SB

342

SFIN

FILE

SENATE FINANCE COMMITTEE REPORT

DATE: 3/13/02

REPORTED OUT
MAR 25 2002
SENATE FINANCE COMMITTEE

FURTHER:

DATE TURNED IN TO OFFICE: 25 March 2002

Finance Committee considered SENATE BILL NO. 342

"An Act relating to the long term care ombudsman."

and recommends:

[ ] be **replaced** with____ **CS** _____ (_____)

[✓] adopt **previous** ____ **CS** SB 342 (HES)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Zero	FN#
Admin.	3/4/02		✓	#1

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
Lyda Green	✓			
Ellen Custer	✓			
Donald C. Olson			✓	
Gary Wilken	✓			
Loren D. Leman	✓			
	✓			
COCHAIR: Gene Therriault			✓	
COCHAIR: Pete Kelly	✓			

FISCAL NOTE

STATE OF ALASKA
2002 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 342
(S) Publish Date: 3/13/02

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act Relating to the Long Term Care Ombudsman
BRU: Central Administrative Services
Component: Protection,Community Services Administration
Sponsor: (S) HES
Requester: (S) HES
Component No.: 2083

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2002) cost:
Check this box (X) if funding for this bill is included in the Governor's FY 2003 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill will have no significant fiscal impact on the Department.

Prepared by: Dwight Becker, Program Coordinator
Phone 907-269-3674
Division: Senior Services
Date/Time 3/4/02 12:10 PM
Approved by: Jim Duncan, Commissioner
Date 3/4/2002
Agency: Department of Administration

(Revised 9/2001 OMB)

COMMITTEE COP

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SENATOR LYDA GREEN
SENATE DISTRICT N

Sponsor Statement
CS Senate Bill 342

Long-Term Care Ombudsman

The each state is required to have a long term care ombudsman under the Older Americans Act. Alaska's long term care ombudsman is located in the Alaska Mental Health Trust Authority. Recently, the long term care ombudsman resigned, citing frustration with Alaska's statutes as one of the reasons for leaving.

Discussion with the executive director of the Alaska Mental Health Trust led to the filing of Senate Bill 342 which brings Alaska's statutes in line with the federal law.

Specifically, SB 342:

- directs the long term care ombudsman to visit long term care facilities and identify problems rather than assuming the more passive role of only responding to complaints;
- provides that no long term care facility may deny immediate access to an employee or volunteer from the long term care ombudsman's office who is responding to a complaint;
- give the long term care ombudsman an active role in developing and providing technical support to volunteer organizations which are interested in the health, safety, welfare and rights of older Alaskans

The long term care ombudsman's role is critical in protecting the health and safety of our most vulnerable older Alaskans. It is essential that we provide the office with the tools necessary to do this job.

Sec. 3058g. - State Long-Term Care Ombudsman program

(a) Establishment

(1) In general

In order to be eligible to receive an allotment under section 3058b of this title from funds appropriated under section 3058a(a) of this title, a State agency shall, in accordance with this section -

(A)

establish and operate an Office of the State Long-Term Care Ombudsman; and

(B)

carry out through the Office a State Long-Term Care Ombudsman program.

(2) Ombudsman

The Office shall be headed by an individual, to be known as the State Long-Term Care Ombudsman, who shall be selected from among individuals with expertise and experience in the fields of long-term care and advocacy.

(3) Functions

The Ombudsman shall serve on a full-time basis, and shall, personally or through representatives of the Office -

(A)

identify, investigate, and resolve complaints that -

(i)

are made by, or on behalf of, residents; and

(ii)

relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees), of -

(I)

providers, or representatives of providers, of long-term care services;

(II)

public agencies; or

(III)

health and social service agencies;

(B)

provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents;

(C)

inform the residents about means of obtaining services provided by providers or agencies described in subparagraph (A)(ii) or services described in subparagraph (B);

(D)

ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;

(E)

represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(F)

provide administrative and technical assistance to entities designated under paragraph (5) to assist the entities in participating in the program;

(G)

(i)

analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;

(ii)

recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and

(iii)

facilitate public comment on the laws, regulations, policies, and actions;

(II)

(i)

provide for training representatives of the Office;

(ii)

promote the development of citizen organizations, to participate in the program; and

(iii)

provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and

(I)

carry out such other activities as the Assistant Secretary determines to be appropriate.

(4) Contracts and arrangements

(A) In general

Except as provided in subparagraph (B), the State agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) Licensing and certification organizations; associations

The State agency may not enter into the contract or other arrangement described in subparagraph (A) with -

(i)

an agency or organization that is responsible for licensing or certifying long-term care services in the State; or

(ii)

an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.

(5) Designation of local Ombudsman entities and representatives

(A) Designation

In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity, and may designate an employee

or volunteer to represent the entity.

(B) Duties

An individual so designated shall, in accordance with the policies and procedures established by the Office and the State agency -

(i)

provide services to protect the health. safety, welfare [1] So in original. Probably should be followed by a comma.

(ii)

ensure that residents in the service area of the entity have regular, timely access to representatives of the program and timely responses to complaints and requests for assistance;

(iii)

identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;

(iv)

represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(v)

(I)

review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(II)

facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(vi)

support the development of resident and family councils; and

(vii)

carry out other activities that the Ombudsman determines to be appropriate.

(C) Eligibility for designation

Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall -

(i)

have demonstrated capability to carry out the responsibilities of the Office;

(ii)

be free of conflicts of interest;

(iii)

in the case of the entities, be public or nonprofit private entities; and

(iv)

meet such additional requirements as the Ombudsman may specify.

(D) Policies and procedures

(i) In general

The State agency shall establish, in accordance with the Office, policies and procedures for monitoring local Ombudsman entities designated to carry out the duties of the Office.

(ii) Policies

In a case in which the entities are grantees, or the representatives are employees, of area agencies on aging, the State agency shall develop the policies in consultation with the area agencies on aging. The policies shall provide for participation and comment by the agencies and for resolution of concerns with respect to case activity.

(iii) Confidentiality and disclosure

The State agency shall develop the policies and procedures in accordance with all provisions of this part regarding confidentiality and conflict of interest.

(b) Procedures for access

(1) In general

The State shall ensure that representatives of the Office shall have -

(A)

access to long-term care facilities and residents;

(B)

(i)

appropriate access to review the medical and social records of a resident, if -

(I)

the representative has the permission of the resident, or the legal representative of the resident; or

(II)

the resident is unable to consent to the review and has no legal representative; or

(ii)

access to the records as is necessary to investigate a complaint if -

(I)

a legal guardian of the resident refuses to give the permission;

(II)

a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(III)

the representative obtains the approval of the Ombudsman;

(C)

access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities; and

(D)

access to and, on request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

(2) Procedures

The State agency shall establish procedures to ensure the access described in paragraph (1).

(c) Reporting system

The State agency shall establish a statewide uniform reporting system to -

(1)

collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and

(2)

submit the data, on a regular basis, to -

(A)

the agency of the State responsible for licensing or certifying long-term care facilities in the State;

(B)

other State and Federal entities that the Ombudsman determines to be appropriate;

(C)

the Assistant Secretary; and

(D)

the National Ombudsman Resource Center established in section 3012(a)(21) of this title.

(d) Disclosure

(1) In general

The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c) of this section.

(2) Identity of complainant or resident

The procedures described in paragraph (1) shall -

(A)

provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B)

prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless -

(i)

the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii)

(I)

the complainant or resident gives consent orally; and

(II)

the consent is documented contemporaneously in a writing made by a representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii)

the disclosure is required by court order.

(e) Consultation

In planning and operating the program, the State agency shall consider the views of area agencies on aging, older individuals, and providers of long-term care.

(f) Conflict of interest

The State agency shall -

(1)

ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5) of this section, is subject to a conflict of interest;

(2)

ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3)

ensure that the Ombudsman -

(A)

does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B)

does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C)

is not employed by, or participating in the management of, a long-term care facility; and

(D)

does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4)

establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as -

(A)

the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B)

the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

(g) Legal counsel

The State agency shall ensure that -

(1)

(A)

adequate legal counsel is available, and is able, without conflict of interest, to -

(i)

provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and

(ii)

assist the Ombudsman and representatives of the Office in the performance of the official duties of the Ombudsman and representatives; and

(B)

legal representation is provided to any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and

(2)

the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.

(h) Administration

The State agency shall require the Office to -

(1)

prepare an annual report -

(A)

describing the activities carried out by the Office in the year for which the report is prepared;

(B)

containing and analyzing the data collected under subsection (c) of this section;

(C)

evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(D)

containing recommendations for -

(i)

improving quality of the care and life of the residents; and

(ii)

protecting the health, safety, welfare, and rights of the residents;

(E)

(i)

analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and

(ii)

identifying barriers that prevent the optimal operation of the program; and

(F)

providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;

(2)

analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3)

(A)

provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding -

(i)

the problems and concerns of older individuals residing in long-term care facilities; and

(ii)

recommendations related to the problems and concerns; and

(B)

make available to the public, and submit to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities,

and other appropriate governmental entities, each report prepared under paragraph (1);

(4)

(A)

not later than 1 year after September 30, 1992, establish procedures for the training of the representatives of the Office, including unpaid volunteers, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs, in consultation with representatives of citizen groups, long-term care providers, and the Office, that -

(i)

specify a minimum number of hours of initial training;

(ii)

specify the content of the training, including training relating to -

(I)

Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State;

(II)

investigative techniques; and

(III)

such other matters as the State determines to be appropriate; and

(iii)

specify an annual number of hours of in-service training for all designated representatives; and

(B)

require implementation of the procedures not later than 21 months after September 30, 1992;

(5)

prohibit any representative of the Office (other than the Ombudsman) from carrying out any activity described in subparagraphs (A) through (G) of subsection (a)(3) of this section unless the representative -

(A)

has received the training required under paragraph (4); and

(B)

has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(6)

coordinate ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses established under -

(A)

part A of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.); and

(B)

the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.);

(7)

coordinate, to the greatest extent possible, ombudsman services with legal assistance provided under section 3026(a)(2)(C) of this title, through adoption of memoranda of understanding and other means; and

(8)

permit any local Ombudsman entity to carry out the responsibilities described in paragraph (1), (2), (3), (6), or (7).

(i) Liability

The State shall ensure that no representative of the Office will be liable under State law for the good faith performance of official duties.

(j) Noninterference

The State shall -

(1)

ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful;

(2)

prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office; and

(3)

provide for appropriate sanctions with respect to the interference, retaliation, and reprisals

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[1] and rights of residents;

Prev | Next

The TRUST

The Alaska Mental Health Trust Authority

March 5, 2002

Senator Lyda Green
Chair
Senate Health, Education and Social Services Committee
State Capital
Juneau, Alaska 99811

Dear Senator Green,

I have reviewed the comments submitted by the Alaska State Hospital and Nursing Home Association (ASHNHA) dated March 5, 2002 concerning SB 342. Unfortunately these comments contain a number of serious factual errors.

The ASHNHA comments state that current Alaska law is consistent with 42 USC 42.3058G which requires that the "Ombudsman shall...personally or through representatives of the office- (A) identify, investigate, and resolve complaints that are made by, or on behalf of residents;". AS 47.62.015(a) currently provides that "(T)he ombudsman shall investigate and resolve a complaint made by or on behalf of and older Alaskan who resides in a long term care facility in the state...". Clearly, contrary to ASHNHA's assertion, current Alaska law does **not** specify that the Ombudsman or a representative shall "identify" complaints as required by federal law. This is the very issue placed in dispute by some assisted living care providers, and reflected in ASHNHA's comments, where they contend that the Ombudsman or representative should only have access to a home or resident if a complaint has already been received by the office. Such a restriction would certainly not serve to protect this extremely vulnerable population many of whom are physically and/or mentally unable to lodge such a complaint even assuming they are cognitively aware of problems involving their care.

The ASHNHA comments also state that "It is not in the (federal) law that the ombudsman shall visit the residents, the resident's representatives, and others to identify complaints". In fact, 42 USC 3058g (D) states that the Ombudsman or a representative shall "ensure that the residents have **regular and timely access** to the services provided through the Office ..." (emphasis added) As discussed above, one of the core services of the Ombudsman is the identification of complaints. There is no way that the Office can meet this mandate without having access to the facilities where the residents live. Further, the ASHNHA comments allege that such access "would direct the ombudsman to come into any facility and "search" for possible problems. The term "search" is not contained in SB 342 and is not contemplated in federal law or by SB 342.

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ASHNHA also objects to Section 3 (f) of the bill providing for "technical support for the development of resident councils and family councils whose members are interested in protecting the well-being and rights of or the residents of long term care facilities in the state" as it "goes beyond the federal law, is not needed by residents in Alaska nursing homes and should not be a requirement". Again, contrary to this assertion, 42 USC 3058 (H) (iii) states that the Ombudsman or a representative shall "provide technical support for the development of resident and family councils to protect the well-being and rights of the residents". ASHNHA's presumptuous belief that such council's are "not needed by residents" is a strong argument in favor of their creation and support.

ASHNHA's remaining concerns regarding Section 3 (g) and Section 4 of SB 342 involve the use of volunteers to fulfill the duties of the office. The federal law repeatedly and consistently refers to the duties of the office being carried out by the "Ombudsman or through representatives" (see above) In 42 USC 3058 (f) the term "representative" is defined as "an employee or volunteer ...who is individually designated by the Ombudsman".

Despite the invalidity of these arguments in opposition to SB 342, we are cognizant of and sensitive to the concerns that exist relating to the prior operation of the office and its volunteers. We will work closely with ASHNHA and its members as well as other providers, residents and family members to ensure that the volunteer program is properly run and contributes to the improvement of care for Alaska's elders instead of being an adversarial and time consuming burden to care providers already beset by many obstacles that stand in their way of providing the very highest level of care possible. In addition, we will be held accountable for the actions of the office and will provide procedures whereby aggrieved providers can complain to the Ombudsman, myself, the Trustees of the Trust Authority and ultimately to the legislature to see that the office and its representatives act appropriately and in the best interests of the residents of Alaska's long term care facilities.

Sincerely,

Jeffrey L. Jessee
Executive Director

Alaska State Hospital & Nursing Home Association

We're helping people care for people!

March 5, 2002

Senator Lyda Green
Chair
Senate Health Education and Social Services Committee
State Capitol
Juneau, AK 99811

Dear Senator Green:

I am writing in opposition to SB 342, "An Act relating to the long term care ombudsman." It was stated in the first hearing of the committee that this proposed legislation was to bring Alaska Statutes in line with federal code. I have searched Sec. 3058g, the State Long-Term Care Ombudsman program, and cannot find several of the additions.

In regard to Section 1: Under Federal law 3058.g it allows the Ombudsman to "identify, investigate, and resolve complaints that are made by, or on behalf of residents..." The current Alaska Law is consistent with this federal law. The proposed amendments appear to create a higher standard than the Federal Law. It is not in law that the ombudsman shall visit the residents, the residents' representatives, and others in order to identify complaints. This would direct the ombudsman to come into any facility and "search" for possible problems. We have no problem with access once the complaint has been made. There has not been a demonstrated need for this higher standard and the additional resources it will cause.

Section 2: No objections.

Section 3: (d) No objections.
(e) No objections.
(f) This goes beyond the federal law, is not needed by residents in Alaska nursing homes and should not be a requirement.
(g) I cannot find (1) and (2) in the federal code where it allows volunteers to have these duties.

Section 4: The federal code 483.10 (j) (1) and (2) allows immediate access to the Long Term Care Ombudsman who is investigating a complaint but not for volunteers. It is not appropriate for volunteers to have immediate access.

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Phone: 907-586-1790 • Fax: 907-463-3573 • Web: ashnha.com

I am attaching a list of specific concerns from one of ASHNHA's members that addresses some of the issues with this legislation.

If you have questions, please contact me.

Sincerely yours.

Laraine

Laraine L. Derr
President/CEO

Attachment

According to an ASHNHA long term care facility administrator:

I am opposed to the amendments of SB 342. I am not aware of any unresolved complaints in Alaska nursing homes. These amendments will create a very time consuming process for staff, will pull staff away from patient care and could become quite negative when ombudsman and volunteers are identifying complaints on all visits. It could also create staff turnover as employees really do not like working in a job where they are frequently being watched over there shoulder and seconded guessed about the judgements they make. All facilities attempt to create a positive atmosphere and not one that is always looking for the negative. This bill will cause more problems (less care) than it solves. The past State ombudsman stated that the job is too difficult. This bill would make it much more difficult and potentially much more adversarial with facilities.

I believe the State current adequately allocates scarce resources to the complaint investigation process and that there are no significant problems in nursing homes that require this negativity. It is part of the State and Federal Surveyors job to identify complaints. In Anchorage both facilities are surveyed twice a year by State and/or Federal Surveyors and the rest of Alaska is approximately once a year. As you are aware each survey involves approximately 6-8 surveyors for one week closely reviewing all aspects of quality of care and quality of life. In addition, one Anchorage nursing home had 7 complaint investigations by State Surveyors last year and each time was found to be in compliance with all regulations. In the past 6 years, as an administrator, I can only remember 3 complaint investigations by the ombudsman and 1 of these resulted in a follow up deficiency from the State Surveyors. All 3 of these issues were complex issues that the facility was closely monitoring and attempting to resolve. The most effective role of the ombudsman has occurred when they act as an intermediary trying to solve the unresolved complaint by helping both parties see the problem from the other's perspective and trying to work through it. The likelihood of this occurring is reduced if the focus is shifted to identifying complaints. We are also required to provide and explain all resident rights to the residents which includes the right to have complaints followed up on by the facility and how to contact the ombudsman and other state officials. We are also required to post the rights, the ombudsman phone and address, and Survey results in conspicuous locations in the building. We must also provide a qualified social worker who is trained and required to assist residents in these and other types of matters. Volunteer Ombudsman and possibly even the Ombudsman and Assistant Ombudsman will not have this level of training nor the day to day experience of providing nursing home care. All staff are also required to report within 24 hours to Licensing and Certification if they have reasonable cause to believe that a resident has incurred an injury of an unknown source, willful or reckless nonaccidental physical harm or mental distress including humiliation, harassment, threats of punishment, etc and any misappropriation of resident property. I am sure that there are other safeguards that directly apply to this issue that we must meet and that I am not thinking of. I believe the current safeguards are working effectively as I have never seen any information that there are any significant levels of unresolved complaints in any nursing home in the state.

State resources are limited and I believe there should be an appropriate division of labor between the survey agency and the ombudsman office. Also, this will take time away from patient care within the facilities. We need to use scarce resources where they are most needed and there has not been a demonstrated need to identify complaints in Alaska's nursing homes.

Presented by Carl Garber
Providence Health Care
Mary Conrad Center

Congress looks into abuse at nursing homes

■ **VULNERABLE:** Lawmaker says criminal actions in care facilities go unreported.

Knight Ridder Newspapers

WASHINGTON -- A 66-year-old dementia patient knocked 83-year-old Helen Straukamp unconscious by slamming her against a wall in their Evansville, Ind., nursing home. No one called the police. No one told the hospital treating her that she was the victim of an attack. Three weeks later, in October 1999, she died.

A nursing assistant in Orlando, Fla., was charged with rape last year after DNA tests identified him as the father of a child delivered by a 37-year-old stroke victim who was paralyzed, incontinent and brain-damaged.

Such cases of abuse from fellow patients and caregivers have captured the attention of some members of Congress who don't believe state and federal agencies are doing enough to shield nursing home patients from physical and sexual abuse.

"There is a tendency not to report criminal activity in nursing homes," said Sen. John Breaux of Louisiana, the Democratic chairman of the Senate's Special Committee on Aging. "We made child abuse a priority. These people are more vulnerable than children."

A General Accounting Office report scheduled for release Monday that studied abuse files in Pennsylvania, Georgia and Illinois is expected to show that nursing homes in those states fail to refer complaints to proper authorities in a timely manner, damaging investigations and prosecutions.

It also will show that state agencies are more likely to recommend corrective action rather than civil penalties against nursing homes cited in abuse cases, that police agencies are not properly trained to investigate abuse against the elderly and that statistics about such crimes are practically nonexistent.

Breaux has scheduled a hearing for Monday to examine the incidence of sexual and physical abuse of nursing home residents and to hear recommendations on how to guard them.

The American Health Care Association, which represents most of the nation's skilled care facilities, said it welcomed the congressional spotlight but rejected any suggestions that abuse is on the rise.

Federally required state surveys found that for the fiscal year ending June 2001, the latest reporting period, 2.21 percent of nursing homes were cited for abuse or neglect that caused harm to a resident. The total for the same period ending the previous fiscal year was 3.18 percent. In fiscal 1999, it was 2.91 percent.

"The bad actions of 2 percent of nursing homes overshadow the good works of the hundreds of thousands of health care professionals who are providing quality compassionate care," said Alan DeFend, association spokesman.

Pennsylvania, Georgia and Illinois are among the states with the highest nursing home populations. The GAO investigation is expected to show that in half of the 111 cases reviewed, nursing homes submitted reports days or weeks after the alleged abuse had taken place, even though they are required to report within 24 hours of learning of an allegation.

Such delays, officials say, can hinder police investigations.

Recent studies found that nursing home officials often are skeptical that abuse has occurred or that residents fear retribution if they report an assault. Police officers and state health officials in the three states also told GAO investigators that nursing homes fear bad publicity or state sanctions if they report abuse.

In Straukamp's case, emergency room doctors were not told about the assault.

"They were told it was a fall," said Straukamp's daughter-in-law, Barbara Becker.

Four months later, after Straukamp's family pressed for answers, state health officials fined the nursing home for a series of "serious deficiencies."

But GAO investigators determined that when state agencies find nursing homes responsible for incidents of abuse, officials seldom fine them. Of the 158 case files reviewed in the three states, 26 nursing homes were found to have deficiencies that contributed to the abuse. Only one was ordered to pay a fine.

State officials and nursing home operators maintain that fines can put homes out of business, leaving residents and their families scrambling for new accommodations. They say it is preferable to force homes to fix conditions that contributed to the abuse.

"Every time you take resources that would otherwise be used for patient care, you should take a good, hard look at that," DeFend said

Though the federal government prohibits nursing homes from hiring staff members who have been convicted of abusing elderly patients, it does not forbid them from hiring people who have committed other violent crimes, such as child abuse.

It also does not require nursing home employees to undergo criminal background checks.

Some states have taken steps to speed reporting and prosecutions. In Arkansas, coroners or medical examiners have been required since 1999 to investigate every nursing home death.

In 2000, Mark Malcolm, the coroner in Little Rock, referred 21 deaths for further investigation. Last year, he referred 13.

"I will say this, the level of care in nursing homes in this county today is better than it was July 1, 1999," he said.