the required level of [illegible]

hire an applicant on a conditional basis when the employer receives evidence that the applicant has requested the appropriate drug screening. The employment of an applicant pursuant to this subsection shall be contingent upon receipt of the results of the drug screening. In addition, all persons hired pursuant to § 1141 of this Title shall be informed in writing and shall acknowledge in writing, that his/her results have been requested. Under no circumstances shall an applicant hired on a conditional basis pursuant to this subsection be employed on a conditional basis for more than 2 months.

(e) Any applicant or employer who fails to comply with the requirements of this section shall be subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation."

Section 3. Amend Subchapter IV., Chapter 11, Title 16 of the Delaware Code, by striking the descriptive heading of Subchapter IV as it appears therein and by substituting in lieu thereof the following new descriptive heading.

"Subchapter IV. Criminal Background Checks; Mandatory Drug Testing; Nursing Home Compliance with Title XIX of the Social Security Act."

Section 4. If any provision of this Act or the application thereof to any person, thing, or circumstance is held invalid, such invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application. To that end, the provisions of this Act are declared to be severable.

Section 5. The requirements of the Act shall become effective on January 1, 1999.

has been fingerprinted and both the State and Federal criminal history records have been requested. The final employment of an applicant pursuant to this Subsection shall be contingent upon the employer's receipt of the State Bureau of Identification criminal history record, and a report by the Department of Health and Social Services that there are no disqualifying factors for employment in such person's Federal Criminal Record. Under no circumstances shall an applicant hired on a conditional basis pursuant to this subsection be employed on a conditional basis for more than 2 months

(d) Any employer who hires an applicant for employment and fails to request and/or fails to obtain a report of the person's entire criminal history record from the State Bureau of Identification and/or a written report regarding the suitability of the applicant based on his or her Federal criminal history shall be subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.

Any such employer shall also be subject to this penalty if they conditionally hire an applicant before receiving verification from the State Bureau of Identification that the applicant has been fingerprinted and that the State and Federal criminal background checks have been requested.

(e) Notwithstanding any requirements of 11 Del. C Ch. 85 to the contrary, the State Bureau of Identification shall furnish information pertaining to the entire Delaware criminal history record of any person seeking employment with any employer who operates a nursing home or other entity licensed pursuant to 16 Del. C. Ch. 11. Such information shall be provided to the employer and to the Department of Health and Social Services pursuant to the procedures established by the Superintendent of the State Police.

(f) Every application for employment with a nursing home or other entity licensed pursuant to 16 Del. C. Ch. 11 shall require the applicant to provide any and all information necessary to obtain a report of the person's entire criminal history record from the State Bureau of Identification and a report of the person's entire Federal Criminal history record pursuant to the Federal Bureau of Investigation appropriation of Title II of Public Law 92-544. In addition, every application for employment shall contain a signed statement from the applicant that the applicant grants full release for the employer to request and obtain any such records or information contained on a criminal history record.

(g) Any individual who either fails to make a full and complete disclosure on an application or a full and complete disclosure of any information required to obtain a criminal history record as required by subsection (b) of this section, shall be subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.

(h) The costs for the State Bureau of Identification and Federal Bureau of Investigation background checks made pursuant to this Section shall be borne by the State except where otherwise noted in this Section.

(i) Notwithstanding any provision of this Title to the contrary, any applicant who has been the subject of a qualifying state and federal background check, pursuant to the terms of this section within the previous 5 years, shall be exempt from the provisions of this section. However, employers, at their own discretion and expense, shall have the right to require more frequent background checks."

Section 2. Amend Title 16 of the Delaware Code by adding a new section §1142 in Subchapter III, Chapter 11, Title 16, to read as follows:

"§1142. Mandatory Drug Testing.

(a) No employer who operates a nursing home or other entity licensed pursuant to 16 Del. C. Ch. 11 may hire any applicant, as defined in §1141 of this Title, without first obtaining the results of such applicant's mandatory drug screening.

(b) All applicants, as defined in §1141 of this Title, shall submit to mandatory drug testing, as specified by regulations promulgated pursuant to subsection (d) of this section.

(c) The Department of Health and Social Services shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of the following illegal drugs:

(1) Marijuana/cannabis;
(2) Cocaine;
(3) Opiates;
(4) Phencyclidine ("PCP");
(5) Amphetamines;
(6) Any other illegal drug specified by the Department of Health and Social Services, pursuant to regulations promulgated pursuant to this Section.

(d) Notwithstanding the provisions of Subsection (b), when exigent circumstances exist, and an employer must fill a position in order to maintain the required level of service, the employer may

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Statement of the National Association of Orthopaedic Nurses

Concerning
Safeguarding Our Seniors: Protecting The Elderly From Physical & Sexual Abuse In Nursing Homes
before the Senate Special Committee on Aging
Submitted for the Hearing Record

The National Association of Orthopaedic Nurses (NAON) is the professional nursing society composed of 8,000 nurses throughout the United States dedicated to improving the health of patients with orthopaedic and musculoskeletal problems. NAON has become increasingly active on the issue of elder abuse, including recommendations NAON put forth included as part of the Institute of Medicine report last year on the Education and Training of Health Professionals on Family Violence (see publication Confronting Chronic Neglect). We submit this statement regarding abuse in nursing homes and our recommendations to reduce abuse and increase detection and referral.

THE PREVALENCE OF ELDER ABUSE AND IN NURSING HOMES

A study done by the National Center on Elder Abuse estimated that approximately **one million elders were victims of various types of domestic elder abuse in 1996.** Experts estimate only 1 out of 14 domestic elder abuse incidents comes to the attention of the authorities. Older individuals may feel a social stigma and embarrassment to report rape

or physical abuse for fear of retaliation by caregivers in a nursing home. Abuse in nursing homes remains largely hidden.

ABUSE AND DETECTION

Physical abuse can include cuts, lacerations, puncture wounds, bruises, discolorations, injuries not compatible with the medical record, poor skin condition, poor skin hygiene, absence of hair, hemorrhages below the scalp, signs of dehydration or malnourishment, burns, soiled clothing or bed, marks indicative of ropes or chains or contact with other objects. Sexual abuse can include sexually transmitted diseases, discharges from the vagina, bleeding from the vagina or rectum, prolapsed rectum and extreme fear of a caregiver. In addition, reports of physical abuse or sexual abuse by elders may be discounted due to dementia, Alzheimer's disease or confusion. Reports of abuse by an individual to nursing staff or family members should be taken seriously and investigated.

NAON would like to emphasize the importance of routine screening for signs of violence and elder abuse because of its capacity to identify abuse that may have been hidden or ignored. A study in the August 4, 1999 issue of *The Journal of the American Medical Association* found that less than 10% of primary care physicians routinely screen patients for abuse during regular office visits. Physicians must review all nursing home patients' cases monthly. Careful monthly examinations and reviews could uncover many cases of physical or sexual abuse that has been undetected or unreported. Physicians, nurses and nurse practitioners must know the signs and symptoms of abuse and how to refer suspicious cases to appropriate law enforcement agencies.

EDUCATIONAL NEEDS OF HEALTH PROFESSIONALS

A recent national study of 143 accredited U.S. and Canadian medical schools revealed that 53% of these institutions do not require medical students to receive instructions about violence that may occur against their patients by intimates or caregivers. In a survey of practicing emergency room physicians, only twenty-five percent recalled any education on elder abuse during their residencies.

In schools of nursing, even if programs are offered on violence awareness, it may occur only at a graduate level. Undergraduate programs for nursing state that their curriculum agendas are too full and cannot accommodate other topics. The area of elder abuse in nursing curriculum has received the least attention and is represented least well in nursing curricula. In nursing schools that have included the subject, it is usually one to two hours devoted to the subject. In addition, there appears to be no regulation requirement or consistency for what nursing programs must offer about domestic violence or elder abuse, including screening, detection and referral. This should not continue. Health professional must be aware of the signs and symptoms of abuse and know how to report it quickly.

RECOMMENDATIONS

1. NAON recommends that medical and nursing colleges and universities develop a curriculum regarding elder abuse and intimate partner violence for medical and nursing students, and suggests that a 10-hour curriculum be the minimum requirement.

2. NAON strongly recommends that state medical associations and state nurse associations require education on elder abuse and patient violence screening, detection and referral in order to receive professional licensure and to renew licensure.

3. NAON recommends that hospitals' "annual up-date" requirements for The Joint Commission on Accreditation for Hospitals include testing on elder abuse and violence against patients. Nursing home patients who may have been a victim of physical or sexual abuse be identified and addressed. This would assure that information related to screening, detection and appropriate referral of elder abuse is included with the current required JCAHO updates on fire, safety and needle-sticks.

4.NAON recommends that all health care facilities, including nursing homes, perform criminal background checks to identify employees who have histories of physical or sexual abuse charges or criminal records.

5.NAON recommends that a national roster of individuals who have been convicted of physical or sexual abuse be created and available to care facilities. This information must be current and accessed without difficulty.

7. NAON recommends the establishment of formal guidelines to prevent abuse in long-term care facilities, including screening of individuals and reporting requirements.

8. NAON recommends that facilities be required to monitor (through cameras) employee performance to prevent abuse.

9. NAON recommends greater collaboration between the medical and nursing professions and law enforcement to assure that quick and appropriate referral occurs. Historically, collaboration between the health community and law enforcement, including the judiciary, has been absent due to suspicion and fear. This cannot continue. Health professionals and law enforcement must work together. Health professionals can train police officers and the judiciary on the signs of abuse as evidenced by physical and sexual indicators. Health professionals must be aware of law enforcement phone numbers and agencies where they can report abuse (either overtly or confidentially) by other staff members in a nursing home.

NAON would like to work with members of the Senate Special Committee on Aging to address the problem of elder abuse and abuse in nursing homes. NAON fears that this abuse is truly hidden in its magnitude and must be addressed quickly. Thank you.

Testimony from Toby Edelman, Center for Medicare Advocacy

**SAFEGUARDING OUR SENIORS:
PROTECTING THE ELDERLY
FROM PHYSICAL & SEXUAL ABUSE
IN NURSING HOMES**

The Senate Special Committee on Aging's March 4 hearing on physical and sexual abuse in nursing homes brought public attention to an important issue that too many people would like to believe did not exist -- the physical and sexual abuse of nursing home residents by their caregivers and fellow residents. Last summer's report by the minority staff of the Special Investigations Division of the House Committee on Government Reform documented that abuse and neglect of residents occur with alarming frequency. Between January 1, 1999 and January 1, 2001, 1601 facilities (more than 9% of the nation's nursing homes) were cited with abuse or neglect deficiencies that caused actual harm to residents or placed residents in immediate jeopardy of death or serious injury. *Abuse of Residents Is a Major Problem in U.S. Nursing Homes* 5 (Jul. 30, 2001).

As the Committee develops recommendations for addressing this problem, the Center for Medicare Advocacy proposes several solutions, in addition to the criminal background legislation introduced by Senator Kohl.

Reports and analyses

1. The Committee should require the Centers for Medicare & Medicaid Services to report to the Committee and to the public on implementation and enforcement of current federal rules that require states to (a) investigate possible facility culpability whenever an allegation is made that a certified nurse assistant has abused or neglected a resident or misappropriated a resident's property and (b) take enforcement action against the facility, as appropriate. The Committee should also request that the General Accounting Office conduct a study of implementation and effectiveness of this federal regulatory requirement.

Existing federal rules, promulgated as part of the final enforcement rules in November 1994 (effective July 1, 1995), establish state survey agencies' broad responsibility when allegations of abuse or neglect are made against certified nurse assistants. The rules state:

(h) *Survey agency responsibility.* (1) The survey agency must promptly review the results of all complaint investigations and determine whether or not a facility has violated any requirements in part 483, subpart B of this chapter. [These provisions reflect Requirements of Participation for facilities receiving Medicare and/or Medicaid reimbursement.]

(2) If a facility is not in substantial compliance with the requirements in part 483, subpart B of this chapter, the survey agency initiates appropriate actions, as specified in subpart F of this part.

42 CFR §488.335(h). The preamble to the final enforcement rules clarifies the "new requirement that State survey agencies consider all complaints of resident neglect or abuse, or misappropriation of resident property as a potential reflection on a facility's compliance with Medicaid and/or Medicare participation requirements [emphasis supplied]." 59 Fed. Reg. 56,116, at 56,163 (Nov. 10, 1994).

In our experience, this requirement is rarely, if ever, implemented. Too often, staff members who are accused of abusing or neglecting a resident are simply dismissed by the facility and the matter is considered closed by both the facility and the survey agency. Even when an investigation occurs and the staff member's name is added to the state's registry of abusers who may not be employed in a facility in the future, there are apparently few, if any, instances when the facility's *own* culpability is identified and sanctioned. The General Accounting Office confirmed our experience. In the 158 case files it reviewed, the GAO found only one instance when a remedy was imposed against a facility, and that remedy, a civil money penalty, was reduced on appeal. In the other 25 cases, no remedy was recommended or imposed. GAO, *Nursing Homes: More Can Be Done to Protect Residents from Abuse*, GAO-02-312, pages 5 and 12 (Mar. 2002).

A facility's culpability can be the result of a number of systemic failures. Does the facility properly screen potential employees? Does the facility call references and conduct background checks, as required by state and federal law? Does the facility assure that each staff member is fully and appropriately trained before providing service to residents? Does the facility provide adequate supervision of workers? Does the facility have an appropriate abuse prevention protocol in place? And finally, does the facility employ enough staff to provide care to residents so that staff are not called from one crisis to another, leaving residents vulnerable and subject to avoidable harm?

Both CMS and the GAO need to analyze whether the regulatory requirement has been implemented. If this requirement has not been implemented, why not? If it has been implemented, has it made a difference in preventing abuse and neglect of residents? How can this regulatory requirement be strengthened to be more effective in preventing abuse and neglect of residents?

2. The Committee should require the Centers for Medicare & Medicaid Services to report to the Committee on the use and effectiveness of the Abuse Prohibition Review.

In July 1999, CMS added a comprehensive Abuse Prohibition Review (Task 5G) to the federal survey protocol in order to assure that facilities had "developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all residents." State Operations Manual, Task 5G, page P-62. The SOM describes components of the review:

> These include [evaluation of a facility's] procedures for the following:
> - Screening of potential hirees;
> - Training of employees (both for new employees, and ongoing training for all employees);
> - Prevention policies and procedures;
> - Identification of possible incidents or allegations which need investigation;
> - Investigation of incidents and allegations;
> - Protection of residents during investigations; and
> - Reporting of incidents, investigations, and facility response to the results of their investigations.

Id. How well is this investigative protocol working and has it made any difference in preventing abuse and neglect of residents? CMS should analyze use of this protocol and report to the Committee on its use and effectiveness. (The description of Task 5G is attached to this statement.)

3. The Committee should request that the General Accounting Office conduct a study identifying who commits abuse against residents. Who are the staff members who commit abuse? Who are the residents who abuse their fellow residents?

Senator Kohl has referred in the past to reports indicating that a large percentage of abuse is committed by a small number of workers with criminal backgrounds. The criminal background legislation he has introduced is intended to address this issue. Additional information about abusers would help inform public policy. For example, the GAO study should evaluate whether nursing facilities are permitted to use, and do use, the federal tax credit for employing people with criminal records, as authorized by the Work Opportunity Credit law (formerly known as the Targeted Jobs Credit). Do nursing facilities use the federal tax credit to employ ex-felons who should not be working in nursing homes, such as individuals convicted of violent crimes against dependent people? If facilities receive a tax credit for employing such workers, what are the implications for abuse and neglect of residents and should the federal law be amended to prohibit such use of the tax credit?

Federal legislation

4. Congress should enact legislation requiring nursing homes to report all deaths to state or county coroners.

Mark Malcolm, the County Coroner of Pulaski County, Arkansas, testified at the Committee's hearing about the Arkansas law that requires facilities to report *all* deaths to the county coroner. Arkansas law also requires hospitals to report deaths of patients who are transferred from nursing homes and die within five days of admission. The coroner or a member of his staff examines each resident, reviews medical records, and interviews physicians, facility staff, and family members. Since July 1, 1999, Mr. Malcolm's office has conducted approximately 2400 nursing home investigations and identified 56 deaths where the care provided had been grossly inadequate ("dinner plate-sized bed sores with infected and dying tissue, infected feeding tubes, rapid and unexplained weight loss, dehydration, improperly administered medications, and medication errors that resulted in death.")

Legislation modeled on Arkansas' law should be enacted nationally.

5. Congress should enact legislation mandating specific nurse staffing ratios for nursing facilities. Congress should also enact legislation to improve training for certified nurse assistants and to increase the minimum number of hours of required training.

Phase 2 of CMS' nurse staffing report documents, as did the Phase 1 report released in July 2000, that most facilities have too few staff to meet residents' basic needs. The current staffing standard in federal law – "sufficient staff" to meet residents' needs – is too vague to be enforceable. The result is severe and chronic understaffing, which leads to poor care for residents as well as abuse and neglect.

While some abuse and neglect, including resident-on-resident abuse, occur because facilities employ too few workers to oversee and provide care to residents, other abuse and neglect occur because staff have too little training and too few skills to understand and know how to deal appropriately with residents. Nurse aide training requirements enacted in the 1987 nursing home reform legislation mandated a minimal 75 hours of training. These requirements are clearly inadequate to meet the needs of today's nursing home residents, who are more frail and disabled and have greater health care needs than ever. Aide training requirements need to be strengthened, improved, and enforced.

Thank you for the opportunity to submit this statement for the record.

The Center for Medicare Advocacy, Inc. is a private, nonprofit organization that provides education, analytical research, advocacy, and legal assistance to help older people and people with disabilities obtain needed health care. Our primary focus is on issues concerning the federal Medicare program.

Toby S. Edelman

specific quality deficiencies which have been dealt with or are currently being dealt with should not be reviewed;

o Surveyors may also ask the facility (i.e., the QA committee) to describe a sample of the types of quality deficiencies the facility has identified and how it addressed them. These need not be practices that the survey team has identified as concerns. Such a sample should consist only of quality deficiencies which the facility believes it has resolved through its quality assurance process (i.e., past corrected problems);

o Determine compliance in this phase by interviewing direct care staff to determine if they are familiar with the specific plan(s) for care described by the QA committee and have implemented them. It is not necessary that direct care staff know that the care they are providing is the result of a quality assurance plan, however, they should be implementing the plan as develop as a routine part of their resident care. Also, if the plan described by the QA committee is not being followed, determine whether there is a justifiable reason for the (for example, the facility replaced the process described by the QA committee with a different process based on updated protocols, medical knowledge, etc.);

o If the facility has been out of compliance with a regulatory requirement between two surveys in which they were in compliance, that past noncompliance will not be cited by the survey team if a quality assurance program is in place and has corrected the noncompliance. An exception to this policy may be made in cases of egregious past noncompliance.

TASK 5G - ABUSE PROHIBITION REVIEW

A. General Objective.--To determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all residents. The review includes components of the facility's policies and procedures as contained in the Guidance to Surveyors at 42 CFR 483.13(c), F226. (See Guidance to Surveyors for further information.)

These include policies and procedures for the following:

o Screening of potential hirees;

o Training of employees (both for new employees, and ongoing training for all employees);

o Prevention policies and procedures;

o Identification of possible incidents or allegations which need investigation;

o Investigation of incidents and allegations;

o Protection of residents during investigations; and

o Reporting of incidents, investigations, and facility response to the results of their investigations.

B. General Procedures:

o Utilize the Abuse Prohibition Investigative Protocol to complete this task.

SURVEY PROCEDURES FOR LONG TERM CARE FACILITIES

INVESTIGATIVE PROTOCOL

ABUSE PROHIBITION

Objective:

To determine if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusion and misappropriation of property for all residents.

Use:

Use this protocol on every standard survey.

Task 5G Procedures:

o Obtain and review the facility's abuse prohibition policies and procedures to determine that they include the key components, i.e. screening, training, prevention, identification, investigation, protection and reporting/response. (See Guidance to Surveyors at F226.) It is not necessary for these items to be collected in one document or manual.

o Interview the individual(s) identified by the facility as responsible for coordinating the policies and procedures to evaluate how each component of the policies and procedures is operationalized, if not obvious from the policies. How do you monitor the staff providing and/or supervising the delivery of resident care and services to assure that care service is provided as needed to assure that neglect of care does not occur? How do you determine which injuries of unknown origin should be investigated as alleged occurrences of abuse? How are you ensuring that residents, families, and staff feel free to communicate concerns without fear of reprisal?

o Request written evidence of how the facility has handled alleged violations. Select 2-3 alleged violations (if the facility has this many) since the previous standard survey or the previous time this review has been done by the State.

- Determine if the facility implemented adequate procedures:
  - + For reporting and investigating;
  - + For protection of the resident during the investigation;
  - + For the provision of corrective action;

NOTE: The reporting requirements at 483.13(c) specify both a report of the alleged violation and a report of the results of the investigation to the State survey agency.

- Determine if the facility reevaluated and revised applicable procedures as necessary.

o Interview several residents and families regarding their awareness of to whom and how to report allegations, incidents and/or complaints. This information can be obtained through the resident, group, and family interviews at Task 5D.

o Interview at least five (5) direct care staff, representing all three shifts, including activity staff and nursing assistants, to determine the following:

- If staff are trained in and are knowledgeable about how to appropriately intervene in situations involving residents who have aggressive or catastrophic reactions.

NOTE: Catastrophic reactions are extraordinary reactions of residents to ordinary stimuli, such as the attempt to provide care. One definition in current literature is as follows: ". . . catastrophic reactions [are] defined as reactions or mood changes of the resident in response to what may seem to be minimal stimuli (eg.: bathing, dressing, having to go to the bathroom, a question asked of the person) that can be characterized by weeping, blushing, anger, agitation, or stubbornness. Catastrophic reactions and other behaviors of Alzheimer residents: Special unit compared to traditional units. Elizabeth A Swanson, Meridean L. Maas, and Cathleen Buckwalter . Archives of Psychiatric Nursing. Vol. VII No. 5 (October, 1993). Pp. 292-299.

- If staff are knowledgeable regarding what, when and to whom to report according to the facility policies.

o Interview at least three front line supervisors of staff who interact with residents (Nursing, Dietary, Housekeeping, Activities, Social Services). Determine how they monitor the provision of care/services, the staff/resident interactions, deployment of staff to meet the residents' needs, and the potential for staff burnout which could lead to resident abuse.

o Obtain a list of all employees hired within the previous four months, and select 5 from this list. Ask the facility to provide written evidence that the facility conducted pre-screening based on the regulatory requirements at 42 CFR 483.13(c).

Task 6 Determination of Compliance:

Take account of all the information gained during this review as well as all other information gained during the survey. When a deficiency exists, determine if F225 or F226 provides the best regulatory support for the deficiency.

o 483.13(c), F226, Staff Treatment of Residents:

- The facility is compliant with this requirement if they have developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. If not, cite at F226.

o 483.13(c)(1)(2)(3)and (4), F225, Staff Treatment of Residents:

- The facility is compliant with this requirement if they took appropriate actions in the areas of screening, reporting, protecting, investigating and taking appropriate corrective actions. If not, cite at F225.