

# **CROOKS CARING FOR SENIORS: THE CASE FOR CRIMINAL BACKGROUND CHECKS**

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## **HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED FIFTH CONGRESS**

**SECOND SESSION**

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**WASHINGTON, DC**

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**SEPTEMBER 14, 1998**

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# **CROOKS CARING FOR SENIORS: THE CASE FOR CRIMINAL BACKGROUND CHECKS**

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**MONDAY, SEPTEMBER 14, 1998**

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

The committee met, pursuant to notice, at 1:07 p.m., in room SD-628, Dirksen Senate Office Building, Hon. Charles Grassley, (chairman of the committee), presiding.

Present: Senators Grassley, Breaux, and Kohl.

## **OPENING STATEMENT OF SENATOR CHARLES GRASSLEY, CHAIRMAN**

The CHAIRMAN. I am Senator Chuck Grassley, Chairman of the Aging Committee, and I am joined by Senator John Breaux, who is the ranking Democrat and who has always been very supportive and very involved with the work of this committee, and so, I welcome him, as he is always very regular in attending. We also have other members who will be in and out, and we will give them a chance to make some opening comments and ask questions as well. Also, I am very glad to have Senator Kohl here, who is going to speak shortly as well, because he is very instrumental in this hearing being held and in this bill—or this subject, not bill—this subject that is before the committee.

So, I want to call the hearing to order. This hearing today is on the oversight of the quality of care in nursing homes. Our focus today is on convicted criminals who get jobs in nursing homes and then prey on vulnerable seniors there. It is not an enjoyable subject to talk about, and it is not even enjoyable to think about, but it is our duty to get to the bottom of it.

In all my years of meeting Iowans, I have never met anyone who has said I am just dying to get into a nursing home. That does not mean that nursing homes are places that you have to fear, but people obviously, in America, enjoy the quality of life that you have had throughout your lifetime of being in a home, and so, it is not unusual for people to not want to make that move.

But nursing homes, as a matter of fact, are a part of the continuum of care, one that we must turn to when we need more care than we can receive in our homes or through ancillary services like family caregiving and like home health care. By definition, seniors who end up in nursing homes are more likely to be vulnerable; more likely to be frail and possibly more isolated than other seniors. That is why these seniors need all of us, whether it is in Congress, or whether it is every relative and friend has an opportunity



to be concerned about who is in nursing homes if we are going to have an adequate oversight of the quality of life that they have in the nursing home. So, we all need to be looking out for these people.

In late July, this committee held two revealing days of hearings on the problem of malnutrition in nursing homes. What we learned made all of the members of the committee very uneasy. In a number of nursing homes, residents were failing to receive food and water necessary for life and were suffering terribly as a result. Some of the stories we heard were simply tragic, and the problem to be overcome does not take the advice and the study of some rocket scientist. It is just the basic necessities of life: food, water and to be turned frequently as a very minimum.

So, who is to blame? Well, we found plenty of blame to go around. HCFA's oversight of nursing homes has been far from adequate, as the President acknowledged by announcing a series of regulatory changes and initiatives in July. Of course, facilities that fail to care for the residents while getting paid to do so obviously have to be held accountable, particularly to the extent to which there are just billions and billions of dollars of Medicaid money involved; One of the root causes of the malnutrition problem, we learned, is inadequate staffing levels in these facilities. Often, these low staffing levels result from problems finding nurses aides at wages that nursing homes pay. This is an era of extremely low unemployment, like, for instance, in my State of Iowa, where the unemployment rate is below 3 percent. So, when there is a labor shortage, employers may not be selective in their hiring practice, and that is even going to exacerbate, to a greater extent, the problem that we are examining this very day.

Clearly, there are places where convicted criminals who have paid their debt to society should be able to work. After all, if these people cannot find work, they will not be able to contribute as productive members of society, which is our hope once they are released from incarceration. But if the crime was one of violence or deception, my view is that nursing homes are not one of the places that these criminals should work. If anyone doubts that statement, I believe our first witness today, who has a horrific tale of abuse by an ex-con nursing home employee, will persuade all of us otherwise.

Our first panel will highlight the problems and the potential risk for our seniors. The second panel will focus on one proposed approach to it, and that is a national system of background checks. A number of states have instituted their own background check systems with mixed results. One of my constituents, Kim Schmett, of the Iowa Department of Inspections and Appeals, who is the director there, will fill us in on an Iowa experience.

But one limitation of a state-based system is the ability of criminals to move from state to state one step ahead of the law, so to speak. Another key question right now is the ability of HCFA to administer a new computer background check system. Because of the agency's failure to plan adequately for the Year 2000, they have been telling us that they have very limited ability to institute any new policies that depend on computers. It will be a difficult

task for Congress to weigh the priority of the background check system against its other health care policy priorities.

While today's hearing focuses on the bad apples, let me caution us not to forget the vital work of nurse aides and other nursing home employees and everything that they do. Nurse aides provide the comfort, the care and the companionship for millions of older Americans. While we cannot tolerate abuses of this trust, we should also remember to praise the majority of nurse aides for the light that they bring to our parents and our grandparents.

I now want to turn to Senator Kohl and then Senator Breaux and say that Senator Kohl is the driving force behind this hearing. I want to thank him for his interest and involvement in the Aging Committee's efforts to protect our seniors generally but specifically today in nursing homes.

Senator Kohl.

### OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Thank you, Mr. Chairman.

I would like to thank you and Senator John Breaux for holding this hearing today. We will learn a great deal today about patient abuse, its causes and what we can do to stop it. For too many people in nursing homes, the golden years have turned into a dark nightmare. We will hear today examples of patients terrorized by the people whose job it is to care for them, and we will hear how easy it is for criminals to find work that allows them to prey upon vulnerable patients again and again.

In 1996, there were 13,469 complaints of abuse, neglect and theft in our nation's nursing homes and board and care facilities. In addition, 10 percent of nursing home staff admit committing at least one act of physical abuse, and 40 percent admit to psychological abuse. Thirty-six percent had seen at least one incident of physical abuse by other staff members.

These stats may only scratch the surface. Abuse is typically underreported, but in addition to the studies that have been done, there is no shortage of news articles on patient abuse. Last year, the Milwaukee Journal-Sentinel ran a series of articles describing how easy it is for people with abusive and criminal backgrounds to find work in health care, and similar stories have appeared nationwide.

Before continuing, it is important to acknowledge that the vast majority of health care workers are honest and professional. They work hard under stressful conditions, often for low pay and few benefits. Most care deeply about the wellbeing of their patients and treat them with the respect they deserve. We also want to note that most facilities do the best they can to ensure that they have qualified staff. They, too, want to make sure that people with abusive and criminal histories are prevented from working with vulnerable patients.

Unfortunately, as we will learn today, providers do not have the tools necessary to weed these people out, and that is where the government can step in. Current Federal and State laws are not enough to protect patients. Federal law already requires all States to keep a registry of abusive nurse aides, and 33 States have en-

acted laws that establish criminal background checks for some health care workers.

But as we will learn today, state registries are often not comprehensive or well-maintained, and more importantly, workers can evade registries or state laws by moving from state to state. A worker caught abusing patients in Illinois, for example, will have little trouble obtaining work in a nursing home in Wisconsin.

Last year, Senators Grassley, Reid and myself introduced the Patient Abuse Prevention Act, which would establish a national registry of abusive health care workers and require criminal background checks. In response to our work on nursing home issues, the administration recently announced a series of steps they will take to improve nursing home care.

As part of the administration's initiative, they recommended establishing a national registry and background check system modelled after our original bill. We have been working closely with the administration as well as industry and consumer groups to develop such legislation. This hearing will provide additional useful information as we write that bill.

The problem of patient abuse is one that can and must be solved. The strength of our nation ultimately will not be judged by how many missiles we have; it will be judged by how well we take care of the most vulnerable in our society.

Today, we have the chance to make real progress toward protecting those in nursing homes from pain and indignity. I want to thank all of you for being part of that effort, and I thank you, Mr. Chairman.

[The prepared statement of Senator Kohl follows:]

#### PREPARED STATEMENT OF SENATOR HERB KOHL

Thank you, Mr. Chairman. And I want to thank Senators Grassley and Breaux for holding this hearing. We will learn a great deal today about patient abuse, its causes, and, most importantly, what the federal government can do to stop it.

For too many people in nursing homes, the golden years have turned into a dark nightmare. We will hear today examples of patients terrorized by the people whose job is to care for them. And we will hear how easy it is for criminals to find work that allows them to prey upon vulnerable patients—again and again.

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These statistics may only scratch the surface; abuse is typically underreported. But in addition to the studies that have been done, there is no shortage of news articles on patient abuse. Last year, the *Milwaukee Journal-Sentinel* ran a series of articles describing how easy it is for people with abusive and criminal backgrounds to find work in health care, and similar stories have appeared nationwide.

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maintained. And more importantly, workers can evade registries or State laws by moving from state to state. A worker caught abusing patients in Illinois would have little trouble obtaining work in a nursing home in Wisconsin.

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The CHAIRMAN. Thank you, Senator Kohl.  
Senator Breaux.

### OPENING STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman and witnesses who are going to be testifying for your effort in what I consider to be a very important endeavor by this committee. This is part of a continuing effort by the Aging Committee under the chairman's leadership to really address problems that sometimes are not addressed by other committees of the Congress that have legislative jurisdiction. We seem sometimes to be concentrating so much on bills and legislation that we sometimes, I think, miss the opportunity to really look at problems, and I think that what you see with this committee, we have been focusing a great deal of our time and attention to what I think is a very noteworthy endeavor, to look at some of the most frail and vulnerable people in our society: That is why you see the work that this committee has done in the area of home health care, for instance, and the area of nursing homes and looking at the treatment of the most vulnerable among us, and today's effort is a continuation of what I think is a very important role that the Senate Aging Committee is exercising, and we will continue to do so.

I think that my colleagues have said very clearly and very properly what today's hearing is about and why it is necessary. I would say that what this hearing is not about, it is not about trying to deprive people who have had problems with being able to seek gainful employment when they have been rehabilitated and seek to find a way back into society. I think all of us believe is something that Americans should be able to do; we should encourage them to do that.

The question, I think, is more should potential employers have a complete record and background on potential employees, so that they can then make a wise and informed decision about who they are thinking about hiring? It is clear that there are some people who are more fitted to be in prison than they are to be in health care facilities, working and serving the most vulnerable among us.

But I think that the problem seems to me that States have been able to require background checks for crimes committed in their

State, but just go right across the border, as Senator Kohl has said, and they have no information. In today's mobile society that we have, it is clear that without that ability, potential employers are going to be at an extreme disadvantage in knowing who they are hiring. That is the bottom line. Legislation that we are considering corrects that problem, and we want to hear from the people today to talk about the seriousness of the problem. I would commend the Inspector General, again, for a very good report. You all have really helped in outlining the nature of the problem, and now, I think it is incumbent upon us to respond to it in a favorable and affirmative way, and we intend to do that.

Thank you, Mr. Chairman.

[The prepared statement of Senator Breaux follows along with prepared statement of Senator Harry Reid:]

#### PREPARED STATEMENT OF SENATOR JOHN BREAUX

Thank you Mr. Chairman and Senator Kohl for holding this hearing. Finding ways to protect America's most vulnerable population, the frail elderly, is undoubtedly the most important thing we do on this committee. At a hearing on nursing homes in July, we were asked to sit on our hands in an effort to empathize with nursing home residents. That simple exercise helped me to realize how helpless many of these people are. We need to ensure that those who cannot care for themselves receive the best possible care.

I want to emphasize that the vast majority of health care workers are qualified, caring individuals who are dedicated to the patients in their care. Taking care of the frail elderly is often a difficult and thankless job, but these workers take pride in what they do, and I commend their efforts. Unfortunately, even a few abusive workers can cause pain and suffering that cannot be undone.

Congress has taken some steps to ensure that nursing homes provide a safe environment for their residents. The Omnibus Budget Reconciliation Act of 1987 requires states to establish and maintain a registry of nurse aides who are unfit to provide care because abusive or criminal histories. In addition to the registries, many states require nursing homes to conduct criminal background checks on potential employees.

However, as we will hear today, further steps are needed. Despite current mandates, criminals are continuing to find employment in the long-term care industry. States with criminal background check systems are only able to conduct checks within their states. And, there are many instances in which criminals cross state lines to find employment. In answer to these problems, today we will look at a national background check system as a solution.

At today's hearing, the Department of Health and Human Services Office of Inspector General is releasing a report entitled "Safeguarding Long-Term Care Residents." The report amplifies the call to take further steps to prevent criminals from working with long-term care patients. I look forward to hearing their findings and recommendations.

There are many questions which I hope will be answered at today's hearing:

- is a national background check system feasible?
- how can we build on state systems that are currently in place?
- who will be responsible for paying for this?
- should we broaden the categories of employees included on state registries?
- should we aim these efforts at the entire health care industry?

I look forward to the testimony that we will hear today. I thank the witnesses who have come to share their stories, particularly, Mr. Richard Meyer for his willingness to share his heart-wrenching story. Mr. Chairman, some of what we will hear this afternoon will be unpleasant, but it must be heard. We can no longer pretend that the system is working. It is time to look for solutions. Thank you again Mr. Chairman and Senator Kohl for calling this important hearing.

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## PREPARED STATEMENT OF SENATOR HARRY REID

Good afternoon Mr. Chairman, members of the Committee, and distinguished panel of witnesses. I am pleased that the Committee has dedicated this hearing to the problem of patient abuse in nursing homes and the need for a national criminal background check system for long-term care workers. I would also like to thank all of the witnesses who have agreed to testify before the Committee today.

Americans over the age of 85 are the fastest growing segment of our elderly population. There are 31.6 million Americans over the age of sixty-five, and as the babyboom generation ages, that number will skyrocket. Over 43 percent of Americans will likely spend time in a nursing home. As our nation seeks ways to care for an aging population, we must establish greater protections to ensure that our seniors will receive the best care possible.

One of the most difficult times for any individual or family is when they must make the decision to rely upon the support and services of a long-term care facility. Families should not have to live with the fear that their loved one is being left in the hands of an individual with a criminal record. No one can illustrate this point more effectively than today's first witness, Richard Meyer, whose 92-year-old mother was sexually assaulted by a male certified nursing assistant who had previously been charged and convicted for sexually assaulting a young girl.

Unfortunately, the Meyer family is not the only one that has had to endure the pain and outrage associated with learning that a loved one was violated or abused by a long-term care facility worker with a criminal history. The systemic problem of nursing home abuse by workers with a violent or criminal history was brought to my attention just over a year ago. Shortly thereafter, Senators Kohl, Grassley, and I introduced legislation that would require criminal background checks for potential long-term care facility workers and would create a national registry of abusive health care workers. This past July, an amendment authorizing nursing homes and home health agencies to use the FBI criminal background check system was included in the Commerce, Justice, State Appropriations Bill. This was an important step in the right direction.

I am pleased that the White House has recently acknowledged this problem and called for tough new legislative and administration actions to improve the quality of nursing homes. These initiatives include a criminal background check requirement and the establishment of a national abuse registry that were modeled after our bill. Recently, Senator Kohl and I have been working with the Administration, the industry, and consumer groups to craft this important legislation. The information and solutions proposed by the witnesses at this hearing will serve as an important tool for completing this initiative.

I have visited numerous long-term care facilities in my home State of Nevada. During these visits, I have always been impressed by the compassion and dedication of the staff. Most nurse aides and health care workers are professional, honest, and dedicated. Unfortunately, it only takes one abusive staff member to terrorize the lives of the residents. That is why we must work to weed out the "bad apples" who do not have the best interest of the patient in mind.

Again, I thank the Chairman for convening this hearing and I look forward to hearing from this distinguished group of panelists.

Thank you.

The CHAIRMAN. Well, now, it is time to go to our panel. I am going to introduce three of the people. I am going to ask Senator Kohl to introduce his constituent. So, I am honored to have the opportunity to welcome Richard A. Meyer, from Libertyville, IL. He and his wife of 40 years have three adult children, three grandchildren.

Today, Mr. Meyer will share with us the story of his mother's tragic abuse in a nursing home when she was 92 years old. I understand that she just celebrated her 97th birthday, and, of course, we want to extend a welcome to you but also a happy birthday to her as well, and we appreciate your being here today so that we can discuss with us these difficult circumstances.

Our next hearing is going to be Thomas Roslewicz. He is deputy inspector general of the audit services at the Department of Health and Human Services. In his testimony, he will reveal key findings of the Office of Inspector General's report, Safeguarding Long Term

Care Residents, as well as related information from studies in Maryland and Illinois, and joining him is Tony Rubbo, audit manager from HHS/OIG, and now, Senator Kohl.

Senator KOHL. I am proud to introduce the woman who is going to be our second witness today. She is from Wisconsin, and her name is Claudia Stine. Claudia Stine is the director of long term care ombudsman services for the State of Wisconsin's Board on Aging and Long Term Care. In this capacity, she provides direction and supervision for the advocacy efforts of professional ombudsmen acting statewide. Ms. Stine will share her insight about patient abuse in long-term care and discuss the frequency and nature of complaints reported in Wisconsin.

We welcome you here today.

The CHAIRMAN. Thank you, Senator Kohl. Before you all start, I want to advise you that without your asking, your entire statement, which, if it is longer than 5 minutes, will be placed in the record, and we have asked you to summarize. I am not one of these chairmen who cuts you off exactly when the red light goes on, but I would like to have you finish your statement soon or your idea that you are involved in at that particular time.

Mr. Meyer.

#### **STATEMENT OF RICHARD A. MEYER, LIBERTYVILLE, IL**

Mr. MEYER. Good afternoon.

The CHAIRMAN. Mr. Meyer, you have 10 minutes, I have been informed by my staff, and you should proceed.

Mr. MEYER. Good afternoon. My name is Richard Meyer from Libertyville, IL, and I have a story to tell. First, I want to give you a little bit of a background. This is a true story, a tragic and devastating story, about a caring and loving elderly woman with a declining mental faculty who entered a local nursing home seeking compassionate care and security but within a period of 45 days was a victim of a sexual assault by a male employee of the nursing home.

I ask that you listen carefully to what I am going to tell you; keep the following perspective in mind: the nursing home industry is in this business to make a profit. Moral, competent personnel are a nursing home's most important asset. A nursing home has a moral and fiduciary responsibility to provide reasonable and compassionate care for its clients at all and any cost.

Are nursing homes and their insurance carriers just matter-of-fact accepting sexual abuse and lawsuits as a normal cost of doing business instead of addressing and correcting the problem? I have in my hand a \$20 bill, my only exhibit for this testimony. Keep this in mind. It represents the approximate cost, and it is my uneducated guess, to do a background check, which the nursing home did not do. But for the nursing home's desire to save \$20 in expenses, this incident could possibly have been avoided. Conversely, it cost the nursing home and their insurance carrier an estimated \$1,250,000 for a sexual assault claim and related legal fees that \$20 possibly would have avoided.

The next portion of my testimony relates to the victim. The victim was my 92-year-old mother. She loved her family and her home, and she enjoyed playing the piano and tending to her flowers

and vegetable garden. She was a deeply religious person and always had a smile and a kind, sweet word for everyone she met, in addition to a delightful sense of humor. God bless her. The Meyer family is truly blessed to have her as a mother, grandmother and great-grandmother.

She celebrated her 92nd birthday on January 29, 1993, and was then living an independent life in her own home. Due to her continuing diminished mental faculty, moderate dementia, and becoming increasingly unable to properly look out for her own safety, her immediate family felt it was best for her benefit and safety that she should enter a nursing home to receive the necessary 24-hour, around-the-clock care.

Mother had been found by family members outside her home several times that January in the cold weather and the snow. She was unable to find her way back into her home. Mother entered the local nursing home mid February 1993 but somewhat reluctantly. She was a private-pay; she was not on state aid. On March 29, 1993, my mother, who was unable to properly defend herself and with poor hearing, was sexually assaulted in her room approximately 7:30 a.m. by a male certified nursing assistant, an employee of the nursing home.

The sexual assault was discovered by another female employee of the nursing home upon becoming concerned that the male CNA appeared to be taking too long to get mother up and dressed and then taking her to the dining room for breakfast. God bless forever and ever that female employee who had the foresight to check up on this male employee and the tenacity to report her findings. How many other people did she save from this tragic, criminal act?

Upon discovery of the sexual assault, mother was then transported by an ambulance to a hospital 20 miles away for medical examination in the emergency room and which included a rape trauma test, a rape trauma test for a 92-year-old lady, my mother. She was returned to the nursing home in an ambulance with only a blanket wrapped around her. Yes, her clothes were kept as potential evidence.

Local police officials were notified of the sexual assault and proceeded to investigate the matter with administrative and nursing personnel at the nursing home and interrogate and investigate the alleged perpetrator of this tragic incident. Officials of the Department of Public Health of the State of Illinois involved with nursing homes were notified of the incident, and they commenced a review of the situation. I do not recall the details or the outcome of their review. The nursing home suspended the male employee pending the outcome of the reviews by the local police and the health department.

Approximately mid-June 1993, our worst fears were confirmed. DNA tests confirmed the sexual assault. The Meyer family was outraged as to why and how this could happen to such a kind, caring and loving lady, and she had only been in the nursing home approximately 45 days. We vowed to not let this tragic incident be swept into a closet, the door closed and locked forever. Let the prosecution begin! Let justice prevail!

Upon confirmation of the sexual assault, mother was then transferred to a different nursing home facility in northern Illinois mid-



July 1993. For approximately 3 years and continuing sporadically yet, mother becomes very defensive, belligerent and sometimes outright mean when nursing home personnel touch her or attempt to remove her clothes when helping her with a bath and preparing her for bed in the evening.

Could it just be, could it just be that this incident has been etched in her mind forever and ever, and it still comes back to haunt her? Mother presently resides in a fine nursing home in northern Illinois and celebrated her 97th birthday last January 29, 1998.

This next section, I want to talk a little bit about the perpetrator. The following information related to the perpetrator is based primarily on documents I had access to and read during our prosecution of this criminal act in a court of law. The male employee of the nursing home was approximately 43 years of age and was married; his primary occupations prior to being employed by the nursing home appeared to be that of truck driver and general laborer. In 1985, this man was charged and convicted of the sexual assault of a female minor child and served approximately 1 year in prison. His nature and actions were apparent, and the record was then established in the legal enforcement files of the State of Illinois and, therefore, accessible to those entitled to review it.

This man applied to and was admitted to a local community college to study for and obtain a certificate as a certified nursing assistant. A certificate as a certified nursing assistant was awarded to him in June 1992. January 14, 1993, he was hired as a certified nursing assistant at this local nursing home. This was apparently based on their normal interviewing policy and procedures and without performing a background check. His starting pay was approximately \$5 an hour.

On March 29, 1993, he sexually assaulted my mother in her room at approximately 7:30 a.m. He had only been employed by the nursing home for approximately 2½ months. The nursing home suspended the employee without pay pending the outcome of the reviews of the local police and the State of Illinois Department of Public Health. Upon confirmation of the sexual assault via DNA tests in mid-June 1993, this man was arrested and confined to the local county jail. The state's attorney for the county then commenced legal proceedings for the prosecution of this criminal act.

With overwhelming evidence against him, in late August 1993, this man, without a jury trial, voluntarily accepted a 25-year prison sentence before a judge and within a few days was sent off to prison. Several members of the Meyer family, including myself and my wife, attended the sentencing, a day we shall never forget. It is my understanding from the local county state's attorney that this man will probably be released from prison upon serving 50 percent of his sentence. That will be the year 2006.

The next section has to do with outrage, prosecution and anguish. The Meyer family was outraged. All agreed let the prosecution begin! Let justice prevail! In July 1993, a major law firm in Chicago was engaged to prosecute and handle this criminal action against the nursing home on behalf of my mother. The attorneys that accepted the case and worked on the case were as outraged

as the Meyer family. In September 1993, I was appointed mother's legal guardian of her person and her estate.

The original complaint was filed in Cook County in December 1993. The wheels of justice were in action. Meetings with our attorneys were held; depositions taken; private investigators hired; documents collected and evaluated; a video portraying a day in the life of my mother in a nursing home was prepared for use in court in case it was needed.

Expert witnesses were engaged to provide expert testimony on all issues as necessary. Mediation hearings to effect a settlement were held to no avail, and amended complaints were filed. Then, additionally, the case was then transferred to Kane County, a collar county to Cook County. Finally, a trial date was set for late April 1995. Ladies and gentlemen, 22 months have come and gone since July 1993.

The day before jury selection was to begin, the presiding judge for the trial was able to effect a \$1 million settlement on behalf of my mother. In mid-August 1995, net settlement proceeds of approximately \$585,000 were put in a trust fund for the future benefit and care of my mother. Ladies and gentlemen, 29 months have come and gone since March 29, 1993.

Additionally, in December 1996, we had to file a special final report with the Kane County trial judge who was assigned to our case to conclude the activity involving this case and the court jurisdiction.

Due process of law? Judicial process? Justice? Collectively, perhaps an oxymoron in situations such as this; or, perhaps, it was I; maybe I was just suffering from judicial process frustration and litigation withdrawal. The outrage and anguish suffered by the Meyer family during this period of time and this ordeal was enormous. We all felt the pain. Their help, the family, counsel, encouragement and support to me was immeasurable. It took me approximately one year to unwind from this ordeal. The compassion and concern of our attorneys was deeply appreciated.

The next section has to do with resolution, what can be done? What can I do? What can each of you do? What can the nursing homes and their insurance carriers do? What can the Government do? What can we all do to make a difference and protect our loved ones? Collectively, I believe that all of us together can change this tragic situation, because unless changes are made, could this situation or will this situation happen to your loved ones? Think about it, and think about the consequences.

If, and or when it happens, prosecution of the criminal act is a nightmare you have a hard time forgetting. Did it need to be done? Absolutely yes. Would I prosecute again? Absolutely yes. It is sad to say, but apparently, litigation is needed along with non-confidentiality agreements to expose the guilty parties. Let this testimony and tragic story put nursing home management and their insurance carriers on notice: clean up your act. We will no longer tolerate this abuse or, for that matter, any abuse to be inflicted on our loved ones. Where is your moral and fiduciary responsibilities?

Reality No. 1: to nursing home management and their insurance carriers, think about it: A \$20 investment for a background check

just might save you an abuse claim and related legal expenses in the amount of \$1,250,000.

Reality No. 2: \$1,250,000 will purchase a lot of background checks. Use a portion of this money to pay for moral, competent employees to care for your clients, who are our loved ones. We would all appreciate that change of attitude and vision.

Reality No. 3: to the local community colleges and to all schools of higher education that offer certified nursing assistant certificates, do a background check before awarding a certificate to an undesirable person not worthy to be designated a certified nursing assistant.

The last section, I label the crime scene revisited. On Tuesday, September 8, 1998, a delightful lady from the Senate's Aging Committee called me at work to ask if I would participate in this hearing. I agreed. She is here, and I thank you. That Tuesday night, after work, I proceeded to review past litigation documents to see what I could contribute to this hearing and the efforts of the Aging Committee. The documents that I have at home comprise two banker boxes full of documents, depositions, videos, documents, files, complaints, amended complaints; you name it, I have got it.

Well, I did not sleep well that night after looking at these documents for about 3 hours. In fact, for the next couple of nights, I did not sleep well, for I was revisiting the crime scene and reliving the 29 months of outrage and anguish that I had experienced. Yes, it was worth it.

Thanks for listening and for your attention, and God bless America.

[The prepared statement of Mr. Meyer follows:]

**TESTIMONY FOR SENATE AGING COMMITTEE HEARING**

September 14, 1998

Richard A. Meyer  
412 West Golf Road  
Libertyville, IL

**Background**

This is a true story - a tragic and devastating story about a caring and loving elderly woman, with a declining mental facility, who entered a local nursing home seeking compassionate care and security, but within a period of approximately 45 days was the victim of a sexual assault by a male employee of the nursing home.

I ask that you listen carefully to what I'm going to tell you, and keep the following perspective in mind:

- The nursing home industry is in this business to make a profit.
- Moral competent personnel are a nursing home's most important asset.
- A nursing home has a moral and fiduciary responsibility to provide reasonable and compassionate care for its clients at all and any cost.
- Are nursing homes and their insurance carriers just matter of fact accepting sexual abuse and lawsuits as a normal cost of doing business, instead of addressing and correcting the problem?

I have in my hand a \$ 20 dollar bill - my only exhibit for this testimony. It represents the approximate cost (my uneducated guess) to do a background check, which the nursing home did not do. But for the nursing home's desire to save \$ 20 in expenses, this incident could possibly have been avoided - conversely, it cost the nursing home and their insurance carrier an estimated \$ 1,250,000 for a sexual assault claim and related legal fees.

**The Victim**

The victim was my 92 year old mother - she loved her family and her home, and enjoyed playing the piano and tending to her flowers and vegetable garden - she was a deeply religious person and always had a smile and a kind sweet word for everyone she met, in addition to a delightful sense of humor. God bless her - the Meyer family is truly blessed to have her as a mother, grandmother and great grandmother.

She celebrated her 92nd birthday on January 29, 1993 and was then living an independent life in her own home. Due to her continuing diminished mental facility (moderate dementia) and becoming increasingly unable to properly look out for her own safety, her immediate family felt it was best for her benefit and safety that she should enter a nursing home to receive the necessary 24 hour round-the-clock care.

Mother had been found by family members outside her home several times that January, in the cold weather and snow - she was unable to find her way back into her home.

Mother entered the local nursing home mid February 1993, but somewhat reluctantly. She was a private pay - she was not on state aid.

On March 29, 1993, my mother, who was unable to properly defend herself and with poor hearing, was sexually assaulted in her room at approximately 7:30AM by a male Certified Nursing Assistant, an employee of the nursing home. The sexual assault was discovered by another female employee of the nursing home upon becoming concerned that the male CNA appeared to be taking too long to get mother up and dressed, and then taking her to the dining room for breakfast.

May God bless forever and ever the female employee that had the foresight to check-up on this male employee and the tenacity to report her findings. And how many other people did she save from this tragic criminal act?

Upon discovery of the sexual assault, mother was then transported by an ambulance to a hospital 20 miles away for a medical examination in the emergency room and which included rape trauma test. She was returned to the nursing home in an ambulance with only a blanket wrapped around her - yes, her clothes were kept as potential evidence.

Local police officials were notified of the sexual assault and proceeded to investigate the matter with administrative and nursing personnel at the nursing home, and interrogate and investigate the alleged perpetrator of this tragic incident.

Officials of the Department of Public Health of the State of Illinois (involved with nursing homes) were notified of the incident and they commenced a review of the situation - I don't recall the details of or outcome of their review. The nursing home suspended the male employee pending the outcome of the reviews by local police and the Health Department.

Approximately mid June 1993 our worst fears were confirmed - DNA tests confirmed the sexual assault. The Meyer family was outraged as to why and how this could happen to such a kind, caring and loving lady - and she had only been in the nursing home approximately 45 days. We vowed to not let this tragic incident be swept into a closet, and the door closed and locked forever - let the prosecution begin, let justice prevail.

Upon confirmation of the sexual assault, mother was then transferred to a different nursing home facility in Northern Illinois mid July 1993.

For a period of approximately 3 years, and continuing sporadically yet, mother becomes very defensive, belligerent and sometimes mean when nursing home personnel touch her or attempt to remove her clothes when helping her with a bath or preparing her for bed in the evening.

Could it just be that this incident has been etched in her mind forever and ever? And it still comes back to haunt her?

Mother presently resides in a fine nursing home in Northern Illinois and celebrated her 97<sup>th</sup> birthday last January 29, 1998.

### The Perpetrator

The following information related to the perpetrator is based primarily on documents that I had access to and read during our prosecution of this criminal act in a court of law.

The male employee of the nursing home was approximately 43 years of age and was married. His primary occupations, prior to being employed by the nursing home, appeared to be that of truck driver and general laborer.

In 1985, this man was charged and convicted of the sexual assault of a female minor child and served approximately 1 year in prison - his nature and actions were apparent and the record was then established in the legal enforcement files in the State of Illinois and therefore accessible to those entitled to review it.

This man applied to and was admitted to a local community college to study for and obtain a certificate as a Certified Nursing Assistant - a certificate as a Certified Nursing Assistant was awarded to him in June 1992.

On January 14, 1993, he was hired as a Certified Nursing Assistant at this local nursing home - this was apparently based on their normal interviewing policy and without performing a background check. His starting pay was approximately \$ 5.00 per hour.

On March 29, 1993, he sexually assaulted my mother in her room at approximately 7:30AM. He had only been employed by the nursing home for approximately 2 ½ months. The nursing home suspended the employee without pay pending the outcome of the reviews of the local police and the State of Illinois Department of Public Health.

Upon confirmation of the sexual assault via DNA tests in mid June 1993, this man was arrested and confined to the local county jail. The States Attorney for the county then commenced legal proceedings for the prosecution of this criminal act.

With overwhelming evidence against him, in late August 1993 this man, without a jury trial, voluntarily accepted a 25 year prison sentence before a judge and within a few days was sent off to prison. Several members of the Meyer family including myself and my wife attended the sentencing, a day we shall never forget. It is my understanding, from the local county States Attorney, that this man will probably be released from prison upon serving 50% of his sentence (the year 2006).

### Outrage, Prosecution and Anguish

The Meyer family was outraged and all agreed - let the prosecution begin, let justice prevail.

In July 1993 a major law firm in Chicago was engaged to prosecute and handle this criminal action against the nursing home on behalf of my mother - the attorneys that accepted the case were as outraged as the Meyer family. In September 1993 I was appointed mother's legal guardian of her person and her estate.

The original Complaint was filed in Cook County in December 1993. The wheels of justice were in action - meetings with our attorneys were held, depositions taken, private investigators hired, documents collected and evaluated, a video portraying a day in the life of my mother in a nursing home was prepared for use in court if needed, expert witnesses were engaged to provide expert testimony on all issues as necessary, mediation hearings to effect a settlement were held to no avail, and amended Complaints were filed. The case was also transferred to Kane County - a collar county to Cook County. Finally, a trial date is set for late April 1995 - 22 months have come and gone since July 1993.

The day before jury selection was to begin, the presiding judge for the trial was able to effect \$ 1,000,000 settlement on behalf of my mother - in mid August 1995 net settlement proceeds of approximately \$ 585,000 were put into a trust fund for the future benefit and care of my mother (29 months have come and gone since March 29, 1993). Additionally, in December 1996 we had to file a special final report with the Kane County trial judge assigned to our case to conclude the activity involving this case and the court jurisdiction.

Due process of law . . . judicial process . . . justice . . . collectively, perhaps an oxymoron in situations such as this. Or perhaps I was just suffering from judicial process frustration and litigation withdrawal.

The outrage and anguish suffered by the Meyer family during this period of time and this ordeal was enormous - we all felt the pain. Their help, counsel, encouragement and support to me was immeasurable. It took me approximately 1 year to unwind from this ordeal. The compassion and concern of our attorneys was deeply appreciated.

### Resolution - What Can Be Done

What can I do - what can each of you do - what can the nursing homes and their insurance carriers do - what can the government do - what can we all do to make a difference and protect our loved ones? Collectively, I believe that all of us together can change this tragic situation.

Because, unless changes are made could this situation or will this situation happen to your loved ones - think about it and the consequences!!!!

If and/or when it happens, prosecution of the criminal act is a nightmare you have a hard time forgetting. Did it need to be done - absolutely YES!!!!!! Would I prosecute again - absolutely YES!!!!!!

Its sad to say, but apparently litigation is needed along with non-confidentiality agreements to expose the guilty parties. Let this testimony and tragic story put nursing home management and their insurance carriers on notice - clean up your act - we will no longer tolerate this abuse (for that matter, any abuse) to be inflicted on our loved ones - where's your moral and fiduciary responsibilities??????

Reality!!!!!! To nursing home management and their insurance carriers - think about it, a \$ 20 investment for a background check just might save you an abuse claim and related legal expenses in the amount of \$ 1,250,000.

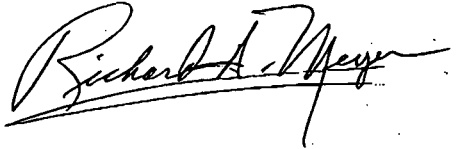
Reality!!!!!! \$ 1,250,000 will purchase a lot of background checks. Use a portion of this money to pay for moral competent employees to care for your clients (our loved ones) - we all would appreciate that change of attitude and vision.

Reality!!!!!! To the local community colleges - do a background check before awarding a certificate to an undesirable person not worthy to be designated a Certified Nursing Assistant.

#### Crime Scene Re-Visited

On Tuesday September 8, 1998, a delightful lady from the Senate's Aging Committee called me at work to ask if I would participate in this hearing - I agreed. That Tuesday night, after work, I proceeded to review past litigation documents to see what I could contribute to this hearing and efforts of the Aging Committee.

Well, I didn't sleep well that night, or the next couple of nights - for I was revisiting the crime scene and reliving the 29 months of outrage and anguish that I experienced. YES, it was worth it. Thanks for listening and your attention - GOD BLESS AMERICA!!!!!!

A handwritten signature in black ink, reading "Richard A. Meyer". The signature is written in a cursive style with a horizontal line underneath the name.



The CHAIRMAN. Mr. Meyer, we appreciate your testimony very much, and I know it is just very difficult for you to relay it, and for your coming here and doing it and suffering through it again, we thank you very much.

Ms. Stine.

**STATEMENT OF CLAUDIA STINE, DIRECTOR OF OMBUDSMAN SERVICES, MADISON, WI**

Ms. STINE. Good afternoon. I am Claudia Stine. I am the director of long term care ombudsman services for the State of Wisconsin. We are the program in our state that is charged under the Older Americans Act to provide complaint resolution and informational services to residents and families of nursing homes and those folks living in board and care or assisted living facilities. I would like to thank you for the opportunity to be here today.

In my state as well as most others, this issue is of the most critical concern to families and folks facing nursing home admission. During the 1996-97 biennium, the ombudsman in Wisconsin received about 350 abuse complaints against Wisconsin's nursing homes. This number represents about 7 percent of all of the complaints that we take about residents in nursing homes.

The vast majority of these complaints concern situations where alleged abusers were caregivers employed by the facilities. We hear about and we sometimes actually witness violations of residents' rights to be safe and free of abuse. The kinds of incidents that I am talking about here are primarily physical abuse: hitting, slapping, rough handling, twisting limbs and, yes, even rape of a resident. Use of profanity against the resident; threatening behavior; yelling and calling a person names, these are common types of verbal or mental abuse.

If that were not enough, we also see cases of gross neglect, including withholding necessary treatment, withholding pain medications, ignoring a resident's toileting needs or failing to promptly and adequately attend for a resident's personal hygiene requirements.

Currently, Wisconsin's nurse aide abuse registry contains 460 names. That is pretty current as of August 3. About 69 percent of these folks were determined to be abusive. The remainder were people who were determined to be charged with misappropriation of resident funds. While it is widely believed that nursing assistants or CNAs are responsible for almost all abuse situations, because after all, they are the ones who provide most of the hands-on care to residents, even so, we have found that other professional nursing staff as well as other employees in the facility, those folks having direct access to residents have also been found to be abusive.

Just earlier this year, we investigated a case of a licensed practical nurse who, over the course of several weeks had hit a resident several times, twisted her arm, yelled at her, and while the facility fired this licensed practical nurse, this person is still free to work in other health care settings.

We have also witnessed abuse committed by staff who provide other kinds of services for residents, services that are not included in the registry. These include housekeeping, physical, occupational

and speech therapists, food service workers and administrative staff. These people are not commonly thought of as potential abusers; yet, they have continual interaction with residents, and some of them have access to resident funds. Nurse aides who are listed on the registry are not precluded from working in other geriatric care settings. Quite commonly, at least in our state, these persons will go to work in board and care or assisted living facilities. Unfortunately, under current law, these folks are only barred from working in nursing homes.

Other staff, such as nurses and folks who provide other kinds of services may and often do find similar work in other health care settings. A certified nursing assistant on the abuse registry, and, for that matter, any caregiver found to be abusive in Wisconsin, could go to another state to find employment, as those folks from other States come to Wisconsin. We do not know how frequently this happens, because there is no national system to track these folks across state lines.

While some states have voluntary agreements to exchange at least CNA abuse registries, that system, even, is sorely insufficient. Currently, Wisconsin shares and receives lists from only nine other States and, of course, those lists, in turn, go to the providers in Wisconsin, but again, that barely scratches the surface of the problem.

Wisconsin recently enacted far-reaching law to address some of these issues. Effective October 1, all health care providers in Wisconsin will be required to conduct criminal background checks on all health care workers. But a major shortcoming in this new system is the inability to check for criminal convictions in other States. If the provider has no indication to indicate that the person lived and worked in another State, it has no means at all to discern a person's criminal background that occurred out of the borders of Wisconsin. No reliable data is currently available to determine how prevalent this situation is, but we do know that it occurs.

We also know that abuse in nursing homes is greatly under-reported. The most common reason is that families and residents alike fear retaliation from the abusing caregiver and from the other nursing home staff. Families cannot be in a facility continually to protect their loved one. Particularly, once they voice concern, that person is even more vulnerable. We hear from residents themselves when we go out to check on a situation, well, they are so over-worked here, and here she is, doing the best she can. I do not want to get anybody in trouble, and it was probably my fault anyway. These are the kinds of things that we will hear from residents who are able to express themselves.

For very similar reasons, some nursing home staff are reluctant to report abuse. They fear retaliation; they fear the loss of their job; they fear retribution of their peers who have contributed to the inaction, and, to compound this, some facilities do not report abuse as they are required to do under the Federal law. Sometimes, these instances are uncovered, and surveyors will cite the facility. In the licensed practical nurse that I cited earlier, the facility had been aware but had failed to report it, and they were, in fact, cited. But we are certain that there are many, many instances that neither we nor the survey organization are aware of.

As I mentioned earlier, our state's legislature recently enacted legislation to mandate criminal background checks for all health care providers, but we have no means to track these persons across state lines; we do not have access to nurse aide registries of other states to make sure that folks are not employed in Wisconsin. Speaking for the Board on Aging and Long Term Care, we offer every support that we can to the work of this committee in legislating remedies to these dire problems.

You know, some people should never be allowed to care for the most frail in our society. I try to speak for them, because many of these folks cannot speak for themselves.

Thank you.

[The prepared statement of Ms. Stine follows:]



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**TESTIMONY**
**UNITED STATES SENATE AGING COMMITTEE**

CLAUDIA STINE, Director of Ombudsman Services

*September 14, 1998*

Good afternoon. I am Claudia Stine, Director of Long Term Care Ombudsman Services for the State of Wisconsin. We are the program in our state charged under the Older Americans Act to provide complaint resolution and informational services to residents and families of nursing homes and board and care facilities. We also provide these services to elders living in the community and receiving Medicaid and other supportive services under a Medicaid waiver program.

I would like to thank Senator Grassley, Senator Breaux and Senator Kohl for inviting me to appear here today. This issue is the most critical concern for those folks who need and are receiving long term care. "Will those people caring for me treat me right? I don't want to go to a place that will hurt me. You hear so much...."

During the 1996-97 biennium, Ombudsmen received 357 abuse complaints in Wisconsin's nursing homes. (See Attachment #1) This number represents about 7% of all the complaints taken on behalf of facility residents. While some of these complaints were residents abusing other residents, the vast majority concerned situations where the alleged abusers were caregivers employed by the facilities. We hear about and some times actually witness violations of a resident's right to be safe and free of abuse. These often involve physical abuse, which take the form of hitting, rough handling, or twisting a limb. Use of profanity against the resident, threatening behavior, yelling and calling a resident names are common types of verbal or mental abuse. We find cases of gross neglect including withholding necessary treatment or pain medications, ignoring a resident's toileting needs, or failing to promptly and adequately attend to a resident's personal hygiene needs.

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**ADVOCATE FOR THE LONG TERM CARE CONSUMER**



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It is widely believed that certified nursing assistants are responsible for almost all abuse situations. After all, they provide most of the hands-on care to residents. But we have found that professional nursing staff, as well as other employees of the facility with direct access to residents, has also been found abusive. For example, earlier this year, we investigated a case of a licensed practical nurse who hit a resident several times, twisted her arm and yelled at her. While this facility fired the nurse and the state's nursing home surveyors cited the facility for abuse, this person is legally able to seek and be employed in another facility or with another health care provider. The regional Ombudsman is requesting that the nurse's license be revoked but in the meantime, this nurse may well be employed in another health care setting.

Wisconsin's Nurse Aide Abuse Registry contained 460 names as of August 3, 1998. Of these persons, 319 or about 69% were determined abusive. The remaining names on the list are those people who were found to have misappropriated resident funds. One person was culpable in both categories.

However, abuse committed by staff who provides *other kinds* of services for residents are not listed. These may include housekeeping personnel, physical, occupational and speech therapists, food service workers and administrative staff. These people are commonly not thought of as potential abusers, yet they have continual interaction with residents. Under current federal law, there is nothing stopping these abusers from going to work at another facility or other geriatric care setting. Nor is there a way for facilities to find out about this type of employment history when they hire a new person. We know this happens because we have found these folks working in other facilities. When that occurs, the Ombudsman alerts the nursing home, but this circumstantial method is clearly woefully inadequate as a protection for vulnerable seniors.

Similarly, nurse aides listed on the abuse registry are not precluded from working in other geriatric care settings. Quite commonly, these persons will go to work in board and care places. Unfortunately under current federal law, they are only barred from working in nursing homes.

A certified nursing assistant listed on the Abuse Registry (and any other caregiver found to have committed abuse in a nursing home in Wisconsin) could go to another state to find similar employment. We do not know how frequently this happens for there is no national system that tracks these persons across state lines. While some states have voluntary agreements to exchange abuse registries, the system is solely



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insufficient. Currently, Wisconsin shares and receives lists from only nine other states.

Wisconsin recently enacted a far-reaching law to address some of these issues. Effective October 1, 1998, all health care providers in Wisconsin will be required to conduct criminal background checks on all health care workers. A major shortcoming in this new system is the inability to check for criminal convictions in other states. If the provider has no information to indicate that the aide lived and worked in another state, it has no means to discern a person's criminal background that occurred out of state. No reliable data is available to determine how prevalent this situation is, but we do know that it occurs.

We know that abuse in nursing homes is greatly underreported. The most common reason is that families and residents alike fear retaliation from the abusing caregiver and from other nursing home staff. Families cannot be in a facility continually to protect their loved one against retaliation once they have voiced concern about abuse. "They're so over-worked here and h/she is doing the best they can. I don't want to get anyone in trouble. It was probably my fault anyway". This, too, is an often-heard response heard by regional Ombudsmen when talking with residents about an alleged abuse. The resident is living in the facility 24 hours a day and she doesn't want to "make any waves".

For similar reasons, some nursing home staff members are reluctant to report abuse. Fear of retaliation, of losing their jobs, or of retribution from their peers contribute to this inaction. Most nursing home staff are caring people. A facility employee might report abuse or neglect under the protection of anonymity or request her name be kept confidential. Some facilities do not report abuse, as they are required to do under federal law. Some of these instances are uncovered and surveyors cite the facility. But we are certain that there are many other instances. Unexplained bruising, frightened behavior from a resident when the abusing caregiver is near, and reticence to ask for help are all signs that something is definitely wrong in the resident's life in the facility.

As I mentioned earlier, our state's legislature recently enacted legislation to mandate criminal background checks for all health care providers employed in Wisconsin. However, we have no means to track these persons across state lines, nor do we have access to the Nurse Aide Registries of other states to assure that these persons will not be employed in Wisconsin. Speaking for the Board on Aging and Long Term Care we offer every support we can to the work of this Committee in legislating remedies to these dire problems.



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Simply put, some people should never be allowed to care for the most frail of our society. I speak for them because many cannot speak for themselves.

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**ADVOCATE FOR THE LONG TERM CARE CONSUMER**

**State of Wisconsin Board on Aging and Long Term Care  
Ombudsman Program**

**Abuse Complaints 1996-97**

<b>Abuse Complaints</b>	<b>Nursing Home</b>	<b>Board Care</b>	<b>Total</b>
<b>Financial exploitation</b>	<b>13</b>	<b>4</b>	<b>17</b>
<b>Abuse, physical</b>	<b>66</b>	<b>22</b>	<b>110</b>
<b>Abuse, sexual</b>	<b>22</b>	<b>2</b>	<b>24</b>
<b>Abuse, verbal/mental</b>	<b>66</b>	<b>31</b>	<b>97</b>
<b>Gross neglect</b>	<b>59</b>	<b>15</b>	<b>74</b>
<b>Resident-to-resident physical or sexual abuse</b>	<b>94</b>	<b>8</b>	<b>102</b>
<b>Other</b>	<b>15</b>	<b>3</b>	<b>18</b>
<b>Total:</b>	<b>357</b>	<b>85</b>	<b>442</b>

Prepared Sept. 1, 1998



The CHAIRMAN. Thank you, Ms. Stine.  
Ms. Roslewicz.

**STATEMENT OF THOMAS D. ROSLEWICZ, DEPUTY INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC., ACCOMPANIED BY TONY RUBBO, AUDIT MANAGER, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Mr. ROSLEWICZ. Thank you, Mr. Chairman, Senator Kohl, Senator Breaux. I am Tom Roslewicz, the deputy inspector general for audit services at the Department of Health and Human Services. Today, I have Anthony Rubbo with me, who is the manager for Inspector General's report that we are releasing today. I am pleased to be here to discuss the safeguards for identifying people who pose a threat of elder abuse and neglect in nursing homes and other long term care facilities. Our recent review demonstrated that there is no nationwide assurance that nursing home staff who pose this threat are systematically identified and excluded from employment.

My statement today will highlight our findings on criminal background checks and registries, the employment of nursing home staff with criminal convictions and the impact of current safeguards on elder abuse prevention. Overall, Mr. Chairman, the states we reviewed used a patchwork of measures to identify persons posing a threat of elder abuse in nursing homes and to minimize and prevent such abuse. As seen in my first chart, you can see the blue represents the states where there are no requirements that background checks be done. The red shows states that require that a background check be done. However, coverage varies widely. For example, not all facilities serving the elderly are included. A majority of states require checks of nurse aides seeking employment but not already employed nurse aides or other personnel such as nurses, housekeepers, contractor staff or volunteers.

To conduct criminal background checks, 24 States consult statewide records. Nine states permit the use of both State and the FBI records, although two of these States do not, in practice, use the FBI records. Many states have specified criminal convictions which would automatically disqualify a person from employment, but these crimes vary by state.

In addition to background checks, registries can be an effective tool for identifying known abusers, provided they are promptly updated with court and independent investigative findings, but this is not always the case. For instance, convictions for crimes committed outside nursing facilities were not systematically reported to any of the 37 nurse aide registries surveyed. In Maryland, the registry did not record all findings of abuse or convictions. For 45 alleged abuse cases we reviewed, the nursing homes believed they had sufficient evidence to terminate or suspend seven employees. However, these cases were neither substantiated nor prosecuted and consequently not flagged in the registry.

In addition, of 24 nurse aides convicted of abuse by the Maryland Medicaid Fraud Control Unit, 12 were not flagged.

Next, Mr. Chairman, I will briefly discuss the employment of individuals with criminal backgrounds at certain long-term care facilities. We obtained criminal data on all of 1,068 current employees at eight randomly selected nursing homes in Maryland. Of this total, 51, or 5 percent, had been convicted of a variety of crimes. Chart two shows the kinds of crimes that we are talking about: assault, theft, drug violations, welfare fraud, disorderly conduct, battery, robbery, forgery, prostitution, child abuse, handgun violations, alcohol violations, property violations.

We believe this number is actually understated, because both the FBI and state criminal information systems lacked conviction data on more than half of the crimes committed. The individuals with convictions include nurse aides as well as staff holding jobs not subject to criminal background checks, such as nurses, dietitians, and housekeeping staff, just as Claudia Stine has indicated.

If I may, on chart three, entitled "51 Employees with convictions," the red shows that 27 of the 35 direct care employees who are certified nurse aides. Eight of the direct care employees were nurses, and 16 were non-direct care employees—the housekeeping, dietary and other staff who work in nursing home facilities. Illinois, the only state in our survey that requires checks on current and prospective employees, found a similar number of convictions for current staff. Of 21,000 checks conducted, 5 percent had disqualifying crimes. We also noted that 15 nurse aides and two other employees with prior disqualifying criminal backgrounds would have been identified and excluded had the Illinois law been in place before their employment. All 17 of these employees were later involved in instances of alleged elder abuse.

So, what is the impact of the states' screening systems? Although we attempted to answer that question, data was not available to conclude with certainty on an increase or decrease in elder abuse. However, we did gather evidence, some of it anecdotal, suggesting the benefits of current safeguards. In general, nursing home officials viewed background checks as a strong deterrent to elder abuse, because applicants with criminal histories are either identified through the background checks, or they do not apply because they know the checks will disclose their crimes. A number of officials believe the checks had reduced the instances of abuse.

The effectiveness of these checks is, of course, only as good as the criminal data in the state and the FBI systems, which we have found to be incomplete at times. Also, most states do not subject prospective employees other than nurse aides or any current employees to background checks. We believe both of these requirements would add a large degree of protection to the elderly.

While we support the states' efforts, we believe that stronger Federal oversight, as well as stepped up collaboration with the states, would improve the safety of the elderly. Our report, which we are releasing today, includes specific recommendations to HCFA and the Administration on Aging. Chart four pretty much sums up what our recommendations are. We recommend that they consider first of all establishing Federal requirements and criteria for performing criminal background checks of all workers in all long-term care facilities, and second, assisting in developing a national abuse

registry and expanding the current state registries to include all abusive workers.

If a national abuse registry is approved, we suggest that it be included in an expanded version of the current Health Care Integrity Protection Data Bank, which the Office of Inspector General is developing, as required by the Health Insurance Portability and Accountability Act of 1996. We will be happy to work with the committee and the department to effect this expansion.

Thank you for the opportunity to testify today. At this time, I would be happy to answer any questions.

[The prepared statement of Mr. Roslewicz follows:]



**Testimony**  
**Before the Special Committee on Aging**  
**United States Senate**

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**Improving Safeguards in**  
**Long-Term Care**

**Statement of**  
**Thomas D. Roslewicz,**  
**Deputy Inspector General for**  
**Audit Services**

**September 14, 1998**



**Office of Inspector General**  
**Department of Health and Human Services**

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**INTRODUCTION**

Mr. Chairman and members of the Committee, I am Thomas D. Roslewicz, Deputy Inspector General for Audit Services of the Department of Health and Human Services. I am pleased to be here today to discuss safeguards for identifying people who pose a possible threat of abuse and neglect to residents of nursing homes and other long-term-care facilities. We share the Committee's longstanding interest in preserving the safety of these residents.

We recently completed a review in this area which demonstrated that there is no nationwide assurance that nursing home staff who could place elderly residents at risk are systematically identified and excluded from employment. We are recommending stronger Federal oversight, as well as stepped-up collaboration with the States, to improve the safety of the elderly. Our recommendations, as well as a detailed discussion of our findings, are provided in a report which we are releasing at this hearing. The report consolidates information gathered during audits of two States and surveys of State and nursing home officials.

My testimony today will highlight our significant findings on the States' requirements for and use of criminal background checks and registries, the employment of nursing home staff with criminal convictions, and the impact of the various safeguards on elder abuse prevention. First, however, I would like to briefly describe current Federal requirements for identifying and preventing potential abusers from working in nursing homes.

### ***Current Requirements***

Residents of nursing homes and other long-term-care facilities have the right to reside in a safe and secure environment, free from abuse and neglect, as reflected in the Medicare statute and regulations. To help achieve this type of environment, each State is required to establish and maintain a registry of nurse aides which includes information on any finding by the State survey and certification agency of abuse, neglect, or misappropriation of property involving the elderly. The Health Care Financing Administration (HCFA), which administers the Medicare program, does not require registries for other health care providers, such as registered nurses (RN), licensed practical nurses (LPN), or medical practitioners.

Nursing facilities must report to the State nurse aide registry or appropriate licensing authorities any knowledge they have of court actions against an employee that would indicate unfitness for service as a nurse aide or other facility staff. Additionally, HCFA prohibits facilities from employing individuals who have been found guilty by a court of law or who have had a finding entered into the registry for abuse, neglect, or mistreatment of residents or misappropriation of their property.

Although the Violent Crime Control and Law Enforcement Act of 1994 permits States to conduct national criminal background checks, there is no Federal requirement to conduct these checks of current or prospective employees of federally assisted long-term-care facilities. States, however, are expected to provide the Office of Inspector General (OIG)

with information on individuals convicted of elder abuse or neglect. Using this information, the OIG excludes those individuals from participation in Federal health care programs and publishes a monthly Cumulative Sanction Report, available on the Internet, which identifies those individuals and entities excluded from participation. No program payments may be made for items and services furnished, ordered, or prescribed by excluded parties.

### *Objectives and Scope of Review*

The objectives of our review were twofold. First, we determined whether States required background checks of current and prospective employees of long-term-care facilities and, if so, we solicited their assessment of the results achieved. Second, we determined if States maintained registries on various health care workers. At a selected number of States, we also assessed whether registries properly identified individuals involved with elder abuse or other crimes.

We reviewed applicable State laws for the 33 States that require criminal background checks. We interviewed officials of 52 nursing homes in 6 States (Illinois, Indiana, Maryland, Minnesota, Ohio, and Virginia) about their procedures and experiences relating to background checks. In a few selected States, we also tested the accuracy of the registries in recording (flagging) individuals who abused residents of nursing homes.

In Maryland, we used the FBI criminal history record system to obtain criminal background

data on all employees at eight randomly selected nursing homes receiving Medicare and/or Medicaid funds. We also compared the individuals convicted of elder abuse by the Maryland Medicaid Fraud Control Unit (MFCU) with those cited in the FBI system and in Maryland's registry to determine if that information was properly recorded and if individuals had prior convictions. In Illinois, we obtained criminal background data on a selected number of individuals who had a substantiated finding of abuse to determine if any had a prior criminal record.

### ***Criminal Background Checks***

Overall, Mr. Chairman, the States we reviewed used a patchwork of measures to identify persons posing a possible threat of elder abuse in nursing homes and to minimize and prevent such abuse. While 33 States require criminal background checks, coverage varies widely.

For example:

- Not all facilities serving the elderly are included.
  
- A majority of States require checks of nurse aides seeking employment but not already-employed nurse aides or other personnel, such as owners, nurses, dietitians, housekeeping staff, contractor staff, or volunteers.
  
- The sources used to make criminal background checks vary. State records are



used by 24 States. Nine States have laws permitting the use of both State and FBI records, although two of these States do not, in practice, use FBI records.

- Many States have specified crimes which, when individuals are convicted of such crimes, would automatically disqualify a person from employment, but these crimes vary by State. Also, only a few States have identified factors to consider in determining suitability for employment when a person has a disqualifying conviction, such as the level, seriousness, and date of the crime. Thus, nursing home officials, particularly in States without disqualifying crimes, use their own judgment in deciding whether to employ applicants with criminal records.

Many facilities conducted more comprehensive checks than required by their State law. Some said they requested Statewide criminal background checks on all of their applicants, not merely those covered by State requirements. Others indicated they automatically excluded from employment everyone with a criminal conviction, including convictions for crimes not specifically cited as disqualifying. Regardless of how they applied the various requirements, nursing home officials generally believed that background checks provided the most reliable source of information during the employment process. I will elaborate on this later in my statement.

### *State Registries*

In addition to background checks, registries can be an effective tool for identifying known abusers, provided they are promptly updated with court and independent investigative findings. All 37 States we contacted maintained registries for nurse aides, LPNs, RNs, and medical practitioners, although only the nurse aide registry is required by HCFA regulations.

In our opinion, Mr. Chairman, the usefulness of the registries could be improved. For instance, all registry officials indicated that convictions for crimes committed outside nursing facilities were not systematically reported to the nurse aide registry. Such information could be obtained during background checks and recorded in the registry. Also, of the 37 registries surveyed:

- 94 percent did not initiate criminal background checks on applicants when they applied for certification or licensing,
- 29 percent did not require prior arrest or conviction information on renewal applications, and
- 13 percent did not provide a penalty for making false statements on the certification or license application.

According to registry officials in all 37 States, facilities are required to report alleged abuse and neglect so that an investigation can determine if the allegations are substantiated. If so, the findings must be recorded in the nurse aide registry. In Maryland, the registry did not always record findings of abuse or convictions. For 45 alleged abuse cases we reviewed, the nursing homes believed they had sufficient evidence to take action on 7 cases and either terminated or suspended all 7 employees. However, these cases were neither substantiated nor prosecuted and consequently not flagged in the registry.

In addition, as described in our November 1997 report to Maryland, many aides convicted of abuse by the State Medicaid Fraud Control Unit (MFCU) were not flagged on the registry. Of the 24 aides who were found guilty or who pled guilty in a court of law for elder abuse, 12 were not flagged.

Our May 1998 report, which focused on Illinois, also noted some shortcomings. We sampled 88 closed cases of alleged abuse by nurse aides and found that in 13 cases, Illinois did not substantiate, through independent investigations, whether these allegations had occurred. Although all 13 aides were terminated from employment or had disciplinary actions imposed, they were not annotated on the registry and were free to seek employment at other long-term-care facilities or allowed to continue their employment, which could place residents at further risk. We also noted that Illinois is the only State that records background check results (both positive and negative) in the registry. However, convictions for crimes

other than those designated as disqualifying by State law are not provided to the registry or the employing facility. The disqualifying crimes in Illinois are abuse/neglect of an adult or child, arson, assault, kidnaping and abduction, murder, and theft.

### *Employed Nursing Home Staff with Criminal Convictions*

Since Maryland's background check requirements do not cover on-board staff, we obtained criminal data on all 1,068 current employees at 8 randomly selected nursing homes. Of this total, 51, or 5 percent, had been convicted of a variety of crimes—many involving serious offenses. We believe this number is actually understated because both the FBI and the State criminal information systems lacked conviction data on more than half of the crimes committed. If that information were available, the numbers of people with criminal convictions working in nursing homes could be as high as 10 percent.

Many of the individuals with convictions worked in occupations providing direct care to residents. They included nurse aides, as well as staff holding jobs not subject to criminal background checks, such as nurses, dietitians, and housekeeping staff.

Based on data from the FBI and State systems, the 51 employees had 97 convictions for such crimes as assault; child abuse; possession, manufacturing, and distribution of illicit drugs; robbery with a deadly weapon; theft; and handgun violations. On their job applications, 43 of these employees did not truthfully state that they had been convicted and 4 did not respond

to the question.

Although contractor staff are not required under Maryland law to undergo background checks, the dietary service contractor at one nursing home allowed us to obtain criminal background data on all 26 current contract employees. The data showed that 5 of the 26 had been arrested for 55 crimes. According to the FBI system, 4 of these employees had 18 convictions for such crimes as fourth degree sex offense, various assault charges, battery, larceny, and armed robbery. Records did not show conviction information on the fifth employee.

In Illinois, the only State in our survey that requires checks on current and prospective employees, a similar number of convictions was found for currently employed nursing home staff. Of 21,000 checks conducted, 5 percent had disqualifying crimes; 759 nurse aides were fired and 216 were granted waivers.

However, before Illinois implemented the law which now requires background checks, we noted that many individuals with a disqualifying criminal conviction were employed in nursing homes. We found that 15 nurse aides and 2 other employees with prior disqualifying criminal backgrounds would have been identified and excluded had the Illinois law been in place prior to their employment. All 17 of these employees were later involved in instances of alleged elder abuse. Fourteen of the 15 nurse aides are no longer employed by nursing

facilities; 7 were terminated as a result of substantiated findings of abuse and 7 were dismissed or resigned subsequent to the abuse allegation. The remaining aide was transferred to a non-direct resident care position. The two non-nurse aide employees were terminated by the facility due to elder abuse. We also noted in Maryland that 6 of the 24 nurse aides who were convicted of abuse or neglect by the MFCU had prior convictions.

### *Impact and Shortcomings of Current Safeguards*

So what is the impact of the States' screening systems? Although we attempted to answer that question, data was not available to conclude with certainty on an increase or decrease in elder abuse or in the employment of abusive employees. However, we did gather evidence—some of it anecdotal—suggesting the benefits of current safeguards, and we want to share this evidence with you today, along with our thoughts on how these safeguards could be improved.

In general, nursing home officials viewed background checks as a strong, but not absolute, deterrent to elder abuse because applicants with a history of criminal offenses are either identified through the checks or do not apply because they know the checks will disclose their crimes. A number of officials also believed that background checks had reduced the instances of abuse. However, of the 33 States that required checks, only Maryland maintained data to measure their effectiveness. Maryland's legislatively mandated review of the impact of criminal background checks credited the checks for reducing the number of

applicants with criminal records from 22 percent in the third quarter of 1996 to 19 percent in the fourth quarter.

Our attempt to obtain nationwide data on the trends in elder abuse from AoA Headquarters was also unsuccessful. The AoA was able to furnish elder abuse data only for 1995, which 29 States had voluntarily provided, but did not have data on all States or for any States over a multiyear period.

We believe that criminal background checks offer long-term care facilities an important safeguard against hiring persons who abused or neglected vulnerable elderly residents or who have been convicted of other serious crimes. The effectiveness of these checks is, of course, only as good as the criminal data in the State and FBI systems—which we have found incomplete. For instance, between 1989 and 1996, Maryland's MFCU identified 35 nursing home staff (including the 24 nurse aides mentioned earlier) who were found guilty or pled guilty in a court of law to elder abuse. All of these individuals were sanctioned/excluded from participation in Federal health care programs by the OIG, but arrest and conviction data on 10 of the 35 individuals was not recorded in either the State system or the FBI system. Clearly, more comprehensive and accurate reporting to these criminal information systems would improve the effectiveness of background checks. Also, as mentioned earlier, most States do not subject prospective employees—other than nurse aides—or any current employees to background checks. We believe both of these requirements would add a large

degree of protection to the elderly.

Similarly, State registries can be an effective preventive measure, provided that abusers are promptly flagged for all substantiated findings. As we have already stated, however, the Maryland and Illinois registries omitted some abusers, and most State registries did not include information on substantiated crimes committed outside nursing facilities. So this, too, is an area where improvements are needed. Additional opportunities for identifying potential risk to the elderly are available from the OIG Cumulative Sanction Report. But none of the nursing homes surveyed in six States was aware of this list or its availability on the Internet.

To conclude, Mr. Chairman, there is certainly no question of the value in the States' use of current safeguards. But the situation remains that the safety of the elderly cannot be assured because potentially abusive nursing home staff are not fully and systematically identified and excluded from employment.

### *Recommendations for Improving Safeguards*

While we support the States' efforts, we believe that HCFA and AoA should consider additional measures, at the Federal level, to provide a safe and secure environment for residents in nursing homes and other long-term-care facilities reimbursed by the Department.



As a result, in our report to HCFA and AoA, we recommended that they:

- ▶ Consider (1) establishing Federal requirements and criteria for performing criminal background checks of all workers in nursing homes and other long-term care facilities and (2) assisting in the development of a national abuse registry and expansion of the current State registries to include all workers who have abused or neglected residents or misappropriated their property in facilities that receive Federal reimbursement.
  
- ▶ Work collaboratively with the States to improve the safety of long-term-care residents and to strengthen safeguards against the employment of abusive workers by elder care facilities.
  
- ▶ Require improved State reporting of abuse statistics to better monitor national trends in the rise or decline of abuse.

As we indicate in our report, HCFA and AoA agreed with our recommendations and have taken action to implement them. Specifically, on July 29, 1998, the Administration forwarded proposed legislation to the Congress, based on HCFA's recommendations, which addresses the need for criminal background checks, the expansion of State registries, and the development of a national abuse registry. We note, Mr. Chairman, that you and others are

co-sponsors of an earlier bill introduced by Senator Kohl, that would establish a national registry of abusive workers in the health field. The HCFA is also considering, in consultation with AoA, further studies to identify additional preventive measures. This would include examining the relationship between abuse of residents and such factors as employee working conditions and pay. In addition, AoA plans to determine the extent and types of data appropriate for focusing on the incidence of abuse and neglect and to delineate related State and Federal roles.

If a national abuse registry is approved, we suggest that it be included in an expanded version of the current Healthcare Integrity Protection Data Bank (HIPDB), which the OIG is developing as required by the Health Insurance Portability and Accountability Act of 1996. The expanded data bank would be a Healthcare Integrity and Patient Protection Data Bank.

Our work in the area of nursing homes is continuing. We are, for example, examining trends in data maintained by State Adult Protective Services, Survey and Certification programs, and Ombudsman regarding conditions of nursing home residents.

This concludes my statement, Mr. Chairman. Thank you for the opportunity to testify today. At this time, I will be happy to answer any questions you may have.

The CHAIRMAN. Thank you; I appreciate very much your agency's involvement in this. We get very good studies out of agencies like yours, and we thank you for your contributions to the knowledge and background and in helping us define the problem.

Mr. MEYER, and I would like to have the time so we can do that; thank you. You gave credit to a female CNA who filed a complaint against a male CNA who was found to be the abuser of your mother. To the extent that you can recall, can you go over the developments of the investigation, and, for instance, things like this: what point did you and your family get involved? Did you have to file a complaint yourself? Did you meet or talk with facility management or the local ombudsman?

Mr. MEYER. In response to your first question, the female employee apparently was very cognizant of the fact that this male employee was taking too long. She got concerned; went to mother's room; she opened the door, and there was the gentleman zipping up his trousers. Mother was on the bed; her nightgown pulled up to her chest. I do not think I have to tell you any more or describe what this lady felt had happened. God bless her; like I said before, she had the—she knew that this was wrong, and she had the tenacity to report it.

Well, what can I tell you?

The CHAIRMAN. Well, after that happened was your family notified about it?

Mr. MEYER. Yes, yes; I live approximately 100 miles away from the nursing home. I have brothers and sisters in the area, in the local area of the nursing home and, what, 20 miles away; but anyway, yes, family members were informed about it—

The CHAIRMAN. Within a day or within an hour?

Mr. MEYER. Oh, that morning.

The CHAIRMAN. That morning? OK.

Mr. MEYER. That morning, and, in fact, I think three or four of the family members were at the hospital when mother was brought in for the examination.

The CHAIRMAN. Did you have to file a complaint as a family?

Mr. MEYER. What do you mean, a complaint?

The CHAIRMAN. Yes; a legal complaint.

Mr. MEYER. Oh, the—

The CHAIRMAN. In other words, charges.

Mr. MEYER. Oh, you mean, on the criminal act?

The CHAIRMAN. Yes.

Mr. MEYER. Yes, yes.

The CHAIRMAN. OK.

Mr. MEYER. Yes; it was—it was—when confirmation of the sexual assault occurred via DNA tests mid-June 1993, we said this is it; we are not going to sit back and let it just happen; you know, let the prosecution begin!

The CHAIRMAN. What sort of conversation did you have with facility management about this, or did you not even mess with that, and you just went immediately to the law?

Mr. MEYER. Well, it is my understanding I think one of my sisters and one of my brothers—I am one of nine children.

The CHAIRMAN. Sure.

Mr. MEYER. I have four brothers and four sisters. And our total extended family is somewhere in the area of 130 by last count. I cannot keep track of them all. But it is my understanding that that morning or that afternoon or the next day, a brother and a sister of mine met with management at the nursing home. The nursing home administrator had talked about the incident. I did not have contact with them at all.

The CHAIRMAN. Did your family feel that the nursing home management was fully willing to express their grief about what happened, as you would expect them to do, maybe.

Mr. MEYER. Well, I was not there, but based on conversations that I had with my sister and my brother, they were kind of nonchalant, well, it happened.

The CHAIRMAN. I see, yes.

Mr. MEYER. And that further inflamed the family. It is—you know, it inflamed the family. And again, I did not have any contact. I was not appointed legal guardian until September 1993. But once the confirmation of the DNA came back, I contacted a major law firm in Chicago. Can I mention the name of the law firm?

The CHAIRMAN. I am not a lawyer.

Senator BREAUX. You can.

Mr. MEYER. They did an outstanding job: Wildman, Harold, Allen and Dixon, and I can only praise those two primary attorneys that took this as a cause upon themselves and really pursued the case.

The CHAIRMAN. My next question would be both to you, Mr. Meyer, and then to Ms. Stine. We often hear that families refrain from reporting on abusive situations because they fear retaliation by the facility or by a particular staff member. Mr. Meyer, did you or your family experience any form of retaliation, or do you know of other families who have experienced retaliation due to reporting abuses? And then, Ms.—

Mr. MEYER. I cannot say that we felt that there was any fear of retaliation, because once confirmation of the sexual assault, mother was out of the nursing home within a month; not only that, I did not give a damn if they did.

The CHAIRMAN. Ms. Stine, from the standpoint of your view of the entire state that you work and live in.

Ms. STINE. We have had reports from families after an abuse has been investigated in which they felt that their loved one was retaliated against, and it takes a very insidious form: letting a call light go for a half an hour, for example; not giving enough time to allow someone to eat properly; not changing someone quickly enough; those are the kinds of things that families have reported once they have voiced concern about abuse in a facility and left their loved one in the facility.

The CHAIRMAN. From your standpoint as a policymaker and enforcer, do you have any suggestions of whether, assuming that is a problem, we should not—a situation we should not tolerate, anything that can be done about it in the way of policy?

Ms. STINE. We believe that there needs to be more active enforcement on the part of the survey agency to get at those kinds of care problems, particularly when the family has had—has complained about abuse; has complained about the quality of care in the facility, yes.

The CHAIRMAN. I will call on Senator Breaux now.

Senator BREAU. Thank you very much, and I thank all of the witnesses for their testimony, particularly you, Mr. Meyer. It has been very helpful that you have made the decision to present the evidence to the committee. I mean, what you are doing goes as far as anything to try and rectify what happened to your mother, to make sure that it never happens again anywhere. It is inexcusable; it is behavior that just goes beyond anything that is even hard to imagine, but hopefully, by your testimony, you can make things better for future generations, and I know that is why you are here.

Mr. MEYER. Well, I hope so.

Senator BREAU. Apparently, I am looking at the form that this person actually filed to go to work for the nursing home, and one of the questions that he answered: have you ever been convicted of a felony within the last 7 years? No; he answered, I take it, honestly, because he had been convicted of a felony within the last 8 years. So, he was legally correct by 12 months. Do you think, or can anyone comment on whether they think that any requirement on reporting past convictions, should there be any limits? I mean, should you pick a number, 5 years, 3 years, 2 years, or should it cover a person's lifetime?

Thomas. Mr. Roslewicz.

Mr. ROSLEWICZ. I do not know that you could just honestly pick a number at random, say, 5 years. I really think one should consider the circumstances of the crime or how serious it was. Certainly, I believe people can be rehabilitated. There has to be a system that somehow leaves room for discretion in terms of the nature of the crime itself.

Senator BREAU. Well, knowing what you know now, how would you write the law?

Mr. ROSLEWICZ. I do not think I would put a number of years in there. I do not know exactly how I would phrase it, but I would like to leave some room for reviewing each particular case as to, the efforts of the individual to rehabilitate himself and what kinds of programs was he in?

Senator BREAU. Well, now, that seems to me to be an argument to say that there should be a national requirement of people who are applying for work at these types of institutions, and I am not sure it is just nursing homes; it should perhaps be extended—

Mr. ROSLEWICZ. Right.

Senator BREAU [continuing.] Should be required to report any prior convictions, and we can decide whether it is felonies or misdemeanors as well or just felonies related to the type of work they do in their past lifetime, and then, the employer can take that information and do the appropriate interviews to determine whether they think this person still should be hired, because the felony was not related to this type of work they are going to be doing or that they think this person has been truly rehabilitated. Would that be a correct statement?

Mr. ROSLEWICZ. Yes; what we have found as we were going through our reviews is that was variance between the states as to even what is a disqualifying crime. States differ in terms of identifying the kinds of crimes that should be included. So, the problem, I think, is everyone needs to sit down and look at this and say, OK,

now is there a specific category of crimes that would disqualify employment? Maybe if you murdered somebody—is it really possible for the murderer to ever recover from that?

Senator BREAUX. I do not think we are going to pass a Federal law that says everybody should fill out a form of any prior convictions in any State in the United States in their past lifetime that would be related to the type of job they are applying for. Now, let us be reasonable. We aren't going to do that.

Mr. ROSLEWICZ. Right.

Senator BREAUX. If we did that, we do not get anything out of that anyway. So, I mean, I think that what we ought to do is say anybody who has been convicted of a felony has to report it, and then, the employer can take a look to see whether that type of felony was related to the type of concern they would have in hiring that person, right?

Mr. ROSLEWICZ. I would agree. I would think, though, that you would not say that if the felony was committed beyond the specified period, the person does not have to report it. That is the part I have some concerns with.

Senator BREAUX. OK; I agree with that. We are not going to put a time limit. I would not want to put a time limit on it, and I would not want to put a restriction on the type of felony. I would want them just to report whatever they have been convicted of.

OK; here is my third question. Suppose that the law in this case was that he had to report any felony at any time in his lifetime, and when he got down to have you ever been convicted of a felony within your lifetime, and they have got two boxes to check, and he checks no, and he has been convicted of five felonies the last year; I mean, what is the obligation of the employer to do detailed background checks?

Mr. ROSLEWICZ. Well, I would think you would have—I would hope that they would have done a background check and found this information in the system as to whether or not he was, in fact, convicted of these crimes.

Senator BREAUX. The reason why I am asking that question; I mean, is the Federal law that we are going to be considering to pass, No. 1, going to be one to say have you ever been convicted of a felony at any point in your lifetime, any type of felony; and then, the second requirement would be a Federal requirement that all of the states have to be involved in this, not just the state where the person is seeking employment.

The third and final concern is what obligation do we put on the back of the potential employer for them to do further checks if the person just says no? What is the obligation of the employer in this case? Can they just accept the no? I mean, they have to look at the answer and then look at what they get from the, I guess, from the police or the law enforcement officials. Is that sufficient? Or should they have an obligation to do even more than that?

Mr. ROSLEWICZ. I think the obligation, the duty, should be more than that.

Senator BREAUX. Should be more than that?

Mr. ROSLEWICZ. More than that, yes, sir. In the Medicare program, we have a right to expect that the elderly will receive proper care in these homes. Part of that is to make sure they do appro-

priate background checks; that they do some inquiries before they hire the people to come on board.

Senator BREAUX. OK; well, suppose a nursing home employer says, well, he filled out the form, and he said that he or she had never been convicted of a felony and that nothing shows up in any of the police reports that I have received, and I like him or her, and so, I have hired her. I mean, what is their obligation other than relying on the absence of a red light warning signal coming from the military—I mean, from the police? I mean, you say that there should be more than just that; I guess what I am trying to figure out is what other requirement or burden or standard, if you will, should we put on the back of potential employers, if any? How far do we go? I mean, how far do we tell them they have to hire honest and good people?

Mr. Rubbo. Can I add?

Senator BREAUX. Sure; because I know a lot of nursing homes and employers are going to say look, we have thousands of people; I mean, we cannot—how far do we have to go? Do we have to, you know, check with their parents and their grandparents, their schools, their colleges, their teachers? How far do we have to go in order to meet whatever Congress is getting ready to tell us we have to do?

Mr. Rubbo. Well, the alternative source, sir, for information concerning abusive employees would be a registry in that state or a national registry, if it is established. If the registry is maintained adequately and completely, it should give the history of that particular individual has he ever been involved in abuse before? Does he have any kind of criminal past?

Senator BREAUX. Suppose he has been charged three times with sexual abuse but never convicted?

Mr. Rubbo. Well, then, I think you have to go with the conviction. I mean, yes, he has been brought up on charges, but was there sufficient evidence at the time to prosecute? Apparently, no.

Senator BREAUX. Should the employer have the right to say I am not hiring him based on that?

Mr. Rubbo. The way it is currently structured right now, yes, they have the right now not to hire that individual, because it is left up to the nursing homes to make their own decisions. What Mr. Roslewicz was talking about was disqualifying crimes. It would be nice if certain crimes would be specified to come out and say in these five or six instances, you will not employ that individual. I think that should be left up to the panel of experts to determine which ones they would be excluded from employment.

Then, the other ones would have to be analyzed to see how long ago they occurred. Was he rehabilitated?

Senator BREAUX. It is a difficult area.

Mr. Rubbo. Yes, it is.

Senator BREAUX. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Breaux.

Now, Senator Kohl.

Senator KOHL. Thank you, Mr. Chairman. Just to continue along the lines that Senator Breaux was pursuing, obviously, we cannot, in this or in most anything, devise systems that are totally fool-proof, but we are trying to move the ball forward. And, as you

know, what this bill talks about is establishing a national registry for abusive health care workers, No. 1, and then, providing a quick turnaround background criminal check system that would provide the information to any prospective employer about whether or not that employee had had any conviction on any kind of a criminal charge.

How helpful would this be, if we can get this done; if we can provide this national registry and if we can establish a quick-turnaround national background check system? In your experience, I will ask you, Ms. Stine, to begin with. It is not foolproof. How helpful would this be, improving over what we have now?

Ms. STINE. I think this would be extraordinarily helpful. We have now no way to track folks across states. For those of us who have large labor markets across state boundaries, it would be—I think it would be extremely helpful. Wisconsin, right now, in its criminal abuse law, requires a provider to—if that provider believes that a person had worked in another state to, in fact, get hold of that state and do a criminal background check, which could be costly and certainly time consuming. So, I think for folks in Wisconsin, we would really appreciate that system.

Senator KOHL. OK; Mr. Roslewicz.

Mr. ROSLEWICZ. In our review, we actually have found cases where there were—for example, in Maryland, there were seven nursing home staff who were convicted of elderly abuse at the nursing home. We went back and checked their prior records and found that they had criminal convictions against them. So, the fact that a lot of this happens out of the state where the nursing home currently is further exacerbates the problem, because if the individual is convicted, for example, in California, it may not show up in the State of Wisconsin records.

We do have some examples where this actually happened. One example, there was a certified nurse's aide who actually punched and kicked a male resident and was terminated for abuse. This was after the individual had been employed. We went back and checked the records, and he had been convicted twice prior for armed robbery and once for burglary.

So, had this information been available, perhaps the nursing home may have made a decision otherwise than to hire the individual. So, I think there is a great benefit to having a nationwide registry for the very reason that Ms. Stine pointed out.

Senator KOHL. OK; Mr. Meyer.

Mr. MEYER. What can I say? It happened. I think it ought to be mandatory. Where is management? Where is the insurance carrier? We just—at the company where I work, a couple of months ago, we changed insurance brokers. The gentleman came out to assess personally himself risk and exposure from an insurance standpoint. He came out to our plant. We talked about risk and exposure and the consequences if we did not have it covered. Where are the insurance carriers? Are they not going out to the nursing homes and investigating the process and the procedures and saying look, if you do not check the background, this is going to be the consequence? Where are the insurance carriers coming from? I do not put the blame totally on them. Management has the responsibility for the compassionate and reasonable care; a fiduciary responsibility over



their clients. It has got to happen. It has got to happen. Maybe people will feel different when it happens to them.

I may be biased; yes, I may be biased, but it is not a fun process, and it has not been a good story.

Senator KOHL. Mr. Rubbo, do you want to comment on the helpfulness of this bill if we can get it passed?

Mr. Rubbo. I believe it would be extremely helpful. You may not be identifying all abusive workers, because some of the information that we have showed that are first-time offenders. I mean, you are not going to prevent all abuses. In our example, we found 5 percent of employees had convictions. Further we have examples where abuses could have been prevented had a law requiring background checks been in place earlier or applied more comprehensively. So, I believe it would greatly help.

Senator KOHL. Thank you.

Well, I think it has been a great panel.

Yes, Mr. Meyer.

Mr. MEYER. Senator Kohl, let me just go back to the point of what is the cost of a background check? What is the cost of a background check? Is it \$15, \$20? I do not care about the time it takes to do that. But if a nursing home has to hire 20 people, 20 times 20 is what? \$400? Is that not better to do than to pay out a potential claim of \$1 million and have legal expenses of \$250,000, let alone the anguish and outrage with the victim and the family? It has got to be done. Somebody has got to take the lead and the charge and say we have got to protect the people in the nursing homes. I may be there; you may be there.

Senator KOHL. Thank you; thank you, Mr. Meyer.

Thank you, Mr. Chairman.

Senator BREAUX. I mean, we do it on so many other occasions; I mean, I think I did a home loan the other day, and I had to spell out whether I was ever convicted of a felony just to get a home loan. I mean, if you are going to be putting people in a situation every day caring for someone in that capacity, I think that is not too much to ask.

Do you know, Mr. Meyer, whether after this happened that the nursing home in question, did they change their hiring practices any? And if they did, do you know how they changed it?

Mr. MEYER. I really do not have knowledge as to whether or not they did change. I am aware of the fact that the State of Illinois subsequently, I think, early 1995, it was or late 1994, early 1995, required a background check, and this came about as a result of an article in a newspaper.

Senator BREAUX. Well, thank all of you, and thank you in particular.

The CHAIRMAN. I would like to have one more question for you, Mr. Roslewicz and also Mr. Rubbo, if he wants to respond. An important point was made that the effectiveness of any background check is, of course, only as good as the criminal data in the system, whether that is the state or the FBI systems. It seems that all of your reports revealed pitfalls in the transfer of the data. I understand that the OIG has a proposal that would give the OIG the authority and responsibility of maintaining and operating such a system. So, could you elaborate on how OIG would handle this respon-

sibility? Also, could you tell us a few ways how our national system would improve upon existing state systems and particularly, how would a national system improve recordkeeping of criminal abuse.

Mr. ROSLEWICZ. OK; let us start with the first part. Yes, the OIG is currently authorized to establish what is referred to as the HIPDB, which is the Health Integrity Protection Data bank. What we would like to see is to have that expanded to include a national registry of this sort. Ms. Stine pointed out which were quite interesting to me, because a lot of the cases that are reported through the family members do not get into the registry. The anecdotal information we have, the family members would often say, "Well, the person was fired, so we are happy."

But that person was fired and went on, and that data was not recorded in the registry. So, there needs to be some way in which to be able to get all of this data in a system. The other half of the problem is that if it is only a state system, it is very difficult and time consuming and even problematic if you have to make entries into many various splintered systems. Rather than doing that, it makes sense to me to have a central system where all of this data can be funneled. That would make it easier for the various states to go through the registry and find out if there are any convictions on some of their potential hires or even on their current staff.

With regard to the IG doing this, we certainly would have to discuss this further with the committee and with our Department and find out how could the current HIPDB, the data bank that is currently proposed by the legislation be expanded to incorporate a central registry. That is where we are right now. We are in the process of discussing that with this Department, and, of course, we had mentioned that to the committee, and we are working with the committee staff as well.

But the underlying problem is the fact that we have information where people have committed crimes in other states, and they have moved into another state and were hired, but nobody ever really knew that, because they either did not do the background check or the data was never put into the system as it should have been.

So, there are problems out there. You will never have a foolproof system. One of the things that concerns me is no one really knows when is the first time that an individual, an abuser, is going to abuse. You cannot catch that through any kind of a system you establish. So, you will never have a foolproof system. People ask what do you consider significant? Is 5 percent significant? Ten percent?

Well, like Mr. Meyer, I would have to say my mother has been in a nursing home several times, and if she were abused, as Mr. Meyer has said, that, to me, would be extremely significant. So, significance cannot be determined based upon setting 5 percent, 6 percent, 10 percent. I think it is all very relevant to all of us who have potential family members in nursing homes; perhaps even myself some day, you know, because I am approaching that age.

But I really, honestly would encourage the committee to look at this. In terms of simplifying the system, it would probably make it easier if there was one central system to report to, so there is no confusion as to which system should collect the data. It makes sense to me to have a central system.

The CHAIRMAN. Well, I am going to say thank you for a second or third time, because it has been a very good panel, as Senator Breaux has said. We appreciate very much your information and particularly, as sad as it is, Mr. Meyer, your bringing your experience to us as a perfect example of the need for a different legal environment.

Yes?

Mr. ROSLEWICZ. Can I just make one more comment?

The CHAIRMAN. Yes, you may.

Mr. ROSLEWICZ. On a personal experience I had.

The CHAIRMAN. Yes.

Mr. ROSLEWICZ. I was recently out in Montana on vacation, and a friend of mine provides 24 hour care to an individual. The reason why she has to do this is the individual is paralyzed and cannot get out of bed by herself. But the problem, when I visited this woman, who had been receiving home health services, was that she had been robbed several times. So, now it is necessary to have somebody there 24 hours a day just to protect her from those kinds of abuses.

I think, again, a system of this sort could help eliminate some of those potential concerns.

The CHAIRMAN. Yes; Mr. Meyer.

Mr. MEYER. Just one last comment. If it is going to take litigation and lawsuits to bring it to the attention of nursing home management and insurance companies, let the family members of the sexual assault victims set on the jury!

The CHAIRMAN. OK.

Mr. MEYER. That, I am sure, will get their attention once that verdict is rendered.

The CHAIRMAN. OK; thank you all very much.

I am going to call the next panel now, and will you come even while I am describing who you are? The first panel, as I indicated in my opening comments, is made up of Kim Schmett. He is director of the Iowa Department of Inspections and Appeals. This department is a regulatory and licensing agency for my State of Iowa health facilities. Mr. Schmett will share his insight and discuss his experience with Iowa's background check system. He will also discuss the necessary features of an effective and cost-efficient system.

Next, we will hear from Lee Bitler. Ms. Bitler is director of human services at the Country Meadow Nursing Home and a representative of the American Health Care Association. She will address her facility's experience with state background checks and emphasize the need for a national background check system to act as an interstate barrier to applicants with criminal histories. Her testimony will also discuss the necessary features of an effective and cost-efficient system.

Following Ms. Bitler, we will hear from Richard Reichard. Dr. Reichard is executive director of the National Lutheran Home for the Aged, Rockville, MD. Dr. Reichard will discuss his experience with state background checks and emphasize the need for a national background check system as an interstate barrier to applicants with criminal histories. He will also discuss the features needed for an effective and cost-efficient system.

Finally, we will hear from Melissa Putnam. She, for many years, has worked as a certified nurse aide. She has worked for the past 6 years at Beverly Manor, a nursing home in Reading, PA. She will describe her work as a certified nurse aide and will discuss her views on the need for an effective criminal background check system. She brings a very important perspective, and we are glad that she is here as well.

So, I look forward to the panel, and we are going to go Mr. Schmett, Ms. Bitler, Dr. Reichard, Ms. Putnam. Go ahead, Kim.

**STATEMENT OF KIM SCHMETT, DIRECTOR, IOWA DEPARTMENT OF INSPECTIONS AND APPEALS, DES MOINES, IA**

Mr. SCHMETT. Chairman Grassley, Senator Breaux, Senator Kohl, good afternoon. I am honored to be here today to discuss Iowa's experience with requiring criminal history background checks for nursing facility employees. Since July 1, 1997, Iowa has required that all nursing facilities obtain a criminal history background check on prospective employees prior to hiring the individuals. To date, more than 56,000 background checks have been performed by the Iowa Division of Criminal Investigation on prospective employees. On average, 12 percent of those background checks have identified potential nursing facility employees who have some form of criminal conviction, whether it be for armed robbery, assault or even murder.

We, in Iowa, believe our criminal background check is keeping some of society's most violent offenders from preying upon one of the most vulnerable segments of our society, the residents of our states' more than 430 long-term care facilities. While the current law may be providing a sense of security for nursing facility residents and their family members, that has not always been the case. Prior to July 1, 1997, nursing facilities had the option to check an employee's criminal history, but few administrators ever did so.

Two Iowa legislators, State Representative Mona Martin and State Senator Maggie Tinsman, responded to the concerns of their constituents and spearheaded passage of legislation which required nursing facilities to conduct criminal history and dependent adult abuse record checks prior to their employment. The law also requires that if a person has been convicted of a crime or has a record of child or dependent adult abuse, the Iowa Department of Human Services will evaluate whether the crime or founded abuse warrants prohibition of employment.

The evaluation takes into consideration the following factors: (1) the nature and seriousness of the crime or founded abuse in relation to the position sought or held; (2) the time elapsed since commission of the crime or founded abuse; (3) the circumstances under which the crime or founded abuse was committed; (4) the degree of rehabilitation; (5) the likelihood that the person will commit the crime or founded abuse again; and finally, the number of crimes or founded abuse committed by the person involved.

If the evaluation determines that the individual has committed a crime or has a founded history of abuse which warrants prohibition from employment, that individual will not be employed in any facility licensed by the State of Iowa.

How effective is our law? According to the analysis of statistics, facilities are requesting evaluations for about one half of the potential employees with criminal records or founded abuse. Of those evaluated, our Department of Human Services has determined the following: approximately 60 percent of those individuals are deemed to be employable without further restrictions. Twenty-nine percent of the individuals are deemed to be employable with some restrictions, and the remaining 10 percent are determined to be unemployable under any circumstances in a nursing facility setting.

While there is no list of crimes or abuse circumstances that will automatically preclude someone from employment, the following offenses do warrant serious evaluation: crimes against people; crimes involving firearms; repeat offenses. Also, if an individual has been involved in an alcohol or drug-related crime, he or she must provide proof that they have had substance abuse training to cure that problem.

Also, the Iowa law requires facilities to conduct a criminal history and child and dependent adult abuse record check for anyone who is employed through a temporary agency that supplies personnel to a nursing facility as well as anyone who provides services to nursing facility residents under a contract for services, such as physical therapists, who provide direct care to facility residents.

Failure on the part of a facility to conduct the required checks or obtain proof that employees have clean records could result in a conditional license or denial, suspension or revocation of a nursing facility's license. Also, the Department of Inspections and Appeals could issue a citation to a facility for violations of the law. Fortunately, despite many objections to our law, only one nursing facility has been fined for failure to conduct criminal history and dependent adult abuse record checks.

While we have been fortunate in Iowa in implementing our criminal history record check, there has been some opposition and obstacles to overcome. A few nursing facility administrators have expressed concern regarding the \$13 fee per record check cost, as an additional burden placed upon them. In order to obtain a complete criminal history, a facility must submit every name used by a potential employee, including all maiden and married names. A twice-divorced individual, therefore, could require as many as three or four record checks at a total cost of \$39.

While this may seem insignificant in relation to the overall operating costs of a nursing facility, industry representatives report the statewide cost of criminal history checks as exceeding \$600,000 per year. However, it has been determined that this cost is reimbursable under current Federal Medicaid and Medicare guidelines.

The industry is also concerned that the time involved in the process is too long and prevents facilities from hiring needed employees in a timely fashion. Currently, the Division of Criminal Investigation is able to conduct its criminal history and dependent adult abuse record checks within 24 hours of receipt of an application. Likewise, the Department of Human Services is able to complete its evaluations within a period of 2 to 10 days, depending upon the information submitted by the applicant and the nature and/or seriousness of any claims of founded abuse.

In closing, let me make a few comments regarding Federal legislation requiring criminal history background checks. In order for any system to be effective, it must provide timely service. Nursing facilities are facing a growing shortage of employees. If a job applicant is required to forego employment for any significant period of time prior to completion of a criminal record check, that applicant is simply going to accept employment in another industry. A high percentage of nursing facility employees receive very minimal wages. People in this segment of society cannot afford to wait for a paycheck; the industry cannot afford to lose willing employees.

A viable criminal record check also must be cost-effective. Money spent by a nursing facility to conduct criminal record checks is often money that may have been spent to provide additional direct care and services to the facility's residents. While the criminal record checks are vital to assuring the safety of nursing facility residents, they are obtainable at an often considerable cost.

As indicated earlier, the only way to truly establish an individual's identity and, therefore, determine whether a criminal history exists, is through fingerprints. This procedure will be costly, and additional resources will need to be added in order to address the timeliness issues. A criminal history check based on an individual's fingerprints will prevent individuals from changing jobs by changing locations, as often happens in border areas of our state.

A significant factor in implementing a fingerprint based identification system is the technical expertise involved in getting the actual prints. The average nursing home employee is not experienced in doing this, and, therefore, prospective employees will have to endure extra time and expense associated with traveling to a local law enforcement office to have fingerprints taken.

Also, Federal legislation may be necessary to authorize states to share data in the various criminal history records. Standardization also needs to be addressed. We have seen instances with the current nurse aide registry where states differ in their interpretation of what constitutes abuse. The only way the shared data will be helpful is if a minimum set of standards is established for criminal history records, while, at the same time, states are encouraged to establish even higher standards.

It has often been suggested that professional licensing records also need to be examined if we are going to truly identify potential abusers of nursing facility residents. A professionally licensed employee at a nursing facility who abuses a resident in his or her care may not be prosecuted by local authorities. However, the final report of the survey agency's finding is automatically and routinely sent to the appropriate professional licensing board for future disciplinary action. Unless a hiring facility contacts the professional licensing board, the facility may not be aware of past disciplinary actions. In such an example, a criminal history background check alone would find nothing to concern the hiring facility.

I would suggest that Congress may want to also consider expanding background checks to include the multitude of data maintained by professional licensing boards throughout the country, which has just recently become accessible with the advent of modern computer systems. Finally, I urge Congress to stand firm in its commitment to residents of our country's long-term care facilities.

**We have an opportunity to protect and improve the quality of life for millions of Americans living in long-term care facilities. I urge you to seize that opportunity.**

**[The prepared statement of Mr. Schmett follows:]**

Testimony Delivered by Kim D. Schmett, Director  
Iowa Department of Inspections and Appeals  
Before the Senate Special Committee on Aging  
September 14, 1998

Mr. Chairman, Senator Breaux, Senator Kohl, distinguished senators . . . good afternoon.

I am honored to be here today to discuss Iowa's experience with requiring criminal history background checks for nursing facility employees. Since July 1, 1997, Iowa has required that all nursing facilities obtain a criminal history background check on prospective employees prior to hiring the individuals. To date, more than 56,000 background checks have been performed by the Iowa Division of Criminal Investigation (DCI) on prospective employees. On average, 12 percent of those background checks have identified potential nursing facility employees to have some form of criminal conviction - whether it be for armed robbery, assault, or even murder (see attachments 1 and 2). We, in Iowa, believe our criminal history background check law is keeping some of society's most violent offenders from preying upon one of the most vulnerable segments of our society - the residents of our state's more than 430 long-term care facilities.

While the current law may be providing a sense of security for nursing facilities residents and their family members, that hasn't always been the case. In December 1996, the Quad-City Times published a special six-part series entitled "Abuse and Neglect: An investigative report on Quad-City nursing homes." As part of his year-long investigation, Quad-City Times reporter Clark Kauffman studied literally thousands of state inspection reports, court files, police reports, and nursing home records. In one particular instance, Mr. Kauffman found an area nursing facility was routinely hiring violent criminals, thieves and drug users to work as caregivers. Take, for instance, the following example:

Daniel Ghys worked in a Davenport, Iowa, nursing facility's kitchen, yet he has faced charges of theft and forgery. In 1993, he allegedly used another person's credit card to buy \$1,900 worth



of jewelry and merchandise. He was unemployed at the time, but was hired soon after to work at a Rock Island, Illinois, health care center. He lost that particular job when he failed to appear at work after 'partying' the night before. In 1994, the Iowa Department of Corrections reported that Ghys should be imprisoned due to his criminal record, his prior imprisonment, lack of job stability and his continuing to "commit criminal acts to support himself." At about the same time that report was issued, he was working at the Davenport nursing facility.

This example, while blatantly showing how a convicted felon can move from nursing facility to nursing facility - even across state lines - isn't the worst illustration. In its series, the Quad-City Times chronicled the employment history and criminal records of numerous nursing facility workers who had been convicted of domestic violence, assault, burglary, even murder. Prior to July 1, 1997, nursing facilities had the option to check an employees' criminal history, but few administrators ever did so. Why would someone hire an individual to care for our senior citizens without knowing about the individual's character? Perhaps James Brennan, a former nursing home administrator who now works as a consultant, best explained the hiring practices at health care facilities.

"In the nursing home industry, we have what I call a medical hire - which means that you hire a person if they have a pulse," Brennan explains. "Then, one step up from that, you have the appliance hire - which means you hire a person who has a telephone and an alarm clock and who might show up for work on time."

The administrator of a former Davenport, Iowa, nursing facility - which has since been closed by my Department for numerous violations - said she didn't have time to monitor the off-duty activities of her employees. "We hire down and outs," she explained. "And we know that as soon as they are back 'up' again, they'll be gone." Some nursing facilities were so desperate for workers that they'd hire applicants on the spot, pay them a \$200 sign-up fee and have them report for work that same night. Never once was an individual's criminal history checked or considered.

As a follow-up to its special report, the Quad-City Times' editorial board called upon Iowa lawmakers to pass legislation requiring nursing homes to conduct criminal background checks on aides, nurses, maintenance workers and other personnel. "Nursing homes always have had the option of making criminal record checks, but some of them refuse to be bothered — which is why convicted killers, robbers and thieves are caring for the elderly . . .," the board said. Thank goodness the plea of the newspaper didn't fall upon deaf ears.

Two Quad-City area legislators, state Representative Mona Martin and state Senator Maggie Tinsman, responded to the concerns of their constituents and spearheaded passage of legislation which required nursing facilities to conduct criminal history and dependent adult abuse record checks prior to employment (see attachment 3). The law also requires that if a person has been convicted of a crime or has a record of founded child or dependent adult abuse, the Iowa Department of Human Services (DHS) is to evaluate whether the crime or founded abuse warrants prohibition of employment. The evaluation is to take into consideration the following factors:

- The nature and seriousness of the crime or founded abuse in relation to the position sought or held;
- The time elapsed since commission of the crime or founded abuse;
- The circumstances under which the crime or founded abuse was committed;
- The degree of rehabilitation;
- The likelihood that the person will commit the crime or founded abuse again, and
- The number of crimes or founded abuse committed by the person involved.

If the evaluation determines that the individual has committed a crime or has a founded history of abuse which warrants prohibition from employment, that individual is not to be employed in any facility licensed by the State of Iowa.

How effective is the new law? According to an analysis of statistics, facilities are requesting evaluations for about one-half (47 percent) of the potential employees with criminal histories or

founded abuse (see attachments 4 and 5). Of those being evaluated, the DHS has determined the following:

- Approximately 60 percent of the individuals being evaluated are deemed to be employable without any restrictions;
- Twenty-nine percent of the individuals are deemed to be employable with some restrictions; and
- The remaining individuals, about 10 percent, are determined to be unemployable under any circumstances in a nursing facility setting.

While there is no list of crimes or abuse circumstances that will automatically preclude someone from employment, the following offenses warrant serious evaluation: Crimes against people, crimes involving firearms, and repeat offenses. Also, if an individual has been involved in an alcohol or drug-related crime, he or she must provide proof that something has been done to deal with the substance abuse problem.

Also, the Iowa law requires facilities to conduct the criminal history and child and dependent adult abuse record checks for anyone employed through a temporary agency supplying personnel to a nursing facility as well as anyone providing services to nursing facility residents under a contract for services. This latter category could include occupational or physical therapists who provide direct care to facility residents.

Failure on the part of a facility to conduct the required checks or to obtain proof that employees have clean records could result in a conditional license or denial, suspension, or revocation of a facility's license. Also, the Department of Inspections and Appeals could issue a citation to a facility for violations of the law. Fortunately, despite some objections to the law, only one nursing facility has been fined for failure to conduct criminal history and dependent adult abuse record checks.

While we have been fortunate in Iowa in implementing our criminal history record check law,

there has been some opposition and obstacles to overcome. A few nursing facility administrators have expressed concern regarding the \$13 per record check cost, as an additional financial burden placed on them. In order to obtain a complete criminal history, a facility must submit every name used by a potential employee, including all maiden and married names. A twice divorced individual, therefore, could require as many as three or four record checks at a total cost of \$39. While this amount may seem insignificant in relation to the overall operating costs of a nursing facility, industry representatives report the statewide cost of criminal history checks is exceeding \$600,000 per year. However, it has been determined that this cost is reimbursable under the federal Medicaid and Medicare guidelines.

The industry also is concerned that the time involved in the process is too long and prevents facilities from hiring needed employees in a timely fashion. Currently, the Division of Criminal Investigation (DCI) is able to conduct its criminal history and dependent adult abuse record checks within 24 hours of receipt of the application. Likewise, the Department of Human Services (DHS) is able to complete its evaluations within a period of two to 10 days, depending upon the information submitted by the applicant and the nature and/or seriousness of any crimes or founded abuse.

Just how good are the criminal history and dependent adult abuse record checks? In truth, the record checks are only as good as the information provided by the applicants and facilities. Iowa uses an individual's name, birth date, and social security number as the basis for the criminal history checks. Most law enforcement officials will tell you that the only true way to determine an individual's identification is through the use of fingerprints. In fact, the Federal Bureau of Investigation (FBI) keeps its criminal history records only on the basis of fingerprints. The problem associated with records maintained by name, date of birth, and social security number is best illustrated by the following information from the DCI. Of the more than 350,000 criminal records on file in Iowa, 260 of them contain identical names, birthdays, and social security numbers. Also, a records check based on names and social security numbers does not detect assumed names and duplicate social security numbers used by the criminal element in our

society.

An additional problem faced by facilities is that some states prohibit the release of criminal history data to all but authorized law enforcement agencies. While a facility could contract with a private investigation or security firm to conduct criminal history checks in other states, both the cost and paperwork hurdles could be high. The problems associated with evaluating individuals with out-of-state criminal histories, likewise, could be staggering and time-consuming. For instance, fingerprint checks conducted by the FBI are currently taking between 30 and 60 days to complete.

And what about the "potentially abusive" individuals who have fallen between the cracks of the system? Unfortunately, not all abusive caregivers ever face criminal actions for a multitude of reasons, including a resident's fear of retribution by a caregiver against whom a complaint has been filed or a local prosecutors reluctance to take to trial a seemingly insignificant case. Often, even though disciplinary action has been taken against an individual by a professional licensing board, this information is difficult to obtain. On more than one occasion, a licensed practical nurse or registered nurse has been able to continue working in a long-term care setting simply because nobody contacted the Board of Nursing. Under federal law, certified nurse aides who have a history of founded abuse are prohibited from ever working in a federally-certified long-term care facility. Most nursing facility administrators are aware of this federal mandate and routinely contact the Department's Nurse Aide Registry to verify a certified nurse aide's employability.

Recognizing this lack of information, Iowa lawmakers during the last session enacted new legislation creating a "single contact repository" which will allow facilities to access not only criminal history and dependent adult abuse records but also data maintained by the state's professional licensing boards and child and dependent abuse registries. I believe accessing the information may allow the detection and prevention of hiring abusive individuals before their behavior has attained a criminal level. The computerized repository will allow for a

simultaneous records check for every applicant at an Iowa nursing facility. Unfortunately, funding for this particular project was appropriated at a level which only allows for the initial start-up costs, estimated at \$125,000. We are hopeful that the Legislature will fully fund the remainder of this unique, and vital, service during the 1999 session.

In closing, allow me to make a few comments regarding federal legislation requiring criminal history background checks. In order for any system to be effective, it must provide timely service. Nursing facilities are facing a growing shortage of employees. If a job applicant is required to forego employment for any significant period of time prior to completion of a criminal record check, that applicant will simply accept employment in another industry. A high percentage of nursing facility employees receive very minimal wages. People in this segment of society cannot afford to wait for a pay check. The industry cannot afford to lose willing employees.

A viable criminal record check must also be cost-effective. Money spent by a nursing facility to conduct criminal records checks is often money that may have been spent to provide additional direct care and services to the facility's residents. While criminal records checks are vital to assuring the safety of nursing facility residents, they are obtainable at an often considerable cost.

As indicated earlier, the only way to truly establish an individual's identity, and therefore determine whether a criminal history exists, is through fingerprints. This procedure will be costly and additional resources may need to be added in order to address the timeliness issues. A criminal history check based on an individual's fingerprints will prevent individuals from changing jobs by changing locations, such as often happens in the border areas of our state. A significant factor in implementing a fingerprint-based identification system is the technical expertise involved in obtaining the actual "prints". The average nursing facility employee generally is not experienced in "rolling" fingerprints, thus prospective employees have to endure the time and expense associated with traveling to a local law enforcement office to have his or her fingerprints taken. While this precautionary step is necessary to obtain an accurate and

complete criminal history records check, it does place additional burdens on the prospective employee, the hiring facility, and local law enforcement agencies.

Also, federal legislation may be necessary to authorize states to share data contained in the various criminal history records. Standardization, too, may need to be addressed. We've seen instances with the nurse aide registry where states differ in their interpretations of what constitutes abuse. In fact, some states will place a nurse aide on its registry if the individual is late in making child support payments or has failed to pay local income taxes. The only way the shared data will be helpful is if a minimum set of standards is established for criminal history records while, at the same time, states are encouraged to establish even higher standards.

It has often been suggested that professional licensing records also need to be examined if we are to truly identify the potential abusers of nursing facility residents. Take, for example, a situation not unlike that sometimes found by DIA health facilities surveyors. A professionally-licensed employee at a nursing facility who abuses a resident in his or her care may not be prosecuted by the local authorities who deem the crime "too insignificant" to take to court. However, the final report of our findings - if a 'professional' has a founded instance of abuse - is automatically and routinely sent to the appropriate professional licensing board for further disciplinary action. Unless a hiring facility contacts the professional licensing board, the facility may not be aware of past disciplinary actions. In such an example, a criminal history background check alone would find nothing to cause concern to the hiring facility.

It was this sort of problem, untangling and making sense of the vast number of data bases maintained by various professional licensing boards, that Iowa General Assembly wished to address in its 'single contact repository' legislation that I briefly mentioned just a while ago. I would suggest that Congress, too, may want to consider expanding background records checks to include the multitude of data maintained by professional licensing boards throughout the country which has just recently become accessible with the advent of modern computer systems.

**Criminal Background Checks Completed**  
July 1997 Through July 1998

Month	Criminal Checks	Positive 'Hits'	Percent 'Hits' of Total Checks Conducted
July 1997	3,321	445	13.3 %
August 1997	4,003	502	12.5 %
September 1997	4,286	482	11.2 %
October 1997	4,786	598	12.5 %
November 1997	3,671	491	13.4 %
December 1997	3,667	460	12.5 %
January 1998	4,389	553	12.6 %
February 1998	4,233	508	12.0 %
March 1998	4,117	521	12.7 %
April 1998	4,349	521	11.9 %
May 1998	4,539	519	11.4 %
June 1998	5,054	547	10.8 %
July 1998 *	5,755	622	10.8 %
<b>TOTALS</b>	<b>56,170</b>	<b>6,769</b>	<b>12.1 %</b>

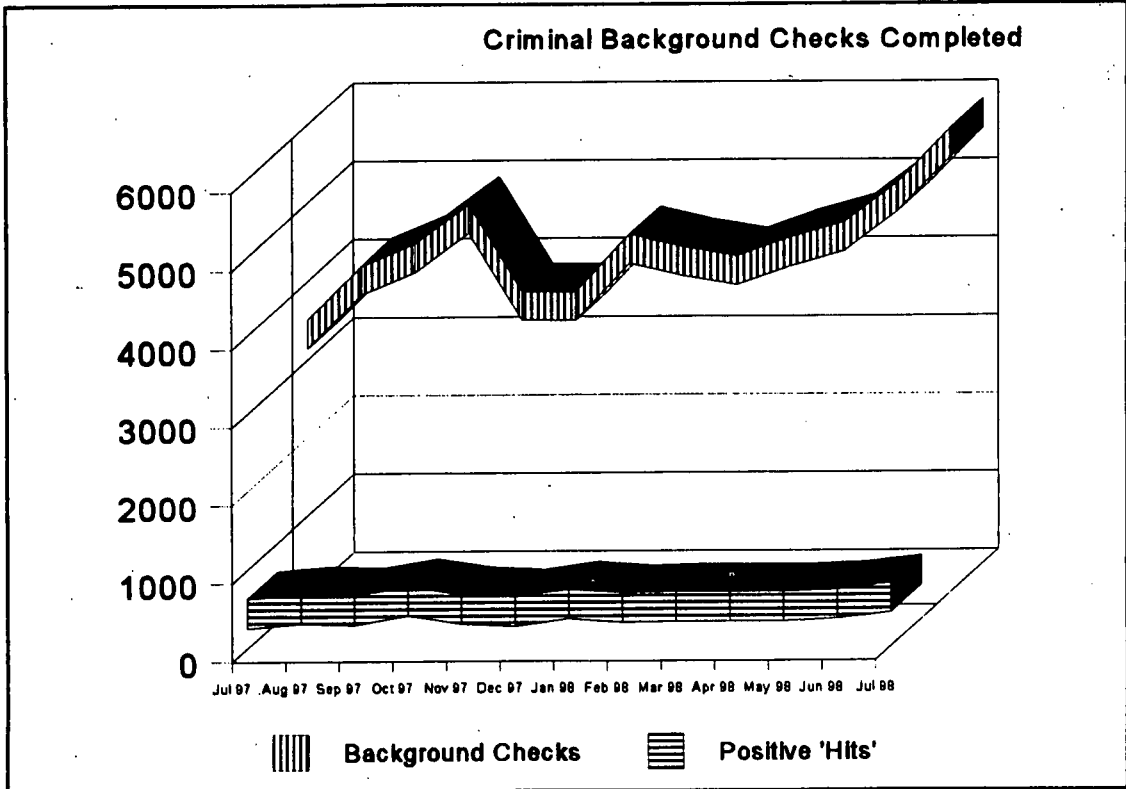
\* Beginning on July 1, 1998, the list of health care providers subject to the state's criminal background check provisions was expanded to include: (a) an employee of a homemaker, home-health aide, home-care aide, adult day care, or other provider of in-home services if the employee provides direct services to consumers; (b) an employee of a hospice, if the employee provides direct service to consumers; and (c) an employee who provides direct services to consumers under a federal home and community-based services waiver.

Source: Iowa Division of Criminal Investigation



Finally, I urge Congress to stand firm in its commitment to the residents of our country's long-term care facilities. We have an opportunity to protect and improve the quality of life for millions of Americans residing in nursing facilities. I urge you to seize that opportunity.

Thank you.



Source: Iowa Division of Criminal Investigation

SENATE FILE 523

AN ACT  
RELATING TO HEALTH CARE FACILITIES BY REQUIRING EMPLOYMENT  
CHECKS OF PROSPECTIVE HEALTH CARE FACILITY EMPLOYEES.

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

Section 1. Section 135C.33, Code 1997, is amended to read  
as follows:

135C.33 CHILD OR DEPENDENT ADULT ABUSE INFORMATION AND  
CRIMINAL RECORDS -- EVALUATIONS.

1. On or after beginning July 1, 1994 1997, with regard to  
~~new applicants for licensure or employment if a person is  
being considered for licensure under this chapter or for  
employment involving direct responsibility for a resident or  
with access to a resident when the resident is alone, or if  
the person considered for licensure or employment under this  
chapter will reside prior to employment of a person in a  
facility, the facility may shall~~ request that the department  
of human services conduct public safety perform criminal and  
child and dependent adult abuse record checks of the person in  
~~this state and in other states, on a random basis. In~~

addition, the facility may request that the department of  
human services perform a child abuse record check in this  
state. Beginning July 1, 1994 1997, a facility shall inform  
all new applicants for employment persons prior to employment  
of the possibility of regarding the performance of a record  
check the records checks and shall obtain, from the applicant  
person, a signed acknowledgment of the receipt of the  
information. Additionally, on or after July 1, 1994, a  
facility shall include the following inquiry in an application  
for employment: "Do you have a record of founded child or  
dependent adult abuse or have you ever been convicted of a  
crime, in this state or any other state?" If the person has  
been convicted of a crime under a law of any state or has a  
record of founded child or dependent adult abuse, the  
department of human services shall perform an evaluation to  
determine whether the crime or founded child or dependent  
adult abuse warrants prohibition of licensure, employment, or  
residence in the facility. The evaluation shall be performed  
in accordance with procedures adopted for this purpose by the  
department of human services.

2. If the department of human services public safety  
determines that a person has committed a crime or has a record  
of founded child or dependent adult abuse and is licensed, to  
be employed by in a facility licensed under this chapter, or  
resides in a licensed facility, the department of public  
safety shall notify the licensee that an evaluation will be  
conducted by the department of human services to determine  
whether prohibition of the person's licensure, employment, or  
residence is warranted. If a department of human services  
child abuse record check determines the person has a record of  
founded child abuse, the department shall inform the licensee  
that an evaluation will be conducted to determine whether  
prohibition of the person's employment is warranted.

3. In an evaluation, the department of human services  
shall consider the nature and seriousness of the crime or

60

founded child or dependent adult abuse in relation to the position sought or held, the time elapsed since the commission of the crime or founded child or dependent adult abuse, the circumstances under which the crime or founded child or dependent adult abuse was committed, the degree of rehabilitation, the likelihood that the person will commit the crime or founded child or dependent adult abuse again, and the number of crimes or founded child or dependent adult abuses committed by the person involved. The department of human services has final authority in determining whether prohibition of the person's licensure, employment, or residence is warranted.

4. If the department of human services determines that the person has committed a crime or has a record of founded child or dependent adult abuse which warrants prohibition of licensure, employment, or residence, the person shall not be licensed under this chapter and shall not be employed by in a facility or reside in a facility licensed under this chapter.

Sec. 2. Section 235B.6, subsection 2, paragraph e, Code 1997, is amended by adding the following new subparagraph: NEW SUBPARAGRAPH. (7) The department of public safety for purposes of performing records checks required under section 135C.33.

Sec. 3. HOME HEALTH SERVICES -- REGULATORY REQUIREMENTS. The departments of public health and inspections and appeals shall review federal and state requirements applicable to providers of homemaker, home-health aide, home-care aide, hospice, and other in-home services to persons with health problems. The review shall include but is not limited to current and proposed federal requirements for quality assurance, fiscal information concerning the source of regulatory funding, feasibility analysis of requiring criminal and dependent adult abuse record checks of employees of the providers, feasibility analysis of implementing state regulation of the providers, and other information deemed

appropriate by the departments. The departments shall submit a report of findings and recommendations on or before December 15, 1997.

\_\_\_\_\_  
MARY S. KRAMER  
President of the Senate

\_\_\_\_\_  
RON J. CORBETT  
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 523, Seventy-seventh General Assembly.

\_\_\_\_\_  
MARY PAT GUNDERSON  
Secretary of the Senate

Approved 4-18, 1997

\_\_\_\_\_  
TERRY E. BRANSTAD  
Governor

## **RECORD CHECK EVALUATION STATISTICAL SUMMARY**

**July 1, 1997 - December 31, 1997**

**Total number received - 1,399**

**Number deemed employable without restrictions - 840**

**Number deemed employable with restrictions - 400**

**Number deemed unemployable - 71**

**Singular, minor offense over 10 years old - 56**

**All record check evaluations are acted on within 24  
hours.**

**The average time for completion is 48 hours.**

**Total criminal/abuse checks done by DCI - 23,734**

**Percentage of persons applying for jobs in facilities -  
[23,734 divided by 46,905 {total positions in health  
care as listed in Iowa Workforce Development}] 51%**

**Total number with criminal/abuse histories - 3,007 - 13%**

**Total number of requests for record checks - 1,399 -  
47%**

**Spot checking child abuse - # checked: 550, founded  
child abuse: 166 30%**

**Source: Iowa Department of Human Services**

## Impact of Criminal History Checks

Total positions in health care facilities - (As listed with Iowa Workforce Development) 46,905

Total criminal/abuse checks done by DCI 7-1-97 through 12-31-97 - 23,734

Percentage of persons applying for jobs in facilities in 6 months - (23,734 divided by 46,905) 51%

Total number with criminal/abuse histories - 3,007 - 13%

Total number of record check evaluations - 1,399 - 47%

Total direct care providers in home care - 4,835 ( As listed with Iowa Workforce Development)

Estimated criminal/abuse checks for six months - (51% of 4,835) 2,467

Estimated number of persons with criminal or abuse histories - (13%) 320

Estimated number of requests for record check evaluations - (47%) 150

Estimated number of direct care providers in home care (Many part time) (Estimated 30,000 - 60,000) 45,000

Estimated criminal checks for six months - (51% of 45,000) 22,950

Estimated # of persons with histories - (13% of 22,950) 2,984

Estimated # of requests for record check evaluations - (47% of 2,984) 1,402

Source: Iowa Department of Human Services

The CHAIRMAN. Thank you, Mr. Schmett.  
Ms. Bitler.

**STATEMENT OF LEE BITLER, DIRECTOR OF HUMAN RESOURCES, COUNTRY MEADOW, INC., ON BEHALF OF THE AMERICAN HEALTH CARE ASSOCIATION, HERSHEY, PA**

Ms. BITLER. Thank you.

Good afternoon. My name is Lee Bitler, and I am the director of human resources for Country Meadows Corporation in Hershey, PA. Country Meadows owns and operates nursing homes and assisted living residences in towns and cities across the state. We have 21 facilities, housing 3,000 residents and employing 1,585 people.

I am here also as a representative of American Health Care Association, AHCA, a federation of 50 state associations representing over 11,000 non-profit and for-profit subacute, nursing facility and assisted living providers nationwide. I appreciate the opportunity to come before you today to speak on a very important topic and to relate my experiences with the criminal history and abuse prevention requirements in Pennsylvania.

On behalf of America's long-term care providers, we fully support a national criminal background check system for prospective long-term care employees. In fact, we have been working for several years to create and implement a national system for criminal background checks and a system which would link state data bases and abuse registries. We have been working on this initiative not because of any legislative or regulatory mandate but because providers like Country Meadows make taking care of residents our life's work.

Protecting them from criminal abuse, theft or mistreatment is an important ingredient in assuring their wellbeing. We have developed a three-prong approach that will advance us on this course. First, it is essentially that Congress nationalize the nurse aide registries that contain important background information on nurse assistants. Under the current system, nurse assistants can move from state to state and nursing facilities without the benefit of being able to access other state registries. Second, we need in place an easy-to-use, one-stop shopping, national criminal background check system for prospective long-term care employees; and third and perhaps most significantly, we recognize that education and prevention are crucial.

Having put forth these three principles to move forward on protecting our residents, I am compelled to also make clear the following three areas of caution, which are critical to the success of this initiative. First, vulnerable elderly and disabled citizens need to be from criminal harm regardless of where they reside. These background checks should apply to home health workers and any other long-term care providers. Second, these checks must be paid for. Preventing criminals from abusing the vulnerable residents in long-term care settings is a legitimate function of the government, and as such, government must allocate the resources necessary to accomplish this noble goal.

As care providers with very high reliance on Medicaid and Medicare, we have limited ability to make any adjustments in pricing

to pay for additional costs. We are often faced with the difficult dilemma of making cutbacks in operations, service, maintenance or other critical functions to pay for a new mandate. I would recommend fully funding the Department of Justice to carry out what I see as their duty, protecting citizens from criminals.

Third, I cannot stress enough that the results of these checks must be returned in a matter of days, not weeks or months. It is my understanding that if every prospective employee of every nursing facility were required to undergo a Federal check, the FBI would have over 1 million additional checks to perform every year, 1 million. Add this to the current delays in results, and we could have several serious problems. These problems include: severe and dramatic shortages of caregivers while we wait for results; if there is no provisional or temporary work authorization, these applicants would likely find work elsewhere if the results took more than 15 days. If there is a provisional work authorization, a system in which results were not returned for several months or more could do more harm than good. It would give our residents a false sense of security, while creating a window in which those who seek to do harm are allowed to enter the door.

In Pennsylvania, we take this system extremely seriously. I can report to you with complete confidence that our providers are using this system and trying hard to make it work. There are severe penalties for facilities and administrators who fail to comply fully with our law. Nursing facilities will lose their licenses if they do not check every resident; on top of this, administrators are held personally liable for compliance of their facilities. They are personally subjected to both fines of \$2,500 and being thrown in jail.

Our experience in Pennsylvania could be instructive as to the strengths and difficulties of such a system. In 1995, the state passed a law requiring criminal history background clearance on all employees in specific long-term care settings, including nursing homes, personal care homes, home health agencies, domiciliary care homes and other in-home service settings. This law applied to every employee, including those on contract, and prohibits employment of individuals with specific criminal convictions from being hired or continuing employment. In 1996, our state legislature revisited the act and added strengthening amendments to improve its applicability.

The amendments removed a provision allowing employment if the convictions were more than 10 years old, thus preventing hiring of persons convicted of crimes from ever working in long-term care. Additionally, two companion acts were signed into law that are designed to eliminate resident abuse through education and mandate reporting of abuse. Act 13 of 1996 requires all staff to report incidents of abuse and suspected abuse to protective service agencies and to law enforcement agencies when the resident has been physically harmed. This law establishes very specific follow-up procedures and stiff penalties for failure to make the mandated reports.

Act 14 requires a criminal history background clearance on nurse aide training candidates prior to enrollment in training programs. This act also expands the curriculum of the training programs to include a course of study on resident abuse detection and preven-



tion. Each of these proposals is being implemented through Pennsylvania's regulatory review process now, and training programs have been teaching these techniques since May 1998.

Pennsylvania's system presents numerous challenges to providers. With Pennsylvania's unemployment rate at an all-time low, providers are struggling to staff facilities. Add on a slow response rate, and our difficulties are increased, particularly when an employee must enroll in a training program. Pennsylvania's law requires Pennsylvania State Police clearance on applicants who have been residents for at least 2 years and an FBI clearance on those who have not been a resident for 2 years. The turnaround time for a state police clearance is approximately 30 to 45 days, and an FBI check can take 90 days or longer. With the added volume of 50 states requesting clearance on an estimated million applicants per year, the system could grind to a halt.

Very few applicants are willing to wait to start training and begin work. A national system must turn around requests for clearance in less than a week in order to be effective and workable for the industry.

Another difficulty created by the Pennsylvania system is the output. If a request to the Pennsylvania State Police uncovers a hit or a criminal record, the state police send the requesters an actual rap sheet. Nursing home and personal care administrators and human resource directors such as myself are forced to interpret these often incomplete rap sheets to determine whether the individual can be hired or retained. I have attached a list of crimes that prohibit employment. We have no argument with the selected prohibited crimes, but it is extremely difficult to distinguish by reading the rap sheets whether an employee has been convicted of a barrier crime. I would recommend a national system that would respond to an administrator's request for a clearance with a simple yes or no answer and leave interpretation of criminal records up to the experts.

I hope this hearing and the Senate's Aging Committee focus will yield serious and thoughtful deliberation on how we can best equip our nation's facilities with the tools needed to maintain quality staffing. With the leadership of Senators Kohl and Reid, I am confident that Congress will continue to work with law enforcement and long-term care providers to meet the challenges that confront those who are America's seniors.

We are an industry that has undertaken a huge responsibility of caring for our most vulnerable citizens. We cherish the awesome responsibility and will continue to work tirelessly to improve upon delivery of quality service.

Mr. Chairman, we are already a part of finding the solution and hope that you and this caucus will join us in the efforts. Thank you for your time, and thank you, Mr. Chairman.

[The prepared statement of Ms. Bitler follows:]

**Testimony of Lee Bitler,  
Director of Human Resources  
Country Meadows**

**September 14, 1998  
Senate Committee on Aging**

My name is Lee Bitler, and I am the Director of Human Resources for Country Meadows Corporation in Hershey, Pennsylvania. Country Meadows owns and operates nursing homes and assisted living residences in towns and cities across the state. We have 21 facilities, housing approximately 3,000 residents, and employ 1,585 people. I appreciate the opportunity to come before you today to speak on a very important topic, and relate my experiences with the criminal history and abuse prevention requirements in Pennsylvania.

On behalf of America's long term care providers, we support a national criminal background check system for prospective long term care employees. We have developed a three-pronged approach that will advance us on this course.

First, it is essential that Congress nationalize the nurse aide registries that contain important background information on nurse assistants. Under the current system nurse assistants can move from state to state, and nursing facilities are without the benefit of being able to access other states' registries.

Second, we need in place an easy-to-use, one-stop shopping, national criminal background check system for prospective long term care employees.

And third, and perhaps most significantly, we have recognized that education and prevention are crucial.

In 1995, Pennsylvania passed a law requiring criminal history background clearance on all employees in specific long term care settings, including nursing homes, personal care homes, home health agencies, domiciliary care homes, and other in-home service settings. This law applied to every employee, including those on contract, and prohibits the employment of individuals with specific criminal convictions from being employed or continuing employment. In 1996, our state legislature re-visited the Act and added strengthening amendments and increased its applicability. The amendments removed a provision allowing employment if certain convictions were more than ten years old, thus, prohibiting employment of persons convicted of crimes from ever working in long term care.

Additionally, two companion acts were signed into law that are designed to eliminate resident abuse through education and mandate reporting of abuse. Act 13 of 1996 requires all staff to report incidents of abuse and suspected abuse to protective service agencies and to law enforcement agencies when the resident has been physically harmed. This law establishes very specific follow-up procedures and stiff penalties for failure to make the mandated reports. Act 14 requires a criminal history background clearance on nurse aide training candidates prior to enrollment in a training program. This Act also expands the curriculum for the training programs to include a course of study on resident abuse detection and prevention. Each of these proposals is being implemented through Pennsylvania's regulatory review process now, and training programs have been teaching these techniques since May of 1998.

Pennsylvania's system presents numerous challenges to providers. With Pennsylvania's unemployment rate at an all-time low, providers are struggling to staff facilities. Add on a slow-response clearance process, and our difficulties are increased, particularly when an employee must enroll in a training program. Pennsylvania's law requires a Pennsylvania state police clearance on applicants who have been a resident for at least 2 years, and an FBI clearance on those who have not been a resident for two years. The turnaround time for a state police clearance is approximately 30 to 45 days, and an FBI check takes 45 to 90 days. Very few applicants are willing to wait to start training and begin work. A national system must turn-around requests for clearance in less than a week in order to be effective and workable for the industry.

Another difficulty created by Pennsylvania's system is the output. If a request to the Pennsylvania state police uncovers a "hit" or a criminal record, the state police send the requester an actual "rap-sheet". Nursing Home and Personal Care Administrators and Human Resources Directors are then forced to interpret these often incomplete rap-sheets to determine whether the individual can be hired or retained. I have attached a list of the crimes that prohibit employment. We have no argument with the selected prohibitive crimes, but it is extremely difficult to distinguish by reading the rap-sheets, whether an employee has been convicted of a barrier crime. I would recommend a national system that responds to an administrator's request for a clearance with a simple yes or no answer, and leave interpretation of criminal records up to the experts.

Pennsylvania's law makes no mention of unemployment compensation, if an employee is dismissed because of a criminal record. Our law is being tested now in the courts by employees who have been dismissed. The facility is caught squarely in the middle and may be forced to bear the costs of unemployment compensation for an employment decision that is clearly out of their hands. I would recommend that the national system operate between the employee and the clearance agency, and leave facilities out of the decision process.

Lastly, I would strongly recommend that a national system take precedence over any inconsistent state laws. By having differing systems in many states, people with criminal records will continue to slip through the cracks. Companies working in many states will be better able to assure compliance.

The American Health Care Association (AHCA) has joined with the National Association of Attorneys General (NAAG) and have developed a unique partnership that teams the long term care industry with law enforcement on a national level. Our goal has been to work together to develop a system that will effectively weed out potentially abusive employees, while at the same time recognizing the staffing obstacles nursing facilities face.

In May of last year, in Boston, former president of NAAG, Attorney General Scott Hashbarger, convened at Elder Summit. At that meeting, AHCA and NAAG announced that they would work together to find a solution. Since that time these partners have worked closely with the Senate Aging Committee (in particular Senators Grassley, Kohl and Reid) to identify and propose solutions to contentious issues that surround the criminal background check issue. The partnership is a work in progress. And because the challenge before us is complex, we welcome the participation of interested parties to constructively address the issues we face in pursuit of this goal.

Let me outline for you the principles agreed to by AHCA and NAAG in pursuit of this legislation. We support the following:

- Law enforcement, local and federal government, and the long term care profession will work in a partnership towards reducing and eliminating incidences of abuse and neglect in our nation's long term care system.
- Nursing facilities and other long term care providers should have the ability to conduct criminal background checks and access a national nurse aide registry through an efficient, one-stop-shopping, and inexpensive national criminal background check system that returns results within 24 hours.
- All states should have access to the successful and effective "Patient Abuse Prevention Initiative."

Our partnership has also identified some problem areas where we need more input from interested parties. The following are examples of unresolved concerns:

- Are only non-licensed facility employees subject to the checks? Some state licensing boards may oppose doctors or nurses being subjected to the checks. Conversely, groups representing nurse aides or other long term care employees might resent being singled out.
- What are the liability issues for facilities that fail to use the system? Or that fail to use it correctly?
- How will the federal system integrate with existing state criminal background check requirements?
- Will the technology exist for us to reasonably expect that national criminal background checks can be conducted in a prompt and inexpensive manner? For this system to work, we need one-stop shopping and we need the information quick. Otherwise, we will end up with more staffing shortages, putting more pressure on existing staff. Waiting 45 to 90 days for clearance from the FBI, which is our system in Pennsylvania, has created problems already. We are unable to enroll nurse aides in training without the clearance, and potential employees cannot wait that long to start work.
- Will there be mitigating circumstances for certain types of crimes and prospective employees? If someone has a 20 year old drug conviction on their record, but has had a clean slate since then, is that person barred from working in our facilities?
- Are there privacy issues that could prevent an early and swift implementation of the system?

These are but a few of the issues we have encountered as we move toward developing legislation. Both law enforcement and the industry are committed to this effort, but even within the partnership, we sometimes approach the issues from different angles. We are not intimidated by that, and on many of the issues we are in agreement. What we are committed to is trying to find answers to these questions -- and finding them soon.

I hope this hearing and the Senate Aging Committee's focus will yield serious and thoughtful deliberation on how we can best equip our nation's facilities with the tools needed to maintain quality staffing. With the leadership of Senators Kohl and Reid, I am confident that Congress will continue to work with law enforcement and long term care providers to meet the challenges that confront those who are for America's seniors.

We are an industry that has undertaken the huge responsibility of caring for our most vulnerable citizens. We cherish that awesome responsibility and will continue to work tirelessly to improve upon the delivery of quality services. Mr. Chairman, we are already a part of finding the solution and hope that you and this Caucus will join us in our efforts. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.  
Dr. Reichard.

**STATEMENT OF RICHARD REICHARD, EXECUTIVE DIRECTOR,  
NATIONAL LUTHERAN HOME FOR THE AGED, ON BEHALF OF  
THE AMERICAN ASSOCIATION FOR HOMES AND SERVICES  
FOR THE AGING, ROCKVILLE, MD**

Mr. REICHARD. Thank you very much, Mr. Chairman and members of the committee for this hearing on this most important subject. I am director of the National Lutheran Home, which is a 300-bed nursing home with light, moderate and heavy care in Rockville, MD. We have a very strong sense of mission, and people are our only business, and we do our very best to make sure they are well cared for and protected. We have tried to achieve high levels of compliance and have been deficiency-free under nursing home regulations for 4 years in a row.

In Maryland, we have had significant experience with background checks. A law in Maryland mandated, as of July 1, 1996, that all staff who are not otherwise backgrounded by the Health Occupations Professional boards, such as nurses, nursing home administrators, doctors, all staff working in nursing homes who are not certified by such boards will have a criminal background check made on them. In the case of our National Lutheran Home facility, we have checked and have found an 8.3 return in positive criminal backgrounds, records. We are allowed in Maryland to have a private agency do this, which has been most helpful in having a very quick turnaround time, within 24 hours. So, we have the check results in hand before we even engage the employee, which we find extremely beneficial. So, one of the considerations that the committee might make in the bill is whether or not a private agency type check should be made, as compared to state checks or even FBI checks, which, as you have just heard testified, can be very, very long.

So, timeliness is extremely important to us. Most of our employees at the home, if they leave, they leave within the first 4 months of their probationary period and typically because they have not been able to meet our expectations in terms of performance. If the background check takes 3 months to obtain, believe me, it will produce an artificial and unnecessary stigma among certified nursing aides and others that they actually left because they had a criminal background. So, that may be a minor matter, but among peer group pressures and feelings, timeliness, again, is extremely important.

We believe the criminal background check should cover health care employees more broadly, not just nursing homes. I have been in the field of long-term care for 31 years. I know nursing home is one of the most emotionally laden terms in our society. I must tell you: I know over 100 nurse assistants whom you would be proud to know, doing work that no one else in our country is standing in line to do; certification of 75 hours' training to be certified and then renewals of that certification have been extremely helpful and important and has raised the level of nursing home performance in our country in a measurable and discernable way, and it has been mentioned, I believe, by the chairman that, again, these

are people who are very often very caring and very dedicated, but there are nursing assistants also in home health care, assisted living, nursing home and hospital. We believe that health care settings more broadly should be subject so that we do not keep them out of nursing homes and then have those with criminal records hop from one type of facility to another. So, we would certainly urge that, but also that checks be kept affordable. Our checks in Maryland, done by a firm contracted through our state association, has a \$7.50 charge for each check. We get the name, Social Security number, the nature of the offense, the date of conviction, the penalty that was conveyed.

I have seen possible bills that say perhaps up to \$50, and, you know, that may be all OK. That may well be worth doing; but also, for those of us who have large Medicaid populations, and we have 60 percent, they should be reimbursable under Medicare and Medicaid rules, as I believe they would be.

So, affordability and timeliness are extremely important. Liability protection is extremely important. We need to be, if you will, legally indemnified for taking the hard actions that we must take to terminate someone whose record is unacceptable when we choose not to either employ initially or keep employed, and there were provisions in the—I believe, Senator Kohl's amendments to the Department of Justice bill that would have allowed for a voluntary criminal background check that had good liability protection provisions in that bill, and we would certainly opt for that. That was S. 2260.

We believe also any effort in criminal background checks should be coordinated among the law enforcement agencies, especially if they have to be State or Federal, so that there is no redundancy. The nationalization of the nurse registry would be a very important development, a one-stop shopping, if you will, that is affordable.

I must conclude by telling you that we have zero tolerance for abuse at the National Lutheran Home. We have not had a lot of cases. Three months ago, we did terminate a nurse assistant who was treating a very demented resident; lost her cool, slapped the resident, bruised an upper lip; was heard by another nurse assistant who dutifully and honorably reported this event. We terminated her immediately. She had been employed by us for 8 years without any prior record of this having occurred. I think those who take care of demented people, there is absolutely no excuse, and I do not want to be interpreted that way, but again, difficult situations where residents often become quite abusive themselves in understandable ways, perhaps because they are demented; terminated the employee; called the ombudsman; ordered by the state survey agency to call the police.

It concerned me because we are going to our third court hearing, our director of nursing and this nursing assistant and the one who is accused; the third court day; another one coming up in November, because in Maryland, you need a conviction to come off the registry. It would be very helpful if there were an administrative process to get the person off the registry first, and then, if it is prosecutable, prosecute. The situation that we now have, at least in Maryland if not other places, is prosecution only, and too often, it may be that the penalty is, in this instance of a bruised upper

lip, a fine or jail time may be further than we needed to go if there had been a careful administrative remedy.

I realize I am over my time, and I apologize. I did want to share this current case to let it be known to all of you that when an individual's rights are protected, of course, under the law, and the abuse is reported, if it has to go to the State's attorney, it gets elongated and cumbersome in a way that, I guess, the old phrase was one might throw out the baby with the bath water, and we need to be very careful that that not occur.

Thank you very much.

[The prepared statement of Mr. Reichard follows:]





**THE AMERICAN ASSOCIATION OF HOMES  
AND SERVICES FOR THE AGING**

**Statement of**

**Rev. Richard D. Reichard, M.A., D.Min.**

*Executive Director  
National Lutheran Home for the Aged  
Rockville, Maryland*

**before the**

**United States Senate**

**Special Committee on Aging**

**The Case for Criminal Background Checks**

**September 14, 1998**

**TESTIMONY OF****REV. RICHARD D. REICHARD, M.A., D.MIN.***Executive Director**National Lutheran Home for the Aged**Rockville, Maryland**Representing***THE AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING**

Mr. Chairman and members of the Committee, I am Richard Reichard, the Executive Director of the National Lutheran Home for the Aged in Rockville, Maryland. This facility, sponsored by the Lutheran Church, has 300 nursing home beds as well as 114 independent living units.

I am here today as a member of the American Association of Homes and Services for the Aging (AAHSA), a national organization of over 5,200 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community-based organizations. More than half of AAHSA's membership is affiliated with religious organizations; the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. With our broad range of facilities and services, AAHSA serves more than one million older persons daily. For the past thirty-six years, AAHSA has been an advocate for the elderly themselves and for a long-term care delivery system that assures all those in need of high quality services and quality of life.

We appreciate the opportunity to address the Committee on the issue of requiring criminal background checks for health care workers. From the outset I want to note that even one incident of abuse against a nursing home resident is one too many. We want to work with this Committee, with other members of Congress, with the Health Care Financing Administration, and with state agencies to improve the current system and ensure the highest quality of care for nursing home residents.

**Background/Nurse aide registry**

The federal nursing home standards under the Omnibus Budget Reconciliation Act of 1987 (OBRA) and its regulations require each state to have a registry listing each individual who has successfully completed a nurse aide training and competency evaluation program. The registry is maintained by the state agency responsible for surveying nursing facilities.

In the event a nurse aide is accused of any act of abuse, neglect, or misappropriation of funds against a resident of a nursing facility, the state survey agency must investigate the allegation. If the state agency finds merit in the complaint, it must enter into the registry the documentation of its investigation, including the allegation and the evidence that led the state to conclude that the allegation was valid, as well as a statement by the nurse aide disputing the allegation, if he or she chooses to make one. This information must be entered on the registry within ten days of the finding.

OBRA regulations required this information to remain in the registry permanently. This requirement was changed by Section 4755 of the Balanced Budget Act, which enables nurse aides to have their names removed from the existing registry on the grounds that their employment and personal history does not reflect a pattern of abusive behavior or neglect and that the abuse involved in the original finding was a singular occurrence. Names must be on the registry for a year before they can be removed.

Under OBRA, these registries are kept by each state, but there is no requirement that states make the information on their registries available to other states. The current lack of communication between states makes it difficult for nursing facilities to obtain background information on a potential employee who previously worked in another state. We are hopeful that the development of a national background check system will lead to greater availability of information from nurse aide registries on an interstate basis, detecting and screening out individuals who pose a direct threat to the health and welfare of vulnerable older persons.

#### **Facilities' experience under Maryland law**

Maryland law requires adult dependent care programs to get a criminal history records check for any potential employee who will have "routine, direct access to residents and the individual is not licensed or certified under the Maryland health occupations article." In a three-month period, July through September, 1996, a survey was taken of how many individuals with criminal records applied for employment with AAHSA members in Maryland. Among these 106 facilities, there were 1,041 applicants for employment during the three-month period, of whom 226, or 22% had criminal records. During the next three-month period, October through December, 1996, there were a total of 1,272 applicants for employment, of whom 237 had a criminal record. The percentage with a criminal record was lower during the second period, 19% versus 22% for the earlier period.

These data indicate that the criminal background check requirement screened out a significant number of people whose backgrounds made them unsuitable for work with nursing facility residents. Arguably, the decline in the number of job applicants with criminal backgrounds in the second quarter could be attributed to individuals' taking themselves out of consideration for these jobs because of their knowledge that they would not pass a background check.

At my own facility, we have done background checks on 121 job applicants between July 1, 1996 and August 31, 1998. Of that number, 10 individuals, or 8.3% of the total, had a criminal record in the state of Maryland. None of the ten individuals who were screened out by the background check were nursing personnel, but instead would have been classified as food service, maintenance, or environmental service workers. Again, our experience shows that the background check has succeeded in preventing individuals with unsuitable backgrounds from working in our facility.

However, our present system allows us to check only for an individual's criminal background in the state of Maryland. We have no means of checking whether a job candidate may have committed crimes in other states, and it is for that reason that a national system of background checks would be useful.

### Federal legislative issues

AAHSA supports the development of a national background check system. In our view, the following issues must be addressed in any federal legislation:

#### Categories of employees subject to a background check requirement

Maryland state law and bills introduced in Congress last year apply the background check requirement only to employees with direct, unsupervised access to residents. There has been some discussion of extending the requirement to all employees of a nursing facility. We are unclear on the usefulness or need for this expansion of the background check requirement to cover employees who have little opportunity to commit crimes of abuse. Unless there has been evidence of abuse having been committed by non-nursing employees, the background check requirement should apply only to those employees who have direct and unsupervised access to residents.

Senator Kohl's own state of Wisconsin recently adopted a criminal background check law that requires only employees who will have access to a facility's clients to undergo a background check. Employees who provide infrequent or sporadic services, including maintenance services and other services not directly related to the care of a client, are exempt from mandatory background checks. We feel that the background check requirement should focus on where the real problems lie.

#### Apply the background check requirement to all health care providers

If a criminal background check requirement is instituted at the federal level, it should apply to all health care providers, not just to nursing facilities. Based on evidence and anecdotal information, situations involving abuse or misappropriation of property have not been limited to nursing facilities but also have taken place in hospital and home care settings. It does not make sense, from a public policy viewpoint, to bar individuals with criminal records from working in nursing facilities while leaving them free to work in hospitals and other health care settings. If the background check requirement were applied to all health care settings, nursing facilities would be better able to screen out and avoid employing individuals who may have abused patients in other health care settings. In addition, nursing facilities already bear the expense of training nursing personnel who frequently go on to work in other settings where wages tend to be higher. We should not be in the position of bearing the whole cost of checking into criminal backgrounds as well.

Looking at the Wisconsin law once again, it requires background checks to be conducted on and by any facility, organization or service that is licensed or certified by or registered with the Department of Health and Family Services to provide direct care or treatment services to clients. This definition includes hospitals, nursing homes, home health agencies, hospices, personal care worker agencies, and supportive home care service agencies.

### Financing and limitations on fees

Legislation must set limits on the fees that state and federal agencies may be permitted to charge for doing background checks. Performing background checks will add considerably to nursing facilities' operating costs. Facilities average 110 employees, with some employing far larger numbers, and many facilities unfortunately experience significant turnover in employment. In the past, some states have charged fees far above the actual cost to their agencies of performing a background check, essentially converting the fee into a revenue-raiser for the state. Federal legislation must limit the amount that facilities will be charged for a background check to no more than the actual cost, up to a set limit.

For each background check that my facility requests, we currently pay \$7.50, plus \$0.25 for faxing. So far, criminal background checks have cost us a total of \$937.75. On average, we do 4.65 background checks per month, at an average monthly cost of \$36.07, or an annual cost of \$418.50. While not exorbitant, this has been a significant cost to the facility. We understand that a federal background check might cost as much as \$50. At our current rate of background checks, that fee would increase our costs by 564%, to an average annual cost of \$2,790, a substantial addition to our operating costs.

AAHSA strongly believes that any fees that facilities are required to pay to obtain background checks on their employees must be fully reimbursable under the Medicare and Medicaid programs. If criminal background checks become a regular cost of hiring staff, the background check would be directly related to the care that is provided to residents, and the fees charged for background checks should be reimbursable by the federal programs that pay for nursing home care.

As indicated above, the cost of criminal background checks will be significant for nursing facilities. The Balanced Budget Act of 1997 already has imposed Medicare reimbursement cuts on facilities under the prospective payment system, new administrative costs for consolidated billing, and potential Medicaid reimbursement cuts through the elimination of the Boren amendment. We do not think it would be equitable, and we do not think that the quality of nursing care would be enhanced, by imposing a major new cost on nursing facilities and then denying them reimbursement for it.

Furthermore, the recent hearing by the Senate Special Committee on Aging paid a great deal of attention to staffing levels in nursing facilities. Requiring facilities to do background checks, but denying them reimbursement for the cost, would be counterproductive to efforts to increase staffing levels, since the heavy fees that would have to be paid for background checks would be a disincentive to hiring more staff unless the fees could be passed through to Medicare and Medicaid.

### Background check mechanics

- There should be reasonable and specific criteria for barring someone from working in a health care setting. Only crimes or adverse findings that have a direct bearing on a person's suitability to work in a nursing facility should disqualify them. There should also be due process protections to enable a health care worker to enter his own statement about an adverse finding that has been made against him on his record.

- Any system for running criminal background checks on health care workers should be coordinated with the state nurse aide registries that have been established under OBRA. In Ohio, where a criminal background check already is required for nursing home employees, facilities must do duplicative searches through two state agencies; one which maintains the nurse aide registry and one which maintains criminal records. This duplicative system is time-consuming and costly. Any federal system that is established should enable health care providers to obtain all the information they need through one search with one agency.
- Some states, including Maryland, that already have instituted background check requirements have permitted facilities to contract with private firms such as detective agencies to do the background check. AAHSA members from these states have indicated that private agencies generally have returned information more quickly, in more usable form, and for a far lower cost than was possible for state agencies. If possible, we would favor an option for facilities to use private agencies to do background checks.
- Any federal legislation must set time limits for state agencies to report the results of background checks back to facilities. Since adequate staffing is required by OBRA, facilities must be able to fill positions as quickly as possible. At the National Lutheran Home, we offer applicants a job conditioned on a satisfactory Maryland criminal background check. We immediately fax a request for a background check to the agency, and the results of the background check are faxed back to our personnel office within 24 hours of the time the agency receives our request. We then are able to withdraw job offers from individuals who have criminal records in Maryland. Because of the short turn-around time for the information on a records check to get back to us, the current system has worked smoothly. If we are forced to wait a longer time, the process will become cumbersome for both the facility and the potential employee.
- If a longer time is allowed for agencies to complete a background check, facilities must be allowed to hire staff on a provisional basis, pending the background check, since facilities generally must fill positions quickly in order to maintain a full staff. If an employee fails the background check, the facility must be permitted to terminate him or her. The termination must be counted as being for just cause for unemployment insurance purposes, in order to prevent the facility from being charged for unemployment benefits.

#### Immunity from liability

Facilities must be protected from being sued by employees who are terminated for failing a background check, a provision that is included in the Maryland law requiring criminal history checks. Employers generally are reluctant to provide much substantive information on former employees because of lawsuits that have been brought charging employment discrimination. There must be provision in any federal legislation to specify that nursing facilities are not liable for any employment action they take on the basis of a criminal background check.

Additionally, in the perhaps rare event that the background check fails to reveal a job candidate's criminal record, facilities must be held harmless for hiring such an individual as long as they have followed all of the required procedures and taken due precautions.

### **Conclusion and summary**

Abuse or neglect of older persons cannot and must not be tolerated. AAHSA supports the development of a national system to verify that caregivers to the elderly do not have a history of abusive behavior.

To summarize our recommendations:

- All health care providers should be required to obtain criminal background checks on those employees that have direct and unsupervised access to patients.
- Searches must be kept affordable, and the timely return of accurate information will be crucial.
- Reimbursement under the Medicare and Medicaid programs must account for the costs associated with the background check requirement.

The development of a national system by which the background of health care workers could be checked for incidents of abuse or neglect of patients would be a useful tool for nursing facilities, enabling them to avoid hiring those who are not suited to caring for vulnerable people. Any system of this kind that is developed should coordinate with the nurse aide registries that already exist so that background searches may be done as expeditiously as possible. Once the mechanism for doing background checks is developed, it should be applied to all health care workers in order to prevent disqualified individuals from taking jobs in a different area of the health care field.

The CHAIRMAN. You are not saying in this instance you just report that that is a burden that as a nursing home, you do not want to fill; you do want to cooperate with the police——

Mr. REICHARD. Absolutely.

The CHAIRMAN [continuing.] In every respect.

Mr. REICHARD. Absolutely. We wanted the police report done; it was done. It is just that——

The CHAIRMAN. So, you are not being required to do anything that you feel is unfair or too burdensome for you.

Mr. REICHARD. Well, I guess when I have my director of nursing out for 3 days, that is probably not too burdensome for us administratively. I am afraid that when it takes another nurse assistant to charge another nurse assistant, the more times that that person must go in a courtroom and confront the person whom they have charged and, again, then, by the peer group regarded as somebody who ratted on somebody else——

The CHAIRMAN. There could be a discouragement.

Mr. REICHARD. It could be a discouragement. I just think it is a real world. We have got the ideal and the real, and I think that the real just has to be part of every legislation and every consideration.

The CHAIRMAN. OK; Ms. Putnam. And you may have to pull that closer to you, about 6 inches roughly. Thank you.

**STATEMENT OF MELISSA PUTNAM, CERTIFIED NURSE AIDE,  
BEVERLY MANOR, ON BEHALF OF THE SERVICE EMPLOYEES  
INTERNATIONAL UNION, READING, PA**

Ms. PUTNAM. Hi; my name is Melissa Putnam, and I am a single mother of four children. I am a certified nursing assistant at Beverly Manor of Reading, PA. I have worked as a nursing assistant for 9 years and at Beverly Manor for the last 6. I am also a member of the Service Employees International Union, Local 1199P. Our union represents more than 100,000 nursing home workers across the country.

Chairman Grassley and Senator Kohl and other members of this committee, thank you very much for this opportunity to testify. I am horrified by the stories we have heard today about abuse and neglect of nursing home residents. I was drawn to nursing home work because I enjoy working with people. Interacting with the residents in my nursing home keeps me going. My days are filled with talking and joking with them. I care about them very much, and I would never want any of them exposed to someone who has committed a crime in the past.

The problem that I see in nursing homes is that too many new workers are constantly coming in the door. Because the job is extremely taxing and of the low wages, it is hard to keep good, committed workers. Let me explain to you what my typical day is like. I work the day shift, which starts at 7 a.m. and ends at 3 p.m. I usually have 13 to 15 residents to care for during my 8-hour shift. I have to pass out breakfast trays, which takes up to 2 hours, because I have to prepare everyone's meals, fix their trays up with the milk and cutting up their food, and I also have to feed two to three of them who cannot feed themselves.



Between 9 a.m. and 11, I do what is called a.m. care, which means bathing and dressing everyone and getting them ready for the day. Also, throughout the morning, I take people to the bathroom and turn and prop the sick ones. In between that, I also try to take a 15-minute break, which sometimes, I do not have time for. Then, I rush out to my lunch break as soon as possible, and I come back to serve everyone their lunch, which means getting some of them transported up to the dining room and helping others eat in their rooms.

Twice a day, I drop everything and distribute nourishments, Ensure drinks, to about half of my residents. I also have a list of people that I have to walk. This means that I have to spend 15 minutes each day with these residents, helping them to walk or do passive range of motion activities.

Every few minutes throughout the day, I have to respond to call bells or alarms that they have on their wheelchairs so they can remain restraint-free. Then, I do my rounds, which is toileting everyone and putting them down for a nap. Finally, at the end of the day, I spend a half an hour doing my book work. For each resident, I must record how they are performing the activities of daily living, or ADLs, which means tracking how much they have eaten, moved around; whatever they had; whenever they had a bowel movement and other details.

As you see, I have so much to do and too little time. I run myself ragged every day, and every day, I am frustrated, because I know I should be doing more. I work as fast as I can, but it is not physically possible to keep up with the demands of my time. I stick with it because I care for the residents, and I know they need my care. They tell me how much they like me and that I am doing such a good job and give me encouragement. Sometimes, I hear these statements a lot; I hear how do you do this work, or do you like your job?

Because we have a union, I also get paid more than the \$6 to \$7 per hour that most nurse aides earn. At Beverly Manor, we do not have turnover rates like 100 percent like most nonunion homes, but we still have constant staff changes. This means strangers coming in and out of the door to take care of the residents.

Recently, we have had some problems with stealing. A VCR and other items disappeared, and we suspected that someone on staff took them. Sometimes, people come in, do not stay very long, and they leave for unknown reasons. Recently, I have found out that one of our workers who had left is in prison, and that makes me very uncomfortable. I do not want people like this coming to our home, but until working conditions improve, there will be lots of people coming and going. Most people cannot handle the stress I feel every day. They will find other work that is easier and pays more.

A lot of people leave because the job is so dangerous. Workers hurt their backs, and then, they try to lift residents alone because there is no one around to help. It is no surprise that the injury rate for nursing home workers is higher than the injury rates of coal miners, construction workers and other people in the steel mills.

Because of the problems keeping people on the job, I agree that nursing homes should be required to run criminal background checks on new applicants. We have such a law in Pennsylvania, and to some degree, this makes it easier for me to feel comfortable with the parade of new workers who rotate through the home where I work. Criminal background checks can be useful protection to weed out the wrong kind of people. If the Federal Government is going to require them, I urge you to avoid some of the mistakes we have made in Pennsylvania to respect the workers' rights.

I have three specific suggestions: first, nursing homes should be prohibited from passing on the cost of the checks to workers. In Pennsylvania, homes are charging applicants \$10 to \$15 for their own checks. If Federal checks are also required, the cost will be even greater. Asking the workers to pay is not fair. I do not know if I was asked to pay \$20 to \$50 up front, that it would make me think twice before applying for this job.

Second, there should be some kind of appeals process for people who believe that they have been wrongly accused of having a criminal background. In big systems like this, there are always mistakes, and people should have some way of protecting themselves from being the victims of these mistakes.

Finally, systems must be in place to process these checks quickly. If the scope of the check is broadened, and the Federal systems are not ready to handle all of these checks, it will take much longer. Workers should not have to linger for months on probationary status, waiting for their checks to be completed. A resident should not be exposed to a long-term basis of workers who have not been screened.

Let me sum up this by saying on behalf of my coworkers of Beverly Manor and my union brothers and sisters of SEIU, I support criminal background checks for nursing home workers, because I do not want to work with bedside criminals, and I do not want the residents I care for to be in danger. I urge this committee to move forward on this issue. As you are working on this issue, I urge you not to forget about the root causes of these problems. Until nursing homes are adequately staffed, and workers are properly trained and fairly compensated, we will continue to have a revolving door work force. High turnover rates compromise the quality of care and leave residents at risk of abuse and neglect. For the wellbeing of the workers and the residents they serve, I urge you also to address these larger and more challenging issues.

Thank you again for this opportunity to be here, and I will be happy to answer any questions you might have.

[The prepared statement of Ms. Putnam follows:]



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**TESTIMONY OF**

**Melissa Putnam, Certified Nurse Aide  
Beverly Manor of Reading, Pennsylvania  
Member, SEIU Local 1199P**

**SUBMITTED TO**

**The Special Committee on Aging  
United States Senate**

**September 14, 1998**

My name is Melissa Putnam. I am a certified nurse aide at Beverly Manor in Reading, Pennsylvania. I have worked as a nurse aide for nine years and at Beverly Manor for the last six. I am also a member of the Service Employees International Union, Local 1199P. Our union represents more than 100,000 nursing home workers across the country. Chairman Grassley, and other members of this committee, thank you very much for the opportunity to testify.

I am horrified by the stories we have heard today about abuse and neglect of nursing home residents. I was drawn to nursing home work because I enjoy working with people. Interacting with the residents in my nursing home keeps me going. My days are filled with talking and joking with them. I care about them very much. I would never want any of them exposed to someone who had a committed crimes in the past.

The problem that I see in nursing homes is that too many new workers are constantly coming in the door. Because the job is extremely taxing and the wages very low, it is hard to keep good committed workers. Let me explain to you what my typical day is like:

I work the day shift which starts at 7am and ends at 3pm. I usually have 13 to 15 residents to care for. During my eight hour shift I have to:

- Feed everyone breakfast, which takes up to 2 hours because I have to prepare everyone's meals and feed the 2 or 3 of them who can't feed themselves.
- Between 9am and 11am I do what I call AM care - that means bathing and dressing everyone and getting them ready for the day.
- Also, throughout the morning I take people to the bathroom, and turn and prop the sickest ones.
- Then I rush out for my lunch break and as soon as I come back it's time to serve people lunch which means getting some of them transported up to the dining room and helping others to eat in their room.
- Twice a day I drop everything and distribute nourishments - "Ensure" drinks - to about half my residents.
- I also have a list of people on the walking list. This means I have to spend 15 minutes each day with these residents helping them to walk or do passive range of motion activities.

- Every few minutes throughout the day I have to respond to call bells or alarms that we have on wheelchairs so people can remain restraint free.
- Finally, at the very end of the day I spend 1/2 hour doing my "bookwork." For each resident I must record how they are performing the activities of daily living or ADL's, which means tracking how much they ate, moved around, whether they had a bowel movement and other details.

As you can see, I have too much to do in too little time. I run myself ragged everyday and everyday I am frustrated because I know I should be doing more. I work as fast as I can but it is not physically possible to keep up with the demands on my time.

I stick with it because I like the residents. They tell me how much they like me and that I'm doing a good job and give me encouragement. Because we have a union, I also get paid more than the \$6 or \$7 dollars per hour that most nurse aides earn. At Beverly Manor, we don't have turnover rates over 100% like most non-union homes, but we still have constant staff changes. This means strangers coming in all the time to care for the residents.

Recently, we have had problems with stealing. A VCR and other items disappeared and we suspect that someone on staff took them. Sometimes people come in, don't stay very long and then leave for unknown reasons. Recently I found out that one of the workers who left is in prison. That makes me very uncomfortable.

I don't want people like this coming into our home. But until working conditions improve there will be lots of people coming and going. Most people can't handle the stress I face everyday - they will find other work that's easier and pays more. A lot of people leave because the job is so dangerous. Workers hurt their backs when they try to lift residents alone because no one is around to help. It is no surprise that the injury rate for nursing home workers is higher than injury rates for coal miners, construction workers and people who work in steel mills.

Because of the problems keeping people on the job, I agree that nursing homes should be required to run criminal background checks on new applicants. We have such a law in Pennsylvania and to some degree this makes it easier for me to feel comfortable with the parade of new workers who rotate through the home where I work.

Criminal background checks can be a useful protection to weed out the wrong kind of people. If the federal government is going to require them, I urge you to avoid some of the mistakes we have made in Pennsylvania and to respect workers' rights.

I have three specific suggestions:

- First, nursing homes should be prohibited from passing on the cost of the checks to workers. In Pennsylvania, homes are charging applicants \$10-\$15 dollars for their own checks. If federal checks are also required the cost will be even greater. Asking the workers to pay is not fair. I know that if I was asked to pay \$20 or \$50 dollars up front it would have made me think twice before applying for this job.
- Second, there should be some kind of appeals process for people who believe that they have been wrongly accused of having a criminal background. In big systems like this there are always mistakes, and people should have some way of protecting themselves from being the victims of these mistakes.
- Finally, systems must be in place to process these checks quickly. In Pennsylvania, it only takes about a week now to complete the checks. But if the scope of the check is broadened and the federal systems aren't ready to handle all these checks, it will take much longer. Workers should not have to linger for months on probationary status waiting for their checks to be completed. And residents should not be exposed on a long term basis to workers who have not been screened.

Let me sum up by saying that, on behalf of my co-workers at Beverly Manor and my union brothers and sisters at SEIU, I support criminal background checks for nursing home workers because I do not want to work

beside criminals and I do not want the residents I care for to be in danger. I urge this committee to move forward on this issue.

As you are working on this issues, I urge you not to forget about the root causes of these problems. Until nursing homes are adequately staffed, and workers are properly trained and fairly compensated, we will continue to have a revolving door workforce. High turnover rates compromise the quality of care and leaves residents at risk of abuse or neglect. For the well being of the workers and the residents they serve, I urge you to also address these larger and more challenging issues.

Thank you again for the opportunity to be here today. I am happy to answer any questions you might have.

The CHAIRMAN. I thank each of you. I have a few questions, and I am sure Senator Kohl does.

First, Mr. Schmett, does Iowa share information about prospective employees with criminal records with neighboring states?

Mr. SCHMETT. No, we do not. We would if we had any requests, but I am not aware of ever having been requested to do that.

The CHAIRMAN. I suppose contrary-wise, then, you do not check with other states about prospective employees within Iowa, either.

Mr. SCHMETT. No, and that is a major fault. Iowa information is available to people from outside of the state on criminal records. Those records are controlled by our Department of Public Safety, and there is a \$13 charge per name, but anybody anywhere in the United States does have access to the criminal records in Iowa.

The CHAIRMAN. An important point was made that the effectiveness of any background check is, of course, only as good as the criminal data in the system, whether that be the State or the Federal, the FBI. So, I am going to ask Mr. Schmett, and I also ask this of the Office of Inspector General. It seems that in both the testimony that you gave and that he gave, there are a number of examples of potential pitfalls in the transfer of data. My question is how can recordkeeping of criminal abuse be improved, and is it possible to avoid the types of problems that we see at the state level if a national system were to be put in place?

Mr. SCHMETT. That is one of the big difficulties we have had with implementing our checks. We do have a number of sources that we go to in Iowa besides just criminal records, such as dependent adult abuse, dependent child abuse, the nurse aide registry, professional licensing records. When we started to set up our system, we were thinking for the first time, computerization is available, so, this should not be difficult. What we found when we checked on that was that the degree of sophistication of that computerization varied greatly. For instance, my department's nurse aide registry, a person can get on a telephone with a code number from being a health facility, call in and instantly receive a yes or a no on whether a person is on that nurse aide registry.

We also found other lists that were literally a card file sitting in somebody's filing cabinet that they went through hand by hand each time. So, it has taken us a considerable amount of time to make all of these systems work together, and we are still working on a few files to be able to do that, where we have one check.

Our original goal was to be able to go to our surrounding states and do the same thing. We have been waiting until we can get the state's records together before we have approached our neighboring states to try to do that, but we are foreseeing that we will have the same type of problems on coordinating with other states when the time comes. That is one reason I think national checks are so important.

The CHAIRMAN. You made an observation about the element of fingerprinting prospective job applicants. You mentioned that conducting a fingerprint would best be handled by local law enforcement and that this would add both time and resources to the process. Are there benefits to requiring a fingerprint check compared to the current name and Social Security number requirements in Iowa?



Mr. SCHMETT. We currently do checks by name and Social Security number. Since a person can have multiple names, go under aliases and so forth, often, we have to check each one of those names. Also, that check is only going to be as good as the person's honesty in giving us their name or Social Security number. You and I probably have always used one Social Security number for most of our lives. But in the past, I was an administrative law judge. I can remember a hearing when an individual came in applying for some benefits that had to be accessed under Social Security numbers, and he opened up a shoe box and said, "I forgot which one I filed under," and he probably had 40 or 50 Social Security numbers in there.

For a person like that, a Social Security check will not work. Fingerprinting is the only thing that can give us a positive ID.

The CHAIRMAN. In the context of creating a national registry for nurse aides with records of abuse or crime, it has been suggested that such a registry should include additional information. Iowa recently created the single contact repository, providing an interesting model. I understand that it allows facilities and employers to access not only criminal history and abuse records but also allows access to data maintained by the state's professional licensing boards and child abuse registries. Could you tell us more about what initiated this design and, to the extent possible, tell us how it is working and particularly your turnaround time?

Mr. SCHMETT. Approximately 2 years ago, one of our newspapers, the Quad City Times, did a long study on nursing homes and abuse in nursing homes, and as part of that, one of their suggestions was, when they looked at Iowa, was that our neighboring state of Illinois had a criminal records check, and we did not. When we addressed that issue, we had some concerns that the criminal record check alone was not adequate enough to give us a full picture of the seriousness of the possibilities of abuse that were going on in facilities and that we needed a broader picture there. We feel that by adding those professional licensing checks, the adult and child abuse checks, we are able to detect potential abusers before their activities rise to the level of a criminal activity and that that protects us.

We are in the process of implementing a one-contact call on all of those lists. We do require checks of those lists now. We are in the process of computerizing that. The legislature provided half of the funding last year, and it assures us we are going to get our other half to complete implementation of that this year, but that is a process that we are still working on.

The CHAIRMAN. Ms. Bitler and Dr. Reichard, many times, nursing homes will dismiss suspects of alleged abusive employees without filing any charges or alerting the operators of the registry of such abuse, and, of course, this leaves the employees free to move on to other facilities, being unnoted for their abuse or crimes that they have committed. What, if any, incentives could be put in place to encourage nursing home administrators to alert officials when they terminate employees of abusive workers? First you, and then, Dr. Reichard.

Ms. BITLER. That would be ideal. I know currently, administrators involved in Country Meadows, who work for Country Mead-

ows, have a network of their counterparts at other companies. For example, Reading, PA is a neighbor of ours, and by suggesting to our administrators to network with their counterparts at other companies, without putting up an incentive, it is nice that they can do that and find out information that could be crucial for these background checks.

The CHAIRMAN. OK; Dr. Reichard.

Mr. REICHARD. We are blessed to have people with a very high standard of care. Our director of nursing, for example, when I referred to zero tolerance, I really meant it. We feel the ultimate victim will be the institution, the facility's residents. If we have some bad actors on the staff, we are determined to get them out.

Apart from insurance liabilities and the condonation of bad conduct, getting someone reported to the registry, again, I did express my surprise awhile ago that it has to go immediately to the public prosecutor. I think there needs to be an administrative means of addressing the registry first, although some legal analysts may say that you cannot remove someone from the registry until you have convicted them. So, there may be issues of law and personal rights there that I do not know of, but as a nursing home administrator, I believe it is true that the moment that the state chooses to withdraw my license from the health professions, I am gone. I can sue them later, perhaps, and wonder why they did that, but there is no such remedy, at least in my state, for a nursing assistant. It is State's attorney only; court only, unless that person has confessed and settled out of court.

So, I have real concern about whether the process breaks down after the abuse charge has been reported.

The CHAIRMAN. Senator Kohl.

Senator KOHL. Thank you very much, Senator Grassley.

Mr. Schmett, your state's law requires background checks for a variety of nursing home personnel, not just nurse aides, as you know. Also, Iowa expanded the background check requirement to include home care and hospice staff. Can you tell us what led your state to conclude that all of these workers and providers should be covered?

Mr. SCHMETT. Our concern was that if we were basically removing abusers from a nursing home setting, particularly in a home care setting, basically, we were chasing those people over into the home care setting, and that is even a much more vulnerable position for someone to be in, because very often, the person providing treatment in a home care setting is the only person who sees that person. In a nursing home, we at least have other staff who can report suspected abuse.

Senator KOHL. OK; Mr. Schmett, you indicated in your testimony that the State, Iowa, has run 56,000 background checks since the law was enacted and that 12 percent of the applicants for work in nursing homes had prior criminal convictions. That is an extraordinarily high percentage. What is your sense of that, and is it fair to conclude that other states might also run that high a percentage?

Mr. SCHMETT. I would conclude that other states would run at least as high a percentage if we are checking all convictions on records there. We were amazed to find that high of a percentage.

When we started, we were running 13½ percent. Now, it is down to about 11 percent. It has dropped off some, and I would expect as we go on through the system, we are going to find that people who have records, after they are kicked out one time, will not come back, and I would expect to see that lower.

But I would presume that states that have not been running checks would find that they would have at least the same level.

Senator KOHL. Would you then conclude that it is very necessary to have that kind of a background check; if you have that high a percentage of people with the background, the criminal background, you almost necessarily have to have that kind of a check if you are going to provide the kind of assurances to your patients; is that not true?

Mr. SCHMETT. I think we absolutely have to have a background check.

Senator KOHL. OK; Ms. Bitler and Dr. Reichard, I would like to talk a little bit about the cost issue. We certainly do not want to pass legislation that will cause nursing homes to be forced to cut back on services elsewhere. But when the inspector general interviewed nursing home officials in six states, those officials found that the costs associated with their state background check laws were reasonable. In all of those six states, the employer was required to pay at least part of the cost of the check. Do you have any information to the contrary of what the inspector general found? In other words, are you aware of facilities that either have gone out of business or have had to cut back on services as a result of the added costs of doing background checks?

Ms. BITLER.

Ms. BITLER. I am not aware of any facilities that have gone out of business due to the expense of a background check. I know it is a heavy burden, but I am not aware of any business that has been terminated due to the expense.

Senator KOHL. Thank you.

Dr. Reichard.

Mr. REICHARD. As I mentioned, our cost has been \$7.50, and we are required to pay that. We cannot pass that on to the employee. We are required as the employer to pay that. If it went to something like \$50, that would be seven times as much. That might become a little painful at some point; probably still worth doing, but the key point, and, you know, the Balanced Budget Act of 1997 took away a lot of Medicaid money or hopes to. We would like to see these reimbursable under a normal cost reporting process for Medicare and Medicaid.

Senator KOHL. OK; Ms. Putnam, clearly, you are an example of the caring, dedicated and professional worker that we know can be found in the majority of nursing homes. Can you describe how it makes you feel as a nurse aide with 9 years of experience to hear stories of abuse and mistreatment of residents?

Ms. PUTNAM. It makes me feel very sad. I care for these residents so much, and to hear that someone can be hurting them, mistreating them or verbally abusing them in any way saddens me. My eyes are open all of the time. I very seldom, in the 9 years working, have ever seen, you know, any abuse. Some verbal abuse;

it can be in the sense of not only bad language but just shut up; sit down. I do not go for that. It bothers me very much.

Senator KOHL. Thank you.

Thank you, Mr. Chairman. I think this has been an excellent panel and an excellent hearing.

The CHAIRMAN. Yes; I have got a couple of questions I want to ask, too, and then, we will be winding up shortly.

I think I would start with you, Ms. Putnam, because I think through a daughter in law I have, I sense she has worked at a nursing home both in the capacity that you had but starting out as a maintenance worker as well and then, now, working at a nursing home, but I sense the sincerity of what you say through her in the sense that she, even now in the hospital, develops this kind of personal relationship with people who are sick, and I know how bad she feels, not about people being abused, because hopefully, she does not see them being abused, but just because people are sick and because people die, and it bothers her tremendously.

So, I sense that in you as well, and thank you for—actually, it is a dedication that Senator Kohl has spoken of your work. So, I will start with you, and then, I also have one more question for Ms. Bitler and Dr. Reichard. You were referring to the heavy work load that you have on a daily basis, and that, we obviously commend you for; it makes your job more difficult and probably makes you feel guilty from the standpoint that maybe some of the quality time, you could spend with your people to make their life more interesting; you are not able to do that quality of life.

But as part of your busy schedule, I understand that the new law in Pennsylvania requires nurse aides to go through special training programs on resident abuse and detection and prevention. Have you or others you know gone through this training program, and if so, did you find it to be helpful in offering strategies for handling difficult situations?

Ms. PUTNAM. Yes, we have at our facility. We usually have these mandatory in-services twice a year on different subjects of abuse. They are helpful, even as the 9 years of working every year; it seems helpful to even be there to hear about the different ways we can stop the abuse. There is a lot of situations that have to do with the residents being combative and the way they treat us, too, so we need to know how to control a lot of different situations, but it does help in our facility.

The CHAIRMAN. OK; did this training offer suggestions on what to do when you suspect abuse by a nursing home staff member, whether that be a fellow CNA or a medical doctor or even a nurse?

Ms. PUTNAM. We were told to just report it immediately.

The CHAIRMAN. OK.

Ms. PUTNAM. We are told that.

The CHAIRMAN. Not that you have had an experience like this, but do you think that there might be some peer pressure not to report abuse?

Ms. PUTNAM. Definitely.

The CHAIRMAN. There is some?

Ms. PUTNAM. I believe so, yes.

The CHAIRMAN. And do you think—well, you can probably speak for yourself. Do you think that that would be difficult for you to

overcome the peer pressure, or would you not have a—feel that you would not have any problems reporting such abuse?

Ms. PUTNAM. I would probably do it, but I still feel I would have a sense of a problem as a co-worker for maybe many years that worked right beside me; but I would have to do it. I would have to report it.

The CHAIRMAN. From conversations that I have had with CNAs, they say it is very motivating when they are recognized by their management nurse staff for their dedication and hard work. In fact, they say little things, such as when the management knows your name and notices your good work, that that makes a difference. Would you agree with this?

Ms. PUTNAM. Definitely. I think we need a lot more encouragement there of what kind of work we do and how well we perform our duties.

The CHAIRMAN. Are there certain behaviors or practices on the part of management that you would like to suggest and would like to see more of along this line?

Ms. PUTNAM. As of encouragement or—

The CHAIRMAN. In regard to the sort of recognition or dedication of services and stuff like that.

Ms. PUTNAM. We definitely need more thank yous from them in any way that they could possibly give a thank you. It would be more appreciated.

The CHAIRMAN. I know it meant an awful lot to my daughter in law one time a few years ago; at the hospital where she still works, she was recognized as the employee of the month, as an example, and even had a little short picture of her on the television evening news one time through part of the advertisement of the hospital as an example. So, I think you are right.

My last question would be to you two, as I have suggested. Today's hearing is exploring the role of government in improving safeguards for identifying people who pose a possible threat to the safety and wellbeing of millions of frail elderly. It seems reasonable to expect that the industry has a part in meeting the goal. As employers, what do you see as your role in protecting vulnerable nursing home residents from the threat of abusive individuals who may be seeking employment in your facility?

Ms. BITLER. As director of human resources for Country Meadows, I see it as my duty to support my supervisors and my administrators in administrating a standard, easy-to-use policy that is not confusing State and Federal law; that is a standard policy, and if we have that, if we are trained on implementing that, I could support my administrators and my supervisors.

The CHAIRMAN. And Dr. Reichard.

Mr. REICHARD. I guess the age-old term trust but verify applies. We have a very careful process of interviews. We have an application that is filled out that asks do you have any criminal record of any kind. It does not time limit it. The first thing we do when we get the background check is to compare the background check with the yes or no answer that was on the employment application. If there was any falsification there, that employee does not have a whisper of a chance of being hired.

But also, then, when we hire them, the probationary period, extremely important. Some assessment of how much does this person care about other people is a critical issue, and we have, again found people, by and large, who care very deeply; serve their probationary periods; are hired to the permanent staff. So, that observation, we have RN supervisors, 24 hours, round the clock, who have a roaming responsibility to support the nurses in the units. So, there does need to be a management structure that affirms residents first and the staffs next, so that the reputation of the facility will be strongly upheld and not blown to smithereens by the types of cases that we heard described in here today.

The CHAIRMAN. Before I adjourn the meeting, there are a couple of points, administrative as well as an issue I would like to make. I would also like to call on Senator Kohl if he has something in closing, but obviously, to repeat what I said to the previous panel, and specifically to this panel, particularly because you have such ongoing experience in this area, we thank you for the keen insight that you bring to this subject of the problem of abuse of nursing home victims at the hands of people with criminal backgrounds.

Senator Kohl, I want to thank you for urging this hearing. It is a demonstration of your continuing input, interest and involvement of the work of this very important committee. I would also ask each of you, because other members could not be here, and maybe even for Senator Kohl and me, that we might have some questions to submit to you in writing. So, we would ask for your written responses to those, because time did not allow all questions to be asked today. Those questions and your responses will become a part of the record.

I would also reiterate that although this hearing has focused on the problem of abusive nursing home employees, I do not want anyone walking away from here today believing that all nursing home employees abuse their patients. This sort of intolerance that Dr. Reichard expresses is just emblematic of that, and hopefully characteristic of a vast majority of nursing homes, but I happen to believe that a majority of nursing home aides are honest, hard-working individuals who provide the day-to-day care that is so essential to millions of older Americans. It is also a difficult and thankless job, and they are to be commended for it. I hope we have adequately expressed that through Ms. Putnam's work and contribution.

I believe today's hearing provides an important first step in understanding what can be done to prevent criminals from working in nursing homes. So, I want you to know, as chairman of this committee, the Aging Committee, I will continue to work to protect our most vulnerable citizens, and I look forward to working with my colleague, Senator Kohl, along that line as well.

Do you have something you want to say in closing, Senator Kohl.

Senator KOHL. Well, thank you, Senator Grassley, for convening this hearing and for this fine panel and the one that preceded it. I have the strong feeling that this bill, while it is certainly not a panacea and does not cure every ill, but if we can get it passed, it will go some considerable distance in reducing the number of people who are being hired with abusive backgrounds or criminal backgrounds. It will not go down to zero, but it will reduce that

number by a considerable amount, and that is the purpose of this bill, and I have been encouraged by this hearing and listening to people who are involved in the industry that, in fact, this is something that is worth pursuing.

And so, I am very much appreciative of your attendance here today, and I think it has been a great hearing.

The CHAIRMAN. Thank you; meeting adjourned; thank you for everybody coming, including the public that was here as audience.

[Whereupon, at 3:32 p.m., the committee was adjourned.]

**A P P E N D I X**

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**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF ELDER ABUSE  
IDENTIFICATION, INVESTIGATION  
AND RESOLUTION PROCEDURES FOR  
ILLINOIS LONG-TERM CARE  
FACILITIES**

**ILLINOIS DEPARTMENT ON AGING  
ILLINOIS DEPARTMENT OF  
PUBLIC HEALTH**



**JUNE GIBBS BROWN  
Inspector General**

**MAY 1998  
A-05-97-00010**





## DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V  
105 W. ADAMS ST.  
CHICAGO, ILLINOIS 60603-6301  
May 27, 1998

OFFICE OF  
INSPECTOR GENERAL

CIN: A-05-97-00010

Ms. Marilee I. Lindley, Director  
Illinois Department on Aging  
421 East Capital Street  
Springfield, Illinois 62701

Dear Ms. Lindley:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Elder Abuse Identification, Investigation and Resolution Procedures for Illinois Long-Term Care Facilities" for the audit period July 1, 1994 through December 31, 1996. A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In a written response dated April 3, 1998, the IDPH officials generally agreed with our findings and recommendations. However, they stated that staff and resource considerations would limit the extent they could implement some of our recommendations. Our recommendations and the IDPH's comments to our draft report are included as Attachment C to this report and are summarized after each finding and recommendation in the report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to the Common Identification Number (CIN) A-05-97-00010 in all correspondence relating to this report.

Sincerely,

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures

Direct Reply to HHS Action Official:  
Director, Grants Management Division  
Wilbur J. Cohen Building, Room 4643  
130 Independence Avenue, S.W.  
Washington, D.C. 20201



## DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V  
103 W. ADAMS ST.  
CHICAGO, ILLINOIS 60603-6201  
May 27, 1998

OFFICE OF  
INSPECTOR GEN.

CIN: A-05-97-00010

Dr. John R. Lumpkin, Director  
Illinois Department of Public Health  
535 West Jefferson  
Springfield, Illinois 62761

Dear Dr. Lumpkin:

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Paul Swanson  
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Direct Reply to HHS Action Official:  
Director, Grants Management Division  
Wilbur J. Cohen Building, Room 4643  
330 Independence Avenue, S.W.  
Washington, D.C. 20201

**EXECUTIVE SUMMARY****OBJECTIVES**

The objectives of our review were to assess the effectiveness of the procedures established to identify, investigate and resolve reports of elder abuse in Illinois long-term care (LTC) facilities and to evaluate the accuracy and completeness of the certified nurse aide (CNA) registry. We also determined whether LTC facilities employed alleged abusers, who had undisclosed criminal backgrounds which would have been identified if the Illinois Health Care Workers Background Check Act (HCWBC Act) had been implemented sooner.

**FINDINGS**

The Illinois Department on Aging (IDOA) and the Illinois Department of Public Health (IDPH) share responsibility for the identification, investigation and resolution of elder abuse in LTC facilities, although IDPH has primary responsibility. Our audit determined that some alleged abuses reported by the LTC facilities were not fully developed or investigated by IDPH. While employees in 13 of 88 alleged abuse cases in our sample were terminated from employment or disciplined, the IDPH did not determine whether the alleged abuses actually occurred. Although the actions taken by the LTC facilities and the reports of alleged abuse provide some indications that an abusive situation may have occurred, IDPH did not perform additional on-site investigative procedures or initiate other evidence gathering procedures to substantiate the abuse.

We found that IDPH was adequately maintaining the CNA registry for substantiated cases of abuse and that the registry was available to the LTC facilities to screen candidates during their hiring process. Only one instance of substantiated abuse and one instance of abuse conviction were not recorded on the CNA registry. We attribute these minor omissions to an administrative oversight. We did find, however, that background checks without disqualifying criminal histories were not recorded on the CNA registry in a timely manner. We also found that nursing homes terminated 10 CNAs they suspected committed elder abuse. However, because IDPH did not perform an investigation to substantiate whether an abuse occurred and should be posted to the registry, these individuals were free to seek employment at other LTC facilities or allowed to continue their employment which could place residents at risk. The registry can be a valuable resource by providing accurate and comprehensive information which could be used by the LTC facilities in their hiring process. Therefore, we believe that the positive background check information, as well as terminations for alleged abuse which was substantiated, should be posted to the registry.

Finally, the benefit from implementing the Illinois background check law is evident from the results of our review during the period prior to HCWBC Act enactment. We noted 15 CNAs and two non-CNA employees with disqualifying criminal backgrounds who were working at LTC facilities but would have been identified and likely excluded had the Act been in place and non-CNA employees had been subjected to the Act. All 17 of these employees were later involved in

instances of alleged elder abuse. Fourteen of these 15 CNAs are no longer employed by LTC facilities. Seven of the CNAs were terminated as a result of substantiated findings of abuse, and the other seven were dismissed by the LTC facility or resigned subsequent to the abuse allegation. The remaining CNA was transferred to a non-direct resident care position. The two non-CNA employees were terminated by the facility due to elder abuse.

While the above employees were hired before the effective date of the HCWBC Act, it does demonstrate the positive effects that resulted from the State's initiative in this area. These efforts should mitigate the number of future abuses by not hiring prospective employees who have disqualifying criminal convictions. However, the HCWBC Act limits LTC facilities to the use of Illinois State Police (ISP) criminal conviction data for their background checks. The HCWBC Act does not provide for the use of ISP arrest data nor does it authorize the use of other States' or national data bases. Therefore, we believe the provisions of the HCWBC Act should be expanded to allow use of other data bases and ISP arrest and final disposition information.

## RECOMMENDATIONS

We are recommending that IDPH more fully develop incident reports involving disciplinary action by the facility. We are also recommending that IDPH update the CNA registry to include all instances of substantiated abuse or abuse convictions and timely posting of background checks without disqualifying crimes. In addition, we are recommending that the provisions of the Illinois Nursing Home Care Act (INHC Act) be expanded to require registry posting of CNA terminations made by LTC facilities based on alleged abuse which was substantiated. Finally, we are recommending that the HCWBC Act be expanded to allow the LTC facilities to use additional criminal data bases, expand the scope of the background checks to include all LTC staff, not just direct care staff, and use ISP arrest data along with final disposition information.

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In a written response dated April 3, 1998, the IDPH officials generally agreed with our findings and recommendations. However, they stated that staff and resource considerations would limit the extent they could implement some of our recommendations. Our recommendations and the IDPH's comments to our draft report are included as Attachment C to this report and are summarized after each finding and recommendation in the report.

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## INTRODUCTION

### BACKGROUND

Under the Older Americans Act, the States are allotted funds to establish long-term care ombudsman programs and to develop programs for the prevention of elder abuse, neglect and exploitation. Specifically, the States were required to establish mechanisms to identify, investigate and resolve complaints of alleged abuse involving the elderly in LTC facilities. The IDPH and the IDOA are both responsible for the identification, investigation and resolution of alleged elder abuse. The IDPH has the primary responsibility for the investigation and resolution of alleged abuse cases which are received from various sources. The IDOA is responsible for administering the Long-Term Care Ombudsman program and coordinating the efforts of its limited number of employees and local volunteers to identify elder abuse in local LTC facilities.

Under the Illinois statute, entitled "The Abused and Neglected Long Term Care Facility Residents Reporting Act" (Act), the IDPH:

*...shall upon receiving reports made under this Act, seek to protect residents and prevent further harm to the resident who was the subject of the report...*

The Act requires that LTC facility administrators, any physician, hospital, social worker, and field personnel of the IDPH and Illinois Department of Public Aid must report suspected abuse to the IDPH. In addition any person who has reasonable cause to suspect abuse or neglect may report it to IDPH. The IDPH is required to initiate an investigation of all reports of alleged elder abuse, oral or written, and to keep a continuing record of all reports, including the final determination of the investigation and the final disposition of all reports of alleged abuse. IDPH must refer severe cases of abuse, as well as, complaints and potential criminal conduct to the ISP.

The IDOA's ombudsman program, receives reports of alleged abuse from several sources including the facility, residents, family members, and other concerned individuals. Under State law, ombudsmen are required to report a complaint or an investigation showing suspected abuse or neglect of a facility resident to IDPH for further development and investigation.

The IDPH categorizes reports of alleged abuse as complaints or incident reports. Complaints are received from concerned parties, including the ombudsman program, either in writing or through telephone calls to the toll-free hotline, and are recorded in the central complaint registry. Investigations are performed to determine if abuse occurred. The IDPH receives incident reports from LTC facilities that provide the written perspective of their internal investigations of alleged abuse. These reports are manually recorded on the incident report log.

During the course of resolving reports of abuse, IDPH determines whether the allegations are warranted. For the incident reports received from the LTC facility, IDPH either relies upon the facility's written reports, requests additional information, or conducts its own investigation. If

IDPH determines that CNA abuse, neglect, or misappropriation of property occurred, they must notify the employee, the facility and the nurse aide registry. The aide is given an opportunity to contest the finding in a hearing before an administrative law judge or to submit a written response in lieu of the hearing. After the hearing or when findings are not contested, the IDPH will enter the substantiated findings on the nurse aide registry. Although the IDPH can, after notifying the aide, remove the aide from the registry, as a practical matter it is not usually done. Rather, the annotation, in effect, invalidates the CNA's certification. Since the INHC Act requires that IDPH maintain a CNA registry with substantiated findings of abuse and precludes LTC facilities from employing CNAs without first checking the registry, removal from the registry adversely affects their employability. The registry provides a ready reference to an applicant's certification, and disqualifying substantiated abuse or criminal convictions. Allegations of abuse involving licensed physicians and licensed registered and practical nurses are maintained separately and are handled by the Illinois Department of Professional Regulation (DPR).

In July 1995, the Illinois State Legislature passed the HCWBC Act, which required that all non-licensed persons seeking employment in direct care position in LTC facilities after January 1, 1996, have a criminal background check. The Act did not include those licensed under the DPR, i.e., doctors, nurses, chiropractors and those licensed by IDPH such as emergency medical technicians. The Act provides that individuals, expected to have direct contact with facility residents, may not be hired if they have certain criminal convictions. Convictions that would disqualify a person from working in a LTC facility include murder, theft, sexual assault and criminal neglect of an elderly or disabled resident. By January 1, 1997, all current employees in direct care positions, except those licensed by either DPR or IDPH must have a criminal background check initiated on their behalf by the employing facility. In Illinois, checks are conducted against the ISP records which contain only in-state convictions. The results of the background checks, whether positive or negative, must be recorded on the CNA registry. Should the CNA seek employment elsewhere, the background checks are valid for one year. Thereafter, a new background check is required.

### SCOPE OF AUDIT

Our review was conducted in accordance with generally accepted government auditing standards. The objectives of this review were to: (i) assess the effectiveness of the procedures established to receive, coordinate, investigate and resolve reports of elder abuse in Illinois LTC facilities, (ii) evaluate the accuracy and completeness of the CNA registry to include substantiated findings of abuse and results of background checks, and (iii) determine whether alleged abusers with undisclosed criminal backgrounds were employed in LTC facilities prior to the Illinois HCWBC Act being implemented.

To accomplish our objectives, we reviewed applicable Federal and State laws and regulations and the IDPH and IDOA policies and procedures related to elder abuse. We also reviewed

Federal and State requirements for criminal background checks related to employees of LTC facilities for the elderly. We did not evaluate elder abuse allegations resolved by the DPR.

We identified a universe totaling 1,980 abuse reports during the period July 1, 1994 through June 30, 1996. These abuse reports originated from a variety of sources including the resident, relatives, phone calls or letters by concerned individuals, and the LTC facilities. Our universe included cases involving developmentally disabled persons which were not related to elder abuse. We were unable to segregate and exclude these cases from our universe. The established universe consisted of 715 IDPH complaints, 1,102 IDPH incident reports, and 163 IDOA cases not referred to IDPH. The non-referred category included cases previously reported to IDPH by the LTC facility, resident-on-resident abuse situations, and withdrawn cases.

We selected a random sample of 160 of the 1,980 abuse reports. Our sample included 86 incident reports, 64 complaints, and 10 IDOA non-referrals. Of the 160 abuse reports, 36 were developmentally disabled cases, which were not included in the scope of the audit. For the remaining 124 abuse reports, we examined data developed by IDOA or IDPH to resolve the cases. We also determined whether the CNA registry was accurate and complete, in that it contained substantiated abuse findings, convictions of abuse, and background check results.

Out of the 124 abuse reports, 36 related to resident-on-resident abuse and not employee abuse of residents. These reports were excluded from our scope of review. For the remaining 88 abuse reports, we established whether the person involved in the abuse was employed by a LTC facility and had an undisclosed criminal history. We reviewed comprehensive profiles of criminal background maintained in the Federal Bureau of Investigation's (FBI) National Crime Information Center (NCIC) system and the ISP criminal data base for each of the alleged abusers. For background checks that did not contain disposition information concerning criminal arrests, we obtained disposition information from county clerk of circuit court offices to determine whether the arrest resulted in conviction or acquittal.

The audit covered the period July 1, 1994 through December 31, 1996. The field work was performed between January 1997 through November 1997 at the IDPH and IDOA central offices in Springfield and at the Cook County Clerk of Circuit Court Office in Chicago.

## RESULTS OF AUDIT

Our audit showed that the State's procedures used to investigate and resolve instances of elder abuse were generally effective. The IDOA Long-Term Care Ombudsman program performed its role by ensuring that complaints of elder abuse were directed to IDPH for resolution. The IDPH adequately resolved most of the reported cases of alleged elder abuse and generally maintained



an accurate and complete CNA registry. We also found that IDOA and IDPH generally met the requirements of the laws of the State of Illinois and the Federal regulations.

We did find, however, that 13 of 88 incident reports of elder abuse by CNAs, who were disciplined or terminated from employment by the facilities, were not fully developed and resolved independently by IDPH. Since terminations based on alleged abuse were not substantiated, the registry was not updated for a complete employer reference. Although background checks with disqualifying convictions were entered on the registry in a timely manner, those background checks that had no disqualifying convictions were entered as time permitted. We also found that the background checks, as specified by present State law, included only CNAs and employees in direct care positions, excluded those persons licensed under DPR and IDPH, and were limited to conviction information in the ISP records.

We are recommending that IDPH more fully develop incident reports involving disciplinary action by the facility. We are also recommending that IDPH update the CNA registry to include all instances of substantiated abuse or abuse convictions and timely posting of positive findings from background checks. In addition, we are recommending that the provisions of the INHC Act be expanded to require a registry posting for CNA terminations made by LTC facilities based on alleged abuse which were substantiated. Finally, we are recommending that the HCWBC Act be expanded to allow the LTC facilities to use additional criminal data bases, expand the scope of the background checks to include all LTC staff, not just direct care staff, and use ISP arrest data along with final disposition information. Details of our review are presented in the following paragraphs.

#### **ADDITIONAL INVESTIGATION OF REPORTS OF ALLEGED ABUSE**

Although IDPH adequately resolved complaints of elder abuse received through direct contacts or hotline referrals, its procedures for investigating and resolving incident reports, received from LTC facilities, could be more effective in protecting residents from abuse if these cases were fully developed and resolved. We found 13 out of 88 cases alleging physical or sexual abuse that should have been further investigated by IDPH. (See Appendix A.) These incident reports were internally investigated by the facilities and then forwarded to the IDPH for review. In its review of these reports, the IDPH determined that either the actions taken by the facilities were adequate or the investigations by the facilities did not reveal sufficient evidence to proceed with a formal complaint against the alleged perpetrator. In other words, even though these reports alleged physical or sexual abuse and resulted in employee terminations or disciplinary actions by the facilities, IDPH relied primarily on the reports prepared by the facilities without doing an on-site investigation or initiating other evidence gathering procedures to determine whether the allegations were significant enough to refer for criminal enforcement or entry on the abuse registry. Consequently, these 13 CNAs can still be employed by LTC facilities, potentially placing residents at the risk of abuse.

The provisions of 42 CFR 488.335 (a) (2), which are incorporated into the IDPH's Surveyors Guide for Complaint Investigation, state:

*"If there is reason to believe, either through oral or written evidence that an individual used by a facility to provide services to residents could have abused or neglected a resident ..., the State must investigate the allegation."*

Of the 13 employees named in the abuse reports, 10 were terminated by the facility but were not barred from subsequent employment at another facility. For the three other employees, the facilities used administrative actions; a transfer to another facility, probation, and a formal warning, as disciplinary measures. We believe that these actions taken by the facilities for all 13 employees, along with the allegations in the reports, provide some indications that abuse may have taken place. For example, one report stated that a CNA struck a resident on the face and buttocks. Another report stated that a CNA threw a resident onto the bed. Although the two CNAs involved in these incidents were terminated, further development was not initiated by IDPH to establish that actual abuse had occurred or did not occur. Although the IDPH did not accept the facility's referral and termination or disciplinary actions as sufficient bases for inclusion on the CNA registry, it did not have sufficient basis for closing the case and excluding information from the CNA registry.

Since the terminated or disciplined employees were not charged with substantiated abuse and entered on the CNA registry, they remain employable at other LTC facilities. The other facility would not have knowledge of a past history of alleged abuse for these employees. In our opinion, these incident reports should have been more thoroughly investigated by IDPH. If not provided by the facility, further development could include information such as written statements from witnesses, the resident's medical and social records, telephone interviews and follow up with law enforcement officials. This information would provide additional support to either proceed with more investigative work or close the case. On-site investigations should also be considered when the results of additional development disclose inconsistencies between the facility's report and the evidence gathered.

#### **Recommendation**

We recommend that IDPH more fully develop incidents of alleged abuse where the facilities have taken disciplinary actions or terminated CNAs and post to the registry all substantiated cases.

**IDPH Comments:** The IDPH officials agreed that facility disciplinary action is one factor to consider in evaluating a case, but they didn't believe that it should be the only factor to consider in whether cases should be more fully developed. They stated that they have closed some cases in which the facilities took disciplinary action and, on the other hand, taken action against CNAs when disciplinary action was not taken by the facility. They also stated that, because of their

limited staff, they must exercise some judgment as to which on-site investigations are likely to result in actions taken against a CNA.

The IDPH officials agreed that improvements could be made to the handling of incident reports. One of the improvements which has been made is to refer all reports of employee termination for abuse to the ISP for an independent investigation. In addition, they are evaluating other processes to improve, such as, whether other evidence gathering procedures can be used including conducting more on-site visits.

**OIG Response:** We believe the proposed changes will enhance the investigation and resolution of incident reports. However, we believe that these changes will be effective only if IDPH emphasizes the need for facilities to fully develop incident reports, i.e., reports that are accurate and complete and in sufficient detail so that the complaints can be resolved. While IDPH is proposing to refer all cases of terminations for abuse to the ISP for investigation, we believe that because of its workload ISP may not always have the resources to fully investigate these cases. We are also concerned that the ISP's efforts may be focused more on the criminal aspects instead of on the overall safety and well-being of the residents. Therefore, IDPH needs to continue to fully develop these cases on its own. In addition, IDPH needs to follow up on its referrals to the ISP for its resolution of the cases.

### **ACCURACY AND COMPLETENESS OF CNA REGISTRY**

Although the IDPH was adequately maintaining the CNA registry, some improvements could be initiated to increase the usefulness of this registry for employment screening purposes. We noted only one substantiated case of physical abuse and one abuse conviction that were not recorded on the registry. The IDPH officials confirmed that the omissions were inadvertent oversights. In addition, registry enhancements, such as more timely posting of positive background checks, i.e., no confirmed disqualifying criminal history, would improve the quality of the CNA registry as an employer reference tool. The addition of terminations for substantiated alleged abuses, discussed in the previous section, would also improve the usefulness of the registry. The registry can be a valuable resource by providing accurate and comprehensive information which could be used by the LTC facilities in their hiring process. However, to serve this purpose, we believe that, at a minimum, the results of all background checks, including positive results, must be posted timely and an indicator of prior termination of an employee for alleged abuse should be added to the CNA registry, if substantiated. The IDPH officials stated that the INHC Act would need to be amended to provide these enhancements to the registry.

The IDPH posted background checks with disqualifying convictions to the registry but delayed posting background checks which did not have disqualifying convictions until time permitted. Some of these background checks were not posted for up to nine months after the check was completed. The IDPH officials advised that the volume of background checks, generated by compliance with the HCWBC Act, prevented the timely posting of positive background checks to the CNA registry. We commend the IDPH for its initiatives and effort, even with limited staff,

needed to accomplish this task in light of the volume of postings generated by the Act. However, for the registry to be valuable as an employer reference source, background check results need to be posted timely. State of Illinois 225 Compiled Statutes 46, Section 30 (b) states:

*The Department of Public Health shall notify each health care employer inquiring as to the information on the State nurse aide registry of the date of the nurse aide's last UCLA criminal history record check. If it has been more than one year since the records check, the health care employer must initiate or have initiated on his or her behalf a UCLA criminal history record check for the nurse aide pursuant to this Section. The health care employer must send a copy of the results of the record check to the State nurse aide registry for an individual employed as a nurse aide.*

The timely posting of background results would not only be valuable in the hiring process for the LTC facilities but would also provide a record that the required background check had been completed. In addition, timely postings would provide a savings to the LTC facility in that the costs of performing duplicative background checks could be avoided. Therefore, the IDPH should make a concerted effort to post the results of all background checks to the registry in a timely manner.

Posting prior terminations based on alleged abuse, which were subsequently substantiated, would provide potential employers with the opportunity to obtain additional information about applicants' past employment history. In order to protect the rights of the applicants, IDPH should use its hearings process to notify terminated employees that a referral was made and that they have an opportunity to refute the alleged abuse. These persons can provide evidence which they believe could rebut their negative work histories.

The registry requirements, provided in 42 CFR 483.156, establish the minimum information which must be contained in the registry; such as, the individuals name, date individual became eligible for certification, documentation of the State's investigation, date of hearing, if held, etc. These are minimum requirements and the regulations do not prohibit the State from adding additional information to the registry. Therefore, we believe that, for the registry to be effective as an employer reference tool, the IDPH registry should include information related to terminations with substantiated abuse.

### **Recommendations**

We recommend that IDPH update its CNA registry to include all instances of substantiated abuse or abuse convictions and a timely posting of background checks without disqualifying criminal histories.

We also recommend that the INHC Act be amended so that those terminations, which resulted from alleged abuse and substantiated, can be posted to the registry.

**IDPH Comments:** The IDPH officials agreed and stated that the backlog of background checks has been posted to the registry.

**OIG Response:** We recognize that there was a large volume of background checks generated as a result of the State background check law and commend IDPH for its efforts in becoming current in the posting of these checks to the registry.

**IDPH Comments:** While IDPH officials agreed that a past termination was a factor for a prospective employer to consider in the hiring process, they also stated that past employers would be reluctant to provide this type of information to the registry. They further stated that a facility's decision to terminate an employee because of allegations of abuse is not a reliable indicator that abuse occurred. According to IDPH officials, a number of facilities terminated the alleged abuser regardless of the evidence because the facilities believed they must protect themselves. In other cases, terminations were made in retaliation for such things as union activities, filing a Workmen's Compensation claim or cooperating with IDPH during an investigation.

As an alternative to adding this information to the registry, IDPH believes this issue can be better addressed by mandating that past employers provide this information to prospective employers.

**OIG Response:** We have revised the text of the finding to emphasize that the registry should only be updated for those cases of alleged abuse which were substantiated through the hearing process. In addition, we revised our original recommendation to state that those terminations resulting from alleged abuse that was substantiated, should be posted to the registry.

We do not believe that IDPH's alternative solution, i.e., mandating previous employers to provide work history to prospective employers is an acceptable approach. Applicants may not share prior employment references with prospective employers, especially if the applicant has a poor work history. Furthermore, in fear of lawsuits, we believe that previous employers will not share employment history with prospective employers. In those instances where an employee was terminated before developing an abuse case, there may be inadequate documentation for IDPH to reach a decision as to whether or not abuse occurred. Rather than allowing these cases to be dropped with no outcome, use of the hearing process would bring these cases to a conclusion.

#### **EMPLOYEES WITH UNDISCLOSED CRIMINAL BACKGROUNDS PRIOR TO IMPLEMENTATION OF THE HCWBC ACT**

In order to determine whether any of the alleged instances of abuse could have been prevented had the Illinois law been in effect prior to our audit period, we performed background checks on all alleged perpetrators of abuse in our sample. We requested background checks through the ISP and the FBI's NCIC system. The positive benefit of performing background checks is evident

from our results which showed that prior to the Illinois' adoption of their background check law, 15 CNAs and 2 other employees had disqualifying criminal convictions (See Appendix B) and 13 of these alleged abusers could have been barred from employment, if the background check law had been in effect prior to our audit. While these employees were hired before the effective date of the Illinois' Background Check law, it does demonstrate that Illinois' initiative in this area should mitigate the number of future abuses by not hiring prospective employees who have disqualifying criminal convictions.

**Certified Nurse Assistants.** The background checks for 15 CNAs disclosed disqualifying convictions as defined by the State law. The disqualifying convictions ranged in severity from retail theft to aggravated battery to attempted murder. Had IDPH or the LTC facility been aware of these disqualifying criminal convictions, and had the law been in effect, 12 CNAs associated with 88 alleged abuse cases might not have been employed or remained employed after disclosure of the disqualifying conviction. The remaining three instances of alleged abuse could not have been precluded by background checks because the disqualifying convictions occurred concurrent with or subsequent to the alleged abuse incident. Fourteen of the 15 CNAs are no longer employed by LTC facilities. Seven of the CNAs were terminated as a result of substantiated findings of abuse, and the CNA registry was properly annotated for consideration by future employers. The remaining seven were dismissed by the facility or resigned subsequent to the abuse allegation. Should these CNAs seek future employment as direct care providers in LTC facilities, the posting of background check results would provide information to consider during the employment screening process. One CNA, with a 1981 disqualifying conviction, was still employed in October 1997. The facility had not requested a background check for this individual. However, during the course of our audit, a background check was performed and posted to the registry in December 1997. This individual was transferred to a non-direct care position in January 1998.

**Non-CNA Employees.** Two non-CNA employees not involved in direct care, were accused of elder abuse. One of the employees was terminated by the facility. A background check showed that this employee had a disqualifying aggravated criminal sexual abuse conviction. For the other employee, IDPH substantiated the abuse allegation and sanctioned the facility, and the facility terminated the employee. This employee was convicted of three disqualifying crimes, including aggravated criminal sexual assault.

Because the background check law is limited to direct care employees and excludes employees licensed under DPR and IDPH, neither of these convicted felons would be subjected to a routine background check. As a result, they would not be subjected to possible termination from the current facility or barred from seeking employment at another LTC facility.

We believe that consideration should be given to expanding the provisions of the HCWBC Act to include checks for all LTC employees. We noted that a task force also recommended expanding the background check to additional employees. The Act required that a task force be established to make recommendations for changes to the Act. The task force issued its final report in

December 1997. One of the issues the task force addressed was whether additional employees should have criminal history background checks. The task force's report stated that, the task force:

*"...supports increasing covered employees by removing the exemption of individuals licensed by Department of Professional Regulation..."*

The report further stated:

*"Moreover, there appears to be no basis for allowing health care employers to hire licensed direct care workers with criminal backgrounds when they would be prohibited from hiring unlicensed workers with the same backgrounds."*

The task force recommended that the applicability be expanded to include all individuals who provide direct care and are retained or employed by a health care employer.

**Additional Screening Sources.** The ISP background check information obtained by the LTC facilities did not disclose all disqualifying convictions. However, our use of the NCIC for background checks disclosed that one employee had a disqualifying conviction in 1981, or five years prior to being employed. At the time of our audit fieldwork, this conviction was not identified in the ISP records. Since Illinois law requires the LTC facilities to use ISP criminal conviction data for background checks, information related to the status of Illinois arrests or criminal convictions from outside of Illinois is not available. A significant portion of Illinois' population is located along neighboring State lines. The CNAs living in these areas could have out-of-state convictions that would disqualify them from employment. In addition, individuals relocating to Illinois could have disqualifying convictions elsewhere in the country. Therefore, the provisions of the HCWBC Act should be expanded to allow LTC facilities access to a more comprehensive data base of arrests and criminal convictions and to develop the court disposition of arrests.

The task force also addressed the issue of requiring fingerprint-based criminal history records and FBI checks. It recommended that FBI checks be required for a certain category of employee. For example, FBI checks should be required for all individuals who are not Illinois residents or have not been an Illinois resident for a specific period of time, e.g., 24 months, three years. The report went on to state that:

*"While this procedure would alter the current process, the FBI background check would provide information on serious convictions in other states that would not be known if only an Illinois criminal history were available."*

In addition to the FBI data, other data bases, such as, State police records from contiguous States, could be used.

Although most of the background information that we requested from ISP contained both arrest and conviction information, five of the 88 cases showed arrest data but no final disposition of the cases. Arrest dispositions would be needed to determine if any resulted in a disqualifying conviction. We contacted the county clerks of circuit court offices to obtain final dispositions for these cases. Four of the five cases resulted in convictions of disqualifying offenses. The last case resulted in a non-disqualifying conviction. The ISP data base does not always contain the final disposition of arrest data. State law only requires that conviction information on the ISP data base be disclosed to LTC facilities. Since the Illinois law does not require the disclosure or the development of the disposition of arrest information, the four disqualifying convictions would not have been available on the background checks received by the LTC facilities. These examples re-emphasize the need to expand the provisions of the HCWBC Act.

### **Recommendations**

We recommend that the Task Force consider expanding the provisions of the HCWBC Act:

- (i) require background checks for all LTC staff, not just the direct health care providers,
- (ii) include the use of national criminal data bases and neighboring State data bases, and
- (iii) authorize the facilities access to arrest data supplemented by final disposition data from the circuit courts.

**IDPH Comments to Recommendation (i):** In their response, IDPH officials stated that an argument could be made for requiring background checks for all staff. On the other hand, they expressed concern about the increased costs involved for the additional staff. The IDPH agreed that this is an issue that deserves further study and will refer it to the Chairman of the Health Care Worker Task Force for its consideration.

**OIG Response:** We believe that the Background checks should be expanded to include all LTC staff and that the issue of increased costs should be balanced against the need to ensure the safety of residents.

**IDPH Comments to Recommendation (ii):** The IDPH officials stated that the auditors had identified a serious weakness in the HCWBC Act and that the issue would be referred to the Task Force for further study. They agreed that there should be some method for employers to check for out-of-state convictions. They also stated that while the Health Care Worker Task Force recommended that the Act be amended to require such checks for relatively new residents, it also recognized that there may be problems with cost and availability of the federal checks in rural areas. Some concerns were also raised about the possibility that State law could authorize that FBI checks could be sent directly to the employer and about the accuracy of the FBI checks.



**OIG Response:** The IDPH's proposed action has adequately addressed the recommendation.

**IDPH Comments to Recommendation (iii):** While agreeing that the recommendation would help alert employers, the IDPH officials were concerned that arrest information which did not result in a conviction might be wrongly used by some employers, and the wrongful use would have a disproportional effect on minorities. They stated that this issue will also be referred to the Task Force.

**OIG Response:** We believe that arrest information would provide another useful tool to employers. Regarding wrongful use of this information, prospective employees could be provided protection by prohibiting LTC facilities from not hiring someone based solely on arrest information.

## APPENDIX A

**INCIDENT REPORTS  
NOT PROCESSED AS COMPLAINTS BY IDPH**

<b>Sample #</b>	<b>Allegation Description</b>	<b>Employee Outcome</b>
1	CNA slapped resident on leg	Terminated
2	CNA put hand over resident's mouth	Terminated
4	CNA struck resident in the chest	Employee transferred
11	CNA inappropriately transferred resident to bed	Terminated
30	CNA slapped resident on forearm	Terminated
35	CNA slapped resident on face and buttocks	Terminated
55	CNA pushed resident	Terminated
66	CNA threw resident onto the bed	Terminated
72	CNA grabbed resident's wrist and yanked her out of chair	Employee counseled and given extended probation
76	CNA tapped resident on chest	Employee temporarily suspended and given written warning
79	CNA bent resident's finger backwards	Terminated
81	CNA slapped resident	Terminated
86	CNA kissed and fondled resident	Terminated

**APPENDIX B  
SCHEDULE OF ALLEGED ABUSERS WITH DISQUALIFYING  
CONVICTIONS PRIOR TO IMPLEMENTATION OF HCWBC ACT**

<u>SAMPLE #</u>	<u>DISQUALIFYING CONVICTION</u>	<u>DATE</u>
10*	AGGRAVATED CRIMINAL SEXUAL ABUSE	01/85
14	FELONY THEFT BATTERY	01/76 09/95
15	RETAIL THEFT-MISDEMEANOR RETAIL THEFT-FELONY	05/94 07/96
17	THEFT - MERCHANDISE	10/76
19	ARMED ROBBERY ARMED ROBBERY BURGLARY	05/85 11/89 03/94
25	DOMESTIC BATTERY AGGRAVATED BATTERY OF SENIOR CITIZEN	12/94 09/96
27	THEFT - UNAUTHORIZED CONTROL	05/92
28	UNLAWFUL USE OF WEAPON	01/90
40	RETAIL THEFT	01/96
46	THEFT FROM PERSON	03/81
48	THEFT	01/96
55	THEFT	07/93
90a*	THEFT	09/84
90b	BATTERY BATTERY CRIMINAL POSSESSION MARIJUANA CRIMINAL POSSESSION WEAPON ATTEMPTED MURDER	11/81 04/78 03/81 01/82 12/81
102	THEFT	04/87
105	THEFT	06/85
118*	AGGRAVATED CRIMINAL SEXUAL ASSAULT AGGRAVATED CRIMINAL SEXUAL ASSAULT OF THE HANDICAPPED AGGRAVATED BATTERY OF SENIOR CITIZEN	03/97 03/97 03/97 03/97

\* Employees other than CNAs

**Illinois Department of  
Public  
Health***Jim Edgar, Governor • John R. Lumpkin, M.D., M.P.H., Director*

525-535 West Jefferson Street • Springfield, Illinois 62761-0001

April 3, 1998

Mr. Ross A. Anderson, Audit Manager  
DHHS/OIG/Office of Audit Services  
105 West Adams, 23rd Floor  
Chicago, Illinois 60603

Dear Mr. Anderson:

Enclosed are the Illinois Department of Public Health's comments to your most recent draft report entitled "Review of Elder Abuse Identification, Investigation and Resolution Procedures for Illinois Long-Term Care Facilities." We appreciate the time and effort devoted by you and your staff toward considering our previous comments and incorporating many of them into this most recent draft.

Please do not hesitate to contact our staff should you have any questions regarding our comments.

Sincerely,



John R. Lumpkin, M.D.  
Director of Public Health

Enclosure

**IDPH Should More Fully Develop Incidents Of Alleged Abuse Where  
The Facilities Have Taken Disciplinary Actions Or Terminated CNA's.**

While IDPH does not conduct onsite investigations in response to most incident reports, it is wrong to suggest that IDPH does not make an independent determination as to whether abuse occurred based on those reports. As described by the auditors, IDPH reviews each report to determine whether to initiate an action against the CNA, seek additional information from the facility, conduct an onsite investigation or close the case. IDPH has removed approximately 150 abusive aides from the workforce each year for the six years it has been using this process. While IDPH agrees that facility disciplinary action is one factor to consider in evaluating a case, IDPH has found that such action does not necessarily merit the weight given to it by the auditors. Consequently, IDPH does close some cases without taking action against the CNA even though the facility has taken disciplinary action. Conversely, IDPH initiates actions against CNA's in cases in which there has been no disciplinary action taken by the facility, even when the facility vigorously objects to such action being taken by IDPH.

Given IDPH's limited staff, the volume of complaints which IDPH is required to investigate onsite and the volume of incident reports alleging abuse, IDPH must exercise some judgment as to which onsite investigations of incident reports are likely to result in cases that can be successfully brought against a CNA. IDPH would note that when an incident report is received from a facility, there is less of a concern about facility compliance than when a complaint is received because the facility report tends to indicate that the facility is addressing the problem. In addition, many of these reports involve single incidents with few witnesses, so it is questionable as to how much more information could be gained through an onsite investigation beyond the witnesses' written statements, or descriptions thereof, which are included with the incident reports. There is little basis for assuming that facilities would not be forthcoming in these reports, since the reports cited by the auditors are ones in which the facility reported that they took disciplinary action based on the alleged abuse at their facility.

Notwithstanding the above, IDPH agrees that improvements can be made to its process for handling these reports. One such improvement has already been made in that all reports indicating an employee was terminated for abuse are being referred to the Illinois State Police so they can make an independent judgment whether to investigate for criminal violations. IDPH maintains a close working relationship with the State Police, and currently funds an IDPH nurse to work there on a full-time basis. In addition to this improvement, IDPH is looking into improving its evaluation process for incident reports, including whether other evidence gathering procedures can be used including conducting more onsite investigations.

**IDPH Should Update Its Registry To Include All Instances Of Substantiated Abuse Or Abuse  
Convictions And A Timely Posting of Background Checks Without Disqualifying Convictions.**

IDPH agrees with this recommendation; however, IDPH would emphasize that the backlog of background checks without disqualifying convictions had no impact on the safety of patients, residents or clients. This backlog resulted from the huge volume of background checks that came with the implementation of this relatively new law. IDPH has now caught up with the backlog, and the posting of all background checks should proceed in a timely manner.

**The INHC Act Should Be Amended So That Those Terminations And Disciplinary Actions Which Resulted From Alleged Abuse And The Documentation Related To These Actions Are Included In The Registry.**

IDPH agrees that a past termination or disciplinary action resulting from alleged abuse is one factor that a prospective employer should be able to consider in making a hiring decision. IDPH also recognizes that past employers will often not provide this information due to fear of violating certain state and/or federal disclosure laws (e.g., Fair Credit Reporting Act) and possible lawsuits from former employees. However, IDPH does have concerns about adding this information to the nurse aide registry.

Based on its experience and discussions with facility representatives, IDPH does not believe that a facility's decision to terminate an employee based on allegations of abuse is a reliable indicator that abuse occurred. It appears that a number of facilities terminate the alleged abuser regardless of the evidence because it is the facility's belief that termination must occur in order for the facility to protect itself. At times, this occurs without the facility having even discussed the allegation with the accused. Moreover, based on its experience and discussions with advocacy groups, IDPH believes that there are some instances in which these terminations are actually in retaliation for such things as union activity, filing a Workmen's Compensation claim, reporting abuse, or cooperating with IDPH in an investigation. IDPH is concerned that placing these terminations on a state-operated registry may cause the allegations to be given a level of credibility which may not exist, and employers may be afraid to hire simply because the state is involved in making a recording.

IDPH agrees that any law requiring that disciplinary actions arising from allegations of abuse be recorded on the registry would have to include some form of due process. IDPH also recognizes that such due process should alleviate concerns over whether there was any basis for the disciplinary action. However, this would in essence require IDPH to pursue all terminations in the same manner that it pursues cases in which it has determined that sufficient evidence exists to take action against the CNA. IDPH believes that a better use of its limited resources is to evaluate each case individually, taking into account facility disciplinary action as just one factor in deciding whether a case merits further action.

The auditors have raised a very significant point regarding the absence of information for prospective employers. However, rather than adding this information to the registry, IDPH believes this can be better addressed by mandating that past employers provide this information to prospective employers. Any such change in the law could include protections for good-faith reporting. IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study.

**The HCWBC Act Should Be Expanded To Require Background Checks For All Long-Term Care Staff, Not Just The Direct Health Care Providers**

The issue of whether the Act should be expanded to non-direct care workers was debated at some length by the Health Care Worker Task Force which was appointed to study the HCWBC Act. Clearly, an argument can be made that the law should cover all workers with direct access to patients,

residents or clients, and not just to direct care workers. On the other hand, questions were raised as to whether expanding the law would be justified, given the substantial increase in costs that would result and the hardship on low income employees who would be put out of work during the waiver process. In considering these issues, it should be noted that the HCWBC Act covers other health care employers in addition to long-term care facilities, including hospitals.

IDPH agrees that this is an issue that deserves further study, and will refer it to the Chairman of the Health Care Worker Task Force for further study.

**The HCWBC Act Should Be Expanded To Include The Use Of  
Criminal Data Bases And Neighboring State Data Bases.**

IDPH agrees that there should be some method for employers to check for out-of-state convictions, particularly given the number of employees who come from other states to work in Illinois. However, while the Health Care Worker Task Force did recommend amending the Act to require such checks for relatively new Illinois residents, the Task Force also recognized that there may be problems with cost and availability of the federal checks in rural areas. In addition, it may not be possible to authorize through state law that FBI checks be sent directly to employers and concerns were raised about the accuracy of the FBI checks.

Clearly the auditors have identified a significant weakness in the HCWBC Act. IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study as to whether it is financially and technologically feasible to implement the auditors' recommendations.

**The HCWBC Act Should Be Expanded To Authorize The Facilities Access To Arrest Data  
Supplemented By Final Disposition Data From The Circuit Courts**

Under current law, neither IDPH nor facilities are privy to the arrest information that was reviewed by the auditors. While IDPH agrees that following this recommendation would help alert employers to some convictions that have not yet reached the ISP data base, IDPH believes that they may be valid reasons why arrest information is not currently available. Specifically, IDPH believes there are concerns that information on arrests that did not result in convictions might be wrongly used by employers, and that such wrongful use would have a disproportional impact on minorities.

IDPH will refer this issue to the Chairman of the Health Care Worker Task Force for further study.

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DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Office of Inspector General

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**Memorandum**

Date . SEP 14 1988

From June Gibbs Brown  
Inspector General *June Gibbs Brown*

Subject Safeguarding Long Term Care Residents (A-12-97-00003)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Jeanette C. Takamura  
Assistant Secretary for Aging

Attached are two copies of our final report, "Safeguarding Long Term Care Residents", which provides you an insight into measures taken by States to safeguard residents from abuse in long term care facilities, principally nursing homes. Our observations should be helpful in targeting attention to improved systematic protections. We focused on State requirements and implementation of background checks, reporting abusers centrally in State registers, investigations of alleged abuses and experiences of nursing home officials. Our report is a consolidation of information gathered by audits of two States and surveys of State and nursing home officials. The officials we contacted were sensitive to precautions necessary to promote patient safety and were candid in their remarks.

Building on the results of our audit in Maryland and considering the interest expressed by the United States Senate Special Committee on Aging, we expanded coverage to other States. Accordingly, we audited the State of Illinois, visited 52 nursing homes in 6 States and performed certain supplemental survey work in all the States. Our observations were generally limited to nurse aides working in nursing homes. However, through interviews and surveys we obtained information relative to other health care professionals. In all likelihood, measures needing improvement applicable to nurse aides could be considered for application to other health practitioners in long term care facilities.

There was great diversity in the way States systematically identify, report, and investigate suspected abuse. We also found that background checks were usually limited to State records and too frequently individuals with criminal histories were not recorded in State central registries for use in screening prospective employees. We believe that greater assurance can be given to the protection of frail and dependent elderly if national background checks were implemented and if pertinent data from States are provided to the Administration on Aging to help them direct attention and assistance in preventing elderly

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abuse. In considering a Federal requirement for criminal background checks, there are important factors to take into account, such as: use of State and/or the Federal Bureau of Investigation criminal information systems or State registries; use of fingerprinting to ensure accuracy of identity; types of facilities and staff to be covered; whether periodic checks of employed staff are necessary given the indicated high turnover rates; who pays for the checks; and whether specific crimes should exclude a person from employment after considering such factors as rehabilitation and the nature and frequency of crimes.

We recommended that the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA) work with the States to improve the safety of long term care residents and to strengthen safeguards against the employment of abusive workers by elder care facilities. The HCFA should consider establishing Federal requirements and criteria for performing criminal background checks. Also, HCFA should consider assisting in the development of a national abuse registry and expanding the current State registries to include all workers who have abused or neglected residents or misappropriated their property in facilities that receive Federal reimbursement. The Office of Inspector General (OIG) suggested that legislation be enacted to allow the national abuse registry to be included in an expanded version of the current Healthcare Integrity Protection Data Bank, which the OIG has developed as required by the Health Insurance Portability and Accountability Act of 1996.

In response to our draft report, HCFA and AOA generally agreed with our findings and recommendations and discussed their intended action.

We would appreciate your comments and the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact John A. Ferris, Assistant Inspector General for Administrations of Children, Family, and Aging Audits, at (202) 619-1175.

To facilitate identification, please refer to Common Identification Number A-12-97-00003 in all correspondence relating to this report.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**SAFEGUARDING LONG-TERM CARE  
RESIDENTS**



**JUNE GIBBS BROWN**  
**Inspector General**

**SEPTEMBER 1998**  
**A-12-97-00003**

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**EXECUTIVE SUMMARY**

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We found that the States we surveyed used a patchwork of measures to identify persons posing a possible threat of elder abuse to residents in nursing homes and other long term care facilities. Attempts to minimize and prevent patient risk are diverse throughout the States. Without a detailed study of their approaches, we cannot state with certainty what features, if any, appear to be more effective in protecting frail and dependent elderly from abuse and could be considered for adoption by the States. However, we can show anecdotally which features seem to work effectively for certain States.

- From a review of records and through discussions with nursing home officials, the use of background checks for applicants, as well as on board staff, is helpful in rejecting and deterring applicants and terminating employed staff with histories of abuse and crime. Many States do require background checks and, in general, they believe it is the most reliable source for information to consider during the employment process. Although statistics are not maintained, a number of nursing home officials believe that background checks have reduced the instances of abuse. This comes at an administrative cost which appears acceptable to nursing homes.
- Screening registries of Certified Nurse Aides (CNA) can also be an effective tool in identifying known abusers, provided that information is updated timely with instances of substantiated (validated allegations) abusive behavior from court and investigative findings. We found that in one of the two States reviewed, the nurse aide registry did not always record findings of abuse and convictions of aides who committed elder abuse. State registry officials indicated that facilities are required to report alleged abuse and neglect in order to initiate an investigation to determine if the allegations are substantiated and then record findings in the nurse aide registry. All registry officials surveyed also indicated that there is no systematic reporting to the nurse aide registry convictions or crimes committed outside facilities. Such information could be obtained during background checks and reported to the registry.
- Use of the Office of Inspector General Exclusion listing, which identifies individuals and businesses excluded from participation in certain Department of Health and Human Services' health care programs, can make employment screens more effective. However, none of the nursing homes surveyed in six States was aware of this database or its availability on the internet. Therefore, opportunities for identifying potential risk were not fully realized.

- At the 8 Maryland nursing homes visited, 51 employees, or 5 percent of the 1,000 employees according to the Federal Bureau of Investigation records, had been convicted for a variety of crimes--many involved serious offenses. The employees included CNAs, as well as staff holding jobs not subject to background checks.

Also, based on our background check of 35 individuals who were convicted of elder abuse in Maryland, 7 had prior convictions for other types of crimes, including those against people.

- In Illinois, which requires State criminal background checks, there were a similar number of convictions. Illinois is the only State in our survey which requires criminal background checks on current as well as prospective employees and records the results on the CNA Registry. The State conducted approximately 21,000 criminal checks and found 5 percent had disqualifying crimes. As a result of these checks, employers for 759 CNAs were instructed to terminate their employment and another 216 CNAs were granted waivers to continue working.

In some measure, within our limited review, nursing home staff having a criminal history are being identified. Also, some registries are being flagged appropriately for use by current and prospective employers. However, there is no assurance that nursing home staff who could place elderly residents at risk are systematically identified and excluded from employment.

### ***RECOMMENDATIONS***

We are recommending that the Health Care Financing Administration (HCFA) and the Administration on Aging work with the States to improve the safety of long term care residents and to strengthen safeguards against the employment of abusive workers by elder care facilities. The HCFA should consider establishing Federal requirements and criteria for performing criminal background checks. Also, HCFA should consider assisting in the development of a national abuse registry and expanding the current State registries to include all workers who have abused or neglected residents or misappropriated their property in facilities that receive Federal reimbursement. The OIG suggests that legislation be enacted to allow the national abuse registry to be included in an expanded version of the current Healthcare Integrity Protection Data Bank, which the OIG has developed as required by the Health Insurance Portability and Accountability Act of 1996. More specific recommendations are on pages 11 and 12 of this report.

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In written responses, the HCFA and AoA officials generally agreed with our findings and recommendations. The HCFA and AoA comments to our draft report are included as Appendices D & E and are summarized after our recommendations.

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## INTRODUCTION

### **BACKGROUND**

Under Health Care Financing Administration (HCFA) regulations, residents of nursing homes and other long term care (LTC) facilities, have the right to reside in a safe and secure environment and be free from abuse and neglect. Title 42, Code of Federal Regulations 483.156 requires the States to establish and maintain a registry of nurse aides that includes information on "any finding by the State survey agency of abuse, neglect, or misappropriation of property by the individual" involving the elderly. This Code (483.13) also requires that the LTC facility: "...must not employ individuals who have been found guilty by a court of law or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property." The regulations also require that nursing facilities "report any knowledge it has of actions taken by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities." The HCFA does not require registries for other health care providers, such as registered nurses (RN), licensed practical nurses (LPN), or medical practitioners.

States are encouraged to conduct national background checks of job applicants by the National Child Protection Act, as amended by the Violent Crime Control and Law Enforcement Act of 1994. However, there is no Federal requirement to conduct criminal background checks of current or prospective employees of federally assisted LTC facilities or to maintain a registry for staff other than CNAs who work in these facilities. The Federal Bureau of Investigation criminal history record system (FBI system) may be accessed by States, under Public Law 92-544, if authorized by State statute. This national system, which contains records of serious crimes, is dependent on the voluntary reporting of crime data by State and Federal courts, prosecutors, and arresting authorities.

There is a Federal requirement that States provide criminal information to the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) national database which includes individuals who have been convicted of elder abuse and neglect by the States' Attorney General (AG) offices. Using this information, the OIG publishes a monthly Exclusion List<sup>1</sup> which is available on the Internet.

Also, the Health Insurance Portability and Accountability Act of 1996 authorized the OIG to develop the Healthcare Integrity Protection Data Bank (HIPDB). The HIPDB is intended to

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<sup>1</sup> Persons are excluded from participation in the Medicare, Medicaid, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services Programs. These exclusions are mandated by section 1128(a)(2) of the Act (42 U.S.C. 1320-a-7(a)(2)), and are in addition to any sanction an individual State may impose under the authority of State law.

provide a "one stop shop" data base for public information on the imposition of health care sanctions. It includes information about health care-related criminal, civil, and administrative final adverse actions taken against health care providers, suppliers, and practitioners.

### ***OBJECTIVES, SCOPE, AND METHODOLOGY***

The objectives of our review were to determine whether all States: (1) maintained registries for various health care workers and if a selected number of those States were properly identifying on their registries individuals involved with elder abuse or other crimes; and (2) required background checks of individuals working in LTC facilities and, if so, to determine the specific provisions as well as their assessment of results obtained from doing background checks. We obtained applicable State laws for the 33 States that require criminal background checks. In a few selected States, we tested the accuracy of the registries in recording (flagging) individuals who were guilty of abuse to residents in nursing homes. We determined whether States voluntarily used their Surveillance and Utilization Review System (SURS) to screen Medicaid records for potential unreported elder abuse.

In Maryland, we conducted criminal background checks of all employees at eight randomly selected nursing homes receiving Medicare and/or Medicaid funds to determine if any of these employees had a criminal record, particularly crimes against people. We also compared the individuals convicted of elder abuse by the Maryland Medicaid Fraud Control Unit (MFCU) with those cited in the FBI system and in Maryland's registry to determine if that information was properly recorded and to determine if individuals had prior convictions. In Illinois, we conducted criminal background checks on a selected number of individuals who had a substantiated finding of abuse to determine if any had a prior criminal record. These efforts required the use of the FBI system and the Maryland and Illinois district court and circuit court systems for information on arrests and dispositions. The Maryland and Illinois reviews were done in accordance with generally accepted government auditing standards.

We contacted Federal Administration on Aging (AoA) and HCFA officials, various States' Ombudsmen, Departments of Health, Licensing and Certification offices, Boards of Nursing, Physicians Boards, SURS units and States' AG offices to obtain information and statistical data. We interviewed 52 State nursing home officials in 6 States (Illinois, Indiana, Maryland, Minnesota, Ohio and Virginia) who have been conducting background checks to identify their procedures, practices, and experiences relating to these checks. We also interviewed State registry officials, in these six States, as well as, Michigan and Wisconsin. Our field work was performed from July 1996 through January 1998.



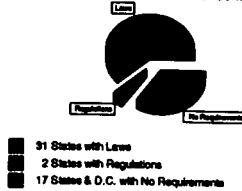
## Observations

### STATE REQUIREMENTS FOR CRIMINAL BACKGROUND CHECKS

Although there is no Federal requirement for criminal background checks of persons employed or seeking employment in nursing homes and other long term care facilities, 33 States require such checks, either by law (31) or regulation (2). However, there are wide diversities in the States' requirements concerning: facilities and personnel covered, systems used for the check--State or Federal records, use of fingerprinting, types of crimes which disqualify employment, factors for determining suitability for employment, costs, and payments for the criminal background check. See Appendix A for a summary of State requirements. Four States (Nebraska, Pennsylvania, Wisconsin and West Virginia) have enacted laws which will become effective in 1998. Seventeen States and the District of Columbia do not require criminal background checks for LTC facilities, although four States have either attempted to pass such legislation or will attempt to in the future.

#### STATE REQUIREMENTS

CRIMINAL BACKGROUND CHECKS



#### Diversities in Background Check Requirements

Where background checks are required, the coverage varies. Not all facilities serving the elderly are included. A majority of the States require background checks of CNAs seeking employment, but do not include current employees or other personnel, such as owners, nurses, dietitians, and housekeeping staff. Most States do not include staff currently employed, contractor staff, or volunteers.

The sources used for the criminal background checks also vary. State records are used by 24 States. Nine States have laws permitting the use of both State and FBI records, although two of these States do not, in practice, use FBI records. Officials from these States informed us that they prefer to use their own State system because it provides a quicker response, is less costly, and contains crimes and disposition data that are not in the FBI system.

There are 24 States that have specified crimes which, if convicted, would automatically disqualify a person from employment, but the disqualifying crimes vary by State. Only a few State laws identified factors to consider in determining suitability for employment when a person has a disqualifying conviction, such as the level, seriousness, and date of the crime, the connection between the person's criminal conduct, duties of the position to be filled, and prison, probation, rehabilitation, and employment history of the person since the crime was committed. As a result, nursing home officials particularly in States without disqualification laws use their own judgment in deciding whether to employ applicants with criminal records.

Costs of a criminal background check depend upon the type of search that is requested and whether or not fingerprinting is used in the search. The costs ranged from "no charge" to as high as \$84 which included fingerprinting and a criminal background check using State and FBI records. Payments for the criminal background check also varied among the 33 States--in most States the employer pays, while employees pay in 4 States.

## STATE REGISTRIES

We contacted 37 States to obtain information on the registries they maintain. All 37 States maintain registries for CNAs, LPNs, RNs, and medical practitioners, although the CNA registry is the only one required by HCFA regulations. The CNA registries are mostly maintained by State officials who issue certificates to approved applicants to practice, whereas the other registries are maintained by respective Boards which issue licenses.

Based on our survey of registry officials, we were informed of the following information about the registries:

- ✓ convictions for crimes committed outside of the LTC facilities, which are required to be reported to the CNA registry as well as other appropriate licensing authorities, are not systematically reported to the registry.
- ✓ 94 percent do not initiate criminal background checks on applicants when they apply for certification or licensure.
- ✓ 29 percent do not require information of prior arrest or conviction on the renewal application.
- ✓ 13 percent did not provide for a penalty for making false statements on the certification or license application.
- ✓ 18 percent are published on the Internet.

The majority of the registry officials stated that when an abuse complaint is filed, an investigation is conducted independently of the court system, and substantiated allegations

disqualifying conditions as specified in the Illinois State law, are not provided to the registry or the facility to determine if the CNA is suitable for employment. In Illinois, the disqualifying crimes are: abuse/neglect of an adult or child, arson, assault, kidnaping and abduction, murder, and theft.

We sampled 88 closed cases of alleged abuse and found that the IDPH did not substantiate, through an independent investigation, whether 13 of these allegations occurred, although these employees were terminated from employment or had disciplinary actions imposed. Accordingly, these 13 cases were not annotated on the CNA registry. These terminated and disciplined CNAs were free to seek employment at other LTC facilities or allowed to continue their employment, which could potentially place residents at further risk.

The benefit of implementing the Illinois criminal background check law is evident from the result of our review. The law should mitigate the number of future abuses by not allowing nursing homes to hire prospective employees who have disqualifying criminal convictions. We noted 15 CNAs and 2 non-CNA employees with prior disqualifying criminal backgrounds who were currently working at LTC facilities but would have been identified and excluded had the Illinois law been in place before their employment and had been applicable to workers in addition to CNAs. All 17 of these employees were later involved in instances of alleged elder abuse. Fourteen of the 15 CNAs are no longer employed by LTC facilities. Seven of the CNAs were terminated as a result of substantiated findings of abuse, and the other seven were dismissed by the LTC facility or resigned subsequent to the abuse allegation. The remaining CNA was transferred to a non-direct resident care position. The two non-CNA employees (who, under current Illinois law, are not subject to a background check) were terminated by the facility due to elder abuse.

#### Other Selected State Registries

We compared the names of individuals contained on the OIG Exclusion List in eight States to the appropriate nurse aide, nurse, and medical practitioner registries and found that, with the exception of Maryland, they generally flagged convictions. Only a few cases were omitted and some of those were due to an administrative oversight.

### SELECTED STATE EXPERIENCES WITH CRIMINAL BACKGROUND CHECKS

We selected six States that have been performing background checks using State records to determine their experiences and opinions of the process. Based on our discussions with 52 nursing home and registry officials in these six States, they generally are in favor of background checks (see Appendix B). While most of these background check laws contained disqualifying crimes which would bar employment, some of the 52 officials said they would automatically exclude everyone with a criminal conviction. The nursing home officials view the background check as a deterrent, although not absolute, to incidents of

are annotated on the registry by the respective board. According to registry officials, their investigations are done because it may take many months or several years before the court renders a verdict.

#### Test of Nurse Aide Registries

The HCFA regulations require that each State's nurse aide registry includes information on convictions for elder abuse and on findings of abuse, neglect, or misappropriation of property. The information must remain in the registry permanently unless it was in error, the individual was found not guilty in a court of law, or the individual dies. In addition, nursing facilities must report to the State nurse aide registry or to licensing authorities any knowledge they have of court actions against an employee that would indicate unfitness for service as a nurse aide or other facility staff. As explained below, these requirements were not always followed.

#### Maryland's Nurse Aide Registry

We reported<sup>2</sup> that the State did not maintain an up-to-date and complete CNA registry to record elder abuse committed by nurse aides of LTC facilities. In our review of 45 alleged abuses, there were 7 cases in which an abuse to a nursing home resident occurred. In six of the seven cases, the CNA was terminated, and in one case the aide was suspended for 3 days because the nursing home felt it had sufficient evidence to take action on the nurse aide's abusive behavior. These seven cases were neither substantiated nor prosecuted and consequently not flagged on the registry.

We also reported that many CNAs convicted for abuse by the MFCU within the Attorney General's Office were not flagged on the registry. Of the 24 CNAs found guilty or who pled guilty in a court of law for elder abuse, only 10 were flagged on the registry. Two others were found guilty prior to establishment of the registry and there was no retroactive provision to include them. The remaining 12 CNAs should have been flagged but were not.

#### Illinois's Nurse Aide Registry

In our review of the Illinois Department of Public Health (IDPH)<sup>3</sup> we reported that IDPH was adequately maintaining the CNA registry for substantiated cases of abuse and the registry was available to the LTC facilities to screen candidates during their hiring process. Illinois is the only State which records criminal background results (both positive and negative) to the registry. However, convictions for crimes, other than those with

<sup>2</sup>OIG Report "State of Maryland's Ombudsman Program for Processing Elder Abuse and Neglect Complaints and Accuracy of Geriatric Nurse Aide Registry", CIN: A-12-96-00016, issued November 28, 1997.

<sup>3</sup>OIG Report "Review of Elder Abuse Identification and Resolution Procedures for Illinois Long Term Care Facilities", CIN: A-05-97-00010, issued in May 1998.

elder abuse because applicants with a history of criminal offenses are either identified through the check, or do not apply for employment because they know the background check will disclose their crimes. We found from the responses received, that many facilities are more comprehensive in their background checks than their State law requires. In most cases, the State law specified certain personnel that are subject to the background check but many nursing home administrators said they check every applicant for employment.

Some may argue that performing background checks for all applicants can be burdensome especially if the current employee turnover rate continues. A number of nursing homes in our survey estimated that the turnover rate for nurse aides averaged 63 percent, with a low of 8 percent and a 300 percent high. However, if the results of all checks, both positive and negative, were to be posted to the registry, as Illinois does, then background checks could be minimized for those who apply for employment in multiple facilities within a specific period of time. Rather than each facility doing a background check of prospective employees, the central registry would already have that information available to them.

Among the positive factors mentioned to us for initiating background checks and utilizing resulting information were: the relatively low cost for the State background check; identification of disqualifying crimes in the State law; motivation for the individual to be truthful on the employment application; State conviction data contains up-to-date convictions; and subsequent to enactment of the background check law, the administrators told us they have experienced fewer instances of abuse. Negative factors include: results of background checks were not always provided timely; arrest outcomes were not always included on the State system; and checks were only statewide and did not cover all employees, such as volunteers and on-board staff.

#### **MARYLAND NURSING HOME EMPLOYEES WITH CRIMINAL RECORDS**

Using the FBI system and the list of employees who were on-board at the 8 Maryland nursing homes we visited, we determined that at least 51 or 5 percent of the employed staff were convicted of crimes which should raise concern over their employability. Many of these individuals were working in occupations providing direct care to residents. We believe the number of employees with convictions is understated because the conviction data available in the FBI system, as well as the State's system, were not recorded in more than half of the cases in which a crime was committed. If that information were available, the magnitude of employed individuals working in a nursing home with a criminal conviction could be as high as 10 percent. Illinois, the only State in our survey that requires checks on current and prospective employees, found a similar number of convictions for current staff. Of 21,000 checks conducted, 5 percent had disqualifying crimes. As a result of these checks, employers for 759 CNAs were instructed to terminate their employment and another 216 CNAs were granted waivers to continue working.

The following is a summary of the arrest and conviction information for employees at the eight nursing homes.

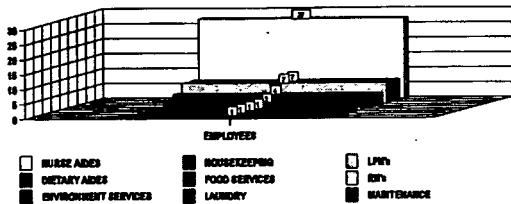
**Arrests and Convictions by Nursing Home**

Nursing Home	Number of Staff	Murder with Armb. Receipt	%	Total Number of Arrests	Total Number of Charges	Disposition (Convictions)			Employees with Convictions	
						No Convictions	Number of Convictions	Not Known	Count	%
A	123	10	8	29	40	13	5	22	4	3
B	37	9	24	26	37	10	5	22	4	11
C	67	11	16	29	43	6	15	22	7	10
D	62	10	16	27	42	8	9	25	5	8
E	156	22	14	66	100	17	16	67	9	6
F	242	24	10	77	116	23	26	67	8	3
G	172	19	11	41	48	19	14	15	8	5
H	209	15	7	20	24	7	7	10	6	3
<b>TOTAL</b>	<b>1,068</b>	<b>120</b>	<b>11</b>	<b>315</b>	<b>450</b>	<b>103</b>	<b>97</b>	<b>250</b>	<b>51</b>	<b>5</b>

Appendix C contains details on these 450 crimes and convictions.

Based on data from the FBI and the State systems, and as illustrated, the 51 employees had 97 convictions for such crimes as assault, child abuse, possession, manufacturing, and distribution of illicit drugs, robbery with a deadly weapon, theft, and handgun violations. See Appendix C for details on the convictions for the 51 nursing home employees.

**51 EMPLOYEES WITH CONVICTIONS**



Of the 51 employees with convictions, we found 43 did not truthfully state on their job applications that they had been convicted and 4 did not respond to the question. For the remaining four employees, two appropriately indicated their convictions and two other employee applications did not have a question regarding conviction information.

### **Crimes after Employment**

We found that 15 employees and 1 contractor staff in our sample were arrested for 58 crimes after they had been employed by the nursing homes. They were convicted of crimes such as: assault, battery, disorderly conduct and forgery. The employees involved were: six nurse aides, four dietary aides, four housekeeping staff, one LPN, and one maintenance staff. Dispositions on 28 of the crimes were not recorded on the FBI or State criminal information systems.

### **Crimes by Contractor Employees**

Although contractor staff are not required under Maryland law to undergo background checks, the dietary service contractor at one nursing home allowed us to perform background checks on all 26 contractor employees. For the six employees hired after July 1, 1996, the effective date for Maryland's background check law, the checks showed that five employees had no criminal record and that one had been charged with a crime but the court records did not show the outcome.

However, for the contractor's other 20 employees who were hired before July 1, 1996, we found a different situation. Based on the FBI system, 4 of these employees had 37 arrests for 54 crimes, as well as 18 convictions for such crimes as fourth degree sex offense, various assault charges, battery, larceny, armed robbery, manufacturing and distribution of illicit drugs, and handgun violations.

## **REPORTS ON BACKGROUND CHECKS**

A number of nursing home officials informed us that the background check laws resulted in a decline in abuses. In the 33 States that had requirements for performing criminal background checks, we attempted to determine if there was a rise or decline in the number of reported cases of elder abuse by seeking national data from AoA Headquarters. However, since AoA did not have elder abuse data for all States over several years, we could not perform this analysis. The AoA was only able to furnish elder abuse data from 29 States for 1995, which the States provided on a voluntary basis.

With the exception of Maryland, the remaining 32 States performing background checks did not have data to show whether the checks were beneficial. In Maryland, the State legislation required the Maryland Association of Nonprofit Homes for the Aging (MANPHA) and the Health Facilities Association of Maryland (HIFAM) to report on the effects of criminal background checks. These reports did not comment on the potential need and impact of mandating national criminal records checks, but offered information indicating benefits obtained from performing checks.

The MANPHA's report stated that, of the 1272 job applicants checked for 70 health care facilities statewide in the last calendar quarter of 1996, about 19 percent had criminal records. This was a decrease from the 22 percent in the third quarter of 1996. The report stated that it "would appear that the new procedures have reduced the number of applications submitted by individuals with criminal backgrounds."

The HFAM's report, which covered such facilities as nursing homes and hospitals, stated that during the period between July 1996 and January 1997, over 10,000 background investigations were conducted and that 22 percent of the individuals had criminal records. There was no other information reported to show whether this was a change from the prior period.

### **CONVICTED MARYLAND NURSING HOME STAFF**

Between 1989 and 1996, Maryland's MFCU identified 35 nursing home staff who were found guilty, or pled guilty in a court of law. All of these individuals were sanctioned/excluded from participation in certain HHS health care programs by the OIG for criminal offenses against the elderly. We found that many of these individuals' arrest and conviction data, however, were not recorded on either the State or FBI systems. Specifically, 10 of the 35 did not have a record of either the abuse arrest or the outcome in either system. The State criminal information system lacked data on 17 arrests and 17 convictions, and the FBI system lacked data on 28 arrests and 33 convictions. As a result, facilities that request State or FBI criminal history information on these individuals would not be informed of all arrests and convictions for elder abuse. Both the State and Federal systems depend on such sources as the arresting agency, the prosecutor, or the court having jurisdiction over the crime to submit arrest and disposition data to the criminal information systems. We did not determine where the breakdown in reporting occurred.

The benefit of performing background checks is again shown by further examination of the 35 nurse aides. Seven nurse aides who were convicted for elder abuse or neglect also had a prior conviction. Since these crimes were committed before Maryland began requiring criminal history checks, the nursing homes were likely unaware of the arrests and convictions when the employees were hired.

### **SURVEILLANCE AND UTILIZATION REVIEW SYSTEMS**

Each State is required, under HCFA regulations, to establish a SURS to safeguard against erroneous payments and unnecessary or inappropriate use of Medicaid services. Although there is no Federal requirement, a few SURS screen medical records of Medicaid patients for the purpose of identifying potential elder and child abuse and referring suspicious findings to appropriate State offices for investigation. These States had identified a limited number of potential elder abuse cases, but generally information was not available to show the overall effectiveness of the screens. However, Idaho informed us that between 10 and



20 cases of possible child abuse were identified each week by screening medical records. We could not tell whether elderly abuse screens were equally successful because performance information was not maintained. To further illustrate the likely effectiveness of screens, Oregon did not screen for elder abuse but, like Idaho, this technique was effective in identifying potential child abuse (22 to 72 cases per week): Accordingly, there is a strong likelihood that screens of medical records could offer an opportunity for surfacing elder abuse cases for further investigation.

## CONCLUSIONS AND RECOMMENDATIONS

Criminal background checks offer LTC facilities an important measure to help safeguard against hiring persons who abused and neglected vulnerable elderly residents or have been convicted of other serious crimes.

Interviews with nursing home officials in six selected States indicated that they were requesting statewide criminal background checks on all of their applicants, many of whom were not covered by their individual State requirements. From the State officials' perspective, this suggests the requirements for performing background checks by nursing facilities be more inclusive. Further, some persons with abusive histories were not reported to the registry system—a system designed to investigate alleged abuse and neglect cases and record those with substantiated findings.

We are recommending that HCFA:

- Ensure States record convictions for, or findings of, abuse and neglect in the CNA registry.
- Work with State officials to ensure that all convictions which could have an impact upon the safety of residents in LTC facilities are properly reported to the State and Federal law enforcement systems.
- Consider developing a Federal requirement for criminal background checks. There are many factors to assess in establishing this requirement, such as: use of State and/or FBI criminal information systems or State registries; use of fingerprinting to ensure accuracy of identity; types of facilities and nursing home and other LTC staff to be covered; whether periodic checks of employed staff are necessary given the indicated high turnover rates; determine who pays for the checks; whether the registry, instead of the individual facilities request the checks and whether specific crimes should exclude or bar a person from employment after considering such factors as, rehabilitation, nature of crime and frequency.

- Consider assisting in the development of a national abuse registry and expansion of the current State registries to include all workers who have abused residents in facilities that receive Federal reimbursement. The registry, using the background check data, should include workers whose behavior outside the facility demonstrates unfitness for working in a health care setting. It should also include workers who were terminated or suspended for abuse and neglect from a nursing home and substantiated by the registry.

The OIG suggests that legislation be enacted to allow the national abuse registry to be included in an expanded version of the current HIPDB, which the OIG has developed as required by the Health Insurance Portability and Accountability Act of 1996. The expanded data bank would be a Healthcare Integrity and Patient Protection Data Bank.

Further, we are recommending that AoA require improved State reporting of abuse statistics to better monitor national trends in the rise or decline of abuse.

***HCFA Response to Recommendations:***

The HCFA generally concurs with our recommendations. Earlier the Administration proposed implementing legislation which was forwarded to Congress on July 29, 1998 requiring criminal background checks, expanding State registries, and developing a national abuse registry for nursing facility employees. However, the HCFA indicated that it must examine further whether the expanded version of the HIPDB is the appropriate vehicle for the national registry. It plans to continue discussions with the OIG and to coordinate possible legislative proposals and an implementation plan for the national registry. In addition, HCFA stated it may be useful to conduct further studies to look beyond the perpetrators of abuse to factors in the broader nursing home environment.

***AoA Response to Recommendations:***

The AoA agreed to take action on our recommendation. The AoA will compile State and national totals of abuse complaints reported by the ombudsman programs, compare the increase or decrease of such complaints against the base year 1996, and indicate for 1996 and all subsequent years the number and percentage of total complaints made to ombudsmen which are categorized as abuse complaints, according to the seven specific categories in the National Ombudsman Reporting System. It will utilize the information to target assistance to State programs showing increased instances of abuse. The AoA will provide this information to HCFA and other interested parties for comparison with data from other sources in order to identify any national trends which might emerge over a multi-year period.

33 STATES WITH CRIMINAL BACKGROUND CHECK REQUIREMENTS

STATE	NO LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECKS
		LAW	REG	STATE	FED	FED & STATE			
Alabama	✓								
Alaska		✓				✓	Nursing Home and Assisted Living	All paid employees, owners and independent contractors	\$84; includes State and Federal check and fingerprinting; Employee pays
Arizona		✓				✓	Long Term Care facility, Home Health Care Service, and Hospice	Operators applying for license, Applicants and employees providing care to elderly/individuals with disabilities. Family members, volunteers, and administrative persons are excluded.	Cost not specified; Employer pays
Arizona	✓								
California		✓		✓			Any facility that employs Nurse Aides and Home Health Aides. Most often this would be a Nursing Home, Home Health Agencies (HHAs), and Hospitals	Nurse Aides and Home Health Aides	\$5 for Nurse Aides and \$25 for Home Health Aides; part of license renewal
Colorado		✓		✓			Nursing Care Facilities	All Applicants	Fee varies; \$14 for Statewide check; payment as agreed to by employee and employer

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STATE	LAW NO LAW	REQUIREMENTS		RECORDS INDEXED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECK
		LAW	REG	STATE	FED	FED & STATE			
Connecticut	✓								
Delaware	✓								
District of Columbia	✓								
Florida		✓		✓			Assisted Living  Adult Family Care Homes	Nurse Aides, Applicants, Administrators, General Partner, and Corporate officers  Nurse Aides, Applicants, House-hold members, Relief person, and all staff	\$15; Employer Pays
Georgia		✓		✓			Nursing Homes, Personal Care Homes, Group Homes, and Alternative Living Unit	All employees	\$27; Employer pays
Hawaii	✓								
Idaho			✓	✓			All Long Term Care Facilities	All employees	\$5 for name search and \$10 for fingerprint search; State Pays
Illinois		✓		✓			Community Living, Long Term Care, Life Care, Home Health Agency, Community Residential Alternative, Nurse Agencies, Respite Care, Hospice, Mental Health, Community Integrated Living, and Hospitals as defined in Law	Direct care employees and Nurse Aides	\$12 for name search and \$15 for fingerprint search; Employer or employer may pay

STATE	NO LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECKS
		LAW	REG	STATE	FED	FED & STATE			
Iowa		✓		✓			Nursing Facilities, Skilled Nursing Facilities, Intermediate Care Facilities (ICF) for the Mentally Retarded, ICF for Persons with Mental Illnesses, Residential Care Facilities (RCF), RCF for the Mentally Retarded, Three to five Bed RCF for the Mentally Retarded, RCF for the Mentally Ill	All employees, anyone providing services to residents, including independent contractors	\$13-\$15; Facility pays
Indiana		✓		✓			Health Facility, Hospital based Facility that employs Nurse Aides or an entity in business of contracting to provide Nurse Aides or other non licensed employee of a facility covered in the law	Operators, Administrators, Nurse Aides, and non-licensed employees	\$7 to \$10; Employer pays but may require employee reimbursement; \$32 by private firm
Kansas		✓		✓			Any elderly or disabled residential facility for eight or more persons that is licensed by the State	Operators and Administrative staff	\$10; State pays
Kentucky		✓		✓			Any nursing facility (Nursing Homes, Adult Day Care, Domiciliary Care, Psychiatric Hospital, Sheltered Housing, Hospice, and Acute Care Hospital) and Agencies (such as Home Health Agencies) providing services to senior citizens	Nursing facility employees providing direct service to senior citizens	\$4; Employer pays
Louisiana		✓		✓			Nursing Homes, Intermediate Care, Adult Residential Care, Adult Day Care, Home Health and Residential Services Agencies, Hospice, and Ambulance Services	Non-licensed direct care employees and licensed ambulance personnel	\$10; Employer pays

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STATE	NO LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECK
		LAW	REG	STATE	FED	FED & STATE			
Maryland		✓		✓			Adult Dependent Care Programs, Adult Day Care, Domiciliary Care, Group Homes, Home Health Agencies, Sheltered Housing, Residential Service Agency, Alternative Living Unit, and Hospice Facility	Compensated employees having routine direct access to dependent adults, and not licensed or certified under the Health Occupations Article (i.e., RNs, LPNs, and CNPs)	\$7 to \$18 for State check; \$24 for FBI check; Employer Pays
Maine			✓	✓			Nursing Homes, Group Homes, HHAs, Psychiatric Hospitals, and Hospice	Nursing Home employees and Nurse Aides	No Charge
Massachusetts	✓								
Michigan	✓								
Minnesota		✓		✓			Hospital, Boarding Care Homes, Outpatient Surgical Centers, Nursing Homes, Home Care Agencies, Residential Care Homes, Board and Lodging establishments	Persons providing services which have direct contact with patients and residents. (Applicants, current employees, contractors, and volunteers)	\$5; Employer pays for State check; \$24 for an FBI check
Mississippi	✓								
Missouri		✓		✓			Continuing Care Retirement Community, Health Care Facilities, Long Term Care, In-home Service Providers, and Employment Agencies for Nurses and Nurse Assistants	Applicants for a full-time, part-time, or temporary position that has contact with any patient or resident.	\$5 to \$22; Employer pays but may require employee reimbursement
Montana	✓								
Nebraska		✓		✓			Assisted Living	Direct care staff of the facility	Not specified

STATE	NO LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECK
		LAW	REG	STATE	FED	FED & STATE			
Nevada		✓				✓	Facilities for Intermediate Care, facilities for Skilled Nursing and Residential Facilities for groups providing food, shelter and assistance to some of the most vulnerable residents of the State including aged, infirm, mentally retarded and handicapped agencies providing nursing in the home and assistance to these vulnerable residents	Each applicant for a license to operate a facility for Intermediate Care, a facility for Skilled Nursing, or Residential Facility for Groups, and of each employee of each facility providing nursing services in the home	\$25-\$30; fingerprinting and a check for the 11 surrounding States \$15 additional; Employer pays and may pass up to 50 percent to employees
New Hampshire	✓								
New Jersey	✓								
New Mexico		✓				✓	Skilled Nursing, Intermediate Care, Care Facility for Mentally Retarded, Psychiatric, Rehabilitation, Kidney Disease Treatment, Home Health Agency, Homemaker Agency, Ambulatory Surgical or Outpatient Facility, Home for the Aged or Disabled, Group Home, Adult Foster Care Home, Private Residence that provides Personal Care, Sheltered Care or Nursing Care for one or more persons not related by blood or marriage to the facility's operator or owner, Adult Day Care Center, Boarding Home, Adult Residential Shelter Care Home, any entity that provides respite, companion or personal care services, and any other health or resident care related facility not a care facility location at or performing services for any correctional facility	All employees, Contractors and Volunteers	\$5 State check; the FBI check has not been yet been implemented and the cost is unknown; Either employer or employee pays
New York	✓								

STATE	NO. LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECK
		LAW	REG	STATE	FED	FED & STATE			
North Carolina		✓		✓			Nursing Homes, Adult Care Home, Home Care Agencies, Domiciliary Care Facility, Group Homes, Residential Service Agencies, Psychiatric Hospitals, Area Mental Health, Developmental Disabilities, Substance Abuse, and Hospices, any other organization or corporation, whether for profit or nonprofit, that provides direct care or services to the sick, the disabled, or the elderly	Non-licensed job applicants and consenting volunteers who provide treatment for or services to the disabled and the elderly, non-licensed applicants for employment in Nursing Homes, Adult Care Homes, and Home Care Agencies	Capped at \$14; Either employer or employee pays
North Dakota	✓								
Ohio		✓		✓			Hospitals, Home Health Care, Adult Day-Care, Adult Care Facility, Nursing Homes, Residential Care facilities, County and District Homes, Homes for the Aging, Passport Agencies.	All applicants under final consideration for providing direct care to an older adult. Does not include volunteers.	\$5 for State check; \$25 for FBI check; Facility pays
Oklahoma		✓		✓			Nursing and Specialized Facility, or Residential Care Homes, Adult Day Care, and Home Health or Home Care Agencies	Applicants for employment or contract offers to non-licensed nurse aids or other person providing nursing care, health related services, or supportive assistance	\$10; Employer pays
Oregon		✓				✓	Adult Foster Care Homes and Residential Care facilities	Administrators, Direct and Non-direct Care Staff	\$36; Employer pays



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STATE	NO LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECK
		LAW	REG	STATE	FED	FED & STATE			
Pennsylvania		✓				✓	Domiciliary Care Home, Home Health Care Agencies, Long Term Care Nursing Care Facilities, Older Adult Daily Living Center, Personal Care Home	All applicants being considered for employment	\$10 for State check and if Federal check is required the State Police may not charge the applicant more than the established charge by the FBI; Employee pays
Rhode Island		✓		✓			Nursing Homes, Home Health Agencies, In-patient Hospice, Nursing Service Agencies, and Assisted Living Facilities	Persons seeking employment at a facility covered by the law	No Charge
South Carolina		✓				✓	Health Facility licensed under this article including, but not limited to Nursing Homes and Community Residential Care facilities	Administrators	\$39; Employee pays
South Dakota	✓								
Tennessee	✓								
Texas		✓		✓			Nursing Homes, Adult Day Care, Home Health Agencies, Adult Day Health Care, Intermediate Care, Adult Foster Care, Custodial Care Home, Personal Care, Non-licensed Attendant Care, and Mental Health and Mental Retardation	Direct Contact Employees	\$8 or less; Employer pays
Utah	✓								
Virginia		✓				✓	Nursing Homes, Adult Day Care, Hospice, and other State licensed facilities	Compensated employees	\$15; Employer pays

STATE	NO. LAW	REQUIREMENTS		RECORDS USED			FACILITIES COVERED BY REQUIREMENTS	PERSONNEL COVERED BY REQUIREMENTS	COST AND WHO PAYS FOR BACKGROUND CHECKS
		LAW	RIGG	STATE	FRD	FRD & STATE			
Vermont		✓		✓			Nursing Homes, Home Health Agencies, Adult Day Care, and Residential Service Agencies	Employees, Contractors, and Grants involved in care giving	No Charge
Washington		✓				✓	Nursing Homes, Home Health Agencies, Adult Day Care, Group Home, and Sheltered Housing for the elderly	All prospective employees and volunteers having unsupervised access to vulnerable adults	No Charge for nonprofit and \$10 for profit businesses
West Virginia		✓		✓			Residential Care Facility, Home Care, and licensed Day Care Facilities	Compensated employees and contractors	\$10; Employer pays
Wisconsin		✓		✓			Nursing Homes and Community Based Residential facilities	All Nursing Home employees	\$13; Employer pays
Wyoming	✓								
<b>TOTAL</b>	<b>18</b>	<b>31</b>	<b>2</b>	<b>24</b>	<b>0</b>	<b>9</b>			

## CRIMINAL BACKGROUND CHECKS SUMMARY OF STATE REQUIREMENTS AND EXPERIENCES

	IL	IN	MD	MI	MN	OH	VA	WI	Notes
<b>1. State Law?</b>	Y	Y	Y	N	Y	Y	Y	Y	
<b>Effective Date</b>	1/96	3/98	7/96	N/A	7/95	1/97	4/93	7/98	
<b>2. Who Pays for Check?</b>	NH	NH	NH	N/A	State	NH	NH	NH	Note 1
		Employee							
<b>3. Cost</b>	\$12-\$15	\$7-\$32	\$7-\$24	N/A	\$5-\$24	\$15	\$15	\$13	Note 2
<b>4. Who is Checked?</b>	Direct Care Employees	Non-licensed Employees	All New Employees	N/A	Direct Care Employees	Direct Care Employees	All New Employees	All New Employees	Note 3
<b>Volunteers/Contractors</b>	N	N	N	N/A	N	N	N	N	
<b>On-Board Staff</b>	Y	N	N	N/A	Y	N	N	Y	
<b>Prospective Staff</b>	Y	Y	Y	N/A	Y	Y	Y	Y	
<b>Other Staff</b>	Y	Y	Y	N/A	Y	N	Y	Y	
<b>5. Are Checks Periodic?</b>	N	N	N	N/A	N	N	N	Y	
<b>6. Query Registry/State Board?</b>	Y	Y	Y	N/A	Y	Y	Y	Y	
<b>7. Extent of Check</b>	Statewide	Statewide	Statewide	N/A	Statewide	Statewide	Statewide	Statewide	
<b>8. Response Time: Per Law</b>	3-4 wks	N/A	N/A	N/A	3-4 wks	3-4 wks	3-4 wks	3-4 wks	
<b>Response Time: Per Nursing Home</b>	1-5 wks	2-6 wks	1-3 days	N/A	4 wks	3-7 wks	1-3 wks	N/A	
<b>9. Use Federal System?</b>	N	N	N	N/A	N	N	N	N/A	
<b>10. Fingerprinting Used?</b>	N	N	N	N/A	N	Y	N	N	Note 4
<b>11. List of Disqualifying Crimes? Comprehensive List?</b>	Y	Y	N	N/A	Y	Y	Y	Y	
	Y	N	N	N/A	Y	N	Y	Y	
<b>12. Penalties for False Statements on Application?</b>	N	N	N	N/A	N	N	Y	N	
<b>Penalty for not Doing Check?</b>	N	Y	N	N/A	N	N	N	N	
<b>13. Aware of OIG Exclusion List? Were Excluded Persons Usually Flagged? Registry for Non-Medical Staff?</b>	N	N	N	N/A	N	N	N	N/A	
	Y	Y	N	Y	Y	Y	Y	Y	
	N	N	N	N	N	N	N	N	
<b>14. Were Crimes Committed Outside NH Reported?</b>	Y	N	N	N/A	N	N	N	N/A	
<b>15. Turnover: Aides</b>	HIGH	HIGH	HIGH	N/A	HIGH	LOW	MED	N/A	Note 5
<b>Nurses</b>	MED	HIGH	HIGH	N/A	HIGH	HIGH	HIGH	N/A	

Note 1: Minnesota recoups the cost of background checks with increased licensing fees. Illinois statute allows nursing home to recoup cost from applicant.

Note 2: Cited costs refer to checks from State agencies. Different charges may apply for private firm or NCIC checks.

Note 3: Illinois does not include doctors or licensed nurses in its definition of direct care employees.

Note 4: Data refers to background checks requested from State agencies. Fingerprinting is used for requests when additional identification is required.

Note 5: LOW = 15%; MED= 10-50%; HIGH= more than 50%

NI = Nursing Home  
NA = Not Applicable

**CRIMINAL BACKGROUND CHECKS**  
**SUMMARY of STATE REQUIREMENTS AND EXPERIENCES**

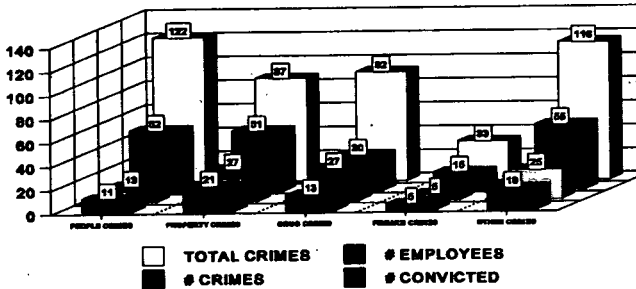
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	IL	IN	MD	MI	MN	OH	VA	WI
<b>Positive Comments:</b>								
List of Disqualifying Crimes	Y	Y	N	N/A	Y	Y	Y	N/A
Check is Incentive to be Truthful on Application	Y	Y	Y	N/A	Y	Y	Y	N/A
Conviction Data Current	Y	Y	N/A	N/A	Y	Y	Y	N/A
Cost Reasonable per Nursing Home	Y	Y	Y	N/A	Y	Y	Y	N/A
Few Instances of Abuse Reported by Nursing Home	Y	Y	Y	N/A	Y	Y	Y	N/A
<b>Negative Comments:</b>								
Only Statewide Check - Federal System Not Used	Y	Y	Y	N/A	Y	Y	Y	N/A
Fingerprinting Used	Y	Y	Y	N/A	Some Times	N	Y	N/A
Arrests Not Reported: Inaccurate-Scan System	Y	Y	Y	N/A	Y	Y	Y	N/A
Checks Are An Absolute Deterrent	N	N	N	N/A	N	N	N	N/A
Checks Are Only of New Hires	N	Y	Y	N/A	N	Y	Y	N/A
Some Nursing Homes Checks Include:								
Doctors	N	N	N	N/A	N	N	N	N/A
Nurses	N	Y	Y	N/A	Y	Y	Y	N/A
Volunteers	N	N	N	N/A	N	N	N	N/A
Contractors	N	N	Y	N/A	Y	N	Y	N/A
High Turnover Rates Aides--New Hires	Y	Y	Y	N/A	Y	Y	Y	N/A
MN Involved in Abuse Investigations	N	N	N	N/A	N	N	Some Times	N/A
Employers Immune from Liability on References	N	N	Y	N/A	N	N	N	N/A
Rely on Registry/Board for Abuse Data	Y	N	N	N/A	N	N	N	N/A
Informed of Investigation Disposition	N	N	N	N/A	N	N	N	N/A

**450 CRIMES BY NURSING HOME STAFF**

The 450 arrests involving 120 employees include:

**CRIMES BY STAFF**

Note: The total number of employees cited is more than 120 because an employee committed more than 1 crime.

- ✓ 122 crimes by 52 employees were against people, such as assault, battery, child and sexual abuse, robbery with deadly weapon, 11 employees were convicted for 13 crimes against people;
- ✓ 87 crimes by 51 employees were against property such as burglary, robbery, theft, trespassing and shoplifting, 21 employees were convicted for 27 crimes against property;
- ✓ 92 crimes by 30 employees involved illicit drugs, such as possession of cocaine, heroin, marijuana, distribution and manufacture of illicit drugs, as well as forged prescriptions, 13 employees were convicted for 27 crimes against controlled substances;
- ✓ 33 crimes by 15 employees involved firearms, such as carrying and use of handguns, 5 employees were convicted for 5 crimes against firearms; and
- ✓ 116 other crimes by 55 employees involved forgery, welfare and unemployment benefits fraud, resisting arrest, bad checks, and prostitution, 18 employees were convicted for 25 other crimes.

### 51 Employees with Convictions

Fifty-one employees had been convicted of a crime based on data from both the State systems and FBI system. They were arrested for other crimes, but the dispositions on these crimes was unknown. The following is a list of the number of employees classified by job and the crimes for which they were convicted.

- ✓ 27 Nurse aides were convicted of: assault; simple assault; assault common; assault strong arm; battery; child abuse; theft; grand theft; robbery; possession of controlled substances, such as PCP and Marijuana; possession with intent to distribute; possession of narcotic paraphernalia; welfare fraud; forgery; conspiracy; false pretenses; resisting arrest; driving while intoxicated; intoxication; and disorderly conduct.
- ✓ 7 LPNs were convicted of : robbery with a deadly weapon, theft, trespassing, larceny, shoplifting, prostitution, driving while intoxicated, disorderly conduct, and possession of narcotic drugs.
- ✓ 7 Housekeeping staff were convicted of: assault, assault common, assault with a handgun, handgun violations, robbery with a deadly weapon, possession of cocaine, violation of probation, driving with suspended license, disorderly conduct, and malicious destruction of property.
- ✓ 4 Dietary aides were convicted of: battery, shoplifting, forgery, possession of marijuana or heroin, distribution of heroin and other narcotics, consuming alcohol, bad checks, and violation of immigration laws.
- ✓ 2 Food service staff were convicted of: handgun violations, and possession of cocaine.
- ✓ 1 RN was convicted of carrying a pistol without a license.
- ✓ 1 Environment services staff was convicted of: possession of PCP and marijuana, and possession with intent to distribute.
- ✓ 1 Laundry staff was convicted of two counts of child abuse.
- ✓ 1 Maintenance staff was convicted of: robbery, possession of marijuana, handgun violation, and violation of probation.



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

APPENDIX D

Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

## DATE:

SEP 3 1998

TO: June Gibbs Brown  
Inspector GeneralFROM: Nancy-Ann Min DeParle *NMD*  
AdministratorSUBJECT: Office of Inspector General (OIG) Draft Report: "Safeguarding Long Term  
Care Residents," (A-12-97-00003)

We have reviewed the above-referenced report that examines measures taken by states to safeguard residents from abuse in long-term care (LTC) facilities. The report focused on state requirements and implementation of background checks, reporting abusers centrally in state registers, investigations of alleged abuses, and experiences of nursing home officials.

The report recommends that the Health Care Financing Administration (HCFA) and the Administration on Aging work collaboratively with the states to improve the safety of long-term care residents and to strengthen safeguards against the employment of abusive workers by elder care facilities. The report further recommends establishing Federal requirements and criteria for performing criminal background checks, expanding the current state registries to include all workers who have abused residents in facilities that receive Federal reimbursement, and HCFA assist in the development of a national abuse registry for nursing home employees. The OIG suggests that legislation be enacted to include the national abuse registry in an expanded version of the current Healthcare Integrity Protection Data Bank (HIPDB).

The Inspector General's conclusions echo our own findings. Nursing home residents and their families deserve compassionate caregivers, not convicted criminals and known abusers. As you know the President on July 21 launched a wide-ranging initiative to better protect nursing home residents and improve their quality of care. This report strengthens the case for the President's proposal to require criminal background checks for nursing home workers and to create a national abuse registry. On July 29, we forwarded proposed implementing legislation to Congress and we hope that members will take quick action.

Page 2 - June Gibbs Brown

We concur with OIG's recommendations for criminal background checks and expanding state registries. We also agree conceptually with the OIG recommendation to develop a national abuse registry for nursing facility employees. However, we must further examine whether the expanded version of the HIPDB is the appropriate vehicle for the registry. While the idea of an integrated database is appealing, a number of operational issues must first be examined. Staff from my office have engaged in preliminary discussions with members of your staff to discuss the capacity of the HIPDB, OIG's proposals for expansion, and the goals of the President's initiative. We plan to continue these discussions and to coordinate possible legislative proposals and an implementation plan for the registry.

In addition to enactment of the legislative proposals, it may be useful to conduct further studies, looking beyond the perpetrators of abuse to factors in the broader nursing home environment. Examining the relationship between abuse of residents and factors such as employee working conditions, pay, and "no-lift" policies to ease injuries may allow us to identify preventive steps that can be taken. The combination of thorough background checks and preventive measures should help reduce abuse of LTC residents.

Additionally, another factor which needs to be addressed is the awareness and sensitivity training which is provided to caretakers in dealing with disabilities common among the beneficiaries who receive LTC. Without understanding these disabilities and how to address them, abuse-even unintentional-can occur because of ignorance and/or frustration, or the lack of adequate accommodations and technical support to properly care for the patient.

Thank you for the opportunity to comment on this report.





DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

APPENDIX E

Office of the Secretary  
Administration on Aging

SEP 2 1998

Washington, D.C. 20201

To: June Gibbs Brown  
Inspector General

From: Assistant Secretary for Aging

Subject: Safeguarding Long-Term Care Residents (A-12-97-00003)

We appreciate having the opportunity to review the draft of this report and to discuss it with staff of the Office of Audit Services.

Regarding abuse data collected at the Federal level, the Administration on Aging's (AoA) role relative to such data and action which AoA is in a position to undertake are provided below and are based upon the following background information.

#### Background

Beginning in FY 1996, all states submit to AoA annual long-term care ombudsman reports which show numbers of complaints made to the statewide ombudsman programs in 133 specific categories. The first seven of these categories are complaints which ombudsmen classify as abuse, gross neglect or exploitation. These include: physical abuse, sexual abuse, verbal/mental abuse, financial exploitation, gross neglect, resident-to-resident abuse and "other". The definition of abuse used in the instructions for documenting complaints is that contained in the Older Americans Act, which is the same definition used by the Health Care Financing Administration (HCFA); definitions and specific examples of types of abuse are from HCFA's "Survey Forms and Interpretive Guidelines for the Long-Term Care Survey Process," April 1992.

While ombudsmen investigate and document numerous complaints about abuse, other state agencies, including adult protective services, the nursing home survey and certification agency, and the Medicaid Anti-Fraud and Abuse Units, also investigate abuse complaints. Thus, the data reflected in the state ombudsman reports provide only part of the picture of the incidence of abuse which might be occurring in long-term care facilities in a state. Also, many complaints may be classified as abuse which are not really abuse but are injuries due to accidents or mishandling.

#### Response

The AoA will provide guidance to the states to eliminate complaints which may be classified as abuse but may instead be injuries due to accidents or mishandling. AoA will compile state and national totals of abuse complaints reported by the ombudsman programs, compare the increase

or decrease of such complaints against the base year 1996, and indicate for 1996 and all subsequent years the number and percentage of total complaints made to ombudsmen which are categorized as abuse complaints, according to the seven specific categories in the National Ombudsman Reporting System (NORS). We will utilize the information to target assistance to state programs showing increased instances of abuse. AoA will provide this information to HCFA and other interested parties for comparison with data from other sources in order to identify any national trends which might emerge over a multi-year period.

Again, thank you for the opportunity to comment on this important report.

  
Jeanette C. Takamura

## Memorandum

Date NOV. 26 1997

From June Gibbs Brown  
Inspector General *June G. Brown*

Subject State of Maryland's Ombudsman Program for Processing Elder Abuse and Neglect  
Complaints and Accuracy of Geriatric Nurse Aide Registry (A-12-96-00016)

To Jeanette C. Takamura  
Assistant Secretary for Aging

This memorandum is to alert you to the issuance on Friday, November 28, 1997, of our final audit report. A copy is attached.

Our objective was to evaluate Maryland's Ombudsman program to identify, investigate, and resolve complaints of elder abuse, neglect, and exploitation. We expanded our review to include a determination of whether findings or convictions of abuse by nursing home employees were appropriately annotated ("flagged") by Maryland's Department of Health and Mental Hygiene, Division of Licensing and Certification, on the Geriatric Nurse Aide (GNA) Registry to indicate that a prior abuse was committed.

The Ombudsman plays an important role in helping to ensure that the elderly are properly cared for and protected from abuse in long term care facilities. We found, in our sample, that the review and reporting network in Montgomery County's Ombudsman program did not provide reasonable assurance that instances of abuse occurring in long term care facilities were properly reported and resolved. Similar deficiencies were found in other counties but to a lesser degree. We also found that the State Ombudsman has not conducted annual monitoring reviews of all local Ombudsman programs.

The Ombudsman program is a featured part of the elder abuse avoidance system in Maryland that needs to work together with the police and various other offices, to provide services which protect residents' health, safety, welfare, and rights. However, we noted that: (1) the local Ombudsmen, who are principally responsible for investigating complaints which include abuse and neglect, were not always following established review procedures and resolving complaints; (2) all long term care facilities, particularly board and care facilities, are not being overseen by the Ombudsman; and (3) for 1993, 1994, and 1995, only 26 of the 57 local Ombudsman programs were reviewed annually as required by the State Ombudsman.

Page 2 - Ms. Jeannette C. Takamura

We also found that the State GNA Registry which is intended to record the history of nurse side abuses, did not always include such information on individuals who were found to have abused residents of nursing homes. This information is important to nursing homes in hiring employees.

In Maryland's Office of Aging (OoA) response to our draft report, they did not agree with some of the findings and the conclusion in the report, but they agreed with all of the recommendations. Subsequent to the issuance of the draft report, the OoA provided additional information on monitoring visits, specific cases included in the report and interpretation of Maryland's criminal law. The report was adjusted, where appropriate, to reflect this new information.

Any questions or comments on any aspect of this memorandum are welcomed. Please call me or have your staff contact John A. Ferris, Assistant Inspector General for Administrations of Children, Family, and Aging Audits at (202) 619-1175. To facilitate identification, please cite Common Identification No. A-12-96-00016 in all correspondence relating to this report.

Attachment

cc:  
Helene Prodeking, HCFA  
Tim Heck, HCFA Region III

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**STATE OF MARYLAND'S OMBUDSMAN  
PROGRAM FOR PROCESSING ELDER  
ABUSE AND NEGLECT COMPLAINTS  
AND ACCURACY OF GERIATRIC NURSE  
AIDE REGISTRY**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 1997  
A-12-96-00016**

## ***OFFICE OF INSPECTOR GENERAL***

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**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**STATE OF MARYLAND'S OMBUDSMAN  
PROGRAM FOR PROCESSING OF ELDER  
ABUSE AND NEGLECT COMPLAINTS  
AND ACCURACY OF GERIATRIC  
NURSE AIDE REGISTRY**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 1997  
A-12-96-00016**



NOV 28 1997

Our Reference: Common Identification Number A-12-96-00016

Sue F. Ward, Director  
Maryland Department of Aging  
301 West Preston Street, Room 1007  
Baltimore, Maryland 21201

Dear Ms. Ward:

Enclosed for your information and use are two copies of final Office of Inspector General (OIG) audit report entitled, "State of Maryland's Ombudsman Program for Processing Elder Abuse and Neglect Complaints and Accuracy of Geriatric Nurse Aide Registry."

Final determination as to actions to be taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG audit reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public, to the extent information contained therein is not subject to exemptions in the Act, which the Department chooses to exercise (see 45 CFR Part 5).

A copy of this final report has been furnished to representatives of the Maryland Department of Health and Mental Hygiene; Administration on Aging; Health Care Financing Administration; Division of Licensing and Certification; and the Medicaid Fraud Control Unit, Maryland Office of Attorney General.

We will be very happy to meet with you to discuss any matters in the report and the specific areas you mentioned which include: risk assessment system, volunteer program, and coordination with the police in their investigation of alleged abuse. Please call me at (202) 619-1175 or Peter Koenig at (202) 619-3191.



Page 2 - Ms. Ward

You may also contact both Sue W. Wheaton in the Administration on Aging at (202) 619-7585 and Lori Smetanka, Coordinator with the National Long Term Care Ombudsman Resource Center, at (202) 332-2275. They are available to provide technical assistance as may be needed in the specific areas. Ms. Wheaton indicated there are numerous models in other States that may assist you with your program. To facilitate identification, please cite Common Identification No. A-12-96-00016 in all correspondence relating to this report.

Sincerely yours,



John A. Ferris  
Assistant Inspector General for  
Administrations of Children, Family,  
and Aging Audits

**Enclosures**

cc:

Lawrence P. Triplett, DHMH  
Carol Benner, DHMH  
Sharon Matthews, AoA  
Sue Wheaton, AoA  
Ed Glatzel, HCFA  
Helene Frodeking, HCFA  
Tim Hock, HCFA Region III  
Timothy Sharpe, MPCU

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**EXECUTIVE SUMMARY**

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The Ombudsman plays an important role in helping to ensure that the elderly are properly cared for and protected from abuse in Long Term Care (LTC) facilities. We found, in our sample, that the review and reporting network in Montgomery County's Ombudsman program did not provide reasonable assurance that instances of abuse occurring in long term care facilities were properly reported and resolved. Similar deficiencies were found in other counties but they were not statistically significant. We found that the State Ombudsman has not conducted annual monitoring visits of all local Ombudsman programs. The Ombudsman program is a featured part of the elder abuse avoidance system in Maryland that needs to work together with the police and various other offices, to provide services which protect residents' health, safety, welfare, and rights. However, we noted that:

- the local Ombudsmen, who are principally responsible for investigating complaints, were not always following established review procedures and resolving complaints;
- all LTC facilities, particularly board and care facilities, are not being overseen by the Ombudsmen; and
- for 1993, 1994, and 1995, only 26 of the 57 local Ombudsman programs received their required annual monitoring visits by the State Ombudsman.

We also found that the State Geriatric Nursing Assistant Registry, which is intended to flag abuses by nurse aides, did not always include such information on individuals who were found to have abused residents of nursing homes.

Subsequent to the issuance of the draft report, the Maryland Office of Aging (OoA) provided additional information on monitoring visits, specific cases included in the report and interpretation of Maryland's criminal law. The report was adjusted, where appropriate, to reflect this new information.

The OoA did not agree with some findings and the conclusions in the report. However, they agreed with all of the recommendations. The OoA comments and the Office of Inspector General's responses are summarized after each section in the body of the report. The complete text of OoA's comments is included in Appendix D.

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## INTRODUCTION

### BACKGROUND

Ombudsman programs exist to benefit and protect the Nation's approximately 2.4 million residents of nursing and board and care homes, and similar adult care facilities. These residents are among the most frail and vulnerable group in the Long Term Care (LTC) system. The State Ombudsman is responsible for training the local Ombudsmen, providing specialized technical assistance related to the care and treatment of residents, and the overall oversight and direction of the Ombudsman program. The Maryland LTC Ombudsman Program is administered through the Maryland Office on Aging by the State Ombudsman. The local Ombudsmen staff and volunteers at all 19 Area Agencies on Aging receive complaints, perform investigations, and work to resolve the complaints. The local Ombudsmen work through mediation and negotiation to resolve complaints. When appropriate, the Ombudsmen refer complaints to the police and the Maryland's Department of Health and Mental Hygiene (DHMH), Division of Licensing and Certification (L&C).

Title 42, Code of Federal Regulations (CFR) §483.156 provides the requirement for States to establish and maintain a registry of nurse aides that includes information on "any finding by the State survey agency [L&C] of abuse, neglect, or misappropriation of property by the individual." According to program officials, a finding of abuse means that sufficient evidence exists to support the conclusion that an abuse occurred.

In 1995, there were approximately 746,000 Marylanders over the age of 60. Over 35,000 of these individuals reside in nursing homes or other similar long term care institutions.

### SCOPE AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. Our objective was to evaluate Maryland's Ombudsman program to identify, investigate, and resolve complaints of elder abuse, neglect, and exploitation.

To accomplish this objective, we interviewed State and local Ombudsmen, officials from the DHMH/L&C, Maryland Department of Human Resources' Adult Protective Services (APS) and Women's Services Program. We also met with officials from the Maryland Office of Attorney General's Medicaid Fraud Control Unit (MFCU).

We reviewed applicable Federal and State laws and regulations regarding elder abuse and policies and procedures of the State and local Ombudsmen. We reviewed applicable records,

including the Maryland LTC Ombudsman program - Quarterly Reports (Quarterly Reports) submitted by the local Ombudsmen to the State Ombudsman and by the State Ombudsman to the Administration on Aging (AoA).

We randomly selected and reviewed 100 cases from the 2,130 (adjusted for duplicates) cases closed by the Ombudsmen for Fiscal Year (FY) 1995. A closed case is one in which the problem/complaint has been resolved and no further action is needed or will be taken by the Ombudsman or the problem/complaint has been withdrawn. The population of cases was stratified and cases were selected as follows:

- 30 cases from Montgomery County;
- 40 cases from the combined counties of Baltimore City and Baltimore County; and
- 30 cases from the remaining counties in Maryland.

We met with 14 of the 19 local Ombudsmen, covering 18 of the 23 counties in Maryland, to obtain an understanding of how these offices investigate and resolve complaints. We also asked the local Ombudsmen what they believe were other issues, both positive and negative ones, related to performing their function.

We expanded our review to include a determination of whether findings or convictions of abuse by nursing home employees were appropriately annotated ("flagged") by L&C on the Geriatric Nursing Assistant (GNA) Registry to indicate that a prior abuse was committed.

Our review did not include an evaluation of: how cases were handled by other State offices (L&C, APS, etc.), allowability of expenditures made by the State or local Ombudsmen, or a determination of the extent of unreported cases.

The period covered by our review was: 1995 for sampling closed cases; 1993 through 1995 for reviewing monitoring visits; and 1990 through May 1996 for determining if aides convicted of abuse were flagged on the GNA Registry. The field work was performed between May 1996 and September 1996 at the Maryland Office on Aging in Baltimore, Maryland, and local Ombudsman offices throughout Maryland. Additional information was obtained and field work was performed in May 1997.

In the Office of Aging (OoA) response to our draft report they did not agree with some of the findings and the conclusion in the report, but they agreed with all of the recommendations. The OoA's comments are appended in their entirety to this report (see Appendix D).

<b>RESULTS OF REVIEW</b>
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**GERIATRIC NURSING  
ASSISTANT REGISTRY**

The GNA Registry, maintained by the DHMH's L&C, does not include all the pertinent information that would be needed by nursing homes in screening individuals during its hiring process. The Registry is a critical tool which should provide accurate information on abuse history for aides to nursing homes which must determine if hiring an aide places nursing home residents at risk. Specifically, the Registry officials were not making findings of abuse independent of the court system. Consequently, individuals that were found to have committed abuse in a nursing home were not flagged on the Registry. We found that 7 aides who had findings of abuse substantiated by the nursing home were not flagged on the Registry as well as 12 other nurse aides who were convicted of abuse, or had the finding of guilt deferred in a court of law. According to L&C, a nurse aide's record must be flagged on the GNA Registry only when convicted of a crime that occurs in a nursing home. This position is inconsistent with Federal and State requirements in that findings of abuse should be flagged on the Registry independent of the court system.

The Health Care Financing Administration (HCFA) regulation on Resident behavior and facility practices, 42 CFR § 483.13, states that a nursing facility must: (1) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; (2) not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the State GNA Registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and (3) report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State GNA Registry or licensing authorities.

The Code of Maryland Regulations (COMAR) Title 10, Subtitle 7 Chapter 2 establishes the Geriatric Nursing Assistant Program in Maryland. The COMAR, which is consistent with HCFA regulation, requires the Registry to include, among other information, "*(h) Any findings documented by the Department [L&C] of resident neglect or abuse, or misappropriation of resident property involving an individual listed in the registry; and (i) A brief statement disputing the finding in §B(4)(h), by an individual, if the individual makes a statement.*" Accordingly, a "finding" flagged on the Registry is not limited to a conviction.

In our review of 100 case files, there were 8 cases in which an abuse to a resident occurred (see Appendix A). Seven cases occurred in a nursing home and one case occurred in a domiciliary care facility. We eliminated the one case in which the resident assistant was terminated by the domiciliary facility since the Registry only includes aides working in nursing homes. In six of

the seven cases, the GNA was terminated, and in one case the GNA was suspended for 3 days because the nursing homes felt they had sufficient evidence to take action on the GNA's abusive behavior. These seven cases were not prosecuted and consequently not flagged on the GNA Registry. In Maryland, the Office of Attorney General initially interpreted the regulations to mean that a "finding" only occurs when a conviction is obtained, which is in opposition to Federal and State requirements. The GNAs were therefore flagged only after being convicted of a crime in a nursing home. Subsequent to our audit results, the Office of Attorney General revised their interpretation of HCFA regulations and L&C will now include independent findings on the Registry.

We reviewed the Registry for the seven GNAs who were terminated or suspended and found that:

- Three individuals are listed on the GNA Registry but no reference is made about the finding of abuse and their termination for future reference.
- Two individuals were removed from the GNA Registry because their licenses expired. If they had been flagged, which they should have been, their names would have remained on the Registry indefinitely.
- For two individuals we were unable to determine if they were on the Registry because the Ombudsman case file did not include the GNAs' name or other identifying factors.

We expanded our review to determine whether convictions contained in the Attorney General's MPCU files were also recorded on the GNA register. The MPCU identified 24 GNAs that were found guilty (convicted) or declared their guilt in a court of law. Only 10 of the GNAs were flagged on the Registry. Two other ones were found guilty prior to establishment of the Registry and there was no retroactive provision to include them. The remaining 12 aides should have been flagged but were not: nine aides who were convicted and three aides who received the disposition of Probation Before Judgment (PBJ)<sup>1</sup>. The Registry officials did not consider PBJ dispositions as convictions, and were not flagged on the Registry. Under Maryland law, PBJ is not a conviction. However, PBJs meet the requirements for a finding and should be included on the Registry.

The GNA Registry should include information on any finding by the State survey agency of abuse, neglect, or misappropriation of property by the individual. This would help protect residents of other facilities in which the GNAs may be later employed. The State Ombudsman's

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1. Probation Before Judgment means whenever a person accused of a crime pleads guilty or nolo contendere or is found guilty of an offense, a court may stay the entering of judgment, defer further proceedings, and place the person on probation subject to reasonable terms and conditions as appropriate, such as pay a fine or pecuniary penalty to the State, or to make restitution, and any type of rehabilitation program or clinic.

office should work with the DHMH and the Office of Attorney General to improve the GNA Registry.

#### *Agency Comments*

Regarding PBJ as a finding, the Registry officials stated that "Under Maryland law, this finding is not a 'conviction' and therefore cannot be reported as such on the Registry. Many of the cases... were cases in which courts made PBJ findings.... Thus, it is L&C's belief that all 'convictions' (as that term is defined by Maryland law) that occurred after the adoption of necessary State regulations were appropriately 'flagged' on the registry." The Registry officials also stated that: "In 1990, L&C was advised, by the Office of the Attorney General, that it could not place 'independent findings' on the Registry without a change in the Maryland statute. Although legislative proposals were submitted by the Department [L&C] two years in a row to make such a change, these bills were defeated by the Legislature. Recently, the Office of the Attorney General reviewed its previous advice and has clarified it as follows: L&C may use a PBJ finding as a basis for making an 'independent finding' for purposes of the Registry without a statutory change. However, until recently only convictions were placed on the Registry because of the prior interpretation of the law. After receiving the new legal advice, L&C began making 'independent findings'...."

#### *OIG Responses*

As noted in their comments, L&C has acknowledged they have not been making and recording independent findings of abuse on the Registry during the 7-year period. We agree that recording a PBJ finding is appropriate and believe that using HCFA and State criteria, court findings of PBJ, even though they were deferred in a court of law, is sufficient evidence for inclusion on the Registry and should have been reported since 1990. The HCFA regulation and statute, as well as the State COMAR, clearly state that findings of abuse, neglect, or misappropriation of property are to be included on the Registry. The HCFA regulation further states that the nursing facility must report any knowledge it [the facility] has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

Information we have differs from L&C's stated understanding that all nurse aides who were convicted after the Registry had been established were appropriately "flagged" on the registry. At the time of our review, the Registry did not flag nine aides who were convicted and who received a probationary sentence. In addition, Registry officials were not consistently using their own criteria for reporting aides on the Registry, because eight aides with PBJs were flagged. We recognize that L&C has reviewed and updated the Registry recently, but these other GNAs should also be flagged. In addition to the nine convicted aides that were not flagged on the Registry, the remaining three aides who received a PBJ should have been flagged because they meet the criteria of a finding.



### *Agency Comments*

Regarding the eight cases where an employee was terminated or suspended, "L&C did not agree with the auditors' conclusions in each of these cases...One of the eight cases occurred in a facility that was not a nursing home and therefore was not even subject to the Registry requirements.... However, even if L&C did agree, these cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making 'independent findings' of abuse."

### *OIG Responses*

Concerning the eight cases where an employee was terminated or suspended, it is true that one of the eight cases occurred in a domiciliary care facility for the elderly and not a nursing home. As the Registry is currently structured, nurse aides in a domiciliary care facility are not subject to the Registry requirements. We adjusted the number of cases terminated or suspended to reflect this change. The L&C stated the remaining terminated or suspended cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making "independent findings" of abuse. As we discussed above, these cases were not classified as a finding by L&C, but should have been declared a finding and reported on the Registry.

### PROCEDURES FOR RESOLVING CASES

The local Ombudsmen did not always follow the procedures established to investigate cases. Our review of 100 cases identified 16 cases in which the police and/or L&C were not notified to conduct an investigation, the Ombudsmen either did not investigate the case, did not conduct a timely investigation, or could not locate a case file for our review.

Title 42 CFR, section 483.13(c)(2) states that:

*The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).*

The Maryland Office on Aging's LTC Ombudsman Program Procedures Manual (Procedures Manual) establishes the reporting requirements for the local Ombudsmen. The local Ombudsmen are to immediately report abuse or alleged abuse of residents to the police, L&C and the administrator of the facility, provided that the administrator is not the one accused. The Ombudsmen may assist with or conduct independently an investigation of alleged abuse. The investigation shall include but is not limited to: personal contact with the resident who has made the complaint or on whose behalf the complaint was made, interviewing officials and staff, visits

with other residents to verify complaint, working with the facility to protect the safety and well-being of the resident.

The problems we noted with the 16 cases (summarized in Appendix B) included:

Note: Several of the cases were found to have more than one problem.

- ✓ 9 cases had no documentation that the police were notified.

In one case, the resident's family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for the resident. The same resident had an incident 2 weeks earlier. In this case, a nurse aide was heard yelling at the resident followed by a clapping sound. The aide was seen grabbing the resident while walking the resident back to the room. This aide was subsequently terminated and the case was closed.

- ✓ 8 cases had no documentation that L&C was notified.

For example, there was no evidence of L&C notification when a social worker was told by several nurses at a hospital that a resident had bruises on her arms, underarms, and torso. The facility indicated that an aide had handled her roughly while transferring her.

- ✓ 5 cases had no documentation that the police and L&C were notified.

In one case, a resident was found with an ankle fracture. The facility did not know what happened.

- ✓ 10 cases had no documentation that the local Ombudsman had investigated on-site the respective complaints; in 8 of these cases only telephone inquiries were documented. The remaining 2 cases did not show evidence that anything was done.

For example, a resident in a nursing home was difficult to contain. He had cancer and was continually begging the nurses for Valium. The resident also would leave the facility between 3 am - 4 am and had left one night but did not return. The nursing home official indicated that the facility did not want him back. About 4 months after the complaint was received, the Ombudsman contacted the nursing home. Upon learning that the resident

was discharged to a nursing home in Virginia, the case was closed. Earlier contact should have been made to discuss measures to restrain the resident and avoid further risk.

- ✓ 2 cases showed the response time exceeded the requirement in the Ombudsman Procedures Manual.

In one case, a resident was admitted to Bethesda Naval Hospital from the emergency room. The hospital was concerned because the patient was severely dehydrated, had a swollen scrotum, and reddened buttocks. According to the case file, the Ombudsman called the facility Administrator approximately 3 weeks after admittance to the hospital even though the Ombudsman was aware of the complaint 2 and one-half weeks earlier. During the discussion, the Ombudsman was informed that the patient had died. The case was closed.

In addition to the 16 cases discussed above, we identified:

- ✓ 1 case which showed that the Ombudsman and L&C were not able to respond timely to the potential abuse.

The resident sustained a small scratch in the middle of her forehead and a bruised right eye after falling. The nurse in charge neglected to file an incident report and was suspended for 1 day. The resident's son contacted the police charging abuse because of the bruised right eye. The police report was received by the Ombudsman 20 days after the incident. The Ombudsman then contacted a nursing home official who indicated that it was an oversight that the Ombudsman was not notified. The police report indicated that a copy was sent to L&C. About 1 month after the incident, the Ombudsman visited the resident at the nursing home and found no signs of abuse. The Ombudsman closed the case because of the length of time when their staff was informed of the incident and that it was unable to validate abuse.

The Procedures Manual sets the response time standards that are to be followed by the local Ombudsmen. These are: (1) cases of suspected/alleged abuse shall be responded to immediately upon receipt of the complaint; (2) serious complaints shall be responded to immediately whenever possible or within 24 hours of receipt of the complaint; and (3) non-emergency complaints shall be responded to within 5 working days.

The local Ombudsmen indicated that required procedures were not always followed because:

- The police are often not called unless the situation is serious. Various local Ombudsmen believe that if the police were called for every minor problem, credibility would be lost when a serious situation occurs.
- The Ombudsmen, when they believed the cases were appropriately handled by themselves, would not notify L&C. In these instances, L&C would not be aware of whether abusive actions or neglect did or did not take place, and whether nurse aides should be flagged on the Registry.
- Volunteer assistants did not investigate all assigned cases.

In one case in which a complaint was never investigated by the volunteer, the resident had black eyes and a scratch on the nose. The complaint intake form indicated that the resident was confused and disoriented and could not give an account of what happened.

Because investigations of abuse are time sensitive, it is important for procedures to be followed and investigations adequately documented. If the local Ombudsman is the recipient of a report of alleged abuse, they are to immediately notify the appropriate law enforcement authorities and L&C. We found that the local Ombudsmen did not always follow procedures established to investigate cases and notify the proper authorities. We identified 16 cases in which the police and L&C should have been involved but were not.

#### *Agency Comments*

Although the OoA disagreed with some findings and the conclusion in the report, it "plans to reemphasize to all staff, including all local Ombudsmen, that they must strictly comply with the mandated reporting requirements."

The OoA stated that: "We can certainly agree that 19<sup>2</sup> out of 100 is an unacceptable rate of noncompliance and could indicate a statewide problem. However, this would only be the case if the 100 cases were a representative sample of the State and if the 19 cases actually contained deficiencies. Neither is the case in this matter.

The 100 cases are not a representative sample of Maryland Ombudsman cases because 30 percent of the cases were taken from Montgomery County, although that county only has approximately 15 percent of the State's nursing home beds. Thus, Montgomery County's cases were

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<sup>2</sup>Based on the State comments to our draft report, we adjusted this number to 16.

overweighted in the analysis. This is significant because problems of one county (Montgomery) have been used to indict the entire State of Maryland."

#### *OIG Responses*

Our statewide sample was statistically selected using various strata from the 2,130 cases of complaints, ranging from abuse, neglect, and theft, to serving dinner without a cup or glass. Of the 100 cases we selected, 45 cases involved abuse and neglect. The number and kind of problems with abuse and neglect we identified were even more significant when related to the 45 sampled cases. Further, Montgomery County may only represent 15 percent of the State's nursing home beds, but it constituted 27 percent of the 2,130 cases that were closed statewide. We randomly selected 30 cases from this county which represented 30 percent of the sample.

#### *Agency Comments*

The CoA stated that "Of the 19 cases identified" in the Proposed Report, 8 were cases from the local Ombudsman programs outside of the Montgomery County Ombudsman. In four cases: "... (1) the police notified L&C and the Ombudsman at the same time in case number 12 making it unnecessary for the Ombudsman to contact L&C...The Ombudsman is to notify the police and L&C if it is the initial recipient of a suspected abuse report; (2) case number 15 was not an abuse case; and (3) cases numbered 16 and 17 did not involve facilities licensed by L&C. Thus, section 19-347 of the Health General Article of the Maryland Annotated Code did not require the Ombudsman to contact L&C and the police in any of these four cases. (Section 19-347 creates the standard that the Proposed Report contends was repeatedly violated.)"

#### *OIG Responses*

Included in the scope of our statewide review, we identified eight cases which were outside of the local Ombudsman program for Montgomery county in which either the reporting or investigation were not handled properly. Of these cases, four were from Baltimore City and Baltimore County Ombudsman programs; and four were from the remainder of the local Ombudsman programs for the State.

- For cases 16 and 17, we agree that both facilities were not licensed by L&C and they were eliminated from the report.
- For case number 12, reporting the abuse to L&C is an arguable issue. We recognize that the investigative report may have been sent to L&C by enforcement officials. However, there was no record to show that the Ombudsman contacted L&C to ensure that they were aware of the reported abuse and that appropriate action was being taken timely to resolve the charge. Also important, the Ombudsman was not notified of the abuse until 22 days after the police became aware of the incident.
- For case number 15, a family member complained that while the resident was in a nursing home for respite care, the resident developed decubitus ulcers (bed sores). The Ombudsman did not consider this an abuse case, and therefore did not conduct an investigation to determine whether the situation was an abuse or neglect. It is

recognized that these bed sores are often attributed to neglect and that the infections they cause can be life threatening. Neglect as well as abuse is a criminal law violation in Maryland. The likelihood of neglect should have been sufficient to conduct a thorough investigation.

#### *Agency Comments*

For the four remaining cases outside of Montgomery County, the OoA stated that "the bottom line is...there were only four cases that could in any way give support to the conclusion...In all four cases the local Ombudsman had conducted a thorough investigation and concluded either that there was no abuse or no evidence to prove abuse."

#### *OIG Responses*

We believe that procedures in these four cases which were included in our statewide review were not followed. We noted that in these cases the procedures were not followed when there was an alleged abuse. The L&C was not notified in each case, and for one case, the police was not notified of the abuse. Notification to L&C provides them an opportunity to investigate the alleged abuse and if substantiated, to flag the Registry.

- For case number 13, the family complaint was coded as an abuse case and the Ombudsman made a site visit the day the call was received. The family was concerned that a skin tear on the resident's arm was a potential abuse. Although the Ombudsman treated it as an abuse case and investigated the case, L&C was not notified.
- For case number 14, the Ombudsman treated the complaint from a social worker at the nursing home's hospital as an abuse case, but did not notify L&C. The social worker was told that several nurses observed bruises on the resident's arms, underarms, and upper torso approximately 1 week before the complaint was received by the Ombudsman.
- For case number 18, when the resident's daughter complained the resident had bruises on her leg, the Ombudsman treated it as an abuse case, but did not call the law enforcement agency and L&C.
- For case number 19, a registered nurse at the nursing home filed the complaint of alleged abuse on this case, but the Ombudsman did not notify L&C.

#### *Agency Comments*

For the 11 cases in Montgomery County, the OoA stated that "four were not even potential abuse cases...Case 7 concerned complaints of inadequate hygiene, inadequate supervision, dehydration, and inadequate care plan, Case 9 concerned a complaint of inadequate supervision of residents; Case-10 concerned a request to assist in determining a resident's competency, and Case 11 concerned a resident's rights issue."

*OIG Responses*

Although the CoA agreed that seven cases in Montgomery County Ombudsman program did not follow procedures, we believe that the other four cases do represent an abuse situation.

- Regarding case number 7, the patient's condition—"severe dehydration, swollen scrotum, and reddened buttocks"—was of such a significant concern to the hospital emergency room staff that they formally complained to the Ombudsman noting the serious condition of the patient. The complaint should have been treated as an abuse or neglect case and the law enforcement agency should have been immediately notified. Although the Ombudsman had been notified, they did not take action to investigate and resolve the complaint until 3 weeks after receipt of the complaint. The extent of the investigation was a telephone call to the facility without any further action or resolution of the potential abuse or neglect complaint because the resident had died.
- For case number 9, the complaint was made and categorized as a patient to patient abuse, contrary to CoA's contention that no abuse was reported. The nursing home's Director of Nursing complained that one resident with Alzheimer's hit another resident on the head with his fist and that resident was "unable to see." The Ombudsman did not visit the facility to determine whether the facility was adequately protecting the safety and well being of the residents.
- For case number 10, the Administrator of the nursing facility asked the Ombudsman to assess a resident's competency because she alleged aggressive sexual behavior by another resident, but was unable to identify the person who kissed her. In this case the Ombudsman intended to visit the facility as annotated in the case file. However, the file did not contain any documentation regarding a visit, only telephone calls between the Ombudsman and the facility were documented. According to the case file, no assessment had been done during the 10-month time period while the case was opened. The case was closed when the complainant died. Again, we believe that the Ombudsman should have visited the facility to document the possible sexual abuse situation and to initiate, as requested, an assessment of competency.
- For case number 11, the nursing home's social worker reported to the Ombudsman that they were having difficulty controlling a resident. The complaint was coded by the Ombudsman as a resident rights issue. However, we believe that it was a possible neglect case. The resident continually begged for Valium and would leave the facility between 3 am to 4 am. When the social worker filed the complaint, the resident left the night before and had not returned. A nursing home official said the resident "was competent but was depressed" and that the nursing home "did not want to take him back" because of his behavior. In reviewing the case file, we found that the Ombudsman had taken no action to determine whether the resident was adequately controlled and safeguarded by the facility and treatment was initiated for his behavior during the 4-month period when the case was received until the time the case was closed—the resident was transferred to another nursing home. There also was no

documentation in the case file to show that the Ombudsman contacted the local Ombudsman where the resident was transferred to seek assistance for the resident. During this time, the resident could have been severely injured while absent from the nursing home. An onsite visit should have been made to interview staff, work with the facility to protect the safety and well-being of the resident, and secure the appropriate services needed by the resident.

#### *Agency Comments*

The OoA stated that "Montgomery County's Ombudsman Program has developed its own pragmatic way of dealing with various types of cases. In some situations the county's approach did not strictly comply with OoA's Ombudsman regulations or Maryland's law on reporting abuse in related institutions, §19-347 of the Health General Article. The OoA is instructing Montgomery County that it must comply with these legal requirements, even if Montgomery County thinks it is impractical to apply the requirements in all cases...This is not to excuse some of the Montgomery County cases where the reporting or investigation was inadequate by any standard. The Montgomery County Ombudsman has informed OoA that several of the cases resulted from the lack of follow-up by a volunteer who had to be 'terminated' for unsatisfactory performance."

The OoA further stated that "some of the local Ombudsman feel that they lose their credibility with the police and L&C if every questionable case is called in an abuse. Maryland's laws require the Ombudsman and the police to conduct their own investigation when they receive an abuse complaint. It is understandable that every questionable case was not reported because some people do not think that it is a good use of resources to have both agencies conduct an investigation into every case involving an unexplained injury...During the time frame in question, nursing homes felt compelled to report injuries of an unknown origin to the Ombudsman, even if there was no suspicion or belief that abuse had occurred...However, the nursing homes were not obligated to report such cases, and the Ombudsman was not legally required to report them to L&C or the police unless someone believed there had been abuse."

#### *OIG Responses*

Potential abuse, neglect or unexplained injury cases should be investigated because the resident's safety and well being is in question. Reporting these cases to L&C would give them an opportunity to assess the facility and/or staff. Being aware of the complaints and results of the investigation would be of value to L&C when it reviews the facility's application to renew its license or fix flagging aides who have been found to abuse and neglect nursing home residents. We also believe that in order to stimulate better coordination of the investigations, the respective State agencies need to be aware of all complaints of alleged or possible resident abuse or neglect. Inquiry is needed to determine the nature of the allegation, completeness and documentation of the nursing home investigation, extent of the investigation to be performed, and the parties that will investigate the case. An informed State agency could rely upon the work of another State agency to prevent unnecessary work. Better coordination can also assist the respective State agency with the disposition of the case and determining whether action should be taken against the nursing home.



**Agency Comments**

In addition, the OoA stated that "the program was cited frequently for conducting investigations by telephone. The Proposed Report treated this as a violation of the regulation that requires that an investigation include 'personal contact with the resident ... on whose behalf the complaint was made'....However, OoA has interpreted the phrase 'personal contact' to include a telephone conversation. The Proposed Report erroneously construed 'personal contact' to require a face to face encounter, which is not required in every single case. There are obviously cases where such personal contact would not be an efficient use of an Ombudsman's limited resources."

**OIG Response**

When there is a potential abuse or neglect case which is a criminal offense, a visit to the facility is warranted to make a thorough inquiry and determine if abuse or neglect did occur, and to identify measures to protect residents more effectively.

**COVERAGE OF OTHER LONG TERM CARE FACILITIES**

The local Ombudsmen do not monitor all required types of licensed long term care facilities in Maryland. Visits of long term care facilities, other than nursing homes, are only made when informed of a complaint. There are over 120 board and care or other adult long term care facilities in Maryland.

The Older Americans Act of 1965, as amended (OAA), Title VII, Chapter 2, §712(a)(3) states that the function of the Ombudsman is to identify, investigate, and resolve complaints that are made by, or on behalf of, residents. The OAA further defines resident as meaning "an older individual who resides in a long term care facility."

The Maryland Ombudsman's Procedures Manual states that the program's scope is to provide services to residents of licensed long term care facilities. These include: (1) skilled nursing facilities; (2) intermediate care facilities; (3) domiciliary care homes; (4) group sheltered housing for the elderly; and (5) other facilities as required by local law and providing personal, nursing, or custodial care for three or more unrelated individuals which is licensed or subject to licensure by the DHMH.

The Procedures Manual also establishes that the Ombudsman is to conduct facility visits of all nursing homes at least quarterly and visits of domiciliary care homes should be conducted quarterly when possible. In addition, facilities that DHMH or the Ombudsman have identified as having serious problems should be visited at least monthly until the situation improves and stabilizes.

In its Long Term Care Ombudsman Program Report for FY 1995 to AoA, the Maryland Ombudsman indicated that:

*Designated Ombudsman representatives are not required to cover board and care and other similar facilities. The primary barrier is insufficient funding from the AoA. Some*

*programs do investigate complaints received from these types of facilities; however, routine monitoring of facilities in these areas is not performed. To overcome this barrier, we have indicated the need for increased Federal funding for the program from the AoA. Additionally, we work closely with the Housing Division staff within our agency to provide support and information about monitoring techniques, and to transmit reports that the local Ombudsman programs receive about their facilities.*

To meet the objectives of the Ombudsman program, the local Ombudsmen need to ensure that: complaints from all types of long term care facilities are being identified, investigated, and resolved; and the Ombudsmen periodically visit all types of long term care facilities. We did not assess investigations and visits by the Division of Housing staff.

#### *Agency Comments*

The OoA agreed and will take action on our recommendations. The OoA stated that it "recognizes that the Ombudsman Program must work to serve residents in all kinds of long term care facilities" and that "resource problems make coverage of all types of long term care facilities quite difficult."

#### REVIEW OF LOCAL OMBUDSMEN PROGRAMS

The State Ombudsman has not conducted monitoring reviews in over a year of all the local Ombudsman programs. The Procedures Manual of the Maryland Ombudsman states that one of the duties of the State Ombudsman is to "... conduct an annual review of all local programs including the use of the monitoring instrument."

The State Ombudsman provided us with copies of the latest monitoring reports on file. Fifteen of the 1993 monitoring reports were provided after the draft audit report was issued. The State Ombudsman was only able to document 26 monitoring reports, covering a 3-year time span, for the 19 local Ombudsman programs. For the period 1993 through 1995, 57 reports of reviews should have been prepared and available. After 1993, there were no monitoring visits to 10 Ombudsman programs, notwithstanding that three of them were the largest programs in the State (Montgomery County, Baltimore City, and Baltimore County). Of the 26 monitoring reports provided: 17 were done in 1993; 7 were done in 1994; and 2 were done in 1995. Appendix C to this report provides a summary of when the last documented monitoring visit occurred.

Had monitoring visits of the local Ombudsmen been conducted, many of the problems noted throughout this report could have been identified and corrective actions taken. As discussed earlier and shown in Appendix B, there were 16 cases in which procedures were not followed, 14 of these cases were from 3 counties that did not have a monitoring visit in the 2-year period. In addition, all seven cases in Appendix A, in which sides were terminated or suspended for abuse, were from the same three counties.

To ensure that local programs comply with all applicable Federal and State statutes and regulations, the State Ombudsman should conduct monitoring visits with all local Ombudsman. Also, some local Ombudsman offices we visited indicated they successfully use volunteers to assist in their reviews. We encourage other offices to consider this alternative because of the limited funding.

*Agency Comments*

The OoA stated that "all 19 local programs were monitored in 1993." The OoA provided 15 of the 1993 monitoring reports subsequent to the issuance of the Proposed Report. The OoA stated that "Monitoring was less than 100 percent in 1994 and 1995 for four main reasons: (1) the State Ombudsman resigned in January of 1994; (2) we were unable to hire a replacement until September of 1994; (3) the replacement was terminated while on probation in July of 1995 for unsatisfactory performance; (4) we were unable to hire a new replacement until 1996 because in 1995 the House of Representatives had approved, and the United States Senate was seriously considering approving, legislation that would have decimated the Ombudsman programs. When the Ombudsman Program was under stress because of staff turnover and under attack by the House of Representatives, OoA sensibly focused on the Program's core responsibilities."

*OIG Responses*

The OoA stated that all 19 local programs were monitored in 1993, but did not provide the monitoring reports for two visits in 1993 to Anne Arundel and Calvert Counties. We adjusted the report to reflect the 15 monitoring reports for 1993 which were provided to us after issuance of the draft report. We believe that other methods could have been used by the OoA to conduct the required monitoring visits during 1994 and 1995; the OoA could have established a task force made of representatives from several of the local Ombudsman programs to conduct the monitoring visits and could have prioritized visits considering potential risks. Although it is true that the House of Representatives approved and the United States Senate was considering legislation to the elimination of the Ombudsman program, the program was continued. We do not believe that it was prudent for OoA to prematurely discontinue its monitoring efforts. The visits could have given the OoA a valuable insight into the local Ombudsman operations which could be used to strengthen the program as we identified in our report.

**OTHER MATTERS**

The various local Ombudsman offices we visited were asked what they considered helpful techniques in managing the program. The responses they provided were similar. The one most often mentioned by the local Ombudsman dealt with the importance of developing a close relationship with the nursing homes and other organizations like L&C, the police, and the State Ombudsman.

**Others included:**

- The ability to use good communication skills working with all interested parties to obtain a full understanding of the nature of the complaint and to resolve them.
- Encouraging residents to become knowledgeable about their rights and avenues for reporting complaints by providing education to the seniors and instructing them to be more vocal about their own situation.

- The program must never miss the focus that the resident is paramount. For example, it is easy to get trapped into thinking about what the family or facility wants when the Ombudsman Program should be about what is best for the resident.
- Frequent visits to nursing homes. Having a regular presence serves as a motivation to the nursing home to be more attentive to resident rights knowing that you are an active and involved Ombudsman.
- Baseline educational qualifications and skills should be established for Ombudsman because they need to have a background and knowledge of many areas, including nursing and psychology.

Also, while many of the local Ombudsmen use volunteers and cited this as a good technique, some were not enthusiastic and do not use them. Often, the local Ombudsmen indicated they do not have the time available to recruit, train, and supervise the volunteers; the volunteers are not accountable for any problems that may occur; volunteers often do not have a professional background which is helpful, such as a nurse or social worker; and volunteers are hard to keep.

The problems which most of the Ombudsmen offered usually dealt with the lack of funding and staffing for the program. The local Ombudsmen believe others view the services they provide as being a "nice thing" rather than a "necessary thing" and they feel this results in the program being underfunded. Although the AoA has requested increases in funding for the nationwide Ombudsman program, the actual funding has been flat lined for several years at approximately \$4.4 million. The AoA reported that although there is a "sizeable Ombudsman network nationwide, the number of local programs, staff, and volunteers are insufficient to meet the demand for Ombudsman assistance with the myriad of questions and problems residents and their loved ones have regarding long term care facilities. As the population ages, the number of older people living in long term care facilities continues to increase, and so the need for Ombudsman services."

Other concerns the Ombudsmen mentioned included:

- The difficulty in keeping track of nursing home employees who have had problems at one facility and move on to another facility. One Ombudsman indicated that she had seen nurse aides working in facilities she knew had problems at other facilities, but had no mechanism to pass this information on to the facilities.
- The lack of enforcement power. The Ombudsmen feel that the program's major tool is its power of persuasion. The Ombudsmen say they cannot enforce penalties on the facilities. If L&C determines during its survey of a nursing home that problems noted in the investigation are not appropriately followed-up, penalties can range from civil monetary penalties to termination of Medicare/Medicaid payments to the nursing home. We were also informed that the Ombudsmen can not review resident charts or incident reports to look for unreported abuse cases. This is in contrast to the L&C office which has such authority.

- The Ombudsmen indicated that, because of staff shortage, they should reduce coverage in other program activities such as housing and guardianship for elders.
- The difficulty in evaluating the program's effectiveness and how outcomes are measured.
- Problems in delineating the significance of the issues which warrant police attention. Procedures do not allow for judgment in determining whether or not to call for police assistance. In one Ombudsman program, there is an unwritten policy with the nursing homes that if there is some ambiguity of the cause of injury or a direct accusation against an employee, the police and the Ombudsman will be called.
- Better communication over roles and responsibilities between the family and the facility is needed.

## CONCLUSION AND RECOMMENDATIONS

The Ombudsman program plays an important role in the detection, investigation, and resolution of cases of abuse in long term care facilities. However, this is only one part of the "elder abuse system" in Maryland. Working together with the police and various other offices, the Ombudsman can provide services to assist the residents of long term care facilities in protecting their health, safety, welfare, and rights. This is not always occurring in Maryland. Getting these other authoritative offices involved also alleviates the burden of investigating alleged abuses to just the Ombudsman office. The GNA registry does not include all the information that would be useful to the Ombudsmen and long term care facilities. The local Ombudsmen did not always follow established procedures in investigating cases, visiting facilities, and conducting annual evaluations of all local Ombudsmen.

### RECOMMENDATIONS

We recommend that the Maryland Office on Aging:

1. Work with the DHMH and the Maryland's Office of Attorney General to improve the GNA registry to include information on any finding of abuse, neglect, or misappropriation of property by a GNA regardless if a conviction has been obtained.
2. Review the procedures used to receive, investigate and resolve complaints timely, and ensure that:
  - a. these procedures are being followed by the local Ombudsmen;
  - b. the local Ombudsmen are identifying, investigating, and resolving complaints from all types of long term care facilities; and
  - c. annual monitoring visits of the local Ombudsmen are performed.

3. Instruct its local Ombudsmen to routinely visit all required types of long term care facilities or, in absence of necessary staff resources, devise a risk assessment system to visit the facilities and consider expanding the use of volunteers.
4. Work with the AoA and the local Ombudsmen to eliminate the barriers identified to achieve a more successful program.

*Agency Comments*

The OoA stated that they "agreed with all of the recommendations" and "plan to work diligently to implement them."

## SEVEN CASES OF ABUSE, WITH GNA NOT FLAGGED IN REGISTRY

1	This case was eliminated because the facility was not licensed by L&C.	Eliminated
2	The resident family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for resident.	Montgomery County
3	A resident indicated to a GNA that he was applying the wrong lotion. The GNA shoved the bottle in resident's face. The resident tried to push him away. The GNA hit the residents hand. The GNA was suspended for 3 days pending further investigation. No other information was included in the case file.	Montgomery County
4	A resident was physically abused by staff. The police were notified and prepared a police report. The Ombodaman was notified through a police report over a month after the incident occurred. The resident's guardian did not press charges because he was satisfied that the employee was terminated from employment.	Baltimore City
5	A GNA grabbed a resident by her wrist and shoved her into a wheelchair. The GNA was terminated from employment.	Baltimore City
6	A resident was scratched by a GNA. The GNA was terminated. A police report was filed, but the resident did not wish to press charges since he no longer felt threatened.	Baltimore City
7	A nursing assistant, using his hat, hit a resident and then poured cold water on the resident. The assistant was suspended then terminated from employment. A police report was filed. The resident was glad the assistant was no longer taking care of him.	Baltimore City
8	A resident was found with a black left eye. An investigation did not determine if this was an accidental injury or not, but Ombudsman notes indicate that GNA was responsible because she was assigned to the resident and did not report anything. After the Ombudsman reported her conclusions to the administrator, the GNA was terminated from employment.	Baltimore County

## SUMMARY OF 16 CASES WHERE PROCEDURES WERE NOT FOLLOWED

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
1	A GNA hit a resident twice on the back. The incident was witnessed by the Assistant Administrator of the nursing home. The GNA stated that the resident had stepped on her foot. The GNA was terminated. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
2	The resident's family had concerns about injuries to the resident. These included broken fingers, broken rib, and black eyes. While the facility could not pinpoint when injuries occurred, the nursing home fired the GNA who had responsibility for resident. There was no indication that the police and L&C were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓	✓	✓	Montgomery County
3	A resident indicated to a GNA that he was applying the wrong lotion. The GNA shoved the bottle in resident's face. The resident tried to push him away. The GNA hit the resident's hand. The GNA was suspended for 3 days pending further investigation. No other information was included in the case file. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
4	A resident had a bruise on the right eye. The cause of the bruise was not determined. There was no indication that the police and L&C were notified.	✓	✓		Montgomery County



Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
5	It was noted that resident had hematomas to both eyes and a scratch on the nose. The resident was confused and disoriented and could not give an account of what happened. There was no indication that the police and L&C were notified. There was no indication that Ombudsman investigated.	✓	✓	✓	Montgomery County
6	A resident had a skin tear on back of the left hand. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only telephone calls were documented.	✓		✓	Montgomery County
7	A resident was admitted to Bethesda Naval Hospital from the emergency room. The hospital was concerned because the patient was severely dehydrated, had a swollen scrotum, and reddened buttocks. Noted in file that patient died. There was no indication that the police were notified. There was no indication that Ombudsman investigated, only a telephone call to the Hospital was documented. The response time for Ombudsman's telephone call was approximately 3 weeks after in-take date.	✓		✓	Montgomery County
8	A resident was found with an ankle fracture. The facility did not know what happened. There was no indication that the police and L&C were notified. Response time for Ombudsman to visit facility was approximately 2 weeks after the incident.	✓	✓		Montgomery County
9	A resident hit another resident. There was no indication that Ombudsman visited the facility.			✓	Montgomery County

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
10	The Ombudsman was asked to assess competency of resident. The resident and another resident had been sexually aggressive. The nursing home felt that this was consensual, but when asked, the resident did not know who had kissed her. There was no indication that the Ombudsman performed the assessment. The case was closed approximately 10 months after it was opened because the resident had passed away months prior.			✓	Montgomery County
11	A resident was a management problem. He had cancer and was continually begging the nurses for Valium. The resident also would leave the facility at between 3 am - 4 am. The resident was competent but depressed. The resident had left the night before and did not return. The facility did not want him back. There was no indication that anything was done with this case from the time it was received to the time it was closed -- 4 months later -- when the Ombudsman was informed that the resident was discharged to a nursing home in Virginia.			✓	Montgomery County
12	This case was eliminated from this chart because there was some record to indicate that L&C was notified.				Eliminated
13	A resident had a skin tear on arm. The family was concerned about potential abuse. There was no indication that L&C was notified.		✓		Baltimore City
14	A Social Worker was told by nurses at a hospital that a resident had bruises on her arms, underarms, and torso. The facility indicated that an aide had handled her roughly while being transferred. When the Ombudsman saw the resident, he indicated that she had not been abused. There was no indication that L&C was notified.		✓		Baltimore City

Case No.	Description	Type of Procedure Not Followed			Ombudsman Program
		Police Not Notified	L&C Not Notified	No Indication Ombudsman Investigated	
15	A resident was in a nursing home for respite care and developed decubitus ulcers (bed sores). It does not appear that the Ombudsman visited the facility, only telephone calls were documented.			✓	Baltimore County
16	This case was eliminated because the facility was not licensed by L&C.				Eliminated
17	This case was eliminated because the facility was not licensed by L&C.				Eliminated
18	A daughter of resident called to report bruises located on the resident's legs. Also indicated that there had been bruises on the resident's arm. The Ombudsman felt that the cause of the bruise was from handling patient during care. The Ombudsman was not able to determine if it was intentional abused. There was no indication that the police and L&C were notified.	✓	✓		Washington County
19	A resident had an unexplained injury --fractured finger. There was no indication that L&C was notified.		✓		Allegany County

LATEST DOCUMENTED MONITORING VISIT  
AS OF DECEMBER 1995

Allegany	October 5, 1994
Anne Arundel	June 7, 1995
Baltimore City	April 21, 1993
Baltimore County	June 18, 1993
Calvert	December 15, 1994
Carroll	May 13, 1993
Cecil	April 5, 1993
Charles	August 9, 1993
Frederick	May 28, 1993
Garrett	October 5, 1994
Harford	May 12, 1993
Howard	April 11, 1995
Lower Shore	November 18, 1994
Montgomery	May 17, 1993
Prince George	May 24, 1993
Queen Anne	June 28, 1993
St. Mary	December 15, 1994
Upper Shore	November 18, 1994
Washington	October 4, 1994

**Agency Comments**

MARYLAND OFFICE ON

*Aging*

Parris N. Glendening, Governor

Sue Fryer Ward, Director

C. Irving Pinder, Jr., Deputy Director

August 19, 1997

Via Telefacsimile and Federal Express

Mr. John A. Ferris  
 Department of Health & Human Services  
 Office of the Inspector General  
 Assistant Inspector General for Administrations  
 of Children, Family, and Aging Audits  
 330 Independence Avenue, Room 5759  
 Washington, D.C. 20201

Re: Proposed Audit Report A-12-96-00016

Dear Mr. Ferris:

Thank you for providing the opportunity to (and extending the time to) respond to the proposed audit report entitled "Review of the State of Maryland Long Term Care Ombudsman Program's Receipt, Investigation and Resolution of Complaints of Elder Abuse, Neglect, and Exploitation." The Maryland Office on Aging ("OoA") and Department of Health and Mental Hygiene ("DHMH") have been working diligently to gather together all of the facts needed to provide a complete picture of the issues addressed in the proposed audit report ("Proposed Report") because the Proposed Report does not convey an accurate depiction of Maryland's Ombudsman Program or Geriatric Nurse Aide Registry.<sup>1</sup>

The second sentence of the Proposed Report states, "We found that the review and reporting network within the State did not provide reliable assurance that instances of abuse were properly reported and resolved and that the Ombudsman program was adequately monitored."

<sup>1</sup> Please note that the title of the Proposed Report is not accurate because your audit covered more than the Ombudsman Program. For example, the Geriatric Nurse Aide Registry is independent of the Ombudsman Program. We suggest an addition such as: "and Review of the Department of Health and Mental Hygiene's Geriatric Nurse Aide Registry."

Mr. John A. Ferris  
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While no programs are perfect, this sweeping condemnation is not supported by the facts. Unfortunately, the Proposed Report was written when certain information was unavailable or had not been obtained. This unfortunate situation, in conjunction with various assumptions that were apparently made from the incomplete facts, led to the erroneous condemnation. The remainder of this letter sets forth the full facts and explains why many of the Proposed Report's conclusions are in error. The information set forth below follows the format of the Proposed Report.

#### Geriatric Nurse Aide Registry

The Proposed Report sharply criticizes the State's GNA Registry based on the State's alleged failure to "flag" all GNA abuse on the Registry. Unfortunately, the auditors were unaware of some crucial facts when making its criticisms, including constraints placed on the Licensing and Certification Administration ("L&C") by Maryland law.

#### Convictions

Although the federal regulations require the State to place convictions on the Registry, many cases of abuse, especially for first-time offenders, result in a finding by Maryland courts of "Probation before Judgment" ("PBJ"). Under Maryland law, this finding is not a "conviction" and therefore cannot be reported as such on the Registry. Many of the cases reviewed by the auditors were cases in which courts made PBJ findings. The auditors incorrectly assumed that such could be considered "convictions" for purposes of the Registry. In addition, some of the cases reviewed by the auditors included "convictions" that occurred prior to the State's adoption of regulations establishing the Registry. For these cases, there was no legal authority for L&C to "flag" these convictions. Thus, it is L&C's belief that all "convictions" (as that term is defined by Maryland law) that occurred after the adoption of necessary State regulations were appropriately "flagged" on the registry.

#### Independent Findings

In 1990, L&C was advised, by the Office of the Attorney General, that it could not place "independent findings" on the Registry without a change in the Maryland statute. Although legislative proposals were submitted by the Department two years in a row to make such a change, these bills were defeated by the Legislature. Recently, the Office of the Attorney General reviewed its previous advice and has clarified it as follows: L&C may use a PBJ finding as a basis for making an "independent finding" for purposes of the Registry without a statutory change. However, until recently only convictions were placed on the Registry because of the

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prior interpretation of the law. After receiving the new legal advice, L&C began making "independent findings" and defending them before an Administrative Law Judge when challenged.

L&C has reviewed the eight cases reviewed by the auditors. L&C does not agree with the auditors' conclusions in each of these cases.<sup>3</sup> However, even if it did agree, these cases would not have gone on the Registry unless there had been a criminal prosecution and a conviction because all eight of these cases occurred before L&C was making "independent findings" of abuse. However, as you are aware, L&C never had control over the prosecution of criminal cases or the outcomes of the prosecutions.

#### Procedure for Resolving Cases

The Proposed Report states on page five, "The local Ombudsman did not always follow the procedures established to investigate cases" (emphasis added). Undoubtedly this statement is true of every state ombudsman program in the country, as no one is perfect. The real issue is whether the Ombudsman Program is performing well. If any program that did not always follow the procedures was deemed guilty of not providing "reliable assurance that instances of abuse were properly reported and resolved" (the charge made against the Maryland program), then every Ombudsman program would be condemned.

The Proposed Report claims to have found deficiencies in 19 of the 100 files reviewed. We can certainly agree that 19 out of 100 is an unacceptable rate of noncompliance and could indicate a statewide problem. However, this would only be the case if the 100 cases were a representative sample of the state and if the 19 cases actually contained deficiencies. Neither is the case in this matter.

The 100 cases are not a representative sample of Maryland Ombudsman cases because 30 percent of the cases were taken from Montgomery County, although that county only has approximately 15 percent of the State's nursing home beds. Thus, Montgomery County's cases were overweighted in the analysis. This is significant because problems of one county (Montgomery) have been used to indict the entire state of Maryland.

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<sup>3</sup> One of the eight cases occurred in a facility that was not a nursing home and therefore was not even subject to the Registry requirements.



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Of the 19 cases identified in the Proposed Report, 11 are from Montgomery County, whose situation is addressed below in a separate section of this letter. Thus, the entire remainder of the state only had eight cases flagged by the auditors. Of those eight cases, at least four were flagged erroneously by the auditors: (1) the police notified "L&C" and the Ombudsman at the same time in case number 12 making it unnecessary for the Ombudsman to contact L&C; (2) case number 15 was not an abuse case; and (3) cases numbered 16 and 17 did not involve facilities licensed by L&C. Thus, §19-347 of the Health General Article of the Maryland Annotated Code did not require the Ombudsman to contact L&C and the police in any of these four cases. (Section 19-347 creates the standard that the Proposed Report contends was repeatedly violated.)

The bottom line is (that outside of Montgomery County) there were only four cases that could in any way give support to your conclusion that "the State did not provide reliable assurance that instances of abuse were properly reported and resolved." While we strive for 100 percent perfection, we do not think four questionable cases out of 70 is a sufficient basis for the disparaging conclusion in the Proposed Report.

This point becomes even more apparent if you examine the four "questionable" cases at issue. In all four cases the local Ombudsman had conducted a thorough investigation and concluded either that there was no abuse or no evidence to prove abuse. As you mentioned in the Proposed Report, some of the local Ombudsman feel that they lose their credibility with the police and L&C if every questionable case is called in as abuse. Maryland's laws require the Ombudsman and the police to conduct their own investigation when they receive an abuse complaint. It is understandable that every questionable case was not reported because some people do not think that it is a good use of resources to have both agencies conduct an investigation into every case involving an unexplained injury.<sup>4</sup> OoA plans to reemphasize to all staff, including all local Ombudsman, that they must strictly comply with the mandated reporting requirements. In the meantime, it is unwarranted to conclude from four out of 70 cases that "the

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<sup>3</sup> The Ombudsman is to notify the police and L&C if it is the initial recipient of a suspected abuse report.

<sup>4</sup> During the time frame in question, nursing homes felt compelled to report injuries of an unknown origin to the Ombudsman, even if there was no suspicion or belief that abuse had occurred. The Ombudsman Program for lack of a better category coded such reports as "A-12 - Physical Abuse." However, the nursing homes were not obligated to report such cases, and the Ombudsman was not legally required to report them to L&C or the police unless someone believed there had been abuse.

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State did not provide reliable assurance that instances of abuse were properly reported and resolved." The conclusion is especially unwarranted when each of those four cases were investigated by a local Ombudsman who concluded there was no evidence to support a finding of abuse.

#### Montgomery County

Montgomery County's Ombudsman Program has developed its own pragmatic way of dealing with various types of cases. In some situations the county's approach did not strictly comply with OoA's Ombudsman regulations or Maryland's law on reporting abuse in related institutions, §19-347 of the Health General Article. OoA is instructing Montgomery County that it must comply with these legal requirements, even if Montgomery County thinks it is impractical to apply the requirements in all cases.<sup>5</sup>

Before addressing the specifics of some of the Montgomery County cases, you should know that the Montgomery County Ombudsman, Vivian Omagbemi, is more than just one of our most respected local Ombudsmen. She is considered an expert on Ombudsman issues nationwide. Ms. Omagbemi was a member of the Committee to Evaluate the State Long-Term Care Ombudsman Programs commissioned by the Administration on Aging. The Committee's study resulted in the publication of a substantial book entitled "Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act." It was published by the Institute of Medicine in 1995. The book is an excellent resource for anyone reviewing the effectiveness of Ombudsman Programs.

Of the 11 Montgomery County cases flagged by the auditors, four were not even potential abuse cases.<sup>6</sup> In addition, the program was cited frequently for conducting investigations by telephone. The Proposed Report treated this as a violation of the regulation that requires that an

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<sup>5</sup> This is not to excuse some of the Montgomery County cases where the reporting or investigation was inadequate by any standard. The Montgomery County Ombudsman has informed OoA that several of the cases resulted from the lack of follow-up by a volunteer who had to be "terminated" for unsatisfactory performance.

<sup>6</sup> Case 7 concerned complaints of inadequate hygiene, inadequate supervision, dehydration, and inadequate care plan; Case 9 concerned a complaint of inadequate supervision of residents; Case 10 concerned a request to assist in determining a resident's competency; and Case 11 concerned a resident's rights issue.

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investigation include "personal contact with the resident ... on whose behalf the complaint was made...." COMAR 14.11.05.04.B. However, OoA has interpreted the phrase "personal contact" to include a telephone conversation. The Proposed Report erroneously construed "personal contact" to require a face to face encounter, which is not required in every single case. There are obviously cases where such personal contact would not be an efficient use of an Ombudsman's limited resources.<sup>7</sup>

#### Coverage of Other Long-Term Care Facilities

The OoA recognizes that the Ombudsman Program must work to serve residents in all kinds of long-term care facilities. We appreciate your recognition in Recommendation three on page 12 of the Proposed Report that resource problems make coverage of all types of long-term care facilities quite difficult.

#### Review of Local Ombudsmen

The monitoring of local programs has not been as scant as suggested in the Proposed Report. The Proposed Report is based on only two monitoring reports being conducted in 1993. However, this is mistaken. All 19 local programs were monitored in 1993. The auditors only examined two 1993 monitoring reports because those were not archived. Had the importance been communicated, we would have worked to retrieve all of the old monitoring reports from our archives. We provided a number of additional reports to Mr. Rubbo during our meeting on July 23, 1997. Attached to the original of this letter are copies of seven additional monitoring reports for 1993.

Monitoring was less than 100 percent in 1994 and 1995 for four main reasons: (1) the State Ombudsman resigned in January of 1994; (2) we were unable to hire a replacement until September of 1994; (3) the replacement was terminated while on probation in July of 1995 for unsatisfactory performance; (4) we were unable to hire a new replacement until 1996 because in 1995 the House of Representatives had approved, and the United States Senate was seriously considering approving, legislation that would have decimated the Ombudsman programs. When the Ombudsman Program was under stress because of staff turnover and under attack by the House of Representatives, OoA sensibly focused on the Program's core responsibilities.

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<sup>7</sup> See "Real People Real Problems" pages 82-83 (Institute of Medicine 1995).

Mr. John A. Ferris

August 19, 1997

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### Conclusion

We agree with all of the Recommendations on pages 12 and 13 of the Proposed Report. We plan to work diligently to implement them. However, we do not agree with some of the sweeping conclusions in the Proposed Report, especially the unwarranted conclusion that "the State did not provide reliable assurance that instances of abuse were properly reported and resolved and that the Ombudsman Program was adequately monitored." The Report would be much more helpful if it offered more detailed recommendations on things such as: (1) how to devise a risk assessment system; (2) how to create a volunteer program when the staff who would have to oversee the volunteers are too overwhelmed to get such a program started; or (3) how to avoid the duplication of effort that occurs when both the Ombudsman and police investigate the same case of alleged abuse. We appreciate all the hard work your staff has performed and would welcome any ideas they have on these three knotty issues.

Sincerely,



Sue F/Ward  
Director, Office on Aging

SFW:cas

### Enclosure

cc: Judy Santine, AoA (w/o enc.)  
Sue Wheaton, AoA (w/o enc.)  
Edward Glatzel, HCFA (w/o enc.)  
Barbara Shipnuck, DHMH (w/o enc.)  
Carol Benner, DHMH (w/o enc.)  
Lawrence Triplett, DHMH (w/o enc.)  
Timothy Sharpe, MFCU (w/o enc.)



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September 9, 1998

Honorable John Breaux  
 U.S. Senate  
 516 Hart Senate Office Building  
 Washington, DC 20510

Dear Senator Breaux:

Enclosed please find Louisiana law pertaining to criminal background checks for unlicensed personnel of health care facilities. It is my understanding that there will be a Senate hearing to consider the need for a national registry or clearinghouse for names of persons who have criminal convictions and attempt to work in health care facilities.

Conceptually, it is a step in the right direction and we support appropriate measures to weed out the bad elements before hire. However, the legislation should be written in a manner that is fair to prospective employees and not onerous to employers. To ensure fairness, the Louisiana law requires that a conviction be rendered, not just an arrest having been made. Also, there is a provision to allow an employer to consider mitigating circumstances, in order for him to determine if the person has been rehabilitated, i.e. age of person at the time of conviction, number of years since conviction, restitution made by the convicted person, etc.

Louisiana lawmakers wanted to limit the criminal background checks to unlicensed personnel, for example nursing assistants, because licensed professionals are scrutinized by Boards, such as the Board of Nursing. It was determined that only unlicensed employees would undergo said checks in Louisiana. This approach seems to be working well thus far.

Also, the national registry must be able to stand the scrutiny of hundreds, if not thousands, of calls per day. Louisiana, alone, has 92,000 certified nurse aides on its registry. Dissemination of wrong information could lead to defamation lawsuits.

Louisiana health care facilities currently use the Office of State Police for verification of a prospective employee's background. We have found the State Police, at times, to be dilatory in issuing reports. The law was amended last year to allow "authorized agencies" to also perform the checks in an effort to issue the background checks in a more timely fashion. We hope they will be more accurate as well.

Lastly, national legislation will only work if there is an ongoing commitment to adequately fund the national registry. Otherwise, the system will break down and potentially cause more harm than good.

Senator, there is a real need for a national criminal background check system. Currently, the law and federal recordkeeping do not allow long term care facilities to obtain comprehensive background checks. As you know, the President has proposed criminal background check legislation as part of its nursing home quality package. While we support the goal, we have concerns with the structure of the proposed system and seek to work with you on developing a national criminal background check system for prospective long term care employees that is efficient and effective - not burdensome and an impediment to meet the staffing and caregiving needs of our residents.

Yours truly,

  
Joseph A. Donchess  
Executive Director

cc: David Seckman

D. (1) If the lease of a truck stop facility, which is a licensed establishment for the operation of video draw poker devices, expires or is terminated without legal cause by the lessor, then, in that event, neither the lessor nor a new lessee shall have the right to apply for a video draw poker device license at the same truck stop location for a period of six years from the date of expiration or termination of the lease.

(2) The former lessee/licensee shall have any of the following rights:

(a) To continue operations at the licensed facility by agreement with the lessor or the new lessee.

(b) To transfer the existing license to any other new or existing truck stop facility which meets all of the qualifying requirements contained in this Part, except:

(i) That such former lessee/licensee shall not be required to wait before making application and commencing video draw poker operation at a new or existing facility.

(ii) That such former lessee/licensee shall be required to perform at the new facility any existing sublease or other contracts with licensed device owners/operators in effect at the time of expiration or termination of the lease.

(3) Nothing herein shall affect or apply to any truck stop facility in which the lessor is the holder of the license for the operation of video poker devices.

Approved June 15, 1993.

## NURSING HOMES AND HEALTH CARE FACILITIES—CRIMINAL HISTORY CHECKS ON NON-LICENSED PERSONS

ACT NO. 594

S.B. No. 764

AN ACT to enact Part XLIV of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:1300.41 through 1300.46, relative to employment of non-licensed persons; to define terms; to require employers of certain nursing facilities, specialized facilities, and residential care home to obtain a criminal history check prior to employing non-licensed persons; to authorize such facilities to obtain criminal history records; to provide a fee; to authorize temporary employment; to limit the arrest record reports to certain crimes; to require notification of applicants for employment of the criminal history check; to provide for refusal to hire or contract with and for termination of employment; to provide for exceptions; to provide for a waiver; to provide for confidentiality of criminal history records and for destruction of such records; to provide for compliance with provisions of this Act; to provide for an effective date; and to provide for related matters.

*Be it enacted by the Legislature of Louisiana:*

Section 1. Part XLIV of Chapter 5 of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1300.41 through 1300.46, is hereby enacted to read as follows:

### PART XLIV. CRIMINAL HISTORY CHECKS ON NON-LICENSED PERSONS

#### § 1300.41. Definitions

A. For the purposes of this Part:

(1) "Department" means the Department of Health and Hospitals.

(2) "Employer" means any of the following facilities, agencies, or programs:

(a) A nursing home, as defined in R.S. 40:2009.2.

(b) An intermediate care facility for the mentally retarded.

(c) An adult residential<sup>1</sup> care home, as defined in R.S. 40:2153.

(d) An adult day care center, as defined in R.S. 46:1972.

(e) A home health agency, as defined in R.S. 40:2009.31.

(f) A hospice, as defined in R.S. 40:2182.

(3) "Non-licensed person" means any person who provides for compensation nursing care or other health-related services to residents in a nursing facility, intermediate care facility for the mentally retarded, adult residential care facility, or adult day care center, and who is not a licensed health provider. "Non-licensed person" also means any person who provides such services to individuals in their own homes as an employee or contract provider of a home health agency or hospice.

(4) "Office" means the office of state police within the Department of Public Safety and Corrections.

§ 1300.42. Employment of non-licensed persons in certain locations; mandatory criminal history checks; temporary employment; notice to applicants

A. (1) Except as otherwise provided in Subsection C of this Section, prior to any employer making an offer to employ or to contract with a non-licensed person to provide nursing care, health-related services, or supportive assistance to any individual, the employer shall request a criminal history check be conducted on the non-licensed person pursuant to the provisions of this Section. If the employer is a facility, home, or institution which is part of a larger complex of buildings, the requirement of a criminal history check shall apply only to an offer of employment or contract made to a non-licensed person who will work primarily in the immediate boundaries of the facility, home, or institution.

(2) Except as otherwise specified in Subsection D(1) of this Section, an employer may obtain the criminal history record maintained by the office of state police of a non-licensed person offering to provide nursing care, health related services, or supportive services to any individual.

B. (1) The employer shall request the office <sup>or licensed investigation agency to</sup> conduct a criminal history check on the non-licensed person and shall provide the office <sup>any relevant information required by the office to</sup> conduct the check. <sup>use the office, it or invest. agency</sup>

(2) An employer <sup>shall</sup> pay a fee of ten dollars to the office for a search of the office's criminal history files on an applicant for employment.

C. An employer may make an offer of temporary employment to a non-licensed person pending the results of the criminal history check on the person. In such instances, the employer shall provide to the office the name and relevant information relating to the person within seventy-two hours after the date the person accepts temporary employment.

D. (1) The office <sup>or inv. agency</sup> shall not provide to the employer the criminal history records of a person being investigated unless the records relate to:

(a) A felony or misdemeanor classified as an offense against the person.

(b) A felony or misdemeanor classified as an offense affecting the public morals.

(c) A felony or misdemeanor classified as an offense affecting the family.

(d) A felony violation of any state law intended to control the possession or distribution of a Schedule I through V drug pursuant to the Uniform Controlled Dangerous Substances Act.

(e) A felony or misdemeanor classified as an offense against property.

(2) Within thirty days of receiving notification by the employer to conduct a criminal history check, the office shall complete the criminal history check and report the results of the check to the requesting employer.

E. An employer shall inform each applicant for employment or each prospective contract provider that the employer is required to obtain a criminal history record before such employer makes an offer of employment to, or contracts with, a non-licensed person.

<sup>1</sup> In subpar. A(2)(c), spelling is as it appears in the enrolled bill (Acts 1993, No. 594).



## 1993 REGULAR SESSION

## Act 594, § 1

## § 1800.43. Refusal to hire or contract; termination of employment; exemption; appeal procedure; waiver

A. (1) Except as otherwise provided in R.S. 40:1800.42(C), if the results of a criminal history check reveal that the non-licensed person has been convicted of any of the following offenses, the employer shall not hire or contract with such person:

- (a) Homicide, as defined in R.S. 14:29 through 31.
- (b) Assault and battery, as defined in R.S. 14:33 through 38.1 and 40 and 40.1.
- (c) Rape and sexual battery, as defined in R.S. 14:41 through 48.4.
- (d) Kidnapping and false imprisonment, as defined in R.S. 14:44 through 46.1.
- (e) Arson, as defined in R.S. 14:51 through 54.4.
- (f) Criminal damage to property, as defined in R.S. 14:55.
- (g) Burglary, as defined in R.S. 14:60 through 62.3.
- (h) Robbery, as defined in R.S. 14:64 through 66. — THEFT, as def in RS 14:67-73.
- (i) Offenses affecting sexual morality, as defined in R.S. 14:80 through 86 and 89 and 89.1.
- (j) Cruelty to the infirm, as defined in R.S. 14:93.3.

B. (1) If the results of a criminal history check reveal that a non-licensed person hired on a temporary basis or any other person who is an employee has been convicted of any of the offenses listed in Subsection A of this Section, the employer shall immediately terminate the person's employment.

(2) The provisions of this Subsection shall not apply to an employee or contract provider who has been employed for twenty-four months of the preceding thirty-six months, or a person who has received a pardon of the conviction.

C. The employer may waive the provisions of this Part.

(1) A waiver may be granted for mitigating circumstances, which shall include but not be limited to:

- (a) Age at which the crime was committed.
- (b) Circumstances surrounding the crime.
- (c) Length of time since the conviction.
- (d) Criminal history since the conviction.
- (e) Work history.
- (f) Current employment references.
- (g) Character references.
- (h) Nurse aide registry records.

(i) Other evidence demonstrating the ability of the person to perform the employment responsibilities competently and that the person does not pose a threat to the health or safety of patients or clients.

(2) The granting of a waiver shall not be construed as creating an obligation upon an employer to offer permanent employment to such person.

## § 1800.44. Confidentiality of criminal history records

A. All criminal history records received by the employer shall be confidential and shall be restricted to the exclusive use of the department and the employer requesting the information.

B. Except on court order or with the written consent of the person being investigated, the records or information obtained from or regarding the records shall not be released or otherwise disclosed to any other person or agency.

C. The records shall be destroyed after one year from the termination of employment of the person to whom such records relate. However, upon receipt of written consent by an applicant for employment with a health provider, the employer in receipt of a criminal history check may send a copy to the employer seeking the referral.

Act 594, § 1

1993 REGULAR SESSION

**§ 1300.45. Compliance**

The department shall review the employment files of any facility or agency required to obtain criminal history records to ensure such facilities are in compliance with the provisions of this Part.

**§ 1300.46. Ineligible for unemployment compensation**

A non-licensed person hired on a temporary basis who is terminated pursuant to the provisions of this Part shall not be eligible for unemployment compensation.

Section 2. This Act shall become effective on August 15, 1994.

Approved June 15, 1993.

**LINKED DEPOSIT PROGRAM FOR AGRICULTURAL LOANS—  
QUALIFICATIONS FOR PARTICIPATION—FUNDS  
AVAILABLE FOR PARTICIPATION**

**ACT NO. 595****S.B. No. 766**

AN ACT to amend and reenact R.S. 49:327.1(B)(2)(g) and (h), (E)(2), (M), (O), and (P), and to repeal R.S. 49:327.1(B)(2)(i) relative to linked deposit programs; to provide for the qualifications for participation in linked deposit programs; to provide for funds available for linked deposit participation; and to provide for related matters.

*Be it enacted by the Legislature of Louisiana:*

Section 1. R.S. 49:327.1(B)(2)(g) and (h), (E)(2), (M), (O), and (P) are hereby amended and reenacted to read as follows:

**§ 327.1. Linked deposit program for low-interest agricultural production loans**

B. As used in this Section:

(2) "Farmer" means any person that:

(g) Has gross income from the agricultural operation which is at least fifty percent of his total income;

(h) Has a positive net worth; and

E.

(2) The maximum amount which may be loaned to any farmer at any one time shall be one hundred thousand dollars.

M. The treasurer and the commissioner of agriculture and forestry shall take any and all steps necessary to implement the linked deposit program and monitor compliance of lending institutions and farmers with the provisions of this Section and the rules and regulations adopted under this Section.

## NOTICE OF INTENT

See notes

Department of Public Safety and Corrections  
Office of State Police

Criminal History Background Checks on  
Licensed Ambulance Personnel and Nonlicensed Persons

The Department of Public Safety and Corrections, Office of State Police, Louisiana Bureau of Criminal Identification and Information, in compliance with and under authority of the Administrative Procedure Act, R.S. 49:950 et seq., and R.S. 15:578 et seq., hereby gives notice of its intent to promulgate these rules and regulations pertaining to criminal history background checks on licensed ambulance personnel and nonlicensed persons pursuant to R.S. 40:1300.51 et seq. As outlined below:

Title 55  
PUBLIC SAFETY  
Part I. State Police

Chapter 2. Criminal History Checks on Licensed Ambulance Personnel and Nonlicensed Persons

Section 201. Statement of Department Policy

The rules contained herein are promulgated by the Louisiana Bureau of Criminal Identification and Information of the Department of Public Safety and Corrections, Office of State Police in order to set forth the policies and procedures applicable to requesting and receiving criminal history checks on licensed ambulance personnel and nonlicensed persons pursuant to R.S. 40:1300.51 et seq. by employers and authorized agencies.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 15:578 et seq. and R.S. 40:1300.51 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR

Section 203. Definitions

For the purposes of these rules, the following words and phrases shall mean:

*Applicant* - a person or entity who has submitted a request to the Louisiana Department of Public Safety and Corrections, Office of State Police, Louisiana Bureau of Criminal Identification and Information in accordance with these rules to be approved as an authorized agency.

*Authorized agency* - a private entity authorized by the Office of State Police to conduct the criminal history checks provided for in R.S. 40:1300.51 et seq.

*Bureau* - the Louisiana Bureau of Criminal Identification and Information within the Department of Public Safety and Corrections, Office of State Police as provided for in R.S. 15:572.

*Criminal History Record* - shall have the same meaning as provided for in R.S. 15:570.

*Employer* - shall have the same meaning as provided for in R.S. 40:1300.51(6).

*Licensed Ambulance Personnel* - shall have the same meaning as provided for in R.S.

40:1300.51(5).

*Nonlicensed Person* - shall have the same meaning as provided for in R.S. 40:1300.51(3).

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 15:578 et seq. and R.S. 40:1300.51 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR

**Section 205. Application to be Approved as an Authorized Agency**

A. An application for a private entity to be approved as an authorized agency must be submitted to the Bureau along with the following documents:

1. Proof of qualification to do business within the state of Louisiana as evidenced by a valid certificate of authority issued by the Secretary of State, and designation of an agent for service of process as required by law. If the entity is operating as a sole proprietorship, a current valid occupational license will be accepted.

2. Proof of a \$1 million dollar liability insurance policy which insures the applicant for errors, omissions, and misuse of confidential information. ✓

3. A written agreement executed by each officer and/or director of the applicant, and every employee and agent of the applicant who will have access to the criminal history information provided by the Bureau, whereby they agree to maintain the confidentiality of any and all information provided to it by the Bureau pursuant to R.S. 40:1300.51 et seq., abide by all applicable laws, rules and regulations pertaining to receipt and use of criminal history information, cooperate in any auditing procedure conducted by the Bureau, inform the Bureau in writing of any known violations regarding the use of criminal history information it obtains. ✓

4. In addition to these requirements, each employee or agent of the applicant who will receive and review criminal history information obtained pursuant to R.S. 40:1300.51 et seq. must meet and maintain the following eligibility requirements: ✓

a. Proof of current and valid licensure as a private investigator or private detective in the state of Louisiana by the Louisiana State Board of Private Investigator Examiners.

b. Not currently be charged by bill of information or under indictment for, or have been convicted of, any felony offense in this state or any other jurisdiction, and submit to a background investigation to determine such.

B. Upon receipt of a completed application for approval as an authorized agency, the Bureau shall review the application and conduct whatever investigation it deems necessary to verify the information. Upon completion of this review, the Bureau shall inform the applicant in writing of its approval or denial of the application.

C. Each authorized agency must maintain the eligibility requirements to be approved as an authorized agency and each employer or agent of the authorized agency who receives and reviews criminal history information pursuant to R.S. 40:1300.51 et seq. shall maintain the eligibility requirements. Failure to continue to maintain the eligibility requirements shall result in cancellation of approval as an authorized agency.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 15:578 et seq. and R.S. 40:1300.51 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR

**Section 207. Request for Criminal History Information**

A. A request for a criminal history check authorized by R.S. 40:1300.52 shall be made on a form provided by the Bureau and submitted to it by an employer or authorized agency.

B. Each request for a criminal history check shall be accompanied by the fee of \$10.00 as established by R.S. 40:1300.52(B)(2) and LAC 55:I.101.A.

C. Each request form submitted by an authorized agency shall be accompanied by a letter of engagement or contract with the employer as defined in R.S. 40:1300.51(2) as proof that the authorized agency may request and receive criminal history information on behalf of the employer. The results of each criminal history check submitted by an authorized agency on behalf of an employer will be reported to the authorized agency.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 15:578 et seq. and R.S. 40:1300.51 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR

**Section 209. Receipt and Use of Criminal History Information**

A. Any employer or authorized agency which receives criminal history information pursuant to R.S. 40:1300.52 shall maintain the confidentiality of the records obtained.

B. The criminal history information received by an employer or authorized agency shall be used for the sole purpose of determining the applicant's eligibility for employment with the stated employer.

C. Any authorized agency who fails to maintain the confidentiality of criminal history information obtained pursuant to R.S. 40:1300.52, or who uses such information for any purpose other than determining the applicant's eligibility for employment with the stated employer, shall have its approval as an authorized agency canceled as an authorized agency and be ineligible to receive criminal history information pursuant to R.S. 40:1300.52. Any authorized agency or employer who fails to maintain the confidentiality of criminal history information obtained pursuant to R.S. 40:1300.51 et seq., or uses such information for any purpose other than determining the applicant's eligibility for employment with the stated employer shall be subject to all other penalties provided by law.

**AUTHORITY NOTE:** Promulgated in accordance with R.S. 15:578 et seq. and R.S. 40:1300.51 et seq.

**HISTORICAL NOTE:** Promulgated by the Department of Public Safety and Corrections, Office of State Police, LR

December 8, 1997

Lt. Randy Johnson  
State Police  
Bureau of Identification  
265 South Foster Drive  
Baton Rouge, LA 70806

Dear Lt. Johnson:

The members of Louisiana Nursing Home Association appreciate the State Police working so closely with our industry in implementing the criminal background check law. In your deliberations in authorizing agencies to perform criminal background checks, we appreciate your office extending the courtesy of getting our input on what credentials have worked for us in the past when contracting with agencies.

We understand your concern is that those with access to your database should maintain its integrity and use the information only within the allowances of the law. In a meeting held last week, our Standards committee, came up with six criteria that we believe will 1) allow our industry accurate information with a faster turnaround time, 2) will lighten the load on your agency, and 3) maintain the integrity of your confidential information. The six criteria that we would suggest be used in authorizing agencies are:

- 1) that they maintain a \$1 million liability insurance policy,
- 2) that they maintain a \$1 million error and omission policy,
- 3) that they maintain a surety bond for misuse of confidential information,
- 4) that they agree to undergo an auditing procedure by the State Police and at the discretion of the State Police,
- 5) that they be licensed as a Private Investigative agency, and
- 6) that the State Police run background checks on the agency personnel conducting the criminal background checks for the agency.

We believe these six criteria will go a long way in assuring that reputable agencies are accessing your database and that our industry gets reliable information. Again, thank you for extending us the courtesy of getting input from Louisiana Nursing Home Association.

Sincerely,

Joseph A. Donchess  
Executive Director

**MEMORANDUM**

**TO:** State Executives  
State Public Relations Directors  
Multifacility Public Relations Directors

**FROM:** David Kylo, Director of Community Relations

**SUBJECT:** National Crime Prevention Partnership

**DATE:** May 14, 1997

AHCA and the National Association of Attorneys General will announce tomorrow in Boston that the two groups have formed a partnership to prevent and eliminate abuse in long term care facilities. A copy of AHCA's press statement is attached for your information.

The partnership has two immediate objectives. First, both groups will work together in coming months to draft legislation creating a national background check system that can be used by providers to screen prospective employees. The second goal is to promote and disseminate a training program that provides additional instruction to employees on preventing and reporting incidents of abuse and neglect. State affiliates will be receiving more information about that training program in the near future.

The partnership is a model of a similar initiative conducted by the Massachusetts Extended Care Federation and the Massachusetts attorney general. That state initiative has resulted in a 20 percent reduction in the number of abuse allegations filed in the state and reduced the number of valid findings against CNAs by almost 50 percent.

Please call me at 202-898-6312 if you have any questions about the announcement. John Schaeffler (202-898-2808) of AHCA's staff will be working with NAAG to draft legislation.

cc: Executive Committee  
Advocacy Committee  
Marketing Subcommittee

Contact: David Kyfio  
202-898-6312

**Statement of Paul R. Willging  
Executive Vice President  
American Health Care Association  
RE: Crime Prevention Initiative**

**Immediate Release:**

**BOSTON (May 15, 1997) –** The American Health Care Association is pleased to announce that it is working with the National Association of Attorneys General (NAAG) on a crime prevention initiative aimed at keeping the nation's 1.5 million nursing facility residents safe and secure.

Nursing facility employees care for a very frail and vulnerable population. It is essential that we have a national criminal background check system to screen prospective employees to ensure that they are fit to work in the long term care profession. We appreciate the leadership of Massachusetts Attorney General Scott Harshbarger and the commitment of NAAG in forming a partnership with long term care providers to develop such a background check system.

Most of the 1.3 million people working in nursing facilities are caring and devoted individuals doing a very tough job. Finding the right people who will provide compassionate care has become more difficult. With our transient society and the growing unwillingness of employers to give useful information about a former employee's character, it has become increasingly difficult to obtain important information about prospective employees.

While many states have created criminal background check systems for long term care workers, those systems can't address one significant fact: people cross state lines.

By working together, NAAG and AHCA have the necessary expertise to develop a comprehensive background check system that can supply a nursing facility with quick, complete and accurate information about a prospective employee regardless of whether the individual has lived in one state or many states. Such a system is an essential tool to prevent people who have committed crimes in any state from being hired by nursing facilities.

AHCA also is pleased that education is a major component of both groups' efforts to safeguard residents. As part of the partnership, AHCA's Massachusetts affiliate and Attorney General Harshbarger have developed a training program to provide additional instruction to employees about how to prevent and report incidents of abuse and neglect. The *Keeping Nursing Facility Residents Safe* training program will be distributed to AHCA's 50 state affiliates and we intend to make it available to 17,000 nursing facilities nationwide as part of AHCA's professional development curriculum.

For anybody with a loved one in a nursing facility, safety and security are primary concerns. Massachusetts is a prime example that a partnership between long term care and the attorneys general works. Abuse allegations have decreased by 20 percent since the two groups began working together. We believe that this partnership model will bring similar results nationwide and will make nursing facilities safer for residents.





Mary Suther  
Chairman of the Board  
Val J. Hakamandaris  
President

NATIONAL ASSOCIATION FOR HOME CARE  
228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

Honorable Frank E. Moss  
Senior Counsel  
Stanley M. Brand  
General Counsel

**TESTIMONY  
SUBMITTED FOR THE RECORD**

**BEFORE THE SPECIAL COMMITTEE ON AGING**

**U. S. SENATE**

**SEPTEMBER 11, 1998**

**ON BEHALF OF THE**

**NATIONAL ASSOCIATION FOR HOME CARE  
228 Seventh Street, S.E.  
Washington, D.C. 20003  
(202) 547-7424**

*Representing the Nation's Home Health Agencies, Home Care Aide Organizations and Hospices*

Mr. Chairman,

The National Association for Home Care (NAHC) appreciates the opportunity to comment on the development of legislation to protect long-term care patients from abuse. We applaud the efforts of this Committee to protect our nation's elderly and especially appreciate the leadership of Senator Kohl.

The National Association for Home Care (NAHC) is the largest national organization representing home health care providers, hospices, and home care aide organizations. Among NAHC's nearly 6,000-member organizations are every type of home care agency, including nonprofit agencies like visiting nurse associations, for-profit chains, hospital-based agencies and freestanding agencies. NAHC has a long history and solid track record of proactive efforts to combat fraud and abuse in home care. These efforts are broad and far reaching, and include support for federally mandated criminal background checks.

A recent spate of media attention has focused on unacceptable, but isolated, cases of abuse of home care clients, fueling consumer anxiety and industry concern about the need for better consumer protections. Although any fraud and abuse is totally unacceptable, it's important to note that cases of consumer abuse in home care are rare. The overwhelming majority of home care workers are honest and perform their duties with compassion and integrity. Likewise, the vast majority of home care agencies provide reputable, legitimate quality care.

Home care providers are often in a position of identifying elder abuse committed by others. In fact, Congressional testimony by the General Accounting Office in 1991 regarding elder abuse indicated "...a high level of public and professional awareness was the most effective weapon for identifying elder abuse; inhome services was considered the most effective factor for both prevention and treatment of elder abuse." However, as in any growing industry, there are a few unscrupulous individuals who defraud and abuse the system and its patients.

As the demand for quality home care increases, it is critical that all services are delivered with care and compassion by ethical providers. Fraud and abuse cannot be tolerated in any form. The care environment must be safe for both patients and caregivers and free of abuse, fear of abuse, neglect, exploitation and inappropriate care. Criminal background checks are an important component, though only one component, of ensuring consumer safety.

#### **Support for Criminal Background Checks and a Federal Registry**

NAHC believes that federal requirements for worker screening should be strengthened to include federally funded criminal background checks for all home visiting staff.

An organized system for criminal background checks should be developed that is reasonable in cost and will provide up-to-date information in a timely manner. Laws should ensure that the rights of patients, providers, employees and job applicants are protected. The law should ensure immunity for a health care facilities/organization that act with reasonable reliance on information secured through a background check.

Statement of National Association for Home Care  
September 11, 1998  
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Although in state laws the trend is toward background checks for home care aides only; NAHC believes that laws should cover all home visiting staff. There is currently no consistent mechanism through which other home visiting staff are checked. It is in the best interest of consumers of home care services for all home visiting staff to be screened.

In addition, as Senator Kohl proposed last year, NAHC supports the establishment of a national registry system listing workers who have been deemed qualified to provide home care services or those who have been found in violation of the law or safety standards.

Finally, home care has been accompanied by both a proliferation of agencies and an increase in the number of independent providers--workers who provide care independent of agencies. This trend is fueled by two factors: the desire among some people with disabilities to exercise greater control over their own care and state policies which require or encourage aged and disabled beneficiaries to take direct responsibility for hiring or supervising home care workers paid with state or federal funds. The influx of workers into home care who are subject to no standards or screening has necessarily heightened concerns about consumer safety. Rarely are these workers subject to any training, competency testing, or professional supervision. NAHC urges Congress to ensure that such workers are not exempt from federal criminal background check requirements.

#### **Beyond Criminal Background Checks**

Criminal background checks, though valuable, cannot be relied on as the sole method of keeping consumers safe. NAHC has provided consultation to member agencies, extensive educational efforts to help consumers to make informed decisions, and encouraged Congress, federal agencies, and state legislatures to mandate quality assurance standards in home care.

Although federal regulations should never be so cumbersome as to pose a barrier to care, basic standards of care must be established to ensure minimum levels of safety for the consumer, the caregiver and the community. A 1995 report by the National Long Term Care Resource Center states: "Federal and state governments have continuing responsibilities for establishing and enforcing the conditions under which programs can be innovative, responsive to consumer preferences, and encouraged to exceed minimum standards."

Quality assurance standards should be required in all federal and state funded long-term care program. Such standards should include minimum standards of training, testing, supervision, and practice in the delivery of in-home services. Quality and safety standards should apply regardless of consumer, provider or payor. Such standards are critically important in protecting consumers from neglect, abuse, and inappropriate care.

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The National Association for Home Care looks forward to working with this Committee to develop criminal background check policy to help protect consumers of long term care services from abuse.



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