Long-Term Care Workers and Abuse of the Elderly
Hearing of the U.S. Senate Special Committee on Aging
Testimony of Beverley Laubert, President
National Association of State Long-Term Care Ombudsman Programs
July 18, 2007

Thank you for the opportunity to talk with you about the problem of abuse and neglect in long-term care facilities. Calling abuse and neglect a "problem" sounds trivial and is better identified as a horrific problem, a tragedy, or a crisis, which is an embarrassment to our country. Every day of my twenty years as a long-term care ombudsman I have been touched by the bravery of residents and family members who entrust their care to strangers.

Chairman Kohl, the National Association of State Long-Term Care Ombudsman Programs appreciates your years of support of our important work advocating for residents who are often otherwise without a voice. Your leadership and the leadership of George Potaracke, the Wisconsin State Ombudsman, give us hope. Mandated by the Older Americans Act, every state has an Office of the State Long-Term Care Ombudsman. Our network of 1,278 paid staff and nearly 9,200 volunteer ombudsmen seek resolution of problems and advocate for the rights of residents of long-term care facilities with the goal of enhancing quality of life and quality of care.

Tens of thousands of long-term care professionals and paraprofessionals provide loving, compassionate, and competent care to our nation's older and disabled

citizens. But today I want to tell you about conditions that can and must be changed. Someday, with your help perhaps, we can say with confidence that all of our nation's older and disabled citizens are receiving the care they deserve where they choose to receive it. In the meantime, however, in a few minutes I will introduce you to Anna's story which provides evidence that we aren't there yet.

In Federal Fiscal Year 2005, ombudsmen received 20,622 complaints of abuse, neglect, and exploitation. Those are just the complaints in which someone used the words. However, we collect data on many other types of complaints that might not be called abuse but result from abusive or neglectful behavior. For example, nationwide we received 91,974 complaints related to resident care. Detailed data is attached to the end of my remarks.

I applaud the introduction of the Patient Safety and Abuse Prevention Act of 2007 (S. 1577). The bill would build upon the work demonstrated by pilot states and others that have developed systems to check criminal records of caregivers. My interactions with colleagues around the country have found that although most states do some type of screening at the time of employment of long-term care facility staff, the methods are inconsistent and gaps have been identified.

Mr. Chairman, we thank you for your steadfast pursuit of this critical area for insuring quality care. The pilot program that you helped to secure in the MMA has led us to this important juncture where Congress should now step forward and ensure a national, consistent approach to doing background checks for all those serving vulnerable long-term care residents. The timing is also excellent because we are extremely hopeful that Congress will also address the broader elder abuse, neglect, and exploitation issues this year.

Senate Bill 1070, the Elder Justice Act, sponsored by Senators Hatch and Lincoln, is another stride along the critical path of justice for this nation's older adults. NASOP is a founding member of the Elder Justice Coalition, which has spent the last three Congresses working toward passage of the Elder Justice Act. The bill would establish a national coordinated approach to elder justice and research as well as support for building a well-trained long-term care workforce. Every provision in the ground-breaking Elder Justice Act including training for surveyors, improving ombudsman capacity and training, and funding Adult Protective Services must be passed as soon as possible. I should also mention that the original Elder Justice Act included a version of a national criminal background check program, which the Elder Justice Coalition supported, as well.

Ohio's criminal background check law has been in effect since 1997. The law requiring fingerprint background checks applies to applicants under final

consideration for employment with a direct care provider. Volunteers are exempted. Although there are five components of the definition of direct care, a key consideration is whether the employee would have opportunity be alone with older adults or have access to older adults' personal property. Fingerprints are used to check state criminal records. If the applicant has not lived in Ohio for the five years prior to application, an FBI check is done as well. At the time of enactment, a provider was permitted to conditionally employ an applicant for sixty days pending the results of the check. Due to the advocacy of family members, the conditional employment period was later changed to thirty days. The Ohio law includes personal character standards which a provider has the discretion to review in determining whether to employ or not. Some offenses such as adulteration of food, elder abuse, and sexually oriented crimes are not subject to reconsideration. In the attachments to my testimony, you will find a recommendation applicable to Ohio's law that was made by a regulatory reform committee of Ohio's Nursing Facility Reimbursement Study Committee a few years ago.

There are several areas of inconsistency among the states; therefore, an older adult cannot rely on a blanket of safety wherever he or she resides. This is important because we have worked with older adults who move from one state to another to be near family as they age. In Alaska, for example, fingerprint checks are submitted within thirty days of hire and every six years thereafter but

in most states, the background check is only done at the time of employment. Senate Bill 1577 would provide a remedy through the "rap back" provision. In Kentucky, federal records are not checked as they are in Ohio and Pennsylvania; Ohio's threshold is five years of residency and Pennsylvania's is two years of residency.

In Kansas, as in other states, the abuse registry required by federal law is checked before hiring but criminal background checks take weeks to be returned. Ohio has found that electronic fingerprinting expedites the process and the funding envisioned in Senate Bill 1577 would enable states to rise to a streamlined minimum standard.

Indiana mandates background checks for certified nursing assistants, but most states apply the law more broadly. New Jersey checks the records of staff usually considered direct care – nurse aides, nurses – but has a gap where activity aides, housekeeping, and maintenance staff fall through the net. In Missouri, staff of unlicensed assisted living facilities are not required to undergo a background check. New York does not require checks in residential facilities and North Dakota does not require checks for assisted living. Kentucky and Minnesota do not require checks of crimes committed in other states but others use the FBI check similar to Ohio's law.

Methods also differ. In Oklahoma, the background checks are not done by fingerprinting but there is an additional requirement to look for the individual's name on the sex offender and violent offender registries. In Delaware, the state takes an extra precaution in mandating drug testing for all applicants for affected positions.

The California State Ombudsman told me about an aide who was taking a resident's pain patches. The facility did the right thing and called law enforcement. Although at the time the aide did not have the patches in her possession, she was arrested on prior warrants. In Ohio, unless she had been convicted in the past, she would be able to work in long-term care. If arrest records were checked, providers would have information leading to additional precautions such as more direct supervision.

The experiences of the Long-term Care Ombudsman Programs around the country tell us that it is time to establish a nationwide system to improve the effectiveness of screening. As written, the proposed federal law would address the problem of caregivers moving from state to state, thereby avoiding effective scrutiny. Unsupervised volunteers having similar duties as direct care staff involving one-on-one contact with residents would be included in screening requirements.

To personalize the issue of abuse and neglect is heart-wrenching. I keep a folder in my office labeled "reminders" and every now and then I open that folder and bolster my resolve to help residents and to be their voice to people like you who have the power to truly make a difference. Now I will tell you about Anna.

> Anna was admitted to a nursing home six years ago. When she was admitted, she had mild dementia but could communicate many of her needs and could walk on her own. In fact, she loved to walk and was traveling the halls of the facility whenever she could. The family felt Anna was getting good care because the home invited her to activities and took her to get her hair done. But that didn't last for long.
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> As Anna declined, so did her quality of life and the quality of care provided. Anna was put on multiple medications that kept her "doped up." Due to those medications, Anna was not able to walk on her own safely so she was tied to a wheelchair and forced to sit up all day. As a result, Anna developed pressure sores.
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> Anna was taken to the dining room for meals but was seated at a table alone. Everyone received their meal tray at the same time but there wasn't enough staff to assist everyone so Anna's meal often sat for long periods of time until staff was available to feed her. By that time, the meal was unappetizing and Anna didn't want to eat. As a result, she rapidly lost weight.
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> When Anna lost her ability to walk, the staff stopped taking her to the bathroom and she was forced to wear incontinence briefs. When family visited, they could smell the urine and feces that Anna was forced to endure. This also contributed to pressure sores.
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> The care continued to decline until the pictures at the end of my testimony were taken shortly before Anna's death. The family felt certain that Anna had been physically abused and neglected.
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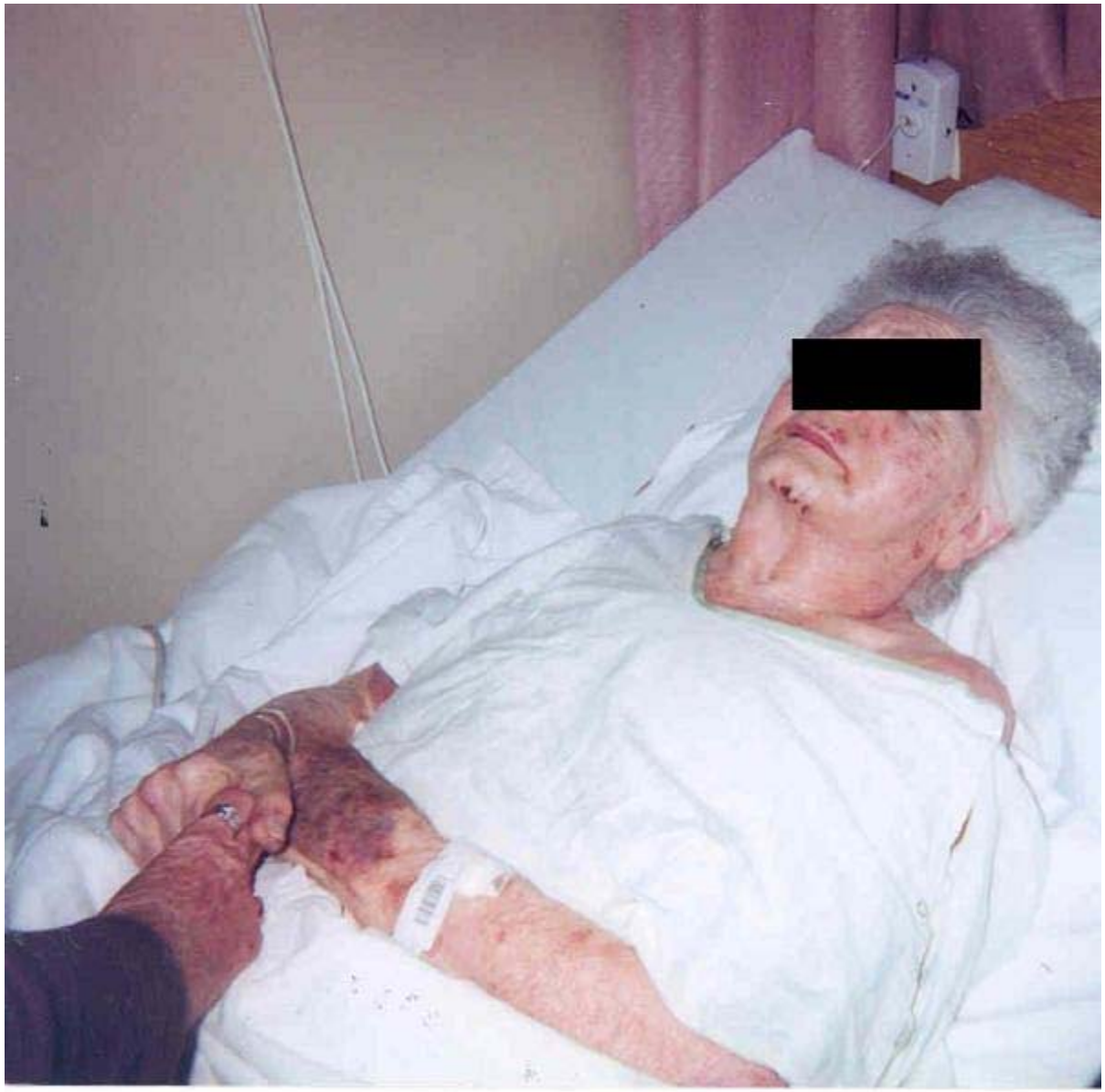
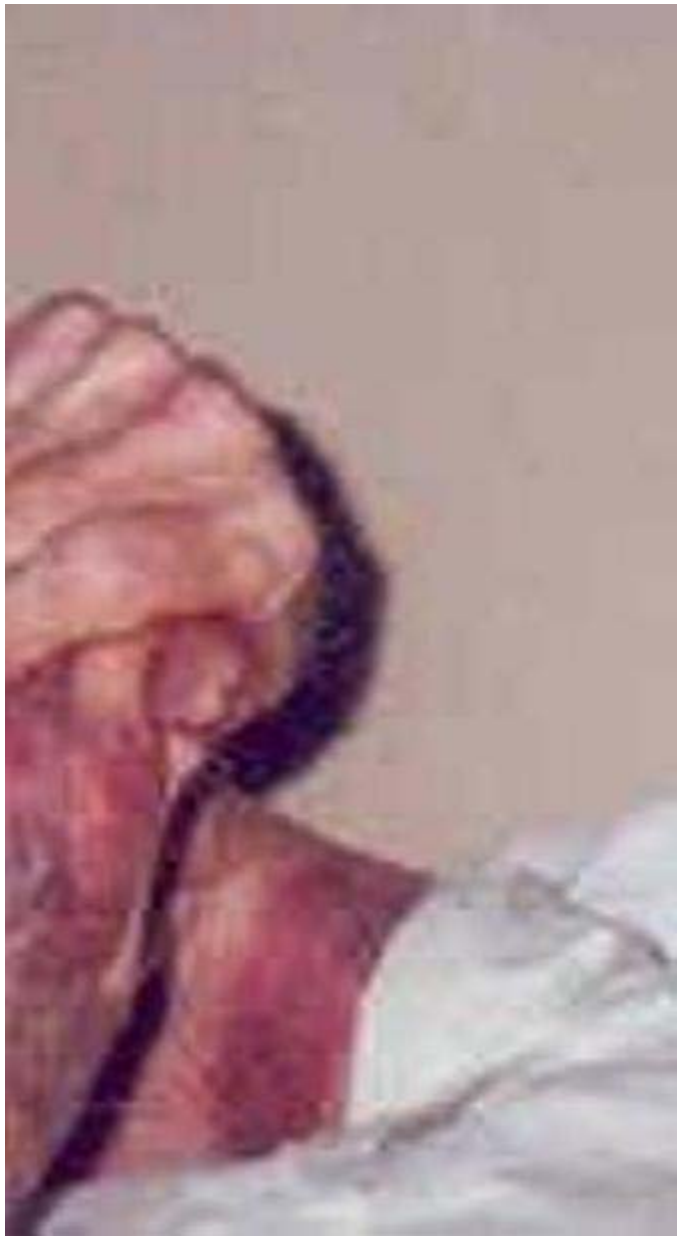
> Anna's family has since discovered that one of the aides at the facility where Anna lived for six years had a criminal record, was

addicted to drugs, and had taken Anna's credit card and charged $5000.00 at a hardware store.

As my "reminders" folder bolsters my resolve as an advocate, I hope Anna's story encourages and supports your efforts to make life better for America's older adults in long-term care.

Thank you for inviting me to speak with you today.





Supplement to Testimony of Beverley L. Laubert
Senate Special Committee on Aging
July 18, 2007
Long-Term Care Ombudsman Data from the National Ombudsman Reporting System 2005

Complaint type National Total 306,867 (includes all provider types)	**Nursing Home 241,684**	**Board & Care 61,646**	**Total Facility-Based 303,330**	**Common Outcomes/Risks**
ABUSE, GROSS NEGLECT, EXPLOITATION	*15,814*	*4,808*	*20,622*	*Injury, pain, fear, decline, loss, depression, withdrawal*
Physical abuse	4,137	1,132	5,269	
Sexual abuse	868	294	1,162	
Verbal/mental abuse	3,056	1,014	4,070	*Fear of retaliation resulting in under-reporting*
Financial exploitation	1,011	512	1,523	
Gross neglect	2,399	761	3,160	
Resident to resident abuse	3,372	906	3,561	
Other abuse	971	189	1,160	
AUTONOMY, CHOICE, EXERCISE OF RIGHTS, PRIVACY	*24,072*	*6,401*	*30,473*	*Fear of retaliation resulting in under-reporting*
Confinement in facility against will (illegally)	1,423	439	1,862	Inability to obtain better care
Dignity, respect, staff attitudes	9,062	1,962	11,024	Verbal abuse, fear, lack of self-determination
Response to complaints	1,562	391	1,953	Problems are perpetuated
RESIDENT CARE	*78,198*	*13,776*	*91,974*	
Accidents, improper handling	8,998	1,516	10,514	Injury, loss of function, decline
Call lights, requests for assistance	14,391	1,184	15,575	Unmet needs often resulting in injury, decline, loss of function
Care plan/resident assessment	8,944	1,585	10,529	Unmet needs, negative outcomes
Contracture	177	23	200	Result of neglect
Medication administration/organ.	7,735	2,955	10,690	Pain

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Personal hygiene	7,554	1,357	8,911	Odors, pressure sores
Pressure sores	2,179	293	2,472	Neglect – almost entirely preventable
Symptoms unattended, no notice to others of change in condition (includes not contacting physician)	5,760	873	6,633	Neglect resulting in harm
Toileting	4,095	474	4,569	Incontinence often resulting in loss of mobility, pressures sores
Tubes – neglect of catheter, NG tube	980	88	1,068	Neglect resulting in infection, weight loss, decline
REHABILITATION OR MAINTENANCE OF FUNCTION	*9,110*	*1,263*	*10,373*	*Physical & psychological decline*
Bowel and bladder training	155	21	176	Incontinence often resulting in loss of mobility, pressures sores
Mental health/psychosocial services	982	316	1,298	Distress, anxiety, pain
Range of motion/ambulation	1,060	81	1,141	Loss of mobility/independence often resulting in incontinence, pressure sores, depression
RESTRAINTS – CHEMICAL & PHYSICAL	*1,247*	*506*	*1,753*	Loss of mobility/independence often resulting in incontinence, pressure sores, depression
QUALITY OF LIFE (i.e. Activities, Social Services, Dietary))	*60,936*	*15,607*	*76,543*	*Distress, anxiety, depression, weight loss, withdrawal*
DIETARY (i.e. Assistance Eating, Fluid Availability, Menu, Weight Loss)	*21,903*	*5,866*	*27,769*	*Neglect resulting in dehydration, weight loss*
ADMINISTRATION	*21,149*	*6,949*	*28,098*	*Inadequate prevention resulting in abuse*
Abuse investigation, reporting	1,316	335	1,651	Perpetrators harm additional victims
STAFFING	*16,793*	*4,320*	*21,113*	*Insufficient quantity and/or quality resulting in any or all of the above*

Source: Administration on Aging