TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-SECOND CONGRESS

FIRST SESSION

PART 19A

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[1] Senator Winston Prouty, Vermont, served as ranking minority member of the committee from September 1969, until his death, September 10, 1971. Senator Robert T. Stafford, Vermont, was appointed to fill the vacancy on September 17, 1971.

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TRENDS IN LONG-TERM CARE

MONDAY, NOVEMBER 29, 1971

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Minneapolis-St. Paul, Minn.

The subcommittee met, pursuant to call, at 9:30 a.m., in the auditorium, O'Shaugnessey Education Center, College of St. Thomas and St. Paul, Senator Frank E. Moss of Utah (chairman) presiding.

Present: Senators Moss and Mondale.

Also present: Val Halamandaris, professional staff member; and Janet Neigh, assistant chief clerk.

OPENING STATEMENT BY SENATOR FRANK MOSS, CHAIRMAN

Senator MOSS. The hearing will come to order.

We welcome all of you here today. This is a good turnout for this hearing, which shows that there is a great deal of interest in the problem with which we are concerned today.

This is a hearing of the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging. We are continuing an inquiry into the operation of nursing homes and similar facilities in this country.

We have conducted, in this subcommittee, 19 hearings in this current series held in various parts of the United States, including Washington, D.C.

Our purpose is to gather the facts and prepare a report for the Congress with our legislative recommendations. Our subcommittee has the responsibility for overseeing the Nation's 23,000 nursing homes because of the substantial amount of Federal public funds going into these institutions. In fact, two out of every $3 in nursing home revenues come from the U.S. taxpayer. Medicare and Medicaid together contribute $1.7 billion out of a total of $2.6 billion spent on nursing home care.

I am informed by the staff that we can expect an excellent hearing here in the Twin Cities area. Our witness list is long, so I will not extend my remarks. However, I do want to comment that I feel that it is highly appropriate that we are having this hearing here today as the White House Conference on Aging convenes in Washington, D.C. I only hope that through these hearings and the conference in Washington, we can consolidate what facts we have and move forward with constructive solutions to improve the quality of life for our older Americans.

I am very pleased to have serving with us today and sitting on the panel at this hearing the Senator from your State, the Honorable Walter F. Mondale.

I am pleased to be in your hometown, "Fritz," and glad that you could be with us today. I would like to have you make any opening remarks you would care to make at this time.

Senator MONDALE. Thank you very much, Senator Moss.

STATEMENT OF SENATOR WALTER F. MONDALE

I have a longer statement that I will submit for the record, but permit me to welcome you to Minnesota and to express, on behalf of our citizens, our appreciation for your willingness to bring the subcommittee here to learn about the critical problems of nursing home care.

I also wish to thank the College of St. Thomas for making these magnificent facilities available to us today.

I think everyone here would agree that we have an obligation to see to it that those who reside in nursing homes should receive the best kind of care possible. Anything less would be, I think, inexcusable. Most of our nursing home residents are senior citizens who have contributed their energies and their talents to society throughout their lives. We owe it to them now to provide a pleasant, safe, and a healthful environment in which they may spend their remaining years.

SPECIAL RESPONSIBILITY TO NURSING HOME RESIDENTS

I think we have a special responsibility toward our senior citizens in nursing homes, for often they have no one to represent them. Old and infirm, they lack the assurance and often the ability to speak for themselves. Frequently they have no family to watch out for their interests. Sometimes they have been abandoned by families if they had them. If no physician feels a responsibility for them, they are truly alone in the most heartbreaking sense of that word. So it is one of our objectives here to see how we can assure that these residents themselves have a voice in their own affairs.

This hearing, I should remind those here today, will focus on the problems, because problems do exist. It is our job to look at those problems and see what we can do to prevent them. No one should misunderstand our purpose. We are not here to condemn the nursing home industry or to suggest that the conditions we learn about today are typical of those prevailing in Minnesota. Indeed, based upon the information collected by the committee, it appears that Minnesota, in fact, is doing a better job than many other States. But merely doing a good job is not good enough for Minnesotans. We are proud of our high standards in the health field and we want to be the leader in the nursing home field, as well. I am hopeful that these hearings will help us achieve that objective.

Thank you very much, Senator Moss.

Senator MOSS. Thank you, Senator Mondale.

(The prepared statement of Senator Mondale follows:)

STATEMENT OF SENATOR WALTER F. MONDALE

Mr. Chairman, I welcome the opportunity to participate in the 19th hearing in the series which the Subcommittee on Long-term Care has been conducting since 1970. I think the hearings are playing a very valuable role in bringing to the attention of the public, the government agencies concerned and the management of the nursing homes, important problems which are deserving of our attention.

The United States Congress has a heavy responsibility for oversight of nursing homes. Almost half of all the income of such homes is derived from Federal programs, chiefly Medicaid and Medicare. We not only have a need, therefore, to find out how these programs are working but we have an obligation to the taxpayers to do so.

Far more important, we have an obligation to those who reside in these nursing homes to be sure that they receive the kind of care which they deserve. Most of our nursing home residents are senior citizens who have contributed their energies and their talents to society throughout their lives. We owe it to them now to provide a pleasant, safe, and healthful environment in which they may spend their remaining time.

We must recognize that these people often have no one to represent them. Old and infirm, they lack the assurance, or the facility, to speak for themselves. Frequently, they have no family to watch out for their interests. If no physician feels responsible for them, they are truly alone. So it is one of our objectives to see how we can assure that the residents, themselves, have a voice in their own affairs.

These hearings will necessarily focus on problems because problems do exist. And it is our job to explore the problems and determine how they may best be solved. No one should misunderstand our purpose. We do not wish to condemn the nursing home industry or to suggest that the conditions we will learn about today are typical of those prevailing in Minnesota.

Based on evidence collected by the committee, it appears that Minnesota, in fact, is doing a better job than some other States. But merely doing a better job than some other States is not good enough, in my opinion, for Minnesota. Our State has been a leader in many fields of health care. I would like to see us become a leader in nursing homes as well.

It is in that light that I regard these hearings as an opportunity for the State and local agencies in Minnesota, and for the nursing home associations—both public and private, as well as for the Congress, to determine what steps must be taken to provide in Minnesota the best possible kind of nursing home care.

Mr. Chairman, I know that you are dedicated to developing Federal legislation to help deal with these problems. You may count on my strong support for such efforts, and I know that you can depend on Minnesota to help.

Senator Moss. At this point, if there are no objections, we will insert into the record some key facts about nursing homes in the United States and the State of Minnesota.

SOME KEY FACTS ABOUT NURSING HOMES IN THE UNITED STATES AND THE STATE OF MINNESOTA

Statistics

Number of nursing homes in the United States.	23, 000.
In Minnesota	431.
Percent for profit in the United States.	80 percent.
In Minnesota	About 40 percent.
Number of nursing home beds in the United States.	1, 200, 000.
In Minnesota	32, 808.
Number of patients in the United States in nursing homes.	900, 000.
In Minnesota	About 28, 000.
Number of nursing home personnel, United States.	500, 000.
Turnover rate	60 percent overall; 75 percent for aides and orderlies
Nursing home revenues, total.	2, 600, 000, 000.
Federal share	Over 1, 000, 000, 000.
State's share	700, 000, 000.
Private sources	900, 000, 000.

Other Federal support to nursing homes:

Small Business Administration makes loans and provides insurance for profit nursing homes for construction and modernization.

The Hill Burton Program provides construction loans to non-profit nursing homes.

The Department of Housing and Urban Affairs provides mortgage insurance for nursing homes through its FHA section 232 program.

The Department of Agriculture aids some nursing homes through its commodities program.

The Veterans Administration has some nursing homes of its own and it contracts services with some nursing homes in the community.

MINNESOTA NURSING HOME REGULATIONS CURRENTLY IN EFFECT

(PART OF 17 PAGES OF REGULATIONS—EXCEPT FOR NO. 10614, EFFECTIVE SINCE 1952)

Nursing Record

1. "A nursing record shall be kept for every patient admitted to the home." (Observations shall be recorded at least every four hours in the first 24 hours and as required thereafter.) 10613(f)

Nurse Supervisor

2. "A supervising nurse shall be in charge of the nursing service. She shall be either a registered nurse or a licensed practical nurse. . . . She shall be responsible for records pertaining to nursing care, including the securing of orders from physicians." 10605(a)

24-hour coverage

3. "There shall be at all times a responsible person immediately available to the patients or residents." 10559(a)

Doctor to be Designated

4. "Each patient . . . shall designate a licensed practitioner of the healing arts for the supervision of the care and treatment of the patient. . . ." 10608(a)

Emergency Doctor

5. "Every nursing home shall designate one or more duly licensed practitioners to be called in emergency when the patient's physician is not available." 10608(d)

Medications By Phone

6. "(Medication) orders *may be given by telephone provided* that such orders are authorized by the physician . . ., recorded by the person so authorized and *signed by the physician* . . . at his next visit." 10614(a)(1)

Passing Medications

7. "The supervising nurse or other nursing staff *trained specifically by the supervising nurse or a physician* in the administration of medications and familiar with the expected action of drugs, shall be designated and held responsible for the administration of medications during each eight hour period." 10614(a)

Drug Records

8. "A record shall be kept of all drugs and medications administered to each patient on the medication and treatment record . . ." 10614(d)

Narcotics

9. "All narcotics shall be placed *under double lock or in a safe* . . . The keys shall be on the person of and available only to those persons designated to administer drugs." 10614(b) "A narcotic record book shall be maintained . . ." 10614 (d)(1)

Stop orders

10. "Medications without a specific time limit shall be automatically discontinued by the supervising nurse after a period of seven (7) days, or in the case of narcotics, within 72 hours." 10614(e)

Reuse of Drugs

11. "In *no case* shall prescription *drugs be used or saved for the use* of other patients in the nursing home." 10614(a)(6)

Restraints

12. "No form of restraint may be used or applied in such manner as to cause injury to the patient." 10598

Disturbed Mental Patients

13. ". . . disturbed mental patients . . . shall not be admitted to or retained in . . . a nursing home. A person for whom the general use of restraints is necessary for his protection . . . shall be considered a disturbed mental patient." 10551(c)

Isolation Area

14. "Each home in which patients do not have private rooms shall be prepared to make available a suitable screened area which can be used for seriously ill or terminal cases or for temporary isolation of a communicable disease case which may develop after admission." 10612

Privacy

15. "Bed screens or curtains shall be available for use in all multi-bed rooms to insure privacy for patients." 10613(b)

Enough Personnel

16. "At all times there shall be enough personnel to provide the standard of care and maintenance in the home for the well-being of the persons received for care." 10559(b)

Equipment

17. "There shall be adequate equipment for nursing care . . ." 10613(a)

Clean Linens

18. "For each patient . . . shall be provided: . . . Clean bedding and bed linen shall be kept on hand at all times. Clean sheets and pillow cases shall be *furnished at least once a week*. The bed linen shall be changed whenever soiled or insanitary . . ." 10586(a)

Food Requirements

19. "Meals for patients or residents on general diet shall be of adequate quantity and quality, well-balanced and sufficiently varied."

Toilets

20. "Toilets shall be provided in number ample for use according to number of patients . . . of both sexes. . . . A minimum is one . . . for every eight. . . ." 10575(e)

Sanitary Maintenance

21. "The licensee shall maintain the sanitation and safety of the building. Walls and floors shall be of a character to permit frequent washing, cleaning, or painting." 10568(c)

The Minnesota Department of Health has the responsibility for *licensing* (according to State law) nursing homes, for *certifying* that they are in conformance with Federal regulations and eligible for Federal funds (Medicare and Medicaid); for *inspecting* nursing homes to see that they comply with State regulations and Federal Regulations under Medicare and Medicaid.

With regard to inspections, the State Department of Health accepts inspections conducted by the Health Departments of St. Paul and Minneapolis and does not do independent inspections.

A nursing home (Of which there are several categories, see below) provides services beyond personal care, (i.e. board and room assistance with bathing and dressing) and less than the acute medical service provided by the hospital.

1. The Extended Care Facility is the category of nursing home closest to a hospital, providing post-hospital post operative, short term nursing services. It provides the extension of the kind of care for which the patient was hospitalized. This is the *Medicare* nursing home program available to all over 65. Government reimburses nursing homes for reasonable costs incurred.

2. The next category going in the direction of less acute services is the *Medicaid* skilled nursing home. These homes are distinguished by the Federal requirement that the home have a full time registered nurse or a licensed practical nurse on duty at all times. *Medicaid* essentially pays for public welfare patients; Federal and State's match funds on a 50–50 basis. States must enforce Federal standards. The Department of H.E.W. oversees. State Medicaid rate is about $14 a day.

3. The third category of nursing homes (in two classes) is the Intermediate Care Facility. Class I requires a licensed practical nurse in charge 8 hours per day 7 days a week. The State pays about $11 a day. Class II, no nurse coverage is required. State pays about $7 a day. Federal/State matching for welfare and indigent patients like Medicaid above on 50–50 basis.

4. Anything less is a Boarding Care Home which provides simply personal care, help with bathing, dressing, etc. State of Minnesota pays Boarding Care Homes about $5 a day.

Senator Moss. We have in attendance also Senator Bob Tennessen, State senator, and I am going to call on him to give a word of greeting. I believe Dick Wexler is also here.

Could we hear from those gentlemen now.

Senator MONDALE. Mr. Chairman, I am very pleased to introduce Senator Tennessen. He is one of our outstanding State senators. I would like to introduce Mr. Wexler also, who is here today representing the attorney general of Minnesota, Mr. Spannaus.

STATEMENT OF STATE SENATOR ROBERT TENNESSEN,[1] MINNEAPOLIS, MINN.

Senator TENNESSEN. Thank you, Mr. Chairman, Senator Mondale.

I appreciate the opportunity to speak briefly to this subject. As the freshman State senator I have had the opportunity to offer some rather minor legislation in Minnesota regarding the regulation of nursing homes, particularly in the city of Minneapolis, and what you will learn in testimony today will indicate the extent and gravity, I think, of the problems of nursing homes in the State and in the country and what the roles of the State and Federal Governments can be to rectify those problems.

I think the public will be somewhat outraged when they learn of some of the conditions that exist in some of the homes, especially since, as you pointed out, two-thirds of all revenue for nursing homes comes from the Public Treasury. I believe the public will demand that the national disgrace be ended and that proper and decent care be provided the elderly and that a public accounting be made of nursing home costs, expenditures, ownership, debt, internal control, and handling of drugs.

In Minnesota the existing statutory authority to establish and enforce reasonable rules and regulations is very strong. Yet, even with the power that is presently provided to the State enforcing bodies, the welfare department, the public health department, the problems have not been alleviated.

I think the inadequate care that results from the current conditions is based on several factors. These factors are the staff, the training that is involved, the particular care of the patients, the facilities, and sometimes the programs for the senior citizens.

There are some other problems I think we could classify as the "We don't know" variety. We do not know whether we are overpaying for patient care or whether the pricing structure of the homes is proper, and we do not know, in some cases, who owns the homes and whether the ownership of homes is integrated on a vertical basis with other types of facilities. Obviously, not all nursing homes are inadequate.

The problems I might list principally are in what are known as intermediate-care facilities which, under Minnesota law, are also classified as nursing homes, not under some of the lesser classifications.

In Minnesota I think the medical assistance program is one of the few that has not been cut back with the cutback in Federal funding. Minnesota continues to fund most types of care in nursing homes.

MINIMUM FEDERAL STANDARDS

I think the way the Federal Government can help the States is to provide some minimum standards which the States must meet, but not to preempt the field and prevent State regulation. I think we need State regulation; I think we can do many things on a State level that

[1] See prepared statement, p. 2189.

the Federal Government cannot do, but we need some Federal regulation to prevent the whipsawing that could occur otherwise.

We would also like to see the Federal Government increase, obviously, its aid to the nursing homes and for the care of patients generally if it is needed.

I think in the State, as an example, the political power of the nursing homes is quite substantial, and we have some difficulty in obtaining enforcement of, adoption and enforcement of, good standards. As an example, I point out that it took 12 years to repeal a bill or an act in Minnesota which prevented the city of Minneapolis from enforcing and adopting any standards, and the bill applied to only the one city out of the whole State. That was repealed with the support of the nursing home association. However, later in the session they came in with a bill to prevent adoption of standards and enforcement by any municipality or local unit of government. That bill, fortunately, did not pass, and it would have been particularly tragic since we do not have adequate staff on a State level to enforce those State standards that we do have.

Generally I think the Federal Government can help, but I do not think they should preempt the field. There is a role for the State and the Federal.

Thank you.

Senator Moss. Thank you very much, Senator Tennessen.

I agree with your observation that the States do have a very important part to play and their supervisory functions should not be preempted because the State is peculiarly cognizant of local conditions, whereas the Federal Government has a broader perspective and, consequently, is not so well tailored to meet individual State needs. But if the present system of joint State-Federal responsibility cannot be integrated and cannot work effectively, then the next step is Federal preemption. I just hope it doesn't have to come to that. I think the States have to step forward and exercise their degree of responsibility.

Thank you very much.

Are there any questions?

Senator Mondale. I have just one question.

What, in your opinion, has been the role of the nursing home industry itself, in terms of trying to deal with its own problems? Has it come before the legislature seeking assistance of the kind that you think will deal with these problems, or what has been its role?

Senator Tennessen. Mr. Chairman, Senator Mondale, I didn't have the privilege of serving on the Welfare Committee before which most of their concerns would have been aired. I think in the past, in the last few years, the nursing home has been attempting to upgrade itself. The problem, obviously, is like most other industries that are trying to regulate themselves, they don't do a very adequate job and it is almost impossible, whether it is lawyers or doctors or any other group.

I think what really is needed in terms of legislation or in terms of control is supervision and enforcement by citizen groups.

I think it is fair to say the Minnesota Nursing Home Association has made some improvements and they have attempted to rectify some of their problems. They just haven't been able to succeed completely.

Senator Mondale. Thank you.

Senator Moss. What you would have is the normal situation for almost any widespread industry, the majority of them will meet the

standards but there will be a few who do not, and they are the ones that the regulation has to force to get in line.

Senator TENNESSEN. I think one of the problems is, I don't really know what percentage that is, and I am not sure that in the State we have the facilities right now to determine that.

Senator MOSS. Yes.

Thank you very much, Senator Tennessen. We are glad to have your statement.

Senator MOSS. We will now hear from Mr. Wexler.

Are you assistant attorney general? What is your title?

Mr. WEXLER. My official title is special assistant attorney general.

Senator MOSS. Very glad to have you and we would appreciate any statement or comments you would like to give us.

STATEMENT OF RICHARD WEXLER, SPECIAL ASSISTANT ATTORNEY GENERAL

Mr. WEXLER. Thank you very much, Mr. Chairman.

As I just noted, I am special assistant attorney general and have as one of my assignments representation of the Minnesota Board of Health and Department of Health.

The attorney general has been most interested in the nursing home situation. This interest has been evidenced in many ways. He has conferred on several occasions with Mrs. Daphne Krause and her staff of the Minneapolis Age and Opportunity Center on matters of mutual concern. At his instruction, I have worked on and have kept him informed of a number of matters in the nursing home area.

Of major importance to the attorney general has been the revision of the nursing home and boarding care home regulations of the Minnesota State Board of Health. I understand that Dr. Warren R. Lawson, secretary and executive officer of the Minnesota Board of Health, will testify later in the day and will probably make more extensive comments regarding these regulations. I only want to say that we have spent many hours with the department and the board of health in advising them on the legal aspects of the regulations and related matters. Close coordination has been necessary, as this was a complete revision of regulations which were last amended in 1962. We believe that the new rules have been sufficiently broadened in scope so as to enable the health department to better fulfill its regulatory responsibility as delineated by statute.

DISCIPLINARY ACTION TOO INFLEXIBLE

A second major area of concern has more recently come to light. Presently Minnesota statutes permit only one form of disciplinary action, that being a hearing after a 30-day notice on the issue of the revocation or suspension of a nursing home's license. The attorney general believes that this system is too inflexible to deal with relatively minor offenses which do not justify the revocation or suspension of a license. Moreover, if conditions in a home are such that the license should be revoked, then, for the welfare of the patient a system should be established by statute which could reduce the present 30-day-notice requirement. This must be carefully studied, for we are faced not

only with the closing of a home but with the placement of patients in different facilities.

Allow me to emphasize that we are not concerned with devising a punitive system which will immediately crush any home which by chance should violate a particular regulation. Rather, we must develop a system by which we can effectively deal with those operations which deliberately or through continual carelessness ignore State regulations and the welfare of their patients. We plan to work closely with the health department in devising a well-coordinated, effective plan which can be presented to the legislature at its next session in 1973.

Mr. Chairman, I would like to thank you for giving me this opportunity to present the thoughts of the attorney general at this important hearing.

Senator Moss. Thank you, Mr. Wexler.

What you say about the enforcement power being primarily the suspension or revocation of license is a limiting factor in many of our States.

Are you attempting to draft legislation that would go before your State legislature when next it meets in legislative session?

Mr. Wexler. I have conferred with the health department on this, and we are beginning to look into the matter. We hope to confer with other States to see what experience they have had with other plans so that we can have some experience factor to work on prior to proposing a definite system to the State legislature.

Senator Moss. Have there been any considerable numbers of suspensions or revocations of licenses during the time that you have been active in this nursing home held?

Mr. Wexler. I have only been with the staff for going on 8 months now and we have not had any.

Senator Moss. Not had any in that length of time?

Mr. Wexler. That's right.

Senator Moss. Our hearings in other areas indicate that, even with this power available, the States have not used it very readily.

In Illinois, when we were having hearings over there, we found only one or two in a year, whereas there would be many allegations of violation, but they just wouldn't enforce the revocation of the license, giving the excuse sometimes that they didn't know what they were going to do with the patients if they did close the nursing home down. In that State we concluded that they don't have any enforcement at all.

I would hope, therefore, that there would be an active effort made to get a more comprehensive enforcement statute worked out here and passed by the legislature, and then have enforcement, strict enforcement of the statute, and, in that way, bring the nursing homes up to standard.

Mr. Wexler. I would agree. I think this is a twofold problem which we are aware of.

I believe Senator Tennessen mentioned that there is a problem as far as the staff is concerned with the department, the inspection staff, and I believe there is a realization on both parts that these are related problems.

Senator Moss. Thank you.

Senator Mondale.

Senator MONDALE. I would direct a few questions to both of you and whoever wishes to respond might do so.

ENOUGH PERSONNEL TO ENFORCE REGULATIONS?

Under State law, the Minnesota Department of Health, as I understand it, has the responsibility for licensing nursing homes, for certifying to the Federal Government for purposes of funding that they are in conformity with Federal regulations and law, and for inspecting nursing homes to see that they comply with State regulation and Federal regulation.

Is it your impression that the State has adequate personnel and adequate policies for enforcement to protect fully the occupants of nursing homes in our State?

Mr. WEXLER. First of all, as I mentioned, the board of health is involved in an extensive revision of their present nursing home regulations. When a revocation or suspension of a license is involved, it generally has to be based upon a violation of regulations.

Senator MONDALE. Yes. My question is, though, whether, in your opinion—and you may not know since you are new to that position—does the State have sufficient numbers of qualified inspectors, and does it have a policy of assuring that all of the nursing home occupants in our State are adequately protected?

Mr. WEXLER. I can only answer based upon several discussions I have had with the department personnel. Generally I would have to say "No."

I believe that Dr. Lawson will be testifying later.

Senator MONDALE. Very well. I will hold that question for Dr. Lawson.

Senator Tennessen, did you want to respond to that?

Senator TENNESSEN. Not particularly to that.

I agree with Mr. Wexler. A point was raised by Senator Moss earlier about enforcement, I think 1969 was the first time the Administrative Procedures Act, the formal hearing and so on, was ever invoked by our State health department to revoke a license. There were two or three instances in 1969 and 1970 and I am not sure whether there have been any since.

Prior to that time the former director of the board of health or executive director, whatever the title is, used to use friendly persuasion to encourage nursing homes that weren't up to standards to think about reducing their classification to a boarding care home. I am not sure the patients ever changed. I just don't know the answer to that. It is my impression that they didn't substantially.

Senator MOSS. Thank you, gentlemen. We appreciate your coming before us and giving this testimony.

As I was explaining to some students earlier before the hearing started, what we are doing is making a record here for the full committee to study and to be used in any legislative action that the Congress might take, and you have helped us in making a record.

Thank you.

Senator TENNESSEN. Thank you, Mr. Chairman.

Mr. WEXLER. Thank you, sir.

Senator Moss. Our next witness will be Mrs. Daphne H. Krause who is executive director of the Minneapolis Age and Opportunity Center. Accompanying her will be John A. Edie, counsel.

We are glad to have you, Mrs. Krause, and we look forward to hearing your testimony. We know that you have been deeply involved and very much concerned with this problem here in Minnesota, and we are hopeful to get in our record some of the experiences and some of the research that you have been able to do here to help us get a picture of how things are operating here in Minnesota.

STATEMENT OF DAPHNE H. KRAUSE, EXECUTIVE DIRECTOR, MINNEAPOLIS AGE AND OPPORTUNITY CENTER, ACCOMPANIED BY JOHN A. EDIE, COUNSEL; JIM VARPNESS, AND CHUCK WIESEN

Mrs. Krause. Thank you.

Mr. Chairman, Senator Mondale, I would like to introduce my attorney, John Edie, and two of our staff, Jim Varpness and Chuck Wiesen, who have helped and assisted in preparing this evidence.

Senator Moss. Thank you. We welcome you before the committee, gentlemen.

Mrs. Krause. I am most pleased to be invited here to testify before the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging, as you continue your inquiry into the Nation's nursing home problems. As all of you know, I have had great interest and devotion in these problems for more than 3 years.

Even before I assumed my present position as executive director with the Minneapolis Age and Opportunity Center, a private agency representing the senior citizens and presently receiving its funding from Model Cities, I had been greatly concerned by the complaints I had received from many nurses, residents, and family members who are associated with nursing homes in some capacity.

At first I dismissed these complaints as relating to the practices of a fringe number of poor homes. As time went on, my concern and anxiety increased, as I began to understand that those early complaints were but the tip of a most unwholesome iceberg.

My approach in those early days was to make these complaints known to the administrator of the nursing home involved or to the appropriate health department. My efforts were met with resistance, if not outright contempt. The examples I raised to justify my conclusions which I postulated were ridiculed by the industry as isolated instances, which impugned both my intelligence and my motives.

In the beginning I was greatly shocked by this recalcitrant attitude on the part of the industry, especially as I have always pointed out the good homes that exist. I can assure you there are and have been many fine nursing homes in Minnesota and in the United States. I applaud them for undertaking perhaps the most difficult job I know and for doing it superbly.

Elimination of Mayhood Law

In the face of the obvious opposition I was receiving in my efforts to improve the industry from within, I sought a new approach. I turned to elected representatives of this State. Some of them, including Sen-

ator William Kirchner, Senator Robert Tennessen, Representative Tom Berg, and Representative Raymond Wolcott, have been particularly helpful. Together we have been successful in eliminating the so-called Mayhood law which forbade the city of Minneapolis from passing any ordinances regulating nursing homes.

On the Federal level I have visited both of the Senators from Monnesota and with your office, Mr. Chairman, and with a great many other legislators. I want to compliment you particularly, Senator Moss, because of your more than 8-year devotion to these problems; you have been struggling with them long before they reached their lofty position as political issues.

One of the things I discussed with your staff some years ago was the possibility of this kind of a hearing in Minnesota. I also asked for advice on how to document the evidence I had been receiving so that no one would question its authenticity, its accuracy, or my motives. In short, I assembled a team of individuals to work with the staff of this subcommittee. It is my hope that what you hear today will convince you beyond the shadow of a doubt that the abuses and inequities you will hear about are widespread. This should come as no great surprise to you, Mr. Chairman, because of your recent hearings in Chicago where you heard the State health department admit that 50 percent of the nursing homes in that State did not meet minimum requirements. In your press release on the subject, you noted the results of a recent audit by the General Accounting Office that documented this situation in three more States, Oklahoma, Michigan, and New York.

Elimination of Substandard Homes a Formidable Task

I suggest that if 50 percent of the nursing homes in those States are substandard, and the same can be proved for this State, then President Nixon's promise to eliminate substandard nursing homes will be a formidable task, indeed.

What you will hear today is a result of 3 years' investigation, which involved more than 125 of our State's 431 nursing homes. My staff and I have taken voluminous testimony on this subject, some of which you see here (indicating), including: tapes, records, copies of complaints sent to the health departments at our request, records of services given to patients, photographs, exhibits connected with patient care, letters, statements, and affidavits, that I will ask to be entered into the record in full, together with 147 photographs collected.[1]

I will quote from parts of them, and you will hear from some of the witnesses themselves. The bulk of our testimony comes from nurses, aides, and orderlies who have worked in nursing homes. Some of our witnesses continue to work in these homes knowing if they resigned, conditions will further deteriorate.

When these affidavits were cross-correlated, certain patterns emerged. The same nursing homes appeared time and time again in testimony. Complaints about some homes given to us by relatives were often corroborated independently by nursing home employees who had worked in these homes. We were able to identify a number of very fine homes. We made a concerted effort to find these homes to illustrate the point that if we have these good homes, then there is no excuse for the bad.

[1] See Part 19B, pp 2231–1251. The photographs are retained in committee files.

We were also able to identify about 40 bad nursing homes. I suppose you would say, what do I mean by bad nursing homes? I am not talking about homes with minimal or temporary violations of standards. As everyone knows, the conditions in nursing homes vary somewhat from day to day. There are many variables. Often a nursing home's care will suffer when key personnel retire. But that's not what I am talking about. I am talking about nursing homes with a consistent pattern of poor care, where profits are more important than people.

In my discussion I will allude to these bad homes and to the recurring patterns we established which, in the words of Ralph Nader, prove that these abuses and the negligence of which we have heard are more epidemic than episodic.

Mr. Chairman, I would like to discuss the first cause of poor care. I have read your Ann Arbor speech and I certainly agree with your assessment of the principal root causes of the problems in the field of long-term care. To be sure, the United States does not have a clear Government policy with regard to the infirm elderly. If further proof were needed, we only have to look to the absence of the kind of medi-supportive services we have at MAO which enables the elderly to stay in their own homes unless nursing home care is clearly indicated. At the present time, a family confronted with the difficult problem of what to do with a loved one who has grown old and in need of help and services presently has no choices. There are no alternatives to institutionalization.

Built-in Incentives for Poor Care

The second cause is that our system has built-in financial incentives to give poor care. This country is unique in that we have 1 million seniors in nursing homes and that we entrust their care to proprietary health care facilities. Some 80 percent of our nursing homes are for profit institutions. The Federal Government is picking up almost 50 percent of the cost of nursing home care, and when the State's share is added, the taxpayer is picking up $2 out of every $3 of nursing home revenues.

It might be noted that the Federal Government, through the Hill-Burton program, through section 232 of the Housing Act, and through the Small Business Administration, makes grants, loans, and insurance available to aid in the construction of nursing homes. Typically, a for-profit nursing home may receive up to 90 percent financing.

After a nursing home is constructed it can count on a virtually guaranteed income at whatever rate that is set by the State legislature. Typically, many nursing homes receive $14 to $15 a day per patient, or about $450 a month for patients under the Medicaid program. Typically, the reimbursement to the nursing home is cut back if the patient is ambulatory. A patient flat on his back receives the highest rate of reimbursement in most States.

Each individual nursing home operator receiving $15 a day can then decide how much of that amount he is going to allocate to patient care and how much he is going to allocate to profit. There is no accountability whatsoever. The inescapable conclusion is that if the operator were to provide the kind of care that we would want him to provide to friends and relatives, then the $15 a day we pay is not

enough, it is far from enough. On the other hand, if an operator wants to cut care, primarily staff and food costs, he can make a fortune on $15 a day. The conclusion is, if you want to make money, make a profit, you must cut back on staff and food, thereby providing poor care. The more profit an operator allows himself, the poorer the care will be. Once again, there is no accountability.

Symptoms of the system are profiteering and penury. I'd like to give you some examples. These are excerpts from the affidavits which you have.

From the testimony of a nurse's aide, Lorraine Kippels, re: the Lexington Avenue Nursing Home:

> The administrator, Louis Thayer, doled out liquid soap an ounce at a time. * * * They rationed toilet paper and we had nothing to clean out bathtubs with. Mr. Thayer told us that Dutch Cleanser was against regulations.

From the affidavit of a patient, Hazel M. Gruss, re: The Richview Nursing Home:

> They told me I would have to go get somebody else's bedpan because they didn't have one for me. * * * There was also no table next to my bed so that I could keep a glass of water and my eyeglasses there. The home just did not have enough equipment. That same night I wanted to wash my face and hands, so I asked for a pan and some towels. They told me I couldn't wash my hands because they didn't have any towels.

From the affidavit of orderly John A. Marotz, re: the Capitol View Nursing Home:

> They reuse catheters at this home. They are supposedly cleaned and sterilized when they have been given to me to insert. However, I have found catheters that had sediment inside of them. Even though they reuse the catheters, they still charge the patients for the cost of a new one. Relatives have asked me why they are charged for a new catheter and I have to tell them that I have not used a new catheter but have put in a used one. * * * I am hired as an orderly but I also end up being a maintenance man, a janitor, and did general cleanup. I want to know why I am asked to carry down the garbage, to repair broken-down articles, to scrub the dayroom and clean up the urination in the hallways. It seems to me that they should have efficient maintenance men so that I can take care of the patients.

From the affidavit of occupational therapist assistant, Mrs. Sandra Dhar, re the White Bear Lake Nursing Home:

> In the winter this home is very cold. * * * I had to put coats over the doors and blankets around the cracks in the windows. They keep the thermostat locked up. I had a key for it. I would go and turn it up. However, next time I came back it was turned down again * * * at times as low as 69° or 65°.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

> When they serve hamburger for dinner, they have 15 pounds of hamburger for 144 patients plus the people that work there. As an example, there was a patient we called Tiny. * * * Before he died he always would say to me, "Jesus Christ, Marx, I'm starving to death." I often took food from home for him, but he was always hungry.

The third major cause of the poor care, the negligence, and the abuse that exists in our nursing homes is the fact that physicians do not provide medical care to patients in nursing homes.

The fact is physicians simply do not view the nursing home as part of the medical continuum. President Nixon acknowledged this in his speech on nursing homes last June in Chicago. He indicated that

doctors don't go to nursing homes because they get depressed and they feel they can't do much for patients anyway. They also feel that with limited time and resources they should devote their attention to the younger members of society because the elderly have lived their lives. A direct consequence of the physician's absence is that the registered nurse gives the medical care, or that untrained aides give the needed medical care, or it isn't given at all.

I would like to read from affidavits concerning this.

From the affidavit of nurse's aide, Barbara Lace, re the David Herman Nursing Home:

> At the home there are people who have not seen a doctor in 2 years. In the time I have been there, I think I have only seen a doctor three times. I don't see how a doctor can prescribe medications and treatment to a patient over the phone. This is done all the time.

The above is confirmed by another aide at the David Herman Nursing Home in the affidavit of nurse's aide Debbie Kleppinger.

According to the affidavit of nurse's aide Gladys E. Danielson, re the Bryn Mawr Nursing Home: A patient, Mrs. One, at the Bryn Mawr Nursing Home was transferred to the nursing home after a bladder operation. The staff told the aids that the stitches should come out in 2 weeks.

> I talked to the nurse administrator, Mrs. Coleman, and she said it would be taken care of Monday. Then on Monday I asked her if the stitches were to come out and she said, "No, let the doctor do it." So I let it go at that and continued to take care of her every morning. Then I was gone from work there until she died.

From the affidavit of Mrs. Gloria Johnson, the daughter of the patient just mentioned, re the Bryn Mawr Nursing Home: Mrs. Gloria Johnson, the daughter of the patient, confirms the testimony of nurse's aide, Gladys E. Danielson.

> There was no follow-up by the doctors from Methodist Hospital, nor did Bryn Mawr see to it that her postsurgical condition was checked or her stitches removed by a doctor. * * * On May 12, 1970, my mother entered the Bryn Mawr Nursing Home. At no time from the point she left Methodist Hospital to the day she died on June 12, 1970, did she see a doctor. * * * I have since contacted the Minnesota State Board of Health to complain of the negligent treatment my mother received. I was informed by Mrs. Ruth Larson of the State board that at no time did the Bryn Mawr Nursing Home even have any medical records of my mother. They did not even know what she had been operated on for at Methodist Hospital.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

> The house doctor at this nursing home is Dr. Mateo, and I wouldn't let him take care of my dog. I have a PDR and I do look up my medications that I give and I know what I'm giving. But I cannot see why Lasix and Diurel are constantly given to the patients every day. When Lasix and Diurel are given to a normal person to relieve water, it will give them muscular spasms in their legs because you're using the potassium in your body. These drugs are for patients that have water retention, they get rid of the water. But the patients, particularly the bed patients, are not even getting enough water to drink; yet, Dr. Mateo prescribes Diurel and Lasix for them. They're dried up, they're dehydrated, and it's inhumane.

From the affidavit of L.P.N. Nancy L. Fox, re the Kenwood Nursing Home, an excerpt from her letter to Dr. Davidner:

> Since you are the house doctor of the Kenwood Nursing Home, I have, for quite some time now, observed your approach to these elderly patients.

Your last visit occurred a couple of weeks ago. On that day you arrived early and I had not yet put on my nurse's cap. The supervisor was off all day and you assumed, obviously, that I was an aide.

All 13 patients had been psychologically prepared for your visit. I had told them you were coming and to be sure to explain all those things which had been bothering them * * * that you would listen and do all you could to relieve their anxiety and pain. They were all awaiting your visit with high hopes.

Unknown to you, Doctor, I timed your visits with them. You started rounds at 9:50 a.m.. You finished at 10:10 a.m. That meant that you spent exactly 1½ minutes, on an average, with each patient. Not one of them did you examine. Your satchel remained on a chair in the hall, unopened. You handed out new orders as glibly as one scatters seed to the birds. * * *

One patient, in particular, you insulted. You said to * * * (him), when he complained legitimately of his chronic severe back and other pains: "All you need to do * * * is to go out and find yourself a nice blonde." * * * The patient can hardly walk and shakes violently nearly all the time.

The fourth major cause of our nursing home problems is, of course, reliance on inadequate, insufficient, and poorly trained staff. With the physician absent from the nursing home, the medical care is either given by the nursing staff or it isn't given at all. We will see that the responsibility for nursing care falls primarily on the nurse's aids and orderlies, hired literally off the street and paid the minimum wages, at the same time asked to undertake one of the most difficult jobs imaginable. Because the aides are untrained, perhaps unschooled, overworked, and poorly paid, poor care results. Nurse's aides on their own initiative prescribe drugs for patients and even assess the cause of death to be recorded on death certificates.

For the beleaguered nurse's aide tranquilizers are a happy solution. If patients are sedated, they cause the staff few problems. The administrator is happy, too, because bed-bound patients bring the highest rate of reimbursement.

From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

There is a heavy use of tranquilizers on our floor. We had a discussion about this once and I got kind of angry and told the nurse. There have been times when they woke the patients in order to give them tranquilizers so that the patients would stay out of their hair. By keeping the patients drugged up, they are being turned into vegetables. Many of these patients are having psychological problems that are not being treated. They are medicated so that we don't have to deal with them.

From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

This nurse would also deliberately increase the dosage of a sedative much higher than the prescription in order to quiet down patients, but then she would put on the chart that she had administered the required dosage. She would take sedatives from the prescriptions of other patients in order to do this.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

The registered nurses on days have aides that never had a day's training in their lives, going around irrigating sores, putting on dressings, giving treatments, and irrigating and inserting catheters. * * * Mrs. Lehman, an aide with a skin disease, inserts catheters with an infected hand.

From the affidavit of nurse's aide Debbie Kleppinger, re the David Herman Nursing Home:

The medications are available to either an RN or an aide. On weekends and at night the aides have the keys to the medications room.

Since I began working at the home I have received no real training. I have never worked in a nursing home before and the only training I received was on

the job and that was given by another aide. No other aide I know who works there has got any formal training from David Herman. Within a few days after I started I was completely taking care of eight people. When I began I was not asked to have a medical check-up or a chest X-ray and have not since been asked.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

My impression was that they would hire anyone off the streets who would come and could stand the conditions and would accept the wages they offered.

I was given absolutely no training whatsoever in the passing of medication; however, I did this on a regular basis. Nurse's aides would also pass medications, and they did not have training in the effects of medications. All the nurses, nurse's aides, and orderlies had access to the narcotics cabinet. It was very common when there were drugs left over from a patient who had left or had died to re-use these drugs.

Other examples indicating aides have the keys to the medication and narcotics containers include:

(a) From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

On my shift an aide would work the first floor and had the key for the medications. This aide would set up the medications and pass them, and then would set up the medications for the morning shift.

(b) From the affidavit of nurse's aid Barbara Lace, re the David Herman Nursing Home:

The setting up of medications should be done by an RN, but on weekends, the key to the medications room and the narcotics cabinet is given to aides. I have seen a nurse stealing meds.

(c) From the affidavit of Occupational Therapist Assistant Sandra Dhar, re the White Bear Lake Nursing Home:

I have seen aides training aides to set up medications for passing. In direct violation of state regulations.

(d) From the affidavit of L.P.N. Nancy Fox, re the Woods No. 2 Nursing Home:

Medications have already been meted out onto trays by the night aide. Here, aides pour and administer medications, in spite of the fact . . . that they have no idea what they are giving or why. Digitalis is shoved down throats, pulses are never taken.

(e) From the affidavit of nurse's aide Gladys Danielson, re the Bryn Mawr Nursing Home:

There is a constant problem with the giving out of medicines. There is an aide who has no nursing training who occasionally gives insulin injections. On one occasion she gave one diabetic patient an injection of insulin in the morning and did not mark it up in the day book. Later that morning an L.P.N. gave her another injection, and I had to feed her sweets all day long.

Medications are often set up by aides, only occasionally by R.N.'s. They make mistakes often. They mix up the pills or leave some out, and the aides do not check to be sure the pills are taken. Many times my sister has found pills of my mother's on the floor at night.

From the affidavit of relative Ann Hurwitz, re the Crystal Lake Nursing Home:

This was on the evening shift, of course, when there was only one nurse to care for about 130 patients.

From the affidavit of relative Milton Abramson, re the Texa-Tonka Nursing Home:

The nurses on duty in these nursing homes are more aware of the conditions than anyone else. An example is a Mrs. Kuehne, R.N., at Texa-Tonka. I heard her deliberately falsify an accident report and also another report on a woman who died.

The fifth and last major cause of poor care is lax enforcement of existing standards and regulations. Certainly enforcement is the major thrust of President Nixon's new nursing home initiative. The President, Secretary Richardson of HEW, and Dr. Arthur Flemming, Chairman of the White House Conference on Aging, which convenes today in Washington, D.C., have been uniformly critical of the haphazard manner in which State health departments have enforced existing standards.

Our State is no exception. I am informed that in the most recent studies conducted by the Department of Health, Education, and Welfare, the State of Minnesota is far from meeting acceptable standards. One of the principal criticisms is that HEW found virtually no communication between the State's department of public health and public welfare. And that is a fact.

To this point, Mr. Chairman, as you suggested. I have addressed myself to the major cause of problems in the field of long-term care. It is appropriate, therefore, at this point, that we focus now on effects.

I. The first and most devastating result or effect of all these problems is negligence which leads not only to poor care but to injury and death of patients. Some examples follow:

From the affidavit of orderly John Marotz, re the Capitol View Nursing Home:

There are some examples of very bad bedsores in this home. In particular there was one that was so bad that a part of the tailbone had been eaten away. This patient died a year ago.

From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

One of the patients there was a retired dentist whose name I do not remember. His wife was dead and he had no relatives or friends that I know of. He had been treated for a bed sore by a heat lamp. Whoever had put the heat lamp on him had forgotten about it and just left it there. When I came on duty I had to treat him, and he had third-degree burns on his back. I was not there when the burns were incurred, but I did take care of the problem when I was on duty.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

This orderly also gave an enema to a patient named Mr. Two when he was sitting up on a commode. Enemas were supposed to be given when the patient was lying down in a bed. So when the enema was given this way, sitting up, at that angle you're pushing against the insides and the colon and something has to give. This is what happened. It ripped his insides and he died from hemorrhaging and shock.

Another patient, Mrs. Three, had her foot stepped on by this orderly, and another orderly was accused and called on the carpet for telling the relatives. But what happened is this:

After the orderly stepped on her foot, she was in her right mind and told her daughter about it, and the daughter complained to the owners. The patient had two broken toes, but nothing was done about it. By the time she was taken to the hospital she had gangerene in the leg, and it had to be amputated. She died about 3 weeks later.

From the affidavit of relative Blanche Lang, re the David Herman Nursing Home:

Later we noticed that my brother's toes were black and that it was beginning to spread. The nursing home people had paid no attention to it. It was only at

our insistence that we got my brother out of there to a hospital where his leg was removed.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

Mrs. Bustamante admitted this patient, and I was told that she had something done with her spleen. So we were to watch her for an insulin reaction. I checked her at 12 midnight and she was all right, and again at 4 a.m. and she was in the same position. I walked over and she was already stiff. I tried to get in touch with her son, but I couldn't. About that time an aide came out and showed me a bottle she had found in her waste basket. I looked at it and it was an empty nembutal bottle which had been issued the day before by her doctor. So I wrote that in the book: "Patient found dead, empty nembutal bottle found in wastebasket." When the personnel director, Mrs. Walls, found that in the book, she cut that out real quick. She said to me, "For heaven's sake, don't say nothing about this. Write this over again. We don't want anybody to know this." Later I found out that Mrs. Bustamante admitted her and never checked her pocketbook for that kind of drug. The son told us that she had threatened suicide if he ever put her in a nursing home. They found out at the postmortem that she had taken the whole bottle of nembutal.

From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

We have only two people who need to be constantly restrained in geriatric chairs all day. The amount of time they are under restraint is not logged. One of them has a catheter. He has cancer of the prostate and can't urinate by himself. We tried to take out the catheter once and it was all bloody when we pulled it out. It had grown to his bladder.

From the affidavit of Ann Hurwitz, R.N., and relative, re the Trevilla of New Brighton Nursing Home:

At one point in August 1970 she, a patient, was in so much pain when they put the catheter in that she went into shock.

From the affidavit of relative Georgia Biller, re the Asbury Hospital Nursing Home Section:

Many cruelties and indignities were experienced by my mother, her hands were tied, food was shoved down her partially paralyzed throat so fast she almost choked to death many times. The food was very poor and cold. Her calls for the bedpan were mostly always ignored until she could not contain herself and she was left for hours in a wet bed. She had one very large bedsore about 4 to 5 inches in size which caused her extreme pain and which they did nothing about. They left a window open by her bed in the winter, she was always very cold, she finally developed pneumonia. The doctor refused to come, stating that there was nothing he could do, and she was left to die without the help that might have been given her and saved her life. It's shocking to me that this could happen to one of our senior citizens in this United States.

II. The second significant result is unsanitary conditions which can easily result from efforts to save money or, of course, from having inadequate staffing.

To make this point, I would like to introduce Myrtle L. Tenney and Dan Henry. Myrtle was a patient in the Queens Nursing Home and Dan was an orderly at the 2200 Park Nursing Home. Dan now works in another nursing home and Myrtle lives independently. I want them to read a brief portion of their affidavits.

Before they do so, I would like to tell you something.

We did not sleep last night because of the threatening calls we received. Mr. Henry received a threat of bombing in his apartment, a fire rig was called out, and there were other disturbances. We finally brought him into our office.

Perhaps I have gotten a little used to harassment over the last 3½ years, but it is very difficult to hear a witness say that he really was on the point of nervous prostration with this kind of harassment.

Senator Moss. Certainly, there is no justification for anything of that sort, and it is shocking to hear that it occurred. I have no response to it other than to say that anyone responsible for threats of that sort should be prosecuted immediately and to the full extent of the law.

We will be glad to hear from Mrs. Tenney and Mr. Henry now, so you may proceed.

Senator MONDALE. Might I ask some questions?

Senator Moss. Yes.

Senator MONDALE. Mr. Henry, would you confirm what Mrs. Krause said?

Mr. HENRY. Yes; I will.

Senator MONDALE. What happened? When were you called?

Mr. HENRY. I was called at approximately 10 minutes of 3. This individual said something to the effect, "I put a bomb in your house," he said, "so, therefore, you will not be able to testify tomorrow."

Senator MONDALE. Then what did you do?

Mr. HENRY. See, I was semiconscious, I had been sleeping, and so I just hung up the phone. I called up Daphne's office immediately and I talked to a police officer there. He sent a sergeant out to look over my premises and then a half an hour elapsed and a firetruck pulled up, and that was too much.

Senator MONDALE. I join with Senator Moss. I hope that will be immediately referred to the appropriate officials. That is not the way we behave here in Minnesota, and this must be looked into.[1]

Senator Moss. Yes, Mrs. Tenney.

STATEMENT OF MRS. MYRTLE T. TENNEY, PATIENT[2]

Mrs. TENNEY. Mr. Chairman and Senator Mondale, thank you and God bless you for being here with us today.

My name is Myrtle Tenney, and I live at 800 Fifth Avenue, North, Minneapolis, Minn.

On January 19, 1967, I had an operation done on my foot in General Hospital in Minneapolis. The bandages on my foot were changed 1 week after my operation. Two weeks later, on February 8, 1967, I went to the Queen Nursing Home at 300 Queen Avenue, North, in Minneapolis. My bandage had not been changed during that 2-week period, and no footbaths.

I stayed at this home for 13 days. While in the Queen Nursing Home, I knew my foot was getting infected. It was getting swollen and was turning colors on me, and it was very, very painful. I just lay there and cried and begged to see a doctor, but no doctor was called. It was 2 weeks from the time I entered the home before I was allowed to go back to see a doctor at General Hospital. By that time the infection was well set in. In 4 weeks, the bandages were finally removed. They had to be soaked off. A nurse had to use a tweezer-like device and soak it a little while more before she could pull it off. The gauze had grown into the old blood. After seeing the doctor, I would not go back to the nursing home except overnight. The next day I went to

[1] See appendix 4, Part 19B, p. 2426.
[2] See affidavit, Part 19B, p. 2343.

my daughter's home where I could soak my foot five and six times a day. May I say when I did the infection really oozed out?

I could not get the care I needed at the home. My bill was paid for by welfare.

Now I am receiving medical assistance and I have my own doctors, for which I am very grateful to welfare.

Senator Moss. Do you live at your daughter's home now?

Mrs. Tenney. No; I am by myself. My daughter is now moved to Houston, Tex., so the last one is gone.

Senator Moss. I see.

Mrs. Tenney. The bathroom condition in the nursing home was filthy. I was on the third floor where all the senile and mental patients were. They mixed senile with the normal. There were two bathrooms on the floor, but both bathrooms were used by men and women. Some of the patients were not too careful when they went to the bathroom. As a result I had to walk with my bandaged foot in urine on the floors of the bathroom.

I had the janitor bring me a bunch of clean rags, which I hid under my mattress. Then I would take two or three rags with me when I went to the bathroom, to tie them on my walker as I made my way to the bathroom. I didn't have very good balance, so when I got there I would drop one rag on the wet places and try to mop up the mess with the legs of my walker. I was not able to bend over very well to do this. Then I would use another rag to put down by the toilet to put my feet on. They were wrapped in gauze, you know. The third rag I used, after wetting it, to wipe up the toilet seat that many times was full of feces.

The medication at night was given to us by aides not in uniform. I didn't have any change of bedding in the 2 weeks that I was at Queen Nursing Home. But if I had stayed there one more day I would have received a change of bedding, I was told.

Your personal things are not safe there. Whatever you have, you've got to practically nail down if you don't want it missing.

I felt like a prisoner there. I never had access to a telephone.

Seniors are truly afraid to go to nursing homes for fear they will get into a bad one. It is a difficult thing for seniors to even talk about. We would rather sit in a small room all alone, with nothing, than to have to go to one of these kind of nursing homes. My relatives even asked me to come to Norway to live with them because they in Norway do not treat their old people like we do here in America.

Now, I know that you have my affidavit, and there are other things there that concern me very deeply, but I know that you are going to be reading it. I want to thank you for listening to me and for permitting me to be here and I want you to know how grateful I am that I was one that got out.

Senator Moss. Thank you, Mrs. Tenney, for coming and giving us your statement of your personal experiences. Terrible as they were, they do serve a purpose now in the record we are making to see if we can make it impossible for these things to continue, and we hope we can.

Mrs. Tenney. I am sure that you are trying and you have been trying for a long time and I certainly appreciate it.

Senator Moss. Thank you, Mrs. Tenney.

Mr. Henry.

STATEMENT OF DANIEL HENRY, ORDERLY, MINNEAPOLIS, MINN.[1]

Mr. HENRY. Mr. Chairman and Senator Mondale, my name is Daniel W. Henry. I live at 3132 Chicago Avenue, South, in Minneapolis, Minn.

I am employed by the Bryn Mawr Nursing Home, but I am here to comment on the unsanitary conditions of the 2200 Park Nursing Home, located at 2200 Park Avenue, South, in Minneapolis, Minn. I have had some psychiatric technician training at the Faribault State schools and hospital.

I worked for the 2200 Park Nursing Home from March until June 1971. I was scheduled from 11 p.m. to 7 a.m. and was stationed on the second floor where most of the residents who were unable to care for themselves lived. I feel that it is imperative that I comment on the smells, odors, and the general condition of 2200 Park Nursing Home, as I would never allow a relative of mine to reside in such an unbelievable environment.

Every night that I worked, I would attempt to get there as early as was possible, and that would be between 10:30 p.m. and 10:45 p.m. As I arrived at work and walked into the building, the smells were so atrocious that I would say to myself, "I'm going home and call in sick." The odor of feces and urine seemed to hit me immediately, but the smells were not as bad on the first floor as that floor was the home of the ones who could take care of themselves with little or no assistance. As I walked up the stairs to the second floor, the odors became stronger with each step. The more it smelled, the more I would contemplate that I should go home, but then I would realize that there were residents on the second floor who needed someone to care for them.

As I entered the second floor, the first thing that I would see were puddles of urine all up and down the hall and as I walked down the hallway my shoes would squeak on the urine on the floor. My feet literally stuck to the floor. This was the condition all up and down the hallway, not one night, but every single night I went to work at 2200 Park Nursing Home.

The only exceptions on this floor were the rooms where residents were not incontinent. But even in these rooms there was a sticky trail of urine where the resident walked to and from the bathroom.

The fact that urine and feces were so visible on the shift that I worked is appalling, and in order to walk into some rooms I had to put towels on the floor. This is not true of only one night I worked, but every night.

Because of my experience working at 2200 Park Nursing Home, I therefore feel justified in stating that I would never allow a relative of mine to reside in a home with such unsanitary conditions.

Thank you.

Senator MOSS. How long did you work at the Park Nursing Home?

Mr. HENRY. From March to June.

Senator MOSS. Then you resigned, did you, is that how you terminated?

Mr. HENRY. Yes, sir.

Senator MOSS. You are, though, still working in this general field at a nursing home?

[1] See affidavit of Mrs. Henry, Part 19B, p. 2227.

Mr. HENRY. Yes; I am.

Senator MOSS. Senator Mondale.

Senator MONDALE. Did you complain to the management of the nursing home?

Mr. HENRY. To tell you the truth, I have never seen the administrator of 2200 Park Nursing Home. The nursing supervisor and I—I would go there and tell her something and she would tell me something, she would lessen my standing in the establishment.

Senator MONDALE. Did you work under her? Was that your job, working under her?

Mr. HENRY. On some nights, I did.

Senator MONDALE. Would you complain to her?

Mr. HENRY. No; I'd complain to the licensed practical nurse in charge most nights.

Senator MONDALE. What did she say?

Mr. HENRY. She just said, "Well, we will see what can be done about it." She said, "This is the night shift, not day shift." Day shift was the shift that the place was to be cleaned by.

Senator MONDALE. Had you worked in a nursing home before?

Mr. HENRY. No, sir.

Senator MONDALE. This is the first one. You now work in another nursing home. Does that have the same conditions that you have testified to in the first nursing home in which you worked?

Mr. HENRY. No, sir; it does not.

Senator MONDALE. Thank you.

Senator MOSS. Thank you, Mr. Henry. We appreciate your testimony and we are glad to have you before the committee.

Thank you.

You may proceed, Mrs. Krause.

Mrs. KRAUSE. Thank you, Mr. Chairman.

III. The third result growing from the combination of causes mentioned before is poor food. To make a profit in a nursing home an operator must cut back on staffing and food. Poor food is one of the most frequent complaints in nursing homes. As so many people have mentioned, it is about all that patients have to look forward to.

From the affidavit of R.N. and relative Ann Hurwitz, re the Heritage of Edina Nursing Home:

> The food itself was not very good, and it got worse after Mr. Leaf, the administrator, left, and was replaced by a new administrator, Mrs. Niebold. She cut the food proportions down to starvation portions. For example, one menu was a half cup of thin soup, a half piece of bread, and one apricot. This was an evening supper.

From the affidavit of R.N. and relative Ann Hurwitz, re the Trevilla of New Brighton Nursing Home:

> As for food out there, dogs eat better. My mother got a puree tray. She got two tablespoons of meat, four tablespoons of squash, and then one scoop of dry potatoes. And this was the meal every day, the same thing over and over again. I brought jello and tapioca and bread from home every day to supplement her food.

From the affidavit of relative Milton Abramson, re the Texa-Tonka Nursing Home:

> We saw "Reuben sandwiches" served to patients with no teeth. The staff claimed this was what the dietitian had put on the menu. We had to take the meat and cheese out of the sandwich for my mother. There was no way she could chew the hard bread.

From the affidavit of relative Marian Villas, re the Heritage of Edina Nursing Home:

The food was horrible. My mother had impaired eyesight and really needed help in cutting meat and eating. I walked in there one day and my mother had a piece of roast beef that I know wasn't any thicker than your shoe leather, and it was so tough that she had it in her hand and was chewing on it like an animal. No one had even come near her to help her.

One time I saw creamed chipped beef served. It was served cold and the cream sauce was crusty. I often went to the kitchen to get an extra dish of ice cream for my mother, who could not eat much of what was served on the unattractive trays. There was an assistant cook or cook's aide who finally let it be known that if I supplied her with a shot of liquor now and then, she would make sure my mother got more to eat.

From the affidavit of orderly John Marotz, re the Capitol View Nursing Home:

Sometime around the middle of September, the home served hot oatmeal for breakfast. There were worms in the oatmeal. This was not the first time that worms had been found in the food. It usually happens on and off during the summer. On this particular day in September I had passed out all of the trays to the people who could feed themselves. When I got the tray for one of the male patients that I fed, I put the sugar on his cereal and started to get a spoonful when I noticed something black in the oatmeal. I looked at it closer and found out that it was a black bug. I looked more carefully through the cereal and I found a lot of bugs in it. I found some smaller white bugs with black heads. I immediately went down and reported this to the kitchen. We tried to get as much of the oatmeal away from the patients as we could, but many of them had already eaten it. The cook told me that she had taken the meal from an open box that was kept in the kitchen area.

One time they made Kool-aid with soap.

One thing that I forgot to mention about the bugs in the cereal was that when the head nurse, Miss Bustamante, found out about it, she said to feed it to them anyway. The food is so bad at this home that I don't eat it anymore. I refuse to eat it. Every time I have eaten there I have had diarrhea.

From the affidavit of relative Ann McAllister, re the Heritage Nursing Home:

I saw people grabbing food off trays because they were starving. This woman was removed from the home within 24 hours of coming in there. She just was not getting any attention.

From the affidavit of L.P.N. Kay Schallberg, re the Weldwood Nursing Home:

I had a lot of problems with the janitor, whose first name was Alex, who lived in the basement. He did not have any cooking facilities down there, just a bed. On the weekend nights I constantly would see him drinking. He would use the kitchen of the nursing home to do his own cooking and, not only that, he did some of the cooking for the patients; at least he did the cooking for the breakfast in the morning. He would use the same uniform that he used to clean up the hallways to go into the kitchen to cook with. Oftentimes it was very dirty and had fecal matter on it. Twice while I was working there I had to call the police in to take this janitor to jail because he had become so unruly and drunk, and was interfering with the work, and I couldn't handle him. This went on every weekend but I only had to call the police twice. Almost every night that I worked there, there was meat setting out in the open uncovered to thaw out. More than once I know this meat was left out for more than a day and always this meat would get very discolored. The kitchen was filthy. They never cleaned the floor. There was always dirty dishes and food left out lying around. They did not have a kitchen staff to speak of. The aides would work in there sometimes. Mrs. Hector, who was the wife of the owner, would come in to help out in the kitchen.

IV. The fourth effect we have called hazards, which refers to the threat to life because of inadequate physical plant, because of the possibility of fire and unclean conditions leading to illness or injury.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

During the 4 months that I was working at this nursing home I was never oriented as to what to do in case of a fire. They never explained to me what the procedures were or where a fire escape was, if there was one. The only instruction I was given was to close the patients' doors.

From the affidavit of L.P.N. Kay Schallberg, re the Weldwood Nursing Home:

Once before I left this home I complained to the fire marshal in Golden Valley. Sometime during the day he came out and looked the place over. He said that they had to unblock the door to the storage room in the basement. This door was blocked with suitcases, beds, and other stuff. Except for a stairway and elevator, this door to the storeroom was the only exit. There were no windows in the basement. If you were standing on the floor of the basement, the ground level would be above your head. There were three nonambulatory patients living in this basement when I worked there. One of them was a 19-year-old quadriplegic. A retarded aide and the janitor also lived in the basement. The fire marshal left a sheet of instructions of things to be done. None of them were ever done.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

This isn't an old building, it was built in 1965, but there are bugs in some of the rooms and closets, and mice, and one time they found a dead rat. But they get by with as little as possible. There are approximately 42 patients on each floor, and normally only four aides on days and a couple of orderlies to give patients baths, change bedding, clean, and take care of the patients' personal needs.

From the affidavit of orderly John Marotz, re the Capitol View Nursing Home:

The smallest of the two elevators is constantly in need of repair. A lot of the time it will miss the floor by 3, 4, sometimes 6 inches. Sometimes it will even stop in-between floors.

V. The fifth problem we describe is lack of dental care, lack of psychiatric care, and podiatry or foot care.

A. An example of the now closed Pillsbury Nursing Home is a typical one with regard to dental care:

From the affidavit of relative Berdene Eyford, re the Pillsbury Nursing Home:

When Lillian was taken to Mount Sinai Hospital, they took her teeth out and they were just filthy. They had not been taken out for some time and were glued to her mouth. On that Saturday night before she was taken to the hospital they had time to put curlers in her hair, but they didn't take care of her teeth.

From the affidavit of R.N. and relative Ann Hurwitz, re the Heritage Nursing Home:

One day I came in and she had someone else's teeth in her mouth.

Referring to her mother.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

In the morning the patient's dentures were always put back in their mouths without being cleaned. I don't believe that the dentures were ever cleaned for these patients during the whole time that I was there. They were corroded.

B. Lack of psychiatric care.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

The judgment as to what patients are put together is based on whatever room they've got available and they can get the most money out of. They don't consider the mental state of the patients.

From the affidavit of Grace A. Gorczyca, relative, re the Lexington Nursing Home:

They had a roommate in with my sister who was a little confused and always upset. For example, one day my sister went over to move the window up a little bit and her roommate got her very upset and even went over and bit my sister on the arm. They finally got her out of my sister's room. I don't think they should mix up people who have a normal state of mind with those who don't.

C. Lack of podiatry.

From the affidavit of relative Signe Johnson, re the Richview Nursing Home:

There was another woman at the home that always walked around barefoot. She had palsy and I asked her why she walked around barefoot since it was so cold. She told me she couldn't put shoes on because they hurt her feet too much because no one would cut her toenails. Many people there seemed to have trouble with their toenails. Twice while I was there I saw this woman with the bad toenails fall and hurt herself badly. At least once she had to be taken to the hospital because of these falls.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

Toenails and fingernails were never cut during my shift. They were supposed to be cut right after their bath, but the baths were not given on our shift. Many times the toenails got so long that they grew around and grew into the toes underneath. The toenails of the majority of patients on the second floor were in that condition. I would say that approximately twenty-five patients had this condition.

VI. There are even numerous recorded cases of deliberate physical violence against nursing home patients. A few examples follow:

From the affidavit of L.P.N. Nancy Fox, re the Woods No. 2 Nursing Home:

One week, after my repeated pleas that a doctor be called because of an obviously injured foot caused by a fall due to neglect, the director, nevertheless, refused to look at it and allowed the aide to continue to try to walk the patient whose name is Mrs. Five. Mrs. Hanson, an aide, then spanked the lady for not cooperating, while she wailed pitifully. Days later, upon my return, I found they had finally called the doctor and his verdict was "severe sprain."

From the affidavit of nurse's aide Beverly Krueger, re the Capitol View Nursing Home:

There was an incident involving a patient by the name of Mrs. Six. She had fallen out of her chair. When Miss Bustamante, the head nurse, came to see her, she walked over to her, sort of kicked her with her foot and told her, "Mrs. Six, you can get up by yourself since you fell down by yourself." She gave instructions that no one should help Mrs. Six get up because it was her own fault and, therefore, she should help her own self to get up.

Some of the treatment that the patients receive at this home is uncalled for. I have seen situations where patients scream and yell and staff people have stuffed washrags into their mouths. I saw a patient named Mrs. Seven mistreated. I saw an aide spit in her face. I have seen an aide slap a washcloth across the face of a patient.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

One night at 10:30 I walked into a room of one of the patients. There was a nurse's aide there who did not work on my shift but worked on the shift that ended at 11 o'clock. The patient was really cussing out this aide. The nurse's aide threw a glass of water in her face and then slapped her five times across the

face. I told her that I was going to report her and she started to cry and said, "Please don't." She gave me the excuse that she was mentally retarded. I said, "Then why are you working in a place like this?" She said, "Because I need the money."

If acts like these examples were done in the community or to children, they would be called by another name. It causes me to question, Mr. Chairman, whether justice or protection by our laws ends at the nursing home door.

VII. There are also numerous examples of misappropriation and theft in the nursing homes. It seems that anything is worth stealing. On the other hand, some things merely get lost because the staff can't keep track of the personal effects of patients. In other instances, money belonging to patients, whether in cash or checks, has been apparently appropriated to their own use by unscrupulous operators. Here are some examples.

From the affidavit of relative Louise Craft, re the Queen Nursing Home:

On the second day that my husband was in the home after I had brought these clothes in all the long underwear was gone except for two pairs; all the dress shirts were gone; all the slacks were gone; all the pajamas were gone; all the socks were gone; and all the handkerchiefs were gone.

From the affidavit of relative Ruth Lehman, re the Crystal Lake Nursing Home:

Money was stolen from Mrs. Eight while she was in this home. Mrs. Eight had a little money in her billfold. Bud would see to it that she always had a little money to spend if she needed it. She got $9 a month from the welfare and he'd always give her a little bit more in case she wanted to get a permanent or something. At one point she had about $50 in her billfold because she wanted to get her hair fixed and buy a few things. So Bud wanted to make sure she had enough money so that on the week end she could do what she needed to do. But Mrs. Eight never did get a chance to go down to do that at that point, and a few days later she told Bud that she didn't want to keep that much money around and would he please take $35 out of there and leave her $15. Bud said OK and went over to get the money and it was all gone, someone had taken it. . . . She had unfortunately no place to lock this money up, and at one point someone stole over $100 from her. She was so upset from this that she didn't sleep for a week.

From the affidavit of orderly John Marotz, re the Capitol View Nursing Home:

Often they will leave the home without their teeth, without their rings, watches, and without any personal effects which they had come in with. One patient bought a brand-new suit because he knew he was going to die before too long. When he died he left the home without that suit. It was never found. * * * Employees regularly take food and groceries from the home. One time a 50-pound roast disappeared.

From the affidavit of nurse's aide Barbara Lace, re the David Herman Nursing Home:

Of the welfare money allotted to the patients, they are allowed to keep $2 with them on the floor. Any more than that is kept in the office. If they go to the hairdresser, the transaction is then carried through the business office. However, there was a woman who received $5 for a Mother's Day present. They talked her into putting the money in the office. She agreed and was assured that she could get the money any time she wanted. When she wanted to sent it to a grandson, someone went down to get it and they were told that the $5 had been taken because the husband owed the nursing home $25. Now he owed them only $20.

VIII. Another major consequence of the causes related earlier in my speech is the lack of adequate control on drugs in nursing homes.

We have already documented this problem in terms of the untrained staff personnel passing out medications, having access to medications, including narcotics, and prescribing tranquilizers on their own initiative. The problem of the flow of drugs throughout the nursing home is almost completely without controls. Some examples follow below:

From the affidavit of L.P.N. Nancy Fox, re the Woods No. 2 Nursing Home:

> Phenobarbital is not kept under double lock. Old medications from patients who have died remain for months in the medicine closet.

From the affidavit of L.P.N. Ellen Marx, re The Capitol View Nursing Home:

> Another thing is the way they handled the medications. When I was on afternoons, when a patient expired or went to another nursing home, if no one asked for the medications, these medications are taken somewhere. I have seen large cardboard cereal boxes full of these drugs by the office. Every once in a while a medicine bottle will turn up with the prescription label ripped off and a piece of tape across it. The tape will have the patient's name and the name of the drug on it. I know where the narcotics go. They go in Miss Bustamante's office and she writes "Out of Stock in Office." She keeps narcotics in her office and she's not supposed to. They have to be taken back to Federal Narcotics.
>
> Other times I have seen large rolls of prescription labels which said "Grant Street Drugs or Pharmacy." So they would reuse the drugs. For example, a bottle of Darvon was prescribed for a patient, that would be about $9, and then if the prescription was changed to Equagesic, the Darvon would be around and if they needed it for somebody else they'd use it. If the patient goes back on something else, they'd use the Equagesic, too.
>
> Another thing that was done with the drugs was this: Sometimes they wouldn't even take a patient's name off a medicine bottle, they'd just paste another patient's name over it and gave them to the other patients. Or often if five patients are getting the same medication, they would just take from one patient's bottle for all five. * * * They're getting rich doing this kind of thing.
>
> If a patient becomes noisy, Bustamante gives them tranquilizers like Equinol or Thorazine every 4 hours until they have quieted down. The constant sedation confuses them. Patients are given sleeping pills, such as Seconal, when they are under other tranquilizers such as Thorazine.

From the affidavit of Rita Lehmen, re the Crystal Lake Nursing Home:

> When Mr. and Mrs. Nine first went in there, they had a little money, so they paid their bills for a while. We noticed when the welfare came in on it, that the bills for the drugs went up immediately. In fact, the bill just about doubled. There were things like vaseline that would sell for 49 cents that would come with a prescription label on it for $1.50. They put prescription labels on everything they ordered for her. For example, she needed Vizine for her eyes that anyone could buy in a drugstore. They would put a prescription label over the regular label and charge more for it. Even their regular prescriptions were double. Once my mother-in-law had dermatitis on her head and needed a special shampoo. So they bought her some Sebulex. Again, this is something you can buy without a prescription. But they would order a prescription for it and put a prescription label right over the bottle. Mrs. Nine was supposd to get vitamins that we had been paying $8 for. When they took over the payments, that is, welfare took over the payment, it went from $8 to $18. It was very hard to check up on any of these things because, when they sent the bill, it just said, "Drugs" and the amount. The bill was never itemized.

Senator Mondale. Would you yield there?

Senator Moss. Yes, surely.

Senator Mondale. As I understand it, a nursing home is reimbursed for Medicare and Medicaid residents, for the costs of such things as drugs, so that if the costs are inflated, they will receive more in return than if the costs were lower; is that correct?

Mrs. KRAUSE. Yes, sir.

Senator MONDALE. It is your impression, then, that there are instances, such as those testified to here, where they deliberatly inflate drug costs and other costs in order to get larger reimbursement?

Mrs. KRAUSE. Yes, Senator; this is definite.

I can remember, for instance, testimony about, not an atomizer, a humidifier, where anyone could go in and buy it—what was that for, John, how much was that?

Mr. EDIE. It was $9.95, the sale price on the humidifier when it came to the home, but it was charged for $14.95.

I believe this exact example will be dealt with in more detail by the witnesses who are to follow who actually witnessed it. I'd prefer to let them speak about it in detail, but that is an example.

Mrs. KRAUSE. Senator, we also have, you know, a number of extra things, such as we have a bottle of shampoo that you can buy anywhere with a prescription label on it among the evidence, and we have bills that are unbelievable and bills for Darvon of $90 for 1 month.

Senator MOSS. Thank you.

You have worked out such a good, detailed statement, that I would suggest, however, maybe if you'd just read excerpts from one affidavit under each example. I am afraid we are going to run out of time. We have quite a number of witnesses to hear.

I don't want you to skip any of your main points, though. You have documented them very well.

Mrs. KRAUSE. Thank you, Mr. Chairman.

Senator MOSS. By the way, the entire statement will be in the record, and so the other excerpts will appear in the printed transcript, even though they are not all read.

Mrs. KRAUSE. Thank you, Mr. Chairman.

IX. Reprisals: Nursing home patients and their families are often afraid to complain to the health department about the practices which occur in nursing homes for fear of reprisals from the nursing home. Here are a few examples:

From the affidavit of Mrs. Martin Hawkins, relative, re the David Herman Nursing Home:

> I was always afraid to say anything or complain about the home for fear of what might happen to my brother. I found myself lying about the home in front of their staff. I would tell them what a wonderful home they had and what wonderful care they gave their patients, though that was a lie, but I felt I had to lie for my brother's sake.

From the affidavit of relative Georgia Biller, re the Asbury Nursing Home:

> I do know that I was made to feel an interfering nuisance by the staff of the nursing home. Whenever I tried to intercede on my mother's behalf, no matter what reasonable request I made to try to help alleviate some of her suffering, it was totally ignored. If anything, it only seemed to make the staff treat her with more coldness and neglect.
>
> I will never forget my mother, a gentle loving woman, kissing the hands of the staff who mistreated her, as though she were begging for some kindness and compassion from them.

From the affidavit of registered nurse and relative Ann Hurwitz, re the Heritage of Edina Nursing Home:

> I complained to the head nurse about the other meals. Because I complained, the head nurse stopped helping my mother with the noon meals. So no one was

feeding my mother. That's the way they handle things in nursing homes, if you complain about one thing, they just make it worse for you.

From the affidavit of relative Milton Abramson, re the Texa-Tonka Nursing Home:

Mrs. Lorraine Bean, R.N., was the administrator at the time my mother was in Texa-Tonka. She said that I had threatened to hit the nurses. She told the staff to watch out for me, that I was a "violent man," "a violent mental case." She also told the staff to ignore all my requests for the care of my mother. She repeatedly told these things to the personnel of the home, including students working there part time who were under my supervision in the public schools where I was teaching at the time. Mrs. Bean typed up notes telling the staff to call the police if I tried to take her, my mother, out of the nursing home.

Mrs. KRAUSE. I would like to introduce to you Glorianne J. McGillivray, Mr. Chairman, at this time. I think she can give us a relative's experience of intimidation.

Senator MOSS. Mrs. McGillivray, we are very pleased to have you come and testify before the committee, and you may proceed.

STATEMENT OF GLORIANNE McGILLIVRAY, RELATIVE [1]

Mrs. McGILLIVRAY. I wish to thank you, too.

My name is Glorianne J. McGillivray, and I live at 4326 North Douglas Drive, Crystal, Minn.

My grandmother, Elvera (Mrs. Henry) Pearson, was in the Maples Nursing Home in Maple Plain, Minn., from the fall of 1968 to April 1969.

She entered the nursing home after an operation on her stomach for an ulcerated tumor. My grandmother was in her eighties. Our family doctor said that with an operation like the one she had and at her age it was difficult, if not impossible, to say that all the cancer from the tumor had been removed. Only rehabilitation and time would tell. In order to get her strength back, he recommended getting up and into a wheelchair every day.

At first Gran had no objections to the nursing home. It was in her hometown and she felt that she would see many people she knew and she could visit with more people. Members of the family went to see her every day.

When my grandmother contracted a virus it left her with a bowel problem. I notice that she was getting thinner and I was told that she was not eating properly. I asked Mrs. Maski, one of the owners, about this. She told me, "Your grandmother is in the last stages of death and these are the signs." At that time I noticed they were giving her spinach, applesauce, and fruit juices which grandmother said would make her diarrhea worse. The bowel problem caused a kidney infection and they began using a catheter on her.

After we got the bowel problem stopped, the catheter remained in. When "Gran" began complaining of the sores caused by the catheter, I checked with our doctor and he said the infection was cleared up and the catheter could be removed. But the catheter remained in until we insisted that the nursing home remove it.

Up until the time of the catheter, Gran had been quite clear in talking. Suddenly I began questioning my grandmother's condition myself because she became more and more drowsy. I noticed one day that when I came earlier she was better. Soon I found by varying my sched-

[1] See affidavit, part 19B, p. 2327.

ule I could predict her condition by the clock. I found that Gran was getting sedation at night that left her with a drowsy hangover through most of the morning. At noon she got another pill that made her drowsy until evening. I asked the doctor about this. He said that it was a practice by all the doctors to leave medicine of this nature in the hands of the nursing home, prescribed, "To be used as necessary." I began to have a few second thoughts about the many patients half dozing in the lobby. I had seen one woman tied into a wheelchair so drowsy that for at least an hour she was bent over with her head touching her tray.

In between the bowel problem, the catheter, and now this drowsiness—and I want to emphasize this, people, for all of you—my uncles and my mother were firmly convinced that Gran was on her last legs. Indeed, the nursing home kept repeating over and over that my grandmother was in the last stages of death. Because my grandmother became high on medication, the nursing home also told my family that Gran was losing her mind. They were so convincing that my uncles ignored what Gran told them, thinking that the nursing home should know what they were doing.

These things were untrue. My grandmother became desperate to get out of that nursing home. I told her that if she wanted to get out she would have to do all she could to exercise and gain her strength back. I would do all I could to get her back up. We felt that if she could get the wheelchair as the doctor suggested this would help a lot. For 2 months we tried to get a wheelchair for her. Mrs. Maski kept telling me, "She does not need a wheelchair because she's going to die anyway. She's never going to walk again. It's bad to do this to your grandmother. Let her die in peace." We, my grandmother and I, finally won the battle for the wheelchair and Gran began improving.

In April 1969 I got permission from our doctor to bring her home. When the nursing home found out she was leaving, they blew their stack.

They started off by telling me that if I took my grandmother out of that nursing home they were never going to let her back in. Second, they threatened me. They said, "If you take her out of here, she will die, and her death will be on your hands. You will kill her, and you will be responsible for her death." Third, they got on the phone to my uncles and mother and told them to stop me from taking Gran from the home because I would indeed kill her. Fourth, they even went to my grandmother and told her that, and I quote, "If you leave this home, you will never get back in here again."

My grandmother looked them in the eye and in a very firm clear tone said, "That's fine with me. I don't want to come back here anyway. You'll drag me in here feet first, dead, before you will get me in here again. . . ."

She was that kind of woman.

Within 2 days she didn't need sleeping pills or any medication. Within 2 weeks she was not only walking under her own steam but helping to do dishes. Two weeks was all it took. Beginning in September, 4 months later, she was able to live in her own home and take care of herself. She lived in her own home independently for 8 months before she moved back with me.

This is the same woman that Mrs. Maski said there was no help for. This is the same woman who would never walk again. I had to go through an incredible fight to get her out of that home. They tried to stop me in every way they knew. My grandmother was labeled not only physically incapable but, worse yet, mentally deranged. She was neither. There is something very wrong when they will keep a coherent person bedridden and doped to the point of insanity. There is something very wrong, drastically wrong, when someone will try that hard to keep a patient in their nursing home.

I would just like to thank you, gentlemen, and I would like to say this. I am not here for me, and I am not here for Gran. I am here in her behalf, because it might be any one of these people that would have to do this, and there is nothing worse than to be sitting where Gran sat and have no one to believe her. I was the only one who believed her, and it was frightening, and she was very lucid to the end.

I thank you, gentlemen.

Senator Moss. Thank you very much. That is an inspiring episode to tell of the fight that you finally won to get your grandmother out.

Mrs. McGillivray. She won, sir; I didn't. She won.

Senator Moss. You and she won together, and it is difficult to understand how this could go on.

I appreciate your telling us about it. How long did your grandmother live after she was finally taken out of the nursing home?

Mrs. McGillivray. May I say this. My grandmother died 20 minutes after it was decided she would have to go back into a nursing home, and that was in June of 1970. I was going to school and I could not take care of Gran. I was quite concerned, she was beginning to fail then, but I have tapes and she remembered everything far before the century, and recipes from last week. You know, many times people have gaps; she did not. But it really hit me hard, sir, when she died that close after it was decided.

Senator Moss. You said in your statement there was an 8-month period when she lived independently in her own home?

Mrs. McGillivray. Indeed she did. She fixed her meals, she had gone back and forth to the bathroom, took her own showers, and grandmother was a person who had very large legs all her life. I think the thing that Gran—well, Gran fought these things for others, because she knew what it was like to sit there with a catheter. You know, we, as human beings, we see someone in a hospital with a catheter or with a bowel problem, and we immediately associate it with imminent death unless it is a young person. By tracing the bowel problem affecting the vagina and the kidney problem and by listening, this was the only thing that helped.

For instance, my grandmother one day thought she heard ice being delivered all day, because she heard this tingling. By sitting and listening to what my grandmother was talking about, I could hear this thing, and it was a fan, you know, a fan was clicking. But as a person coming into the room, you wouldn't believe it. She said, "What did you do?" She said, "It sounded like ice." I said, "It is a fan clicking."

One day she got so disgusted with this nursing home, and this was in the evening, she was going to leave. So she got up to leave and started to dress herself. The nurse's aide came in and said, "Where are you going, Mrs. Pearson?" Now, this is quoted to me, understand. She

said, "I am going to a dance, where do you think I'm going." At this they said she was crazy, but they took it out of context, and she explained it to me.

Senator Moss. How old a lady was she when she died?

Mrs. McGillivray. Grandmother was 83. She was a mortician's wife, by the way, so some things don't faze us, I guess, as much, but still it hurts.

Senator Moss. Senator Mondale.

Senator Mondale. I have no questions.

Senator Moss. Thank you.

Mrs. Gillivray. I thank you.

Senator Moss. Mrs Krause, you may continue.

Mrs. Krause. If the effects of the profiteering, poor nursing care, and the absence of physicians could be summed up in a few words, we could say that in a great many nursing homes there is a complete lack of any semblance of human dignity. This is, after all, the age of consumerism and things once consumed are to be discarded. So it is, too, with human beings who have been useful and are now thrown away. They are treated like bodies, not like people, like inanimate objects to be separated from society. Here are some examples which have earned nursing homes their title of warehouses for the dying and elephant's graveyards:

From the affidavit of nurse's aide Debbie Kleppinger, re the David Herman Nursing Home:

> Many of the seniors got embarrassed when we have to call maintenance men to help female patients into the bath. We put a gown over them when they get up, but they still get embarrassed. The other thing is that the maintenance men don't know how to handle the people well. They don't have any sensitivity towards the patients. They rush in and pull the patient out and scare them to death. This happens constantly. The personal modesty and privacy of the patient is not emphasized. Many rooms don't have screens. Even if there is a screen in the room, it isn't necessarily used.

From the affidavit of relative Signe Johnson, re the Richview Nursing Home:

> One day when I was there an old man who was about 90 years old went into one of the ladies' rooms by mistake. As a result of this mistake by this man, he was ridiculed and laughed at by many of the staff of the home. This same old man never had any underwear on. The home was hard up for underclothes, I guess. He had a big pair of trousers on that he wrapped around his waistline. He had trouble getting to the bathroom, and once he had a bowel movement accident while he was trying to get to the bathroom. This bowel movement rolled out of his pants and onto the floor. He tried to put it over into a corner with his shoe. Of course it got all over his shoe and everyone else was stepping in it. Nobody bothered to come and clean it up. Everybody would wait for somebody else to clean it up.

From the affidavit of relative Milton Àbramson, re the Texa-Tonka Nursing Home:

> My mother was forced to stay in a room over my protests with a terminal cancer patient and the stench in the room was unbearable, partially due to the fact that the patient was not kept clean.

XI. Are inspections effective? As you know, Mr. Chairman, the report of the Sallinger panel which was appointed by the Governor of Maryland to investigate the Baltimore salmonella epidemic reported that inspections were ineffective and that it was their judgment that this was a nationwide phenomenon. The inspections were just

bureaucratic rituals leading to a pile of neatly piled papers which were evidence of a job accomplished rather than signals for action. Most inspections, if not all inspections, were announced ahead of time.

The situation here in Minnesota appears similar. The affidavits of the following witnesses agree that inspections are announced ahead of time:

One, Barbara Lace—David Herman Nursing Home; two, Mark T. Moriarty—LaSalle Nursing Home; three, Debbie Kleppinger—David Herman Nursing Home; four, Ellen Marx—Capitol View Nursing Home; five, Dan Henry—2200 Park Nursing Home; six, Kay Schallberg—Crystal Lake Nursing Home.

From the affidavit of L.P.N. Ellen Marx, re the Capitol View Nursing Home:

> When the health inspectors come, the home is notified. When Margaret Christianson is going to inspect, she notifies them every time. She writes them a letter or calls at least 3 or 4 days ahead of time. When the home finds out, everybody rushes around cleaning up, and they have everything spic and span when the inspector comes. One time one of the registered nurses told me to move some cleaning fluid, which was poison, from a floor cabinet to up high because Christianson was coming. I said, "How do you know?" and she said, "she called."

From the affidavit of L.P.N. Kay Schallberg, re the Crystal Lake Nursing Home:

> This home always knew in advance whenever the health department was due to come out for an inspection. Consequently, they could put extra work in and clean the place up and make it look good before they came. They would also get people from other shifts to be on duty when the inspector was there so it looked like they were not understaffed. That way it would look like they had a full staff when they really didn't.

From the affidavit of orderly Dan Henry, re the 2200 Park Nursing Home:

> This was the only health inspection that took place during the 4 months that I was at the home. It did not happen on my shift. That night when I came in the place was so beautiful I stepped outside of the building to make sure I was at the right place. I walked back in and asked the nurse's aide what was going on. She said that they had just had a health inspection that day. I couldn't believe the condition of the home; even the bottles were standing evenly in rows. The place was very clean and there was no odor. I asked how they knew that the health inspectors were coming and was informed that they find out 3 weeks to a month in advance.

Mr. Chairman and Senator Mondale, we can draw certain conclusions based on the evidence we have compiled from 125 nursing homes. At each end of the spectrum there are sharp divisions in nursing home care and a larger gray area with variables of problems in between. Approximately 25 of these homes are very good, a few even excellent, and about 40 are substandard. From other information we have received, these percentages appear to be statewide.

We have also drawn conclusions as to the five basic root problems in the homes:

1. No definite national policy on how we are going to treat our infirm elderly;
2. Built-in financial incentives to bad care;
3. Minimal coverage in nursing homes by physicians;
4. Poorly trained staff; and
5. Lax enforcement of existing regulations.

These problems are not so difficult to understand, if we want to understand them, or to solve, if we are determined to. Solutions lie throughout the enumerated problems. First we need to come to grips with the fact that we need to decide on a definite national policy. Our elderly deserve to know the measure of our commitment to them. Are we to tolerate the public apathy toward bad nursing home care that is hurting them, maiming some of them, and even killing others? Certainly the aging die, it is the manner of their dying that should appall us.

I would like to emphasize again that we have many good, even excellent, nursing homes in this State, but we are concerned about the poor care that is given in the substandard homes.

I remember Mr. Philip Schumacher, president of the Nursing Home Association, telling me he knew the truth of the charges we had made, but felt the appropriate authorities should have cleaned up the situation. And, of course, he is right.

We must find a way to make the profit motive work for us or abandon the proprietary system altogether. There are many who claim that the proprietary system is inconsistent with good patient care, and I don't think this is being entirely realistic. I would accept and endorse the statement for an incentive system that will provide a higher rate of reimbursement to the nursing home if it provides superior care and becomes, in the State's estimation, a good nursing home.

We must find some way to interest the medical profession in the care of the aged. The development of geriatrics in this country is long overdue. The physician belongs in the nursing home setting if he is to be considered part of the medical continuum. With proper medical supervision, many of the abuses we document today couldn't happen. This problem would be greatly helped if residents and interns would spend part of their training in nursing homes.

Once again, the day is long since passed when the nursing home can be cut off and segregated from society. As long as it is sequestered and kept out of the light of public opinion, dark practices will continue to occur.

Let's also upgrade the training of aides and orderlies. This will be, I know, an expensive proposition, since the only way this can be done is to pay higher wages and give the profession higher prestige.

On the other hand, it may be said that nursing homes that make vast profits by cutting on staff should be prevented from doing so. Again financial incentives are the answer. If a nursing home has high patient-staff ratios, there should be financial rewards from the State welfare department, the primary purchaser of nursing home care.

It is also essential to understand that no reforms we make can possibly provide better care without good inspection and enforcement procedures. These procedures must include, at a minimum, inspections that are unannounced and remedies that are swift and effective.

Last, but not least, we must remember that nursing home residents are people and treat them like that. It is impossible to legislate care and concern. A nation either has it or it doesn't. For my part, I will only quote the historian Toynbee who wrote, and I think correctly, that you can tell a great society by the way they treat their elderly.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Mrs. Krause, for a very detailed and, I think, one of the most comprehensive statements this committee has

received on the general problems that we are treating here today. Your analysis has been excellent, and you have pointed out the many areas where you think we are failing in our nursing home operation, and the Government is failing by not setting standards and enforcing them, all of which brings into focus the problem with which we are concerned.

It is documented with these affidavits from which you quoted during your statement.

Has this mass of information been turned over to the State health department or any governmental body of the State of Minnesota?

Mrs. KRAUSE. Not to the State health department, Senator.

In the beginning I really did not collect affidavits, you know. I wasn't really sure even what I was looking at or for, just simply that senior citizens had asked me to look into some of the problems they felt existed.

By the time I became aware of the pattern of poor care that existed, I became involved with the State health department and our local health department through a number of meetings, task force meetings, sitting on the mayor's council committee of congregate care, with them, and I was told again and again by them that the only time they would investigate was with a signed complaint, so that when people came to me and told me the problem, if it was current, I would tell them to go to the State health department or the local health department with the complaint, so they took the complaints, not I.

Senator MOSS. I see. Did some of these people follow your advice and go in and file complaints?

Mrs. KRAUSE. Oh, yes. I would ask for copies, and they would send me copies of their statements.

Senator MOSS. There are several things that you have documented here that are definitely unlawful; for instance, administering drugs prescribed for one patient to another patient is prohibited by law in the State of Minnesota. Is that right?

Mrs. KRAUSE. Yes, but it is a quite frequent occurrence, sir.

Senator MOSS. Also the keeping of narcotics. That is required to be under a double-lock system; isn't that true, also?

Mrs. KRAUSE. That's correct; yes.

Senator MOSS. And so there are many things that you have documented here that are common practice, really?

Mrs. KRAUSE. Yes.

Senator MOSS. That are prohibited by law and no enforcement seems to stop the practice?

Mrs. KRAUSE. No; I mentioned another one, the putting of normal patients in with seniles is against our State law.

Senator MOSS. Now, among the good nursing homes that you observed—you said some were good and some excellent—were you able to find any indication that they were making less of a profit?

Mrs. KRAUSE. Yes, most definitely, Senator. In fact, some of them were suffering very severely financially, those nursing homes that were giving good care.

Senator MOSS. We have encountered this problem frequently because of the reimbursement formula, Federal and State, for nursing home patients who are there under Medicaid is not adequate.

Is this a general statement that you think is supported by your investigation?

Mrs. KRAUSE. Yes; I do. For one thing, if you want the staff trained, to actually train staff costs money. We find that many of the problems are directly related to poor staffing and underpaid staff, too few staff to do the job and, of course, cutting back on supplies, food, this kind of thing. So, yes, money is a tremendous factor, yes, sir.

Senator Moss. The very high turnover of staff in nursing homes is also indicative, I suppose, of the low wage scale?

Mrs. KRAUSE. Yes, of course it is. Then the kind of people you can hire at that lower wage, too, present problems.

Senator Moss. Thank you.

Senator Mondale, do you have some questions?

Senator MONDALE. Thank you, Senator Moss.

May I join Senator Moss in expressing my appreciation for your outstanding work.

Mrs. KRAUSE. Thank you, sir.

Senator MONDALE. And I have a vague notion of how tough it was to accumulate this information. You do an enormous service to your country in testifying as you did today.

Senator MONDALE. Mr. Edie, are you a private attorney?

Mr. EDIE. No, I am not in private practice. I am the attorney for the Minneapolis Age and Opportunity Center.

STATEMENT OF JOHN A. EDIE, COUNSEL, MINNEAPOLIS AGE AND OPPORTUNITY CENTER

Senator MONDALE. Under the Model Cities program?

Mr. EDIE. Yes.

Senator MONDALE. And you have been working as counsel, then, at MAO in developing——

Mr. EDIE. Yes, I have been working on and off with them about 2 years now. I was in VISTA. Originally when I came back out of law school, I worked with the Minneapolis Legal Aid, and at that time Mrs. Krause came to Harlan Smith, who was the director at that time, and asked for legal assistance, and at that point I was assigned. I have continued to work on and off with them, that was the fall of 1969.

Senator MONDALE. If I might ask you a question. One of the standard suggestions for dealing with the problems that we have heard about today, and which this committee has heard rather consistently throughout the Nation, has been much more effective licensing and licensing inspection and revocation procedures to protect the occupants of nursing homes against practices which violate Federal, or State, or local regulation. Yet this morning we have heard testimony that the licensing process somehow does not seem to be working effectively in this State, and I think this is also what we found in Illinois and in many other States.

In your opinion, what is the reason for the ineffectiveness of our licensing and licensing inspection system?

Mr. EDIE. One of the things that I would like to point to, in particular, in answer to that question, would be that when and if the health department desires to close down a nursing home for continued violations that have not been corrected, it appears to me that the only remedy they have is a long and complicated public hearing and procedure, 30 days' notice, and so forth. I think in the past sometimes, if

the nursing home does not want to voluntarily close, they can drag this whole procedure out as long as 3 years, and this is a real deterrent and I really don't blame the health department for not tying up all or some of their resources and men in a long, drawnout, 3-year hearing and procedures that can drag through the courts.

I really think one of the best improvements that could be made would be new legislation at this point to create some kind of mechanism that wouldn't take so long. I don't mean to the point where it doesn't provide the opportunity for obviously the nursing home to give their side of it, and, you know, an open public hearing or a courtroom hearing, whatever it should be, where both sides can give their say, but the problem is right now that it takes so long that it really is not a remedy at all.

Senator MONDALE. Would you submit for the record your suggestions as to what procedure ought to be incorporated into law to permit the licensing program to work more effectively?

Mr. EDIE. I would be very glad to do so; yes.[1]

Senator MONDALE. Are you convinced that, even with those laws, those who are regulating the nursing home industry will do so on a vigorous, arm's-length basis, or is it occasionally the case that relationships develop between the regulator and the regulated which must also be considered?

Mr. EDIE. I think that's a very definite problem. I don't have any specific examples, but I do know that over the course of inspecting nursing homes the nursing home inspectors do become, you know, quite familiar with the owners. I mean that is to be expected. I would certainly not describe it, from my experience, as an arm's-length type of transaction.

Senator MONDALE. Do you know how many nursing homes have had their licenses revoked?

Mr. EDIE. It is my understanding, I am not positive about this, but up until, I believe, 1969, August of 1969, at which point Mrs. Krause held an open hearing in the mayor's council room in downtown Minneapolis to expose some of the conditions and make these things available to the health department, within a week proceedings were begun against—was it two or three of the homes?

Mrs. KRAUSE. Three.

Mr. EDIE. Against three of the homes. I believe that this is the first—I am not sure about it—but it was the first or the second time this had ever been done. They did eventually close, I believe, those three homes, but, to my knowledge, this was, you know, where they went through the whole procedure.

They have other homes now that have voluntarily closed or been downgraded. I think probably Dr. Lawson will refer to that in his remarks, but I believe that, to my knowledge, the only three times it has ever gone through the procedures where the nursing home wouldn't voluntarily do it was shortly after this hearing in 1969.

Senator MONDALE. Is there a private, legal remedy which, for example, you could pursue to bring an action to have a license revoked or require compliance?

Mr. EDIE. I know of no such remedy at all.

Senator MONDALE. So it is your understanding that where the operator won't change and is dealing wrongly, a person in a nursing home

[1] See p. 2120.

must either find a State inspector who will come and take up his cause or some outsider, a son or a daughter or someone, or an outside attorney, to take up his case? Their only remedy, apparently, is to go back to the State inspectors and complain. Is that your understanding?

Mr. EDIE. Yes, I would agree with that, except perhaps in the case where there was an actual tort or a physical abuse, you know, and you could go through the courts on that.

Senator MONDALE. But if you are trying to prevent damage as distinct from getting compensation——

Mr. EDIE. One of the things I think is most confusing and most frustrating to not only the patients but to their relatives is that when they are either searching for a nursing home—first of all, they don't have anything to go on. They don't know what to look for. They don't know how to tell a good home from a bad home, and they really are sort of stumbling in the dark at first.

Second, when they do have complaints, they aren't sure what they should do with them. They don't know whether they should go to the health department, talk to the caseworker, the welfare worker, to the city. Many of the people to whom I talked and from whom I took affidavits told me, "Oh, I am so glad there is somebody I can finally explain this to because I don't know where to go. Everything I tried has failed and I am at a loss."

So I found this feeling quite common among many of the people to whom I talked.

Senator MONDALE. Would you not, then, recommend some private remedy, as well?

Mr. EDIE. I would very much like to see that.

Senator MONDALE. By which OEO attorneys, Model Cities attorneys, and other attorneys, where complainants could bring their complaints in a way that it was necessary to be heard. Increasingly, in all of our social legislation, if you find a piece of legislation that is designed to serve a powerless group, a group that is unable to complain effectively on its own behalf, you had better have a private remedy somewhere in there; otherwise, in my opinion, the laws usually are not effectively enforced.

Mr. EDIE. I would concur.

Senator MONDALE. That's one of the reasons I have vigorously favored a strong OEO legal services program for senior citizens to speak up for the rights of these people, many of whom are unable to speak for themselves.

Mr. EDIE. That's quite correct and I would concur with that.

Senator MONDALE. Thank you very much.

Senator MOSS. Thank you very much.

We now have some more people whom you intend to introduce.

Do you have an estimate on the length of time? I am trying to judge when our recess should come.

Mr. EDIE. Yes. I would estimate it would take approximately an hour and a half.

Senator MOSS. We are going to be under pressure. Just let me confer.

I have conferred with Senator Mondale. We are convinced, of course, that the time pressure is going to be very severe because both of us have to be on an airplane going back to Washington this evening. We certainly want to hear these people, so we think we will go on now and,

if we have a break, we will have just a very short break for lunch, or maybe even bring some in, if you would be willing to go on at this point. So we will continue now.

Senator MONDALE. Might I make one point, Mr. Chairman?

This is not my prerogative, but some of this information can be inserted into the record and will be there for the review of the committee, so, to the extent possible, it seems to me it would serve the record better to summarize as much as possible. Yet, we want to hear you.

Senator MOSS. Yes, we do.

(The suggestions as to procedures to be incorporated into law as requested by Senator Mondale follow:)

SUGGESTIONS FOR CHANGES IN THE LAWS AND REGULATIONS OF THE STATE OF MINNESOTA TO PERMIT THE LICENSING PROGRAM FOR NURSING HOMES TO WORK MORE EFFECTIVELY

1. Pass legislation enabling the State Board of Health, where it makes a finding that a nursing home facility has continually failed to correct substandard conditions, to take strong affirmative action short of license revocation.

Such action could include the following:

A. Prohibit further referrals of patients by the Welfare Department to the home.

B. Immediate withdrawal of all patients receiving assistance from the Welfare Department.

C. Notify all patients in the home and their relatives that the home has continually failed to correct deficiencies.

D. Require that notice of said finding be displayed openly at the home in question.

This procedure should provide for safeguards to the home in question to present its side at a hearing before the Board, but the decision of the Board should not be overturned unless found to be clearly arbitrary and without factual foundation. The Administrative Procedure Act would probably apply.

It is especially important that the Board of Health be able to act promptly once it has taken time to make a determination. The procedure must avoid the delays which are possible today. Recent attempts at license revocation have been delayed as much as 3 years, thus preventing the Board of Health from taking any action while patients continue to reside in the substandard home.

2. Establish a "Tag System" similar to those employed by housing code inspectors whereby conditions that are contrary to the regulations may be cited and fined. Require that monthly, or quarterly, a list of such violations be posted prominently in the home.

3. Appropriate the funds necessary to hire that number of State inspectors which the Board of Health feels is required to insure adequate inspection of nursing homes.

4. Pass legislation to protect and encourage the employees of nursing homes who report substandard conditions to regulatory authorities. Such legislation should provide that the burden of proof be on the employer to show that dismissal of an employee was not in retaliation for the employee's reporting substandard conditions to a regulatory body. The Board of Health should also provide a clear mechanism whereby employees could confidentially inform the inspectors of substandard conditions.

Senator MOSS. You may go ahead, then, Mrs. Krause.

Mrs. KRAUSE. Mr. Chairman, before I introduce you to the witnesses who will appear before you from the Lexington Avenue Nursing Home, I'd like to tell you why we chose the home.

At first, we were of the opinion that we should bring before you a number of homes, a number of witnesses, but we realized also the time shortage and, therefore, felt that it was more important, more valuable to you, perhaps, to bring an indepth study on one home where you could question the witnesses, because it is the staff who are inside these homes who know what is going on.

I believe it is very important, I say this, it would be a dangerously foolish supposition to believe that the bad care given in the Lexington Avenue Nursing Home is uncommon.

Another reason we chose it, it is a nursing home built a few years ago, it has both welfare and private patients in it, and we did release testimony on this nursing home in April 1971 in the hope that conditions would improve. But in actual fact, Senators, it has deteriorated since we gave that testimony.

To our knowledge, in this home, on the third floor, at this time, there are cockroaches, bedbugs, staph infections, possible gangrene. There is unbelievably bad care, and there are three very contagious bacterial infections transmitted, and, according to the lab report [1] which you have in your packages, this must have very immediate attention. There are photographs of this, photographic evidence of this.[2]

I am most anxious, if I may, just to go on and introduce the witnesses. You do have in front of you the rest of the statement, and what they have to tell you is so important I am just afraid to take any more time.

Senator Moss. Your entire statement will go into the record.

Mrs. Krause. While we believe the Lexington Avenue Nursing Home to be one of the worst nursing homes because of the wide patterns of bad care provided, we have reason to believe there are not only similar homes, but a possibility there are homes with even worse conditions than at the Lexington.

I would like you to understand the respect I have for those staff who stay by their post under difficult conditions in order to provide the patients with the care they feel should be given to them, under circumstances that would make most people leave in disgust and horror.

It is also necessary to understand the kind of fear and intimidation which takes place against the staff, loss of jobs, and perhaps, beyond that, if they lost their jobs they won't obtain a reference, they may well be blackballed. These witnesses who are coming before you today had a greater fear, that of abandoning the seniors in the Lexington Nursing Home. If any of you doubt the fear that exists, then I ask you to start with me and my fear. My agency is dependent on public funding, and, as executive director, I should not "rock the boat." It is not easy to question or to challenge the work of another agency. It is not easy to accept the fact that what I have done may lay a burden on the people I am trying to serve. Beyond that, Senators, look to the absence of the people who should stand with me.

But I count my fear as nothing compared with that of a relative who dares not complain because of the possibilities of retaliation against a loved one, or of a patient who dares not complain because of the additional abuse they must endure if they do so, and who will listen anyway? For such patients must live with their fear, sleep with their fear, and die with their fear.

Senator Moss. If you will introduce the witnesses.

Mrs. Krause. They are Mrs. Lorraine Kippels, Mrs. Lola Finney, Miss Laurie Meyers, and Bob Shypulski. Thank you, sir.

Senator Moss. These four people can come forward.

We are glad to have you before this committee, and we appreciate your coming. We will hear from you in whatever order you have arranged for your testimony.

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[1] See p. 2218, report of findings on culture taken from Lexington Nursing Home, St. Paul, Minn., Nov. 1971.

[2] Retained in committee files.

STATEMENT OF MRS. LORRAINE S. KIPPELS, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME [1]

Mrs. KIPPELS. I have waited a long time, Senators, to be here.

My name is Lorraine Kippels. On my left is Mrs. Lola Finney; next to her is Laurie Meyers; both former nurse's aides at the Lexington Nursing Home. On my right is Bob Shypulski. He was an orderly at the Lexington Nursing Home.

I started at the Lexington Nursing Home on March 6, 1969, to March 23, 1970. I worked there 1 year as a nurse's aide.

The building is approximately 3½ years old. There are three floors on that building. The first floor are for ambulatory patients; second floor are the Medicare patients and the sick; the third floor are senile, although they are mixed on the third floor, normal and senile.

Mr. Louis Thayer was the administrator when I worked at this home. Mr. Trana, the assistant administrator, and Mrs. O'Connell, the supervising nurse.

I have never worked in a nursing home before. I have no license of any kind for nursing. There are three shifts. I worked the 3 to 11 shift. The first day I went to the nursing home to start my job, the nurse told the aide to walk me down the hall and orient me. She introduced me to two patients, showed me the supply room and the utility room. From that I was on my own. I didn't know which patients were diabetics, which patients were blind, which ones could walk. All this I learned for myself.

After the second week, I was doing all the treatments on the second floor such as the bed sore care, removing impactions, doing enemas and any other treatments that were necessary for these patients.

I also passed medications. The whole building, in fact, was so short staffed most of the time the nurses didn't have the time to pass medications. I was doing this on the second floor, which is the Medicare floor. After I found out it was against the law to pass medications on the Medicare floor unless you have a license, I quit.

I floated on all floors. Later I was transferred to the third floor. From there on I worked permanently, or I should say on weekends I'd work on the first floor, and then the rest of the time it was the third floor.

When I got to the third floor, it absolutely reeked of urine. The main reason for this was that we didn't have the supplies to keep it in good condition. There were two mops on this floor. The mops were like mopping urine with urine. As Daphne Krause has said before, the soap had been doled out to us. We got 1 ounce at a time. Also toilet paper and light bulbs were doled out. If a light bulb burned out, we had to take the burned-out light bulb, turn it in to the office, and they would give us another one to replace it.

The only problem we had, we were on the 3 to 11 shift, Mr. Thayer and Mr. Trana were the only ones to have a key to the supply room, so, unfortunately, we were without these supplies on our shift most of the time.

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[1] See prepared statement, p. 2218, see also part 19B, p. 2291.

They also told us not to use any cleanser in the bathtubs as it was against the State health regulations. Therefore, the patients were put in tubs, one after another, regardless if they had infections or not.

If we did get disinfectant on the floor, it was watered down to the point where I don't think it would sterilize anything anyway.

When I was giving treatments, the supplies, there was such a shortage of supplies, in fact, there wasn't a scissors. I asked the nurse if I could get a scissors. She said she didn't have any. We went to all three floors, there was no scissors. In the meantime I saw Mr. Thayer in the hallway. I told him there was no scissors in the building and could I please get some. He told me if I wanted a scissors that he would buy one. I would have to put a 50-cent deposit on that scissors and when I brought it back to him he would give me the 50 cents back. I told him I couldn't do the treatments. I couldn't cut the gauze or the tape, unless I had a scissors. He said, "Well, that's too bad, then," and walked away.

We did try makeshift ways of doing treatments as we did not want the patients to suffer. I later brought my own scissors from home and used them.

I also made many, many lists and gave them to Mr. Thayer and Mrs. O'Connell for clothing for the patients, as the patients on the third floor were very, very low on clothing. Most of them were welfare patients. There were no shoes for some of them, no stockings, very few had slippers, very few underclothes. The men on the floor would put trousers on with no underpants underneath them. When they would urinate they'd become very chafed and this would lead to bed sores or urinary sores, urine burns, and so on.

There was no toothbrushes or toothpaste on the floor. I suggested that they use the welfare funds that each patient was allotted to buy their personal needs. He said that sounded like a good idea. The only thing I got after turning in approximately four lists and talking for an hour and a half with Mr. Thayer in the office, the only thing I got on that floor was the toothbrushes. After about 2 weeks the toothbrushes fell apart, they were that cheap.

I asked him what we were going to do about toothpaste, without toothpaste how were we going to take care of their teeth. He said, "Use mouthwash."

Some of the patients had had their teeth in so long that we had to scrape them, mouthwash wouldn't take the stains that were on their teeth out.

The laundry was in very bad condition in the nursing home. I became quite puzzled about why the linen would come up in such bad shape. I talked to an aide that worked in the laundry room. She told me that the procedure in the laundry room, everything came down one chute. The only thing that was sorted was the colored clothes of the patients from the linens. The infected linens came down the same chute with the other linens, so any disease that was in that home would be very hard to control, as all laundry was put together.

The aide also told me they used one cup of soap, three tablespoons of bleach, and they packed them as full as they could.

Bob Shypulski will tell you more about the linen.

STATEMENT OF ROBERT A. SHYPULSKI, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME [1]

Mr. SHYPULSKI. The laundry people are blind. The linen came up from the laundry as dirty as it went down. The linen is all torn, raveled, it is stained with urine and medication stains. It is just filthy, it is just not clean. It is yellow and gray. I have many a time taken a sheet out of the linen closet, a clean sheet, opened it and laid it on the bed and here would be dry feces in the sheet, mangled right into it.

There is also a shortage of linens. I have had to put patients to bed in their clothes because there are no linens, draw sheets, diapers, or gowns.

There is also a pathetic shortage of clothes for the patients. It gets so bad that I have come on to work at 3 o'clock and their pants are held together, they are too small and the fly on their pants are held together, by a chain of pins because they are so small.

I remember one incident when some relatives came up to me and they asked for some washcloths and towels. They were going to give their mother a bath. I went to the linen closet and there wasn't any, so I picked out one of the clean diapers and I ripped it. Mrs. O'Connell said, "We don't rip up the linen here. You should have just gave it to them as it was."

Also the linen in this home, they have the first floor, it is called the show floor. They take, the laundry people in the laundry, divide the linen. The better linen goes to the first floor, then the next in line goes to the second. Then all the rags and the raveled and stained linen goes to the third where the senile patients are.

Also I'd like to add in the last 6 months there is cockroaches on the third floor. I would like to mention an incident. I went to give a woman a bath one time. I went in the whirlpool room and turned on the light and at least 15 cockroaches flew. I tried to stomp them out as best I could before I gave the woman a bath. This is getting to be kind of a common procedure at the nursing home.

Mrs. KIPPELS. Now, Lola Finney will tell you about the beauty shop at the nursing home.

STATEMENT OF MRS. LOLA M. FINNEY, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME [2]

Mrs. FINNEY. There is a beauty parlor in the basement of the Lexington Home, and this shop they do not follow any sanitation or sterilization procedures. I am a licensed beautician 33 years here in Minnesota. It is a State law that you must have a wet and dry sterilizer. If this beauty parlor has it, they do not use it.

You will find towels that come out of the laundry placed on a stool or chair, anything. You will find combs used from one patient to another, and you are supposed to use one comb and brush per person.

I have seen an operator come to the floor because some of these old patients can't sit and wait and get their hair dried, so she will send them to the third floor and they will get their hair dried, and when she completes her work in the shop she comes upstairs and combs them out. I have seen her comb one head after the other with the same comb.

[1] See prepared statement, p. 2225.
[2] See prepared statement, p. 2229.

On one occasion there was a patient that hadn't had her hair combed in months. She lay there with a net on and then a ratty cap over that. I had to take her down to the beauty parlor. We got her down there, the nurse opened up that hair, she had a scalp disease. She used the same comb, after using it on that patient, on other patients.

Mrs. KIPPELS. The food at this home was a big joke. Patients were always complaining about being hungry. They had one time what they called a mock meatloaf. Mrs. Finney and I thought it looked very good when we were serving the trays. We went down on our lunch break. I tasted it and spit it out. It was the most horrible tasting thing I have ever had in my life. I kind of laughed, joked, the cook was in the kitchen and he was laughing at the same time.

Mrs. Finney then came in, so I thought I'd have her taste it. She proceeded to spit it out. The cook just rolled laughing. I asked him what was in it. He said cottage cheese and cereal. Most of the plates came back to the kitchen not touched.

The meat there was very, very tough. They constantly served weiners in that nursing home, weiners and pancakes was the main diet there; very high carbohydrate foods, macaroni, cheese, weiners, pancakes, and salad. There was no pork served in the home as the home was run by Seventh Day Adventists and they did not believe in pork. To my knowledge there was only one Seventh Day Adventist patient in that home, but the other patients never did get to receive pork either.

From what I understand, they were not told this when they were brought to the home, that they did not believe in serving pork, and many of the patients asked us many times if they could have bacon. They would love to have some bacon or ham.

They also had a stamp scale in their kitchen. This stamp scale, I am sure you have all seen one, very small, it was used to weigh the meat on. When we saw it sitting there we asked the cook. She said, "Can you imagine, they expect me to weigh the meat for each patient on this stamp scale."

We also set up trays on the third floor. We'd go in and clean up patients because we were so short-staffed. We would have to go from cleaning a patient, which many times involved cleaning feces or bad infections, bed sores and so on, directly into the kitchen. In the kitchen, the bread would come up in a loaf. We would take the bread out, put it on the tray, pour the milk into a juice glass and pour the coffee. Most of the glasses on the floor were so badly stained with medications or were just generally dirty that we threw them out. This left us many times without glasses. Sometimes we'd wash them the best we could so all the patients could get their milk.

They also had a refreshment cart that was served in the evening between the time they ate their supper meal and before they went to bed. This refreshment cart consisted of peanut butter sandwiches and watered-down cool-aid. Once in a great while we'd get juice, but it was not too often. People on the third floor had difficulty eating peanut butter sandwiches because most of them were without teeth. I am sure, as you know, there are not too many that do appreciate having peanut butter sandwiches at night before they go to bed.

Mrs. KIPPELS. Bob will tell you some more about the food.

Mr. SHYPULSKI. The food is a complete disgrace. I'd like to bring out one example.

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Lime jello came up one night for supper meal and I was going to try it. I took the bowl and I was going to have some and I took the spoon and it wouldn't even cut it. So I called the staff around and we started to laugh about it and joke and we bounced it on the floor and it wouldn't even break. The only way we could get rid of it was to dissolve it in hot water and none of the patients could eat it that night. Usually they preferred jello because the rest of the meal is so poor.

Patients just don't get enough to eat. One patient, Patient No. 10, came in the home when I first was there and he was a great, big man with a big build and heavy. I would say he has lost 120 pounds. His skin just hung in layers, I mean all over his body, on his belly it was just like in layers.

Mrs. KIPPELS. Mrs. Finney will also tell you some more about the food at the home.

Mrs. FINNEY. I'd like to tell you about that beef bacon. It looked more like corned beef bacon and many times the patient would run to the desk and we'd have to reach our fingers in and pull it out of their throats before they'd choke. So we complained so much to the cook about this bacon she finally stopped sending that bacon to the floor.

Back by the dishwasher, Mr. Thayer has instructed the dishwashers to have a container there. Everything that comes back like butter, eggs, sugar, what-not, they are to put in this container. It is reused.

One Sunday they served baked chicken and mushroom gravy for the main dish. After it was served, that is, the dinner meal, they refrigerated it. The next day they took it out and was going to serve it for the supper meal. They changed their minds and did not serve it. They didn't refrigerate it. They didn't serve it on Tuesday, but on Wednesday evening they served it. Every one of those patients got sick, and I was one of the victims, too.

Mrs. KIPPELS. The heating system in this nursing home was really a mess for being a fairly new building. On the third floor the little dials that control thermostats, and these thermostats are in every other room, these little dials were broken off. I asked and they told me that Mr. Thayer had broken them off. I didn't know the reason why. I did learn that if you put your finger behind the thermostat you could control the heat but during the day shift and some of the other shifts they did not know this. Consequently, many of the rooms were very cold and many of them very hot.

There was one night in particular the heat went off in the building. It was very, very cold outside. There was not much available in the line of linens in the home, but we accumulated as much as we could, wrapped these patients in anything we found. We also wore gloves and coats ourselves. The nurse passed her medication with gloves and a coat on. It took so long for a maintenance man to get there that the building from the first floor to the third floor was very cold. Pipes were breaking all the time. The pipes on the third floor would break and water would run all the way down to the basement floor.

During the first year the building was opened, as I have been told by Mrs. Finney, the roof leaked. They were instructed to put buckets to catch the water, but be sure and empty them, as they didn't want to slip in the water.

The whole process of passing medications was not properly supervised in this home. This led to several bad abuses, including the steal-

ing of medications and sometimes patients not getting their medications at all.

After I was on the third floor for a short while, Mrs. O'Connell came to the floor, asked if I would like to take classes in learning how to set up and pass medications. I told her yes, I would, as I was very interested. Before I did go to the classes, I called the Nursing Home Association and asked them if it was legal for aides to pass medications. They said yes, it was, if we received classes and we passed a test. I took the classes; there were eight classes, 1 hour each. All I learned about in those classes was about the nervous system, and that is very, very complicated. We were never tested. I passed medications on first and third floor. I also passed the narcotics on the first and third floor. I had access to the medication room and the narcotics, but I did not have access to the supplies. They kept the keys for that.

It seemed mighty strange that I could be trusted to go into narcotics and the medications, but I could not be trusted to go down and get a roll of toilet paper or a light bulb.

The stealing of medications went on a great deal in this home. We reported it many, many times. Nothing was ever done about it. We reported it to the nurses. We reported to Mrs. O'Connell. It was reported to Mr. Thayer. I talked at great length with Mr. Thayer, telling him we thought we knew who it was who was stealing the medications on our floor; and, as Mrs. Finney and I were responsible for the barbiturates that were given at night on our shift, we felt that something should be done. Nothing was done.

One night an R.N. on the floor and Mrs. Finney and I decided we were going to set a trap to prove our point. A bottle of chlorohydrate came in. We counted them. There were 30 chlorohydrates on the shelf. The next night we came on there were 13 left. We wrote this down in the daybook. We also told the nurse about it. Nothing was ever done.

Even after I left the home I understood there was still stealing of medications going on. As you see, they try and keep some of the bad help and let some of the more interested help go in the nursing home.

I was also told by Mrs. O'Connell if I ran out of medications that she had some in her office. I have gone down to her office, she has opened the drawer and given me medications out of her desk drawer. There were medications from patients that had expired or had left the home. There were also salves from other patients in this drawer. We were also told if we had to borrow medications, to borrow from the welfare patients.

Mrs. KIPPELS. Now Bob will tell you some more about the medication.

Mr. SHYPULSKI. I was witness to an incident concerning medications that really upset me. About 4:30 one afternoon, Mrs. Demar, L.P.N. on our shift, was in the medicine room. Mrs. Finney here called me and she had showed me, they have a wastepaper basket in the medicine room, and in the bottom of the wastepaper basket there was medications. We looked at them, and Mrs. Demar said that they were daytime medications. Mrs. Bruckner, L.P.N., is responsible for the day medicine. She is the nurse during the day. So Mrs. Demar told me to get a brown paper bag and I did, and she asked me to call Mrs. Clay, the R.N. from another floor, to witness it. So Mrs. Clay and Mrs. Demar noticed that the were daytime medications, and she said, "I am going to

call Mrs. O'Connell." So I was told from Mrs. Demar later on that evening that Mrs. O'Connell was called, and she is our head nurse, the director of nurses, and she said she would have a talk with Mrs. Bruckner tomorrow and see what happened.

So the next day when Mrs. Demar came on, the L.P.N., I asked what had happened about Mrs. Bruckner and the medications. She said that Mrs. O'Connell had said to her that Mrs. Bruckner did not want to pass the medications and chase the patients, and she thought it was a very plausible excuse. Mrs. Demar then told me that this was not the only time she had found this, and that she couldn't stand it any more.

Mrs. KIPPELS. Now Mrs. Finney will tell you about her classes that she had for passing medications.

Mrs. FINNEY. I did not want to be a medical aide because I knew I would not feel qualified after a few lessons to administer medications to animals, let alone human beings.

I attended one class period because I felt as though we would be replacing nurses. Mrs. Moor, an R.N., approached me one afternoon, and this was before the first medical class had be completed. She asked me if I could consider setting up and passing medications because they were so short of nurses. I agreed because I had noticed 15-, 16-, 17-year-old high school kids passing these medications, and I certainly felt that I was more qualified than they.

She showed me how to look at the medication card, then look at the prescription of each patient, and then you place the medication in a cup and place them on the medical tray. I did this. When I had finished—I don't know an aspirin from a mothball. When I finished this, Mrs. Moor walked into the medical room and she checked it out. She says, "Great." She handed me the keys. I was a full-fledged medical aide. That is the only lesson that I have had, and that was all of the supervision. Of course, she was busy going other places because the home is short of help.

Mrs. KIPPELS. I have always understood infectious diseases should be isolated and sterile procedures used, but in this home they made no attempt to do either.

I would like to tell you of patient No. 11. This was a patient that we cared for for quite a long time. He had been a patient on the second floor originally and was transferred to third. He was not very confused. He had dentures. We removed the dentures and cleaned his dentures at night before we put him to bed. We gave him general care, helped with his feeding, and so on.

One day when I came to the floor I heard he had been sent to Midway Hospital. Nothing was said for about 2 weeks about this patient. Then one of the other patients who did a lot of talking told me that she overheard Mrs. O'Connell and Dr. Johnson—Roger Johnson, the house doctor—stating that the patient, No. 11, had died of active tuberculosis at Midway Hospital.

I went to the R.N. in charge and asked her about it and she said, "Yes, didn't you know?" I said, "No, I didn't." She said, "Why don't you talk to Mrs. O'Connell about it?"

I asked Mrs. O'Connell if it were true. She said, "Yes, and I suggest the staff go down for a test." We were not told this as an automatic thing. We had to inquire ourselves as to what patients die of.

We went down to receive our Mantous test. I asked the health department if they were going out to the home and check the other pa-

tients. They said a Mantous test could not be given as the condition of their skin was so bad. I asked if they were going to take a chest X-ray unit to the home. They said "No."

Now, this patient was on second floor and on third floor. As far as I know, on his chart, he did not have active TB when he came to that home. They all became very concerned. One orderly was so upset because he was afraid he'd bring it home to his family. We were told not to worry about it.

After that patient died, the room was not even washed down. Another patient was moved right into the bed that he had been in. This also happened quite often.

Another patient, patient No. 12, he had confirmed staph infection. This patient walked around barefoot all the time as he did not have stockings most of the time and his shoes were lost or laying around someplace. Everything seemed to get lost in that home. He was also not isolated. He was kept in a room with two other gentlemen. There were no treatments given to this man on the shift that I worked. We didn't have the supplies in the first place to give them the treatments if we even wanted to.

As far as I know, there was no way they kept patients that had infectious diseases isolated from the other patients.

The nurse never seemed to want to call the doctors on our shift. In fact, I have heard that they have been told on occasions not to call doctors after a certain hour of the night. Consequently, some of the patients went through very unnecessary suffering.

One of the saddest I have seen in that nursing home, patient No. 13, she came in as an apparent stroke victim. She did have a little difficulty swallowing when she came to the nursing home. Progressively it got worse. It got to the point that she couldn't swallow at all. Mrs. Finney and I passed her her medications. We repeatedly wrote on the day book that she could not swallow. The day book is a book used on each floor for aides and orderlies to write things about patients. This is then later recorded by the nurse onto their charts.

We reported it many times. I wrote it down in red. I underlined it. I told nurses many times that this patient could not swallow, there was something wrong with her throat, take her in and have her X-rayed. They didn't do a thing. They left her. She didn't see a doctor. They didn't bother to call a doctor for her.

This went on for approximately 6 weeks. The patient's stomach became very distended. One day when I came to work there was an aide and orderly in the room. They were given orders by Mrs. O'Connell to pump fluids into this patient as she was dehydrating. This was too late. They said they couldn't even get a teaspoon of water down her. If they could wait 6 weeks, it would be very hard for an aide and an orderly at this time to do anything. She should have been sent to the hospital. She was not. The next day she died. The doctor was not there when she died. The doctor had not been called before she died. We knew this because Mrs. Finney and I checked her chart to see the last time the doctor saw her. We knew it was approximately a month to 6 weeks.

Mrs. O'Connell held meetings of the staff once in awhile. This happened a few days after this patient died. She was confronted as to why nothing was done for this patient and why the doctor hadn't seen

her. She turned red, said the doctor had seen her in the hallway but he didn't chart on it. We know it wasn't true, because we had checked her chart. We went back and checked her chart, and it had been written in.

There was also another patient, patient No. 14. One day I came on my shift. As I come on my shift I usually walk down the hall and look into the rooms and check the patients out. I looked into this one room, the man was sitting in a geriatric chair. Geriatric chairs are chairs with trays that the patient is locked into the chair. He was laying on the tray of that chair with his arm hanging over the side. I walked over to him, he appeared to me to be sleeping. Mrs. O'Connell happened to be on the floor that afternoon. I went to the desk and asked Mrs. O'Connell if I could put him to bed. She said, "No, just leave him. Dinner will be here soon and you can put him to bed after dinner."

That was 3 o'clock in the afternoon. We didn't get the dinner trays until about 5 or 5:30. I then went down, checked the other rooms, came back to his room. I looked at him and he looked strange to me, walked up to him and tried to waken him. He would not respond. His eyes were rolled back in his head, I went back to the desk and told Mrs. O'Connell about it. She brought an orderly with her, checked his vital signs, called the hospital. He was sent to the hospital. He had had a stroke. He was then brought back to the nursing home.

After that time he sat in the geriatric chair from morning to night. When we would come on our shift, we would tell the day aides and orderlies to try and take him out of the chair once in a while as he would be sitting in urine and he was breaking down. Nothing was ever done for this man. Every day we come on he was still in that chair.

He got sick again. He got very, very sick. His temperature went very high. The man was dying. We told the nurse. She did not call a doctor. She said, "There is nothing we can do, anyway." I said, "He is conscious." Mrs. Finney and I were in the room. He looked at both of us with his pleading eyes and the tears running down as if begging for help. There was nothing that either one of us could do, our hands were tied, as aides, we cannot do anything without a doctor or a nurse's order to do it.

I then went back to the desk. I almost begged the nurse on my hands and knees to give him some kind of sedation so his dying could be made easier. Nothing was done. The next day I came to work he was gone.

The death certificate book they use in this nursing home is signed out by nurses. There are very few names of doctors in these death certificate books. Most of the time it is a private doctor or, if the family is there, they will make sure a doctor is called. But this does not happen very often. Therefore, we have no proof of what those patients die of.

The use of tranquilizers was most alarming to me. If a patient walked too much, talked too much, they were given tranquilizers. It got so bad that a patient had to be sent to the hospital to be awakened from an overdose. This is patient No. 15. This patient was an ex-professional boxer. He was a very large man, but yet he was very

gentle and well mannered. He would get up at night quite often and wander in the halls. A lot of people would be afraid of him, but, after you got to know him, he wouldn't hurt a flea. Some of the aides and orderlies didn't like him getting out of bed so much at night. They posied him down. I have seen them use five posey belts on this man. He has gotten out of all five of these posey belts.

Mrs. Finney and I, when he would get up, would give him something to drink or a peanut butter sandwich or some magazines. Eventually he would go back to bed. But then some of the aides couldn't take this, they didn't want him wandering around. They didn't want him up at night. Therefore, they got an order of thorazine for this man to quiet him down. He had been getting chlorohydrates but they didn't do him too much good.

The doctor had ordered the thorazine to be given for 7 days, and then to call him back and let him know how this man was doing on the thorazine. This order was disregarded. He was given this for 15 days. Then it wouldn't have been stopped except for a bad experience we had and Mrs. Finney will tell you about that.

Before she does, I'd like to tell you I have read in the Physician's Desk Reference that thorazine, a tranquilizer, can have adverse action on patients. Instead of quieting them down, it can do the opposite.

Mrs. Kippels. Mrs. Finney will tell you more about this.

Mrs. Finney. This patient No. 15 was a very gentle, well-mannered patient. One night I was working in the medicine room when this patient appeared at the door. He started slugging me and accusing me of going with his wife. There was only one other aide on the floor and she wasn't familiar with the floor, so she started to scream. The more she screamed, the more I screamed, the more I got slugged. So about that time an orderly came on the floor—thank goodness for that—he had come early. He looked at the gentleman and he knew him very well. He just called his name, spoke gently to him, and set him down in the hallway there and gave him a peanut butter sandwich and a glass of milk.

I proceeded to call the nurse on the second floor. She came to the floor, she called the police. They called St. Paul Ramsey and that's where he was taken and from there he was taken to Hastings.

Mrs. Kippels. Another patient, Patient No. 16, this happened on March 15, 1970, 8 days before Mrs. Finney and I were fired. This patient was overdosed with a tranquilizer. He was sent to the hospital to be awakened.

Another drug used in extreme amounts in that home is Darvon. Darvon is to relieve pain.

Patient No. 17 was a welfare patient. She got Darvon constantly for over a period of 2½ years or better. It cost the welfare department approximately $80 a month to keep this woman on Darvon. On the daybook it says that she was given Darvon for headaches, yet no doctor ever came in to check to see why she got headaches, no nurse ever checked to see why she got the headaches. She was continually given Darvon, and the Physician's Desk Reference also says the side effects of Darvon are headaches.

There are also many other patients on that floor that get Darvon and in large amounts.

There were occasions when the nursing home experimented with patients without permission or notifying families. Five patients from that nursing home were picked to receive a drug called Duraphil. This was an internal deodorant. These five patients were picked by Mrs. O'Connell. After starting the medications, all five patients seemed to get loose, runny, green stools. One patient in particular, No. 18, she had an extreme loss of weight during this time. She was black under her eyes. We walked behind her and mopped up from her loose stools. Her clothes were stained with loose, green stools.

The family used to visit her—they were from out of town—about every 2 weeks. They came to ask me what was wrong with her system. As we very seldom had a nurse on the floor, and they gave the responsibility to Mrs. Finney and myself to practically run that floor, I felt it was my duty to tell them that she had been losing weight steadily since she was put on this drug. They said they had not given permission for them to use this on her. They took her out of the home.

Living in a nursing home at its best is not easy, but when you mix normal patients with the confused patients you get pure havoc.

Patient No. 19 was a patient who was moved from the first floor to the third floor. He was a very, very nice patient. We couldn't understand why he was moved from the first floor to the third floor. As I told you before, when I came on the floor, I walked to the rooms and checked some of these patients. I found this man 3 days later, after he had been transferred to the third floor, sitting in a geriatric chair, in a gown, with his bare feet on the floor, tearing up papers, talking as if he had completely gone insane.

This happened to be one of my favorite patients. As I told you, I worked on the first floor. He used to come down and keep me company later at night. I was so upset by this that I went out to the desk and I said, "Who in the hell did this to this man? He does not need to be in a geriatric chair." They said, "I don't know," which was usually the case. I then tore downstairs to see Mr. Thayer. Mr. Thayer and Mr. Trana were in the hallway and I am sure they will remember this. I told them about this patient being in that room, that they had driven him to a point of insanity by keeping him in a geriatric chair, and he had been used to going to the store for other patients and buying them things they needed.

On the third floor a patient is not let out. They stay on the third floor.

Mr. Halamandaris. Lorraine, let me cut in if I can.

We are having a little difficulty with time, so we are going to ask you, if I can be this presumptuous, to cut your testimony a little bit. If I may, maybe I can help you get through it by asking a number of questions, and I hope you can appreciate the necessity of doing so.

Mrs. Kippels. I can't.

Mr. Halamandaris. We will apologize one more time and make the best of the situation. I am sure that you wanted to make a statement for the record beyond your affidavit, which I have here.

I wanted to ask you whether you had gotten to the point of discussing the use of experimental drugs in this nursing home.

Mrs. Kippels. I wanted to explain for us, I know Mr. Shypulski has got some testimony that relates to what is on that board over there [indicating]. If Mr. Shypulski would talk about the people that he

has leading up to the items that are on that board, I think that will expedite the situation.

Mr. SHYPULSKI. On display over there on the board [indicating] we have some teeth, and I will go into teeth right now.

At the Lexington Nursing Home very seldom we had toothbrushes, and when we did finally get them they were cheap toothbrushes, and I remember an incident very well when I went into a room and I was going to brush these two patients' teeth and I started to brush their teeth and their gums really started to bleed and said, "Please, don't brush our teeth. Don't even bother. The pain is bad." So I quit, and then I got some mouthwash and washed their mouths out so they wouldn't get any infection. Then I noticed that some of the bristles from the toothbrushes had got in between their teeth.

I would now like to mention another patient, and this patient is patient 29. He is on third floor. His gums and teeth are rotting and they are all red and inflamed. They have been like this for I don't know how long and nothing is done about it.

You can see over there [indicating], we have eyeglasses, and these are eyeglasses that are misplaced. Like they will take a patient's eyeglasses off at night and then when we come the next day they are gone, and they get thrown in a box in a room and, because we don't remember what their eyeglasses look like and they aren't marked, we can't put them back on. Now and then we will gather the staff around and try to put glasses on patients.

Many times we will have catheters that are left in too long like you can see that one [indicating] is rotten. I have seen many like this in the home.

There are some prescriptions there. Those are prescriptions that are reused, ointments. For example, I remember one for instance, we had a patient and he had some kind of foot trouble. They kept his prescription and used it on other patients, Garamycin ointment, which many times we used on other patients.

You can see also that regular medications from the medicine room are used, like chlorohydrate, sedatives, narcotics.

Also we have, if you see the scissors and the tongs [indicating], these were used—just a minute, please. The scissors and tongs that you can see up above on the board [indicating], I'd like to bring you up on this. This patient, because of his neglect, he was ignored, this patient got bed sores and he broke down extremely bad and no one did nothing for him. A doctor was never called, and we couldn't do anything for this man without doctor's orders. One day after Mrs. O'Connell had refused to follow doctor's orders, she went in the room and she started to remove the dead tissue with the scissors and tongs that are all rusty and the tongs are also rusting, and that is a dimestore paper scissors, as you can see.

Mrs. KIPPELS. He was given no anesthesia.

Mr. SHYPULSKI. Also there was no sterile technique used for doing this at all.

Mrs. KIPPELS. I want to tell you about the teeth you see up there. When I first came to that floor, the teeth had never been taken care of. I went to take teeth out of one patient. I tried to pry them out. When they did come out, the skin and blood came right with it. I thought after that time I was never going to pull anybody's dentures out again, they'd have to stay in their mouth.

Mr. SHYPULSKI. Also you can see an example of the washcloths up above [indicating]. They are all like this. All the linen is like this at the nursing home.

There is a specimen of a bed bug there. I remember one patient who was taken and he was put in the chair and when we came to put him to bed at night he had all these red sores all over his behind and up and down his legs. I didn't know what they were. I told the nurse. She thought maybe it was just from sitting in urine constantly, she didn't know. Also there is an incident that we have proof on—we also have photographs on a lot of this.

Mrs. KIPPELS. We have photographs on most of the things we discuss, so there is proof on it, so any question that comes up we'd be glad to show you those.

I'd also like to say that there was an incident when an aide and an orderly removed a diaper from a patient. In this diaper it was full of bugs.

I will bring up this humidifier incident as it was brought up before you were questioning about it.

We had an order for a patient to get a humidifier. This was at night on the 3-to-11 shift. It was late enough that we couldn't get it from the usual pharmacy which was Grant Street Pharmacy. Therefore, it was ordered from Desnick's Drugstore. The humidifier came to the home. On the box it was marked $9.95 sale price. On her bill, which was to go to the welfare department, it was marked $14.95. Mrs. Finney was also there that night. We brought the bill to the nurse. She said, "Oh, my, isn't that strange? I will call the drugstore." She called Desnick's Drugstore. They told here, "We get $5 more from the welfare department." She said, "What do I have to pay for it, can I get it for $9.95?" They said, "Yes."

Mr. HALAMANDARIS. Did you talk about the amputee? Have you mentioned his case?

Mr. SHYPULSKI. No.

Mr. HALAMANDARIS. Would you say a couple of words about that.

Mr. SHYPULSKI. When I first came to the home, there was this one patient, he was on second floor. He used to walk to the bathroom and he used to putter around. Anyway, he started to get mean and he used to fight the aides and orderlies a little bit so he was moved to third floor. When he got to third floor, he was ignored. His teeth were never brushed. He was never shaven. He was never dressed. He just sat with a gown on, with a blanket over his knees, and sat in urine with his feet in urine.

He began to break down, and when Mrs. Finney came back after she was reinstated by the National Labor Board, she looked at this patient the first time since she had been back, she looked at his leg and I noticed before when we touched it he hollered in pain. It was a darkened area above the ankle and swollen. I told the nurses but nothing was ever done.

So finally Mrs. Finney touched his leg when she saw him and he hollered and she said, "Call the nurse." I called the nurse, Mrs. Demar, one of the finest nurses I know, the best one they have ever had there since. So, anyway, he was sent to the hospital the next day and his leg was amputated between the knee and the hip. When he came back from the hospital, he was in good condition. His teeth were clean, he was shaven. He started to look bad again, and he started to break down. I

think a reason a lot of them break down, he was drugged with librium. They got a doctor's order for librium. They had him so lethargic he couldn't drink or hold his head up. It was more like the restraint was holding him up instead of his being restrained in the chair.

I can't even describe this. He got these bed sores. We have pictures if you'd like to see them. We had to treat this man and Mrs. O'Connell, the director of nurses, gave us a prescription, you know, the treatment, use sugar peroxide treatment. It got so bad that Mrs. Demar called Dr. Roger Johnson, the house doctor, and he prescribed elase for the sores and garamycin.

The next day Mrs. O'Connell came up to the floor and she said, "We will not use them prescriptions. We will go back to the sugar and peroxide. This works better." So she went against doctor's orders and we kept on this.

At the same day the incident with the scissors came on when she was doing him up good there.

So we went on with the sugar and peroxide treatments. Then early in September a doctor did come and see this patient and about 3 or 4 days later, they had sent a lab specimen in, and we had talked of staph at this time, and it got so nobody would go near him except a couple of us that worked our shift, none of the other shifts would take care of him.

So he came back and he had confirmed staph. It took them 2 days to put him in an isolation room. He was left with two other patients, one bed patient and one ambulatory patient that walked around. They put him in the so-called isolation room, and I know because one of the aides that works at the home is going to be a nurse and she had told me that day about isolation procedures. This room was a farce. I can't even describe it. They had gloves in there. The gloves didn't fit. They'd slip. They had one paper mask and we are supposed to use gowns in an isolation room. If we used them, then we couldn't have gowns for the patients, so we had to go without.

The peroxide was taken in and out of the room. The door was never closed. People would wander in and out. Patients would go in and use the bathrooms. There was bathrooms on both sides of the hall of the isolation room, and they'd wander in and out. There was no disinfectant. There was no supplies in there to do the treatments. There was a scissors that we had to take in and out of the room because there weren't any others. Sometimes there wasn't even soap in there to wash the patient off. The door was left open and on November 6, after I had been suspended from the home, the patient died.

Mr. HALAMANDARIS. I'd like to ask Laurel Meyer if she has a brief statement to make.

You haven't said a thing so far. I would like to hear something from you.

STATEMENT OF LAUREL MEYER, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME

Miss MEYER. The one thing that I'd like to tell you about is one evening a patient fell out of the third-story window. She fell approximately four stories to the ground. We put this patient to bed early that night because she was very irritated by a very confused roommate. She had diabetes. We had no idea that she had diabetes. She had been

telling us she was leaving as soon as she got her shots. We had no idea that she was even a diabetic. We were very busy that night, the staff had been rotated. Nobody was too familiar with the patients. We put her to bed early, as I have said, and a bed check was made at 10 o'clock. This patient was not in her bed, nor on the third floor. Mrs. Richardson, the L.P.N. on the third floor that night, was notified. At 10:45 the patient had still not been found. I remembered an open window that I had found on my search for the patient and checked outside. The patient was found at the bottom of a basement stairwell. She was mangled but she was alive. The charge nurse never left the building; an orderly checked her vital signs.

I called the hospital later that night to see how she was and was told that this patient had expired about 2:30. I thought that when something as terrible as this had happened that the health department would finally have to do something about the conditions in this nursing home. Unfortunately, this type of condition still exists today.

Mrs. KIPPELS. I'd like to add that she was put in a room with a patient that was very, very, very confused. She slapped her around all the time. This other patient was sent to Hastings. That was one of the reasons that this patient was trying to get out of the home. She was so afraid of her roommate.

Mr. HALAMANDARIS. I have a couple more quick questions.

Laurel, where are you employed at the present time? Are you still at Lexington?

Miss MEYER. No; I work at St. Paul Ramsey Hospital parttime in pediatrics.

Mr. HALAMANDARIS. Bob, are you employed by Lexington? When did you quit or were you fired or what was the situation?

Mr. SHYPULSKI. When I started getting this information together, my employer, Mr. Thayer, found out and he suspended me from my job from the home, and until this matter is cleared up he said I will not be notified.

Mr. HALAMANDARIS. I understand there was a case before the National Labor Relations Board which related to Mrs. Finney and Mrs. Kippels and that you were both reinstated with backpay. I understand, Mrs. Finney, you chose not to go back?

Mrs. KIPPELS. I chose not to go back. Mrs. Finney did go back.

Mr. HALAMANDARIS. I see; Lola, you are still employed at this nursing home?

Mrs. FINNEY. No; I terminated myself as of the 1st of November. I couldn't take no more of that, watching the suffering of those old people.

Mr. HALAMANDARIS. So then we have some sort of chronicle of what has happened in this nursing home from 1968 until November of 1971.

My question, then, is what are the conditions like in this nursing home now, do we have any record?

Mrs. KIPPELS. In the last 2 weeks affidavits have been taken from employees of this nursing home. Two of these employees still work there.

The affidavits are from the following: Greg M. Stage, Jean Heininger, David L. Van Dyke, and Mary Jane T. Bozych. They are aides and orderlies at this nursing home.

The following conditions still exist in that home: There are still cockroaches on the third floor. There are new aides who don't know

what a commode is or a bedpan is. Salves and medicines are still used from dead patients on other patients. The laundry of the infected are still being thrown down with the other laundry. These are not sorted yet. There is one thermometer on the third floor. It is used for both oral and rectal. At least nine employees have left the home in the last 5 weeks because of the bad conditions and the added pressure of the administration.

In conclusion, I would like to show you how bad this home has become over the past 2½ years. The average rate of death at the Lexington Nursing Home has been three patients a month. But since October 20, 1971, when Mr. Halamandaris and Dr. Lawson of the health department visited the Lexington Nursing Home, 15 patients have died in that home, and at least three strains of lethal bacteria have been discovered among these patients. Ten of them are from the third floor, by the way.

Mr. HALAMANDARIS. Clarification. Was that 15 people who have died since I visited the nursing home on the 20th of October?

Mrs. KIPPELS. That's right.

NOTE.—Since October 20, 1971 (the date of the visit to the Lexington by the M.A.O. team, Val Halamandaris—the Staff Council to the U.S. Senate Subcommittee on Aging and Doctor Lawson—head of the Minnesota State Health Department) the following patients have died at the Lexington Nursing Home:

Elizabeth Sperlich	Oct. 20, 1971
Archie Siegert	Oct. 27, 1971
Edna Gillespie	Oct. 30, 1971
Peter Lojogan	Nov. 3, 1971
Myrtle Clardy	Nov. 4, 1971
Einer Eckland	Nov. 5, 1971
Edward Gabrielson	Nov. 6, 1971
Oscar Peterson	Nov. 11, 1971
Matilda Berg	Nov. 12, 1971
Isador Nussbaum	Nov. 14, 1971
Matilda Karp	Nov. 18, 1971

Approximately during this period of time—the following four patients from the Lexington Nursing Home died in area hospitals:

Ida Bique	Nov. 7, 1971
Mable Deyo	Nov. 8, 1971
Alfred Johnson	Nov. 10, 1971
Hazel Pepin	Nov. 17, 1971

Senator MOSS. Thank you very much. What you have told us, of course, is repelling, indeed, to hear, and you have documented it well.

I understand that your statements also are contained in affidavits that were taken from you?

Mrs. KIPPELS. Yes; they are.

Senator MOSS. Those are part of the record so we will have that in full.[1]

You know, this is so shocking that it is hard to contemplate this sort of a condition going on.

I don't think that I have any particular questions. I have been able to follow this rather closely.

Senator Mondale may have some questions.

Senator MONDALE. Thank you very much, Senator Moss.

Mrs. Finney, you say you have worked at this nursing home since 1968?

Mrs. FINNEY. Yes.

[1] See prepared statement, p. 2218 and Part 19B, p. 2291.

Senator MONDALE. Do you happen to know what this nursing home charges per month for care, whether it is an expensive nursing home, a moderate-priced nursing home or inexpensive, do you know?

Mrs. FINNEY. This I cannot say. All I know is about the help.

Mrs. KIPPELS. I know it is about $15 a day, but I do know of a private patient that paid $800 a month in that nursing home. This private patient got exactly the same kind of bad treatment and bad food as the other patients that were paying $15 a day.

Senator MONDALE. Mrs. Finney, you have been there since 1968. How often have you seen State inspectors or local inspectors at the nursing home?

Mrs. FINNEY. Senator, I went there a month after the place opened, and I don't even know who the inspector is. I have never seen any inspector there. Somebody said Mrs.—what is her name—Christiansen was there, but I have never seen her.

Senator MONDALE. Have you worked full shift since 1968?

Mrs. FINNEY. The 3 to 11 since October 21, 1968.

Senator MONDALE. And you don't recall having seen an inspector?

Mrs. FINNEY. I don't know her.

Senator MONDALE. How often would you see physicians visiting?

Mrs. FINNEY. Pretty rare. I couldn't say I saw any once a week.

Senator MONDALE. Thank you.

A VOICE. Senator Mondale, if I may, I had a brother that was out in that very same place. We didn't keep him there very long because, when we entered the room, it stunk so you could not sit in there to visit him.

Senator MOSS. Thank you very much. We, of course, can't accept volunteer statements from the floor or we will be here all day, and we are going to be here all day, anyway.

I appreciate it, and I understand your feelings, and I hate to cut off anybody who would like to make a contribution, but we must try to get through as orderly as we can. We do have others whom we have asked to testify whom we must get to this afternoon.

I do thank all of you very much for your testimony.

We will have a 30-minute recess and then we will go on this afternoon.

(Whereupon, the subcommittee recessed at 1 p.m., to reconvene at 1:30 p.m.)

AFTERNOON SESSION

Senator MOSS. The hearing will come to order.

We will call Mr. J. I. Green, executive director of the Minnesota Nursing Home Association, who will have accompanying him three or four other people. I'm not sure just who it will be. Mr. Schumacher and Mr. Meillier, the president and president-elect of the Nursing Home Association, Dr. Henry Blumberg is expected to be here.

We will ask you gentlemen to proceed in whatever order you care to.

STATEMENT OF J. I. GREEN, EXECUTIVE DIRECTOR OF THE MINNESOTA NURSING HOME ASSOCIATION, ACCOMPANIED BY DR. HENRY BLUMBERG, JOHN BROEKER, MRS. JENEAN ERICKSON, DAVE OLUFSON, JERRY HUSET, DENNIS LAYER, PHILIP SCHUMACHER, AND DAVID MEILLIER

Mr. Green. Thank you, Senator Moss and members of the committee for the opportunity to testify before your committee today. My name is J. I. Green, executive director of the Minnesota Nursing Home Association.

I have held this position for 3 years, and 6 years prior to that I was executive director of the Missouri Nursing Home Association.

The Minnesota Nursing Home Association is a voluntary nonprofit organization, composed of long-term care facilities, licensed by the Minnesota Department of Health.

Our membership does represent a cross section of long-term care facilities in the State of Minnesota. Among our members are proprietary facilities, those operated by municipalities, we have county homes, those operated by religious groups, and those community oriented. At present we represent over 40 percent of the facilities in the State, and we are growing.

At the present time, the majority of our new members that are coming into the association are in the nonproprietary category, in spite of the fact that there is an organization in the State that represents those on an exclusive basis.

By a federation arrangement, we are also members of the American Nursing Home Association in Washington, D.C.

While the association has many programs, our major focus is on education. We firmly believe that the quality of care in the State of Minnesota can be elevated through the means of education. Mr. Dennis Layer, who I hope to have a chance to call later on, is our director of education and he can elaborate on our program.

Our annual convention is reputed to be one of the largest and finest conventions in the United States, and I think the reason is because it is about 90 percent education oriented. Last year, for instance, we had 27 educational sessions in 2½ days involving over 1,600 persons.

We are also interested in peer review. Now, it is my opinion that there is no way, and I repeat that, no way, that excellence can be legislated. We feel that the quality of care can be elevated and maintained through education, motivation, and peer review. We feel that peer review can be much more effective than statutes, regulations, investigations, and inspections.

About a year and a half ago, the association attempted to implement a self-policing program. The project died for lack of funds. We have renewed our efforts and hope to have a fully structured and funded program by the middle of next year.

Each year, with the American Nursing Home Association, we participate in National Nursing Home Week. In just a few days we will be conducting, the association will be conducting, its third MNHA senior shoppers spree, where nursing home residents go to three shopping centers this year in the twin cities. We have a choral group singing, we crown a king and queen, the oldest lady and gentleman, we

have coffee and doughnuts for them, and then they do their Christmas shopping without their sons and daughters looking over their shoulders. We feel it is very important. We feel it is a meaningful program, and to date over 900 nursing home residents are already scheduled to participate.

Time does not permit me to fully describe the programs of the association. Perhaps I can do that at a later date.

Over the past 2½ years, many allegations about the quality of care in Minnesota nursing homes have been made. Today we have heard more allegations, many of the same ones we heard 2½ years ago, but some new ones, however. I have a lot of pride in my own personal work in the Nursing Home Association, and especially the nursing home profession. In spite of what has been said here today, I will walk out of this room just as proud as when I walked in at 9:30 this morning.

Having this pride it would probably be natural for me to want to attack those that have been garbage mouthing our profession, and while this might even be my preference, I won't do that. I don't want to lower myself into the same category.

I will state, however, that through the repeated charges over the past 2½ years, the charges have destroyed some public faith in nursing homes, faith that was justified because of our gradual but consistent sophistication and dedication to total care of our residents. The charges have put a "tainted" label on the entire profession, a label that's totally unfair, untrue and unwarranted. The charges have made an already difficult job of staff recruiting even more difficult. Naturally, the providers of care are sensitive. I think that you would expect that. But the allegations have also been very upsetting to residents of nursing homes and their families.

Can you imagine how a resident might feel when they see or hear the media reports about the charges and the investigations and so forth, or can you imagine how a son or daughter might feel, the son or daughter that probably already is extremely guilty about placing Mom or Dad in a nursing home to start with.

If you'd like to know how people have reacted, I think you could ask any of the nursing home administrators in the room and they could tell you exactly what this has caused. The friends, and I quote that, the "friends" of the aged have complained about lack of enforcement by the health department. It is common knowledge, that the department is short staffed. Yet, when the department went before a legislative committee to request additional personnel, the "friends" were nowhere to be found. I was there. In fact, I represented the only group outside of the health department or welfare department that supported their request. Where were the "friends" then?

In spite of the fact that some claim that the 2-year attack on the nursing home profession has been beneficial, and that the charges have even moved mountains, to date, I really don't think that I can say that there has been any concrete, constructive accomplishments. It is my opinion that if, in fact, the charges of abuse, neglect, poor food, inadequate care, and personal indignities were true 2 years ago, and because of their failure to properly inform the authorities, very possibly permitted them to continue, those "friends" of the aged have been grossly negligent and have done a great, great disservice to those they are purporting to help.

The Minnesota Nursing Home Association has repeatedly offered to cooperate with these "friends," and has many times challenged them to document the evidence and deliver it to the people that have the authority to do something about it. Our pleas went unanswered and the challenges were not met.

Tell me then, really, who is concerned?

I think it is unusual that any time the context of a statement written 2 years ago can be valid 2 years hence, I think it is really an unusual case, and I am going to give you some excerpts of an article that I wrote in September of 1969 for the "Better Life," which is the official journal of the Minnesota Nursing Home Association. It reads as follows:

> In assessing any problem, one must be objective, must be knowledgeable, competent to evaluate and, of course, must be sincere in their approach. In any profession, business or occupation, some always do a better job than others. This has always been the case and, of course, it always will be. To say that there are no substandard conditions in Minnesota would be sheer folly. And just as ridiculous is the statement that substandard conditions exist in a majority of Minnesota facilities.

Now, while these charges haven't been made just recently, they have been made several times in the past. With approximately 28,000 nursing home beds in Minnesota, there are then potentially some 10,220,000 patient days per year. Considering the volume of care being rendered, complaints are sure to be made. An official from the Minnesota Department of Health recently stated that "our office receives an average of about five complaints per working day." Among the complaints are complaints about food, refunds, care, doctors' charges, Medicare, et cetera. Some of these are telephone, some by letter, some valid, and some not. To me, five complaints per working day compared to over 10 million patient days per year are not cause for undue alarm.

The primary sources of complaints come from residents, relatives, and employees. I would like you to listen as I examine each category.

First the resident. Complaints by residents are sometimes valid, and yet, due to the process of aging, they cannot all be accepted as fact. The unfortunate presence of guilt complexes among some relatives can very easily cloud their interpretation of comments by those whom they visit and, at the same time, their evaluation may be correct.

Employees, due to their presence in a facility, are in a good position to observe conditions. However, the testimony of former employees, especially those that have been involuntarily terminated, are not always credible. What I have been saying is that the matter of charges and substantiation of such charges has many facets.

The operation of a nursing home is a very complex one. It is many things to many people. To the resident, it can mean life removed from familiar settings, medical problems, social problems, and loneliness.

To the nursing home, it means a staggering, and I repeat that, it means a staggering responsibility of trying to provide a full life for the resident, meeting all of his needs, medical, social, physical, emotional, and spiritual, needs that no longer can be met by their relatives. It means trying to provide the better life through total care.

Where substandard conditions do exist, it is my opinion that they must be corrected within a reasonable time or the facility is closed. Nursing homes are in a service profession. If a facility cannot render quality service, it is failing in its responsibility. Since the welfare of

our aged hangs in the balance, a strict quality control must be maintained.

As I stated recently in a television interview, I, too, am concerned and so is my association. We will work to identify problems and seek solutions with any person or organization that is sincere, knowledgeable, and will conduct themselves in a responsible manner.

I have a philosophy that's guided me well through the 9 years that I have been associated with nursing homes, and it is like this. "I believe that old age is an accomplishment, not an affliction, and that it must be treated with kindness, understanding, and dignity."

Thank you, Mr. Chairman. That's the conclusion of my testimony. Other persons from our witness list will be called.

I am now free to answer questions.

Senator Moss. Thank you very much, Mr. Green, for that opening statement, and we look forward to hearing the other witnesses.

Do I take it from your statement that you feel that there is no substance to the allegations, as you called them, that were made by other witnesses?

Mr. Green. Senator, the thing that has concerned me all the way through this, going back 2½ years, and I have never and I am not right now questioning anyone's integrity, but I just can't imagine, if these conditions did exist, why there was not enough concern to do something constructive then. By that, I interpret that the same people have been involved in those conditions since that time 2½ years ago. We repeatedly challenged people to deliver the evidence, and it was never done. So what happened to these people that were supposedly involved in those conditions 2½ or 3 years ago?

Senator Moss. Well, I asked a similar question and was told by the witness that they instructed people who had a complaint to go and make that complaint to the health department.

Mr. Green. I can't answer for the health department. I am sure Dr. Lawson will, but I have checked with the health department, I suppose, monthly over the last two and a half years, and the question was "Has anyone from MAO or people in this category turned over this purported evidence to you?" The answer has been emphatically, "No."

Senator Moss. But does your association undertake to deal with conditions where there is a substandard home? You talk about education, motivation, and peer review. Are you engaged in such programs?

Mr. Green. As I stated in my statement, we tried to get a self-policing program off the ground. We figured it would cost $40,000 or $50,000 the first year, we did not have the funds. When complaints have been made to the association, they have been referred to a standards and ethics committee and they have been investigated. Now, many times I have had complaints over the phone, and I would say fine, send me a letter, I need something in my file and we will take it from there. Very rarely have I ever received a letter.

Senator Moss. Well, let us hear from the other witnesses.

Senator Mondale. Might I ask some questions?

Senator Moss. Yes, Senator Mondale.

Senator Mondale. How would you recommend the committee treat the testimony we heard this morning—as having no basis whatsoever, as having some, substantial, or a great deal? Would you dismiss it entirely, or do you find a basis of truth in some of what we heard today?

Mr. GREEN. Senator, I can't answer that because I haven't personally seen the evidence, and I would hope, in fact, if I were in a position to demand, I would really demand that we have an opportunity to see it.

Senator MONDALE. You are the executive director of the Minnesota Nursing Home Association, you have been a professional executive secretary for 8 years?

Mr. GREEN. Nine.

Senator MONDALE. Nine years. Doesn't that background give you some basis for giving us your version of how the committee should evaluate and weigh what we heard this morning?

Mr. GREEN. Well, I would think that the committee, if they haven't, is going to have to absolutely ascertain that the charges made are, in fact, true.

Senator MONDALE. Do you think there is no basis to what we heard this morning?

Mr. GREEN. No; I wouldn't say that at all, Senator. I'd say there must be some.

Senator MOSS. Thank you.

Mr. GREEN. Senator, I would like to call Dr. Henry Blumberg now. He is a physician who has cancelled some appointments to be here this afternoon.

Senator MOSS. We are pleased to have Dr. Blumberg.

You may proceed, Dr. Blumberg.

STATEMENT OF DR. HENRY BLUMBERG, PAST PRESIDENT, ASSOCIATION OF MINNESOTA INTERNISTS

Dr. BLUMBERG. Thank you, Senator.

My name is Dr. Henry Blumberg, B-l-u-m-b-e-r-g. I am the immediate past president of the Association of Minnesota Internists, which is a component of the American Society of Internal Medicine.

The American Society of Internal Medicine has been the first organization of doctors which has devoted itself exclusively to medical socioeconomic problems, and our members throughout the country have been leaders in the medical socioeconomic area.

Now, I haven't prepared a script for what I have to say because I was brought in at the last minute. I think to give some depth to the understanding of the nursing home movement in the State of Minnesota, my experience with it, in detail, dates back some 15 years, and I think by relating to you what I have been through, particularly with my professional insight into it, I think that perhaps a better understanding of just where nursing homes stand at the present time can be forthcoming.

Back in 1956, I moved up to St. Paul from southern Minnesota. I came up to St. Paul because I had become a board certified specialist in internal medicine. Sometime during that year I succeeded in getting my certification, and on becoming certified, applied for staff membership to what was then called Anchor Hospital, it is now the St. Paul Ramsey County Hospital, and this automatically placed me in a position to become an assistant clinical professor at the University of Minnesota.

This sort of positions are at the disposal of one who has become board certified in his specialty, for both the county hospital and the

University of Minnesota are badly in need of such people. However, upon receiving my staff membership to St. Paul Ramsey Hospital, I was asked to see the superintendent, Dr. Thomas Brodie, and he approached me rather furtively about a matter which he felt I might not want to accept. He said to me, "Henry," he said, "the Federal Government has insisted that every patient on old age assistance who is in either nursing homes or some other type of special care in the county has to be seen once every 6 months by a doctor, and we would like you to go out and see them." He said, "Now, I'm not insisting that you do this, but somebody's got to do it and you are the newest member of our staff." He said, "I want to warn you a little bit, you might have some trouble with the social workers of Ramsey County, because they don't see things as doctors do."

I accepted this position, and from the years 1957 through 1961 I went out near and far to all or virtually all of the nursing homes in the county of Ramsey, where St. Paul lies. I went out to farmhouses where two or three elderly people were being taken care of along with the children and the dogs. I went into small apartments where one or two people were being taken care of by a person. I went into old houses where dozens of people were being taken care of in facilities which were, to say the least, terribly inadequate. I was dreadfully upset at first, and I soon became acquainted with the people in the Ramsey County Welfare Department and soon became their friend, for the nurse at the Ramsey County Welfare Office felt exactly as I did, as did the administrators, as did the social workers. But it was a darn tough situation. One of the worst aspects of this situation at the time was as follows:

The laws which existed at that time required that anyone who was on old age assistance in the county had to be taken care of at the St. Paul Ramsey Hospital. No one at the St. Paul Ramsey Hospital made house calls, so no one came to the nursing homes, aside from me, and mind you, my schedule was once every 6 months to see these people.

In order to take care of this superficially, three doctors were hired on a part-time basis for approximately $3,000 a year to take care of whatever house calls or emergency calls were necessary for all the indigent in Ramsey County. To make matters worse, these three doctors, not being board certified specialists, were not eligible for admission to the staff of St. Paul Ramsey Hospital and, as a consequence, were at loggerheads with the interns and residents who were responsible for admission to these hospitals.

One of the worst difficulties was a complete lack of communication between the hospital and the nursing homes. I heard nursing home proprietor after nursing home proprietor complain about the fact that people were sent to the hospital because, in the opinion of the nursing home proprietor and the nursing home personnel, they needed hospitalization, and they were sent home, they were sent back to the nursing home in 4 or 5 hours with nothing, they were just sent back. The nursing home people could only scratch their heads and wonder why and what was to be done.

Well, I, of all people, was in a position to do a little something about this. I could serve as a sort of a bridge, because I was on the staff of St. Paul Ramsey, and I endeavored to make that bridge, and I had visions of doing a great deal more with this situation. After all,

I had most of the pieces there, I was in a position to influence with respect to the welfare board people. I was on the staff at St. Paul Ramsey, and I was in communication with the nursing home people. My tendency at that point in the game was to create a revolution, with me as the hero of it. And there came a day when a meeting was called, not by me, but by somebody else, in response to the nursing home situation, and I rather rationally started to talk about these problems and to my dying day I will be grateful, some guardian angel must have been looking over my shoulder, because I did not expose people. I held my tongue, and many of the problems which I looked at in 1959 when this meeting occurred have been corrected. The old mansions have been closed down.

About 1959 the State board of health, on its own initiative, looked into this problem and made unbelievable improvements in the care of the elderly in the State of Minnesota, and anybody who saw the problem in 1957 or 1958 or 1959 and looks at it as it exists at the present time could not help but be impressed by those improvements.

In 1961 I was asked to be a member of the board, the executive board of the Association of Minnesota Internists, and in the years which have intervened between then and now, I have both become its president and have been almost constantly on its legislative committee. As such, I have touched with Daphne Krause who, as I understand, testified this morning, and I have held correspondence with Senator Mondale, as perhaps he remembers, on numerous problems.

Now, about two years ago, partly through my background, we endeavored to do something with regard to the nursing home problem as an organization, and we put together a resolution to correct some of the problems that we as doctors thought existed with respect to them. We presented that resolution to the American Society of Internal Medicine and to the Minnesota Medical Association, and both groups adopted the resolution. However, this resolution relates to another problem than the status of the existing nursing home. It is our feeling, and it is my devout feeling, that if the elderly need one thing it is a facility to match their needs, and that, on the whole the older person is worse off when he is overtreated. If he is kept on his feet, if he can be kept on his feet, if his mind is kept active by semi-independence, if he can handle that semi-independence, that is where he belongs.

One of my experiences in going around to the nursing homes was to find that, to my surprise, elderly people were sometimes better off with dogs and cats and young kids running around in farmhouses than they were in the best nursing homes in the State. Why? Because they had to do certain things for themselves. One of the most clear-cut impressions of the situation that I can think of is that of a little girl who was the daugher of a woman, not a nurse, but a woman trying to run a nursing home in an old mansion by herself, and to see the eyes of the elderly light up at the sight of the little girl, because I think little girls are good for old people.

I think I have one more comment to make regarding the situation that exists today, and that is as follows.

I think that if there is a doctor who knows the difference between good nursing home care and poor nursing home care, it is likely to be me. I am very careful about where I send the people I take care of when they are placed in a nursing home, and one of the nursing homes

that I have four patients in is the one that was most vigorously attacked this morning. I'd like to tell the committee and the audience about two of my personal patients who are in this nursing home.

One is an ex-school teacher who perhaps taught some of you in St. Paul. However, about 7 or 8 years ago she developed premature cerebral arteriosclerosis and could no longer think clearly. At that point she was put into a nursing home, and later put into another nursing home, and then a third nursing home, none of which could handle this patient. She happened to be the patient of an elderly doctor with whom I became associated and who subsequently developed cancer of the lung and 6 months later passed away. During the 6 months between the time he was incapacitated and the time I took over, while they were waiting for him to come back, and he never did come back, the patient was not seen at the Lexington Nursing Home, and when I first came to see her 6 months after she had last been seen by a doctor she was clean, she was well controlled, and she was in good health, as good health as she could be maintained in. This lady dresses immaculately but has no control over either her urine or her stools. I have visited her at least once a month and have never seen her filthy, and when I suggested to the closest relative, a brother who resides in Chicago and had come up to see her, that I'd like to take her into Miller Hospital in order to clarify certain neurological things about her that I didn't quite understand, he would not let me do it because he was afraid that she'd lose her place in this particular nursing home. Now, that's one of the patients I take care of in this nursing home.

The other is a 93-year-old lady who has been under my care for the past 3 years, and who lived at home with her two elderly daughters. At 93 you can have elderly daughters. Mother is a lovely person. In spite of the fact that she is senile, she is a blessing to be around, she is always smiling, but mother also, in her senility, was an awful problem to take care of. She'd be found up on chairs trying to remove light bulbs at 93, and finally one day or one night, she got up around midnight and fell down the stairs from the second floor to the first floor and fractured her pelvis. She had to be taken into the hospital, of course. While she was there I found that she also had pernicious anemia and a urinary infection, and her hospitalization was prolonged, and after the hospitalization she needed further care in the long-care department of St. Mary's Hospital in Minneapolis.

Now, with the termination of this lengthy hospital stay, we have the problem of putting her in a nursing home. The elderly daughters recognized the fact that they could no longer take care of her, and I suggested that they put her into the nursing home that has been so violently castigated this morning. The two daughters did not want to put her in there for one big reason, that being that this elderly lady had a somewhat younger sister who was 88, I believe, who was already in this particular nursing home, and they were afraid that the elderly lady would bother their mother, and this was something to worry about. At any rate, they put her in a different nursing home, and they called me up 48 hours later and said you've got to move mother because mother is going to die unless something else is done. So I arranged for an ambulance and she was taken to this particular nursing home. She was admitted to this particular nursing home and I can testify to the fact that she has been fine ever since.

I guess that's all I have to say.

Senator Moss. Thank you, doctor. We appreciate your testimony. You reiterated what we all believe, I'm sure, that it is much better for people to be in their own home than in a nursing home, obviously. I don't think anybody looks forward to sending people to nursing homes. It is a question of, when it is necessary for them to go, what is proper care.

I was interested to hear your recital based on the experience with your two patients. I take it you were not here this morning to hear the testimony that was given.

Dr. Blumberg. No, sir.

Senator Moss. Well, some of it, accompanied by photographs and other things, was rather moving, I can assure you.

You have pointed out that things are a lot better than they were in 1956. Well, wouldn't we expect them to be better than they were in 1956?

Dr. Blumberg. I know of places where they aren't, Senator.

Senator Moss. Yes. We didn't have any Medicare or Medicaid in 1956, and the AMA was telling us, you know, that this would be disaster if we ever had Medicare or Medicaid. Now we have it and we do have the opportunity to take care of people much better now than we did before; isn't that right, I mean financially?

Dr. Blumberg. Financially is not the only——

Senator Moss. No, Dr. Blumberg, I say not only, but without the financial base for taking care of people you can't do much for elderly people who generally are poor. They don't have much income; is that right?

Dr. Blumberg. Yes, but I believe that Minnesota has done a better job along these lines than almost any other State. I know the situation in quite a few of them through my national organization. I think Minnesota can be proud of the advances they have made.

Senator Moss. Well, I am very glad to hear that, and I am perfectly willing to accept that. Of course, that doesn't say very much for some other States.

But what the problem is, how are we going to deal with situations where people do not get proper care in nursing homes? That's what we are trying to get our hands on. We hope that all nursing homes would be good, ideal, that they would give the best of care, but some do not. Now, how are we going to see that they all do?

Dr. Blumberg. I don't think we can. That's one of the points I have been trying to make. The whole thing about the facts in 1957 was that they could not be solved overnight, and anybody who thought they could and tried to do so was likely to wreck the ship. It is a slow, difficult, extremely complex and extremely difficult problem that you are talking about, with many facets.

It reminds me a little bit of a patient I've got in the hospital at the present time. She had a breast removed for cancer in 1958. In 1968, 3½ years ago, I found that she had a chest full of metastases, filled up with fluid. In spite of this, I have kept her alive for 3½ years with the added help we received, and today I've got her in the hospital because she has developed one of these metastasis along the esophagus which is making it difficult for her to swallow and she demands of me that I get her back on her feet as quickly as possible.

Well, 5 years of survival after surgery for cancer of the breast usually means cured, and she went 10 years. They talk with considerable optimism about 90 days of improvement after metastatic disease for a cancer like this, and she has gone on for 3½ years, and it isn't that easy to give her something to get rid of that esophageal metastasis, believe you me. I did do one thing for her yesterday, however. I told her in no uncertain terms that what she needed more than anything else was patience, and for the past 24 hours she hasn't been having any difficulty in swallowing.

Senator Moss. Senator Mondale.

Senator MONDALE. Just one question. Dr. Blumberg, I think you said during your testimony you knew of some bad nursing homes. What is being done about them?

Dr. BLUMBERG. I can't tell you, Senator.

Senator MONDALE. In light of the fact that there are some bad nursing homes, do you see a need for some changes that might protect persons from receiving what might follow from being an occupant in those nursing homes?

Dr. BLUMBERG. I think that constant surveillance along these lines is an absolute necessity.

Senator MONDALE. And by whom?

Dr. BLUMBERG. The State board of health.

Senator MONDALE. Do you think that they have adequate staff and policies now with which to do that?

Dr. BLUMBERG. They do.

Senator MONDALE. Well, then, why do these bad nursing homes continue?

Dr. BLUMBERG. It is a difficult job.

Senator MONDALE. No further questions.

Senator Moss. Mr. Halamandaris has a question.

Mr. HALAMANDARIS. Doctor, I have a couple of questions here. I want you to take this card, and while we are waiting I want you to write the names of your two patients for me. I don't want you to utter them publicly, but will you write them down for me?

Dr. BLUMBERG. I don't think that's in accordance with professional ethics.

Mr. HALAMANDARIS. I do.

Dr. BLUMBERG. I don't think I will write them down for you.

Senator Moss. Well, we won't compel you, Doctor, if you don't want to reveal them.

Mr. HALAMANDARIS. When was the last time that you saw these patients, Doctor?

Dr. BLUMBERG. Saturday.

Mr. HALAMANDARIS. Do you love your wife?

Senator MONDALE. You better get counsel.

Dr. BLUMBERG. If I do I won't tell you.

Mr. HALAMANDARIS. One last question, I'm sure you won't answer this either. Would you put your wife in the Lexington Nursing Home?

Dr. BLUMBERG. Yes.

Mr. HALAMANDARIS. I think you just answered my previous question, also.

Senator Moss. We will have the next witness, please.

Mr. GREEN. I would like to now call Mr. John Broeker, legal counsel for the Minnesota Nursing Home Association.

Senator MOSS. Mr. Broeker, we are very glad to hear you, sir.

STATEMENT OF JOHN BROEKER, LEGAL COUNSEL, MINNESOTA NURSING HOME ASSOCIATION

Mr. BROEKER. Senator Moss, Senator Mondale, and others present at this hearing.

I am John Broeker. As Mr. Green indicated, I am an attorney with the law firm of Broeker, Bachman & Heetland. In this capacity, but not always with this firm, I have served the Minnesota Nursing Home Association as their legal counsel for approximately 3 years.

I am not going to talk long. I am going to talk about those areas of nursing homes that I am familiar with, and I am going to talk, for the most part, about positive action that the association is taking toward meeting some of the problems that I know some of you are deeply interested in.

I would like to respond initially to a question asked by Senator Mondale of Mr. Green. I think I can safely speak for those in the association when I say that there may be some abuses. All I think Mr. Green was trying to say and all that I am trying to say is that we felt deep frustrations because for the 2½ years that I have been aware of alleged abuses, we have been unsuccessfully trying to find out for ourselves what some of these abuses are. Offers of help to Mrs. Krause and others have been made from time to time. Today I think we learned more about specifics than we have before in many, many different areas.

Senator MONDALE. Would you yield there? I think that's an important statement.

For nearly 5 years I served as Minnesota's attorney general, and I found that every profession and every industry, including my own, the legal profession, has some bad problems. The profession can either admit it and try to deal with those problems frankly and effectively, or unlike too many of them, stand and argue that nothing is wrong and defend the bad apples in the barrel. I think when that happens everybody suffers.

What we need here is a candid admission by everyone that there are some very serious problems. That's not a condemnation, that's a realistic situation, a realistic appraisal and then let's work together in terms of legislation, in terms of funding, in terms of training and professional help to end these problems. Putting the association in the position of helping us find what the problem is and helping us solve it—then I think you will have more public support than if the position is taken that nothing is wrong because nobody believes that. That's what you are proposing and I commend you for it. I think with that attitude we can go ahead and do something.

Mr. BROEKER. I would like to add, though, that, while making that admission, I think and I would suppose that the record of this hearing will be left open for a period of time so that where specific allegations were made this morning they can at least be looked at and perhaps discredited. We then can get the true basis from which we can start on any problems that may exist. I think we all realize some comments were

made this morning that may or may not be true. I think we would say clearly that there are some problems.

As I said, I am going to explore this area.

Senator MONDALE. Mr. Chairman, I would move that the record remain open.

Senator MOSS. I will announce that.

Mr. BROEKER. I will now move into what I hope is the positive portion of my testimony. As I say, I have been primarily involved with the Minnesota Nursing Home Association and with various profit and nonprofit nursing homes in two areas, legislative and legal. I would just like to briefly go over some of the things I have been involved in to point up some of the things that we have been working on.

When I first started with the Minnesota Nursing Home Association, it was this association that took the lead in the State of Minnesota in seeking passage of the bill to license nursing home administrators. I drafted the original legislation that was introduced, and the people in the association carried that through.

An argument can logically be made that we were worried about such legislation only for selfish reasons, but I would point out that Minnesota is one of the few States having such legislation where we intentionally did not put a majority of nursing home administrators on the board. I think this is an indication of the type of people who are involved in this association and who are concerned for good legislation and not just vested interests.

We worked this last session on several pieces of legislation. I feel a particular need to comment on one because it was raised this morning. That has to do with what we call the State uniform inspection bill. I think the innuendo was made this morning, and perhaps not intentionally that we were trying to lower standards. The concept that we were trying to push and did push throughout the entire session was that we need a uniform set of standards. We don't care if the locality adopts the same standards as the State. We don't care if a locality enforces their local standards or the State standards. We are arguing for uniform administration. The point we tried to make throughout the legislative session was that these standards can be high. We are willing to live with whatever standards you come up with. We are looking for uniformity, and I think that needs to be clarified as a result of some of the comments that were made this morning.

We have just completed, and by we I mean one of my law partners and myself, a lengthy, 18 months of preparation for a lawsuit that was tried in Ramsey County District Court last week. I am not going to take the committee's time to comment about a lot of the details on the lawsuit, but I want to point out one important fact because I think it points out the dedication of the people that I am working with.

This lawsuit is going to cost my client thousands of dollars. Yet, they are not going to get a cent in recovery from this lawsuit, win, lose, or draw. The entire purpose of this lawsuit is twofold. No. 1 is to get guidelines from the State department of public welfare in the administration and reimbursement of the nursing home program and No. 2 is to get some guidelines for the counties to work under. In Minnesota we have a county-administered, State-supervised system, and this goes to the heart of something that this committee is talking about; that is, paying for patient care. We are looking for guidelines whereunder we can get some desperately needed coordination between our department of public welfare and our department of health to

know what is required for us and how we are going to pay for it. The reason this is of such concern is we've got at least 65 percent of nursing home patients in the State that are on some type of welfare program. It is crucial for the people in this profession to know what they can do and what the guidelines are. They aren't going to gain anything out of this lawsuit except that answer, if we can come up with that answer.

I would point out, as just an aside, that we have been interested in the concept of combining our department of health and department of public welfare into a State HEW, such as you have at the National level, in an effort to simplify some of the problems that can only lead to better patient care.

I want to touch, and I mean just touch, very briefly on two other points that were raised this morning.

In a discussion between Senator Mondale and Mr. Edie the concept of a better way to get at substandard nursing homes is through a quicker licensure removal procedure was talked about. I would disagree with Mr. Edie on the point that citizens cannot initiate procedures for license removal. I have not checked the statutes between this morning and now, but it is my recollection that citizens can initiate these proceedings. Be that as it may, I think it is a great idea to try and come up with some streamlined procedure under due process of law. That is, you have to have procedures to protect what might be false claims, but you also have to have procedures to make the department effective. We haven't talked about this but knowing the people that I work with I am sure that they would agree. It is a novel approach and I would hope that Mr. Edie and myself might be able to get together and work on something in the next legislative session along those lines.

The final point is just a very small one, but I raise it because some confusion was evidenced up here. The payment for drugs to nursing homes is not part of the per diem rate paid to nursing homes for the care of welfare patients. It is paid directly, under promulgated schedules by the department of public welfare, to the vendors of the drugs. This may or may not be a problem, I don't know, but I would point out simply that it is not one that involves the nursing homes, at least in the State of Minnesota.

I would be available for any further questions and I thank the committee for the opportunity to testify.

Senator Moss. Thank you, Mr. Broeker, for your testimony. I think, as Senator Mondale indicated, that you have taken a very constructive and forward looking attitude. Your suggestion that you would be willing to cooperate in drafting the type of legislation that would be needed to permit complaints to be swiftly processed with due process to protect those accused but, at the same time, get to the root of the problem and quickly dispose of it would undoubtedly improve greatly the situation that apparently exists in some places. So I think that is a very forward looking thing.

I am sure, as you are saying, that there are in the nursing home association many, many proprietors of nursing homes who are doing everything they possibly can for the welfare of their patients, and there are good nursing homes, but that, nevertheless, should not blind us to the problems that do exist in some, and that's what we are trying to delineate so that we may determine how we might deal with those problems. We do appreciate your testimony.

Mr. BROEKER. Senator Moss, if I may I would like to add just one concluding comment on that thought. It was interesting to me as I was calculating percentages during the testimony this morning that apparently 125 nursing homes were investigated by MAO. Of that total, 40 were found to be substandard which is, in my way of thinking, less than a third. Even if all of these allegations can be sustained as pertaining to all of these 40 homes, that's a significantly less percentage than I understood to be the case in the rest of the country.

Senator MONDALE. I believe that's correct. I said in my opening statement, and I think this is what our preliminary investigations disclosed, that Minnesota is probably a better State than many of the others, for whatever reasons, but we still have many tragic situations.

Mr. BROEKER. I don't mean to minimize the problems which we must deal with.

Senator MONDALE. That's what we must deal with.

I remember one time we went on a poverty tour among Alaska Eskimos, and one of my colleagues got mad and said all we are looking at is poor people. He went on a prosperity tour instead, and left us. Some people say all you are doing is concentrating on the problem. Well, that's our job, you know, and that's your job, and that's the association's job. We've got to eliminate these problems. As long as one Minnesotan has to go through anything remotely approaching what we heard this morning it is wrong, and everybody ought to be against it. I think you agree with that.

Senator MOSS. Thank you very much, sir.

Mr. Green.

Mr. GREEN. Senator Moss, now I'd like to call Mr. David Meillier, president-elect of the association.

Senator MOSS. Mr. Meillier, we are glad to hear from you, sir.

STATEMENT OF DAVID MEILLIER, PRESIDENT-ELECT, MINNESOTA NURSING HOME ASSOCIATION

Mr. MEILLIER. Senator Moss, Senator Mondale.

I am the administrator and owner of a 63-bed nursing home south of Minneapolis and as was stated I am president-elect of the Minnesota Nursing Home Association.

I should like to address my remarks to the failure of the Federal Government to develop a consistent policy with regard to the care for the elderly. Although formal institutional care predates all of us here, we remember it in the form of county poor farms. Such places were necessary because people did exist who had neither means or ability to support themselves, nor relatives to do it for them. Those who were fortunate enough to have private resources sought to bring someone into their home to assist with care or sought other facilities to provide it. Inevitably, too many exhausted their resources and were faced with the dilemma of how to solve the problem. Thus evolved the welfare program. Individual States could not cope with the ever mounting costs and logically turned to the Federal Government for financial assistance. Unfortunately, this assistance has continually been manifested sporadically in diverse directions. We have seen a myriad of programs such as old age assistance, a State program jointly funded by the Federal Government, aid to the blind, aid to the disabled, Kerr-Mills legislation, the medical assistance legislation, Medicare and

Medicaid. All of these programs are the result of a concentrated effort in a specific area. However, they all lack coordination of effort. They were conceived by different laws or different segments of the same law and try different groups of interested legislators.

To further compound the confusion, the minimum standards for qualifying for participation in the aid varies between the programs. By this I mean the minimum amount of assets a recipient may be allowed to have and still qualify. Some programs allow the retention of a $10,000 homestead, another a $15,000 homestead. One program requires the levying of liens against the property while another does not. One program allows the recipient to retain $11 per month from their personal income to provide for personal needs while another allows $14 per month. Many nursing homes, in an effort to provide the highest quality of care for the needs of the patient, maintain a level of staffing required for extended care facilities and skilled nursing facilities, yet receive patients under the other categorical aid programs.

Medicare seemingly was designed to help the elderly convalesce after a hospital stay, yet is only creating confusion. At its inception the elderly were told that they were entitled to 100 days' benefits in a nursing home. Because the Government soon discovered that the program costs were triple the original estimation it attempted to reduce the costs by stricter interpretation of the type of care which the Medicare program would pay for. The result was denial of benefits at a much sooner date during the convalescent period. The patient was in no way able to return to home living. Although Medicare agencies classify their needs as custodial, the patient many times is incapable of doing anything for himself. In an effort to provide for continued medical care, many of these same patients previously subscribed to private insurance policies to pay for care not covered by Medicare. Unfortunately, this meant payment of the deductibles under the program for care after the 100 days of benefits were exhausted. However, as soon as benefits were terminated midway during the 100-day period, the insurance companies terminated coverage under their policies also. Even in many States the qualification for skilled care under a welfare program ceases with these terminations of benefits under the Medicare program. These are the things which are causing confusion.

Through all of this confusion is the ever-present fact that the elderly need quality medical assistance.

Gentlemen, it is my understanding that you are here to discover what failures exist in the delivery of quality health care to the citizens of our country. I ask that you not return to Washington, D.C., and work to create still another piece of legislation which will further compound the confusion in the delivery of health care to the elderly, but rather coordinate and standardize existing programs to provide adequate health care in the future.

Thank you.

Senator Moss. Thank you, Mr. Meillier. Let me say I agree with you most heartily that we ought to have an overall program by the Federal Government, and this is something we have been crying for for a long time. I am glad to have your testimony on the subject.

Mr. Meillier. Senator Moss, if I may add, it seems to me that these various programs are funded in various categorical aid departments

under different legislation, and it seems that the Federal Government, and by this I mean our legislators in Washington, attempt to camouflage the cost for providing of care and obviously if all of these were lumped into one program the American public might be truly staggered by the overall cost. Yet if we don't do it this way, how are we going to get a smooth flow of care to the elderly?

Senator Moss. Well, I agree with you heartily and I will send you some copies of my speeches.

Thank you.

Mr. Green.

Mr. Green. Senator, I would like to call on Mrs. Jenean Erickson, R.N., chairman of our education committee and administrator of Claremar Nursing Home.

STATEMENT OF JENEAN ERICKSON, R.N., ADMINISTRATOR, CLAREMAR NURSING HOME

Mrs. Erickson. Senator Moss, Senator Mondale, honored guests, and ladies and gentlemen.

I have prepared some remarks concerning the lack of physician involvement in the nursing home setting today.

The failure to place and accept responsibility is endemic to the entire system of health care for the elderly.

First let me give you some of my background. I graduated from Swedish Hospital School of Nursing in 1956, the same year that my parents realized their lifelong dream and finally opened the Claremar Nursing Home. For 12 years I worked as a registered nurse while my husband got his masters in social work and we had three children. Then in December 1968, my mother became extremely concerned about some of the problems in our nursing home and somehow she challenged me to take a leave of absence from my hospital job and to become the director of nurses at Claremar until she could get someone else. During the first few months I became sensitized and challenged by the elderly. I somehow overcame my initial fear and depression and I began to realize that I really cared about these people. My philosophy became to treat them as I would want to be treated, and soon I realized I could not leave them. I then became the administrator in May 1969, and after taking that first step my involvement has continued to the place where I find myself testifying today at a public hearing.

The role of the doctor in the nursing home is an ambiguous one. The Federal Government initially recognized the need for close supervision by physicians in nursing homes that provided extended care. However, the resulting flood of paperwork, the frequent denial of physicians' decisions, as well as the extremely high cost of this type of care are only a few of the problems. The ultimate result for most nursing home patients is further removal from the direct care of the doctor. For some it means a brief visit from the physician once or twice a month. For others it means little supervision of their care on a day-to-day basis, prescriptions that run too long or are not refilled, and changes in conditions that are not met by changes in prescribed treatment. While sometimes the nursing home staff may be at fault for not reporting a patient's condition, evidence also points to the fact that some doctors are not available as often or as consistently as the medical needs of the patient demand.

I would like to point out that many physicians are conscientious, and certainly we realize that they are overworked. The quality of patient care at the present time is usually measured in terms of the goals of those professionals participating in the care of the patient. In the care of the aged, I question whether the goals we set are always relevant. For example, we know that many professionals today are preoccupied with technical accomplishments, with identification, with status, and with the protection of their own vested interests. I suggest that these goals are not always consonant with the delivery of health care to the aged. Those of us in the profession of health care are finding ourselves charged with the necessity to do it better; not only to be able to heal or prolong life, but also to be concerned with the reverence for life shown by the way we do it.

Nursing homes are concerned with what is probably the most vital question in the survival of the human race: the quality of life when it is no longer productive. How do we take the knowledge we have and interpret it in such a context that there is an affirmation of the value of human existence? I believe the medical profession must become flexible, must set new medical goals for quality based on values derived from the changing society we live in today.

A serious omission of the medical profession has been the failure to assume the responsibility for the nursing home as a whole. I realize doctors are frequently critical of some nursing homes. However, I seldom see signs that they have taken any initiative to upgrade them or to provide adequate medical direction for the total nursing home program. Often I feel they believe their responsibility ends with individual patients which are assigned to them.

Even though by law a client has free choice of physician, I recall last year when an 83-year-old woman in my facility was unhappy with her doctor. She gave me three names of doctors to contact. They all stated they were taking no new nursing home patients. I then called 12 doctors that I knew personally from my years of working in the Twin City hospitals, and again I found no physician wished to take on another nursing home patient. I was reminded after a call to the local medical society that the doctor has a right to choose how he spends his time. They had no solution for me. About 3 months later, I finally found an internist who is now delivering quality care to my patient.

Another very real need of our elderly, who suffer from the same mental sicknesses as the young, is expert diagnosis and treatment. In the United States there are very few active psychotherapeutic centers for geriatric patients. I have personally been refused help for my disturbed, agitated resident because she lacked "rehabilitative potential" because of her age.

Another very real problem is the shortage of physicians in the United States. Training an adequate supply of physicians to meet the demands of a population constantly outdistancing them in growth seems perhaps, if not hopeless, certainly not realistic in the foreseeable future. In my opinion, pouring more money and people into the current health care delivery systems will only produce chaos and not first-rate medical care nor efficient utilization of health resources. There seems to be overwhelming evidence, at least in the health care field, that we are so preoccupied with the unknown that we fail to deliver enough of what is already known. Instead, we appear to perpetuate, duplicate,

and almost honor a system of doling out medical and nursing home care in the same episodic, discontinuous, and uncoordinated fashion which was typical in the 19th century.

The role of the doctor caring for the elderly needs more professional emphasis in medical schools. Because of human and economic pressures on young doctors, the roles of the medical school, Government, and the public become vital in persuading more doctors to become concerned about the aged.

On the other hand, I might suggest that possibly we have enough doctors but maybe too many hospital beds. Since doctors are subject to the same problems as we are, they should not be blamed for choosing to make the best use of their time. The efficient doctor will group as many patients as possible in one hospital, see as many patients as possible during office hours, and attempt to reduce the hours of non-productive time whenever possible.

As the areawide comprehensive health planning agencies become more efficient, this should improve. While the physician is a highly qualified specialist, there are time when the path of physician convenience must be directed by economic guideposts. While I fully subscribe to the theory that adequate health care is the right of every citizen, I subscribe just as heartily to the theory that this right should not be abused by anyone.

Speaking as a registered nurse, the most frustrating problem in facing deficiencies in patient care is lack of support from doctors who ought to be our allies. Let me identify some of these frustrations for you.

1. Failure to examine newly admitted patients within 24 hours unless they are admitted from a medical facility.

2. Occasionally patients arrive in poor physical condition, without diagnosis or treatment orders, indicative of medical neglect.

3. A high percentage of patients admitted from hospitals neglect to have copies of laboratory and/or X-ray data.

4. Patients on digitalis and other potent drugs are at times unaccompanied by treatment orders.

5. Preventive care and periodic health evaluation services are usually not initiated by physicians.

6. Frequency of physician visits are unrelated to the condition of the patient.

Let me say at this point that I don't feel it appropriate for legislation to regulate physicians' visits. This should be a professional judgment possibly within a framework of Federal recommendation.

7. Patients on digitalis, diuretics, with diabetes and/or heart disease, often have no clues from the doctor or the chart to indicate such a diagnosis.

Notable improvements have been made in facilities and in activities programs, but in my opinion little, if any, growth has occurred in the quality and delivery of medical care. If the quality of medical care for the aged is disappointing, an effort ought to be made to pinpoint some of the reasons for it. Most of us who work in nursing homes will readily agree to the following: Many homes have too few medical staff members, budgets are forced to be too lean, and some attending physicians either don't understand or don't care about chronically ill patients.

Dr. Martin Cherkasky, director of New York's Montefiore Hospital, recently enumerated incorrect assumptions made by both laymen and physicians that often lead to inadequate funding for chronic care facilities. He said many people believe the following; a low level of nursing and medical care is needed for chronically ill patients, and only patients receiving acute care require costly health resources. These views lead to the greatest misconception of all, that good care for the chronically sick is cheap.

This mistaken notion seems to be shared by members of government, for while they ask us, on the one hand, to provide social, recreational, diversional, and rehabilitative programs, they budget us for only minimal care.

The need for orienting, educating, and training doctors is an urgent one. Researchers have found medical care of the aged to be characterized by "negativism, defeatism, and professional antipathy." Medical professionals who are inexperienced in dealing with aged patients frequently display their feeling by allowing personal prejudice to influence their decisions. Many physicians cannot see the elderly for anything but his age; and, therefore, consider him senile. Some doctors still seem to think that confusion and depression in the aged are purely psychotic disorders. In reality they could be related to a broad spectrum of physical disabilities, or as elementary as confusion and depression because of weakened vision and hearing.

I realize that the term "gang visit" has a derogatory implication which probably developed when an already overworked doctor tried to do more than he could handle. However, I believe that with proper direction and organization a "gang visit" by a qualified physician could be the cornerstone on which to build quality health care. Regular medical attention and guidance are imperative.

They are the basis for preventive medicine which is as important to the elderly as it is to the young. It can only be provided if the patient is seen regularly by a physician who is committed and interested in the geriatric patient. In order for him to use his time efficiently, Government must recognize this and leave medical judgments to the discretion of the doctor.

I would also call on the public as well as the professionals to stop the traditional belief that nurses who care for the elderly are a step lower than other nurses. Nurses in Minnesota have formed a professional geriatric conference group with the sole objective to provide professional development in the area of geriatric and long-term nursing care. Many of our doctors depend on these dedicated nurses to provide them with an accurate assessment of the patient's condition, to suggest medication and treatment changes as the patient's condition changes, and even to serve as their liaison with the family when there is a need.

Somehow I believe part of the answer to the lack of physician involvement will be found by educating and recognizing qualified nurses. She needs incentives for continuing education, legal guidelines to operate within, and financial reimbursement for the responsibility she has already been forced to assume in many cases. Nurses are already performing highly specialized tasks and exercising independent judgment once considered strictly the physician's responsibility.

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As nursing homes grow, nurses will be forced to make even more medical judgments in the absence of the physicians. In the large gray area where there is constant overlapping of functions and responsibilities, the nurse-physician relationship has become one of mutual interdependence.

Whenever possible when identifying problems, I believe it is required to discuss possible solutions. The use of qualified physicians' assistants must be developed and recognized federally as a valid improvement. The Minnesota Nursing Home Association supported this legislation, but it was defeated in the recent session.

1. The entire spectrum of chronic disease must be more extensively researched and then implemented.
2. Major changes need to be made on the legislative level to provide economic incentive for physicians to keep our elderly healthy.
3. Professional surveyors should be trained and have the sole authority in correcting deficiencies, thus eliminating unqualified, publicity-seeking investigators who serve little, if any, worthwhile purpose.
4. A comprehensive, coordinated system of health services involving all aspects of health care must be developed and available to our aged. This program must be legislated and funded.
5. A continuing program of education about the aging process should be required for physicians and nurses and available to the general public.
6. Efforts should be coordinated and responsibilities specifically assigned to provide our elderly with the requests which result from the 1971 National White House Conference on Aging. A national commitment to serve the elderly is desperately needed. There is an overall pessimistic philosophy policy at the national level. The champions for the elderly seem to materialize during the fever of election time. Historically, the United States has viewed the aging citizen as a problem, not a challenge. We need national leadership committed to creating a climate of progress in our attitudes toward the aged. Usually when the political campaign is over, the promises and hoopla are erased from the public's mind and the elderly are again forgotten except for those dedicated people who continue to care and to serve in our Nation's nursing homes.

The nursing home profession, the Government, and the medical professions must work together to achieve the degree of excellence our elderly deserve.

We must not be afraid to risk in any area since it is imperative that only positive change occur in the lives of our elderly. The fiscal impact of age must be erased. The challenge and motivation must be assumed by responsible people willing to get involved.

Certainly many of our physicians are aware that geriatrics is a challenging and rewarding field and I am confident that more physicians would find this out if they would give themselves the opportunity.

Jim Sova from the Minnesota Medical Association today stated that they had never received complaints on physicians from any Minnesota patient, M.A.O. representative or employee on physician involvement in nursing homes in Minnesota.

As a result of today's hearing, action rather than simple rhetoric is required. Hearings without positive action merely serve to destroy the confidence of the Nation's ill and elderly in our nursing homes.

Thank you.

Senator Moss. Thank you, Mrs. Erickson.

Mr. Green, would you urge your people now to begin to summarize. We are right up against the line on time.

Mr. Green. Does that mean, Senator, that we cannot call additional persons for testimony?

Senator Moss. Well, I don't know how we are going to get to the others on the list if we do begin to call additional ones. Schumacher is here at the table. Do you have others on this list that you expected to call?

Mr. Green. We had planned for Mr. Schumacher to give a summary. I have one to speak on training, as was described in your letter to myself as one of the issues, and especially Mr. Halamandaris' suggestion, the testimony about some innovative programs being used in our nursing homes.

Senator Moss. We'd be glad to hear them, but let's see if we can have them summarized, put the statement in the record and highlight it for us.

Mr. Green. Thank you, Senator.

I will call on Mr. David Olufson now.

Senator Moss. Glad to have you, Mr. Olufson, and if you can highlight your statement, the entire text will be in the record as though it were read in full.

Mr. Olufson. I don't think it will take too long to read it through, Senator.

Senator Moss. Go right ahead.

Mr. Olufson. Yes, sir.

STATEMENT OF DAVID OLUFSON, ADMINISTRATOR, GOOD SAMARITAN NURSING CENTER, EAST GRAND FORKS, MINN.

Mr. Olufson. First of all, I want to thank the committee for the opportunity of being able to testify here today.

My name is David Olufson. I am the administrator of an 111-bed skilled nursing home in East Grand Forks, Minn. The Good Samaritan Nursing Center, a nonprofit facility, of which I am the administrator, and have been for the past 3½ years, is owned by the Evangelical Lutheran Good Samaritan Society, which owns and operates 150 nursing homes in 18 States, of which 22 facilities are located in the State of Minnesota.

My area is inadequate and/or untrained personnel in the nursing home. In this area there have been allegations leveled at the nursing home profession. Many of these allegations, we feel, are unfounded and unfair; others possibly are true. The question is what can be or is being done to provide better training for these personnel in our nursing homes.

First of all, there is always a question of cost. I know it has been alluded to before today, but most nursing homes do not have the financial means of providing adequate training programs for their personnel. In many instances, nursing homes are receiving less than their actual costs for welfare patients who account for more than 65 percent of Minnesota nursing home patients.

There is a limit to what the private paying patient can subsidize. Despite the cost obstacle, many facilities have had in-service directors to train their nurses and nurses' aides on the job. In smaller facilities where this is not possible, the director of nursing fulfills this duty.

In the facility I administrate, we have had an in-service director for more than 4 years. In fact, when we first hired this person, at various seminars throughout the State, the other people had never even heard of such a person and wanted to know what her duties were. I think it has grown to be a more common position in nursing homes nowdays.

Her primary job has been to hire and train nurse's aides. This includes everything from training films, film strips, classroom testing, to working side-by-side with the patient in the practical application of what they have learned.

Our in-service director, director of nursing service, and a limited number of aides as our budget will allow have also attended such courses offered in our community on the topics of inhalation therapy, views of nurses toward patients, leadership development, food supervisors, delegating authority, care of the stroke patients, care of the emphysema patient, a 3-week course on rehabilitation, which, incidentally, is offered through the Kenney Rehabilitation Institute in Minneapolis, continuity of patient care, resources available to hospitals and nursing homes, nutrition and feeding the handicapped, courses on how to teach training courses to nurses' aides, and a list of others.

In instances where only a few could attend these sessions, it has been replayed back to the rest of the staff through inservice education classes.

I would like to bring out the fact that nursing homes have had to take a back seat to hospitals in many areas. One of these areas is in the training of R.N.'s and L.P.N.'s. Traditionally nurses have always been trained in a hospital setting. Most of the nurses seeking employment in nursing homes have done so only after first attempting to find employment in the local hospitals or clinics. Furthermore, I cannot say I blame them; it is only natural they would want to work in the area of their training. What the nursing home profession needs is a specific nurse training program designed for the field of geriatrics, not something left over from the hospital training program.

In the field of nurse's aide training, vocational and technical schools are beginning to offer programs in these areas. Presently most nursing homes are training their own nurse aides. It is seldom that an experienced nurse's aide calls or applies to a nursing home for employment. Unfortunately, again, the cost factor enters in and many of these new nurse's aides have to work on their own after only a few days of orientation, as the nursing home cannot afford double staffing to break in a new aide.

As Jim Green mentioned previously, unfavorable press articles have made the job of recruiting good personnel even harder. Although these articles may have stated that not all nursing homes are substandard, the headlines certainly would lead you to believe otherwise.

Within the last month both nursing homes and hospitals in our area, through the Agassiz Health Planning Council, have met to attempt to coordinate our educational programs and coordinate educational sources available in our area and those which could be brought to our

area through our coöperative effort. Although we are only in the planning stages, we feel that this approach is only logical in our less-populated area of the State.

Incidentally, this council covers four counties in North Dakota as well as 12 Minnesota counties. We all have recognized the need for education of our staff.

I might add that the Minnesota Nursing Home Association has made great strides in the field of education, and if there is time I believe Dennis Layer will speak on that.

I would like to mention a program the Good Samaritan Society has had for the last 10 years, it is called Program Outreach. The program consists of such contacts with the elderly in the community as telephone reassurance. This has been done by both staff and patients.

In addition to that, we have been involved in meals on wheels, bringing patients to the nursing home to enjoy a meal with the patients, not just eating a meal by themselves in their own home. Rev. August Hoeger, Jr., the executive director of the Good Samaritan Society, will submit a written statement on this program for the committee.[1]

In summary I would like to say a few words on behalf of the nurse's aides who are serving our elderly in nursing homes throughout the State of Minnesota. They are often doing a thankless and very oftentimes extremely unpleasant job. It takes a dedicated, certain type of a person to care for the aged. Obviously money is not a motivating factor, as certainly no nurse's aide ever became wealthy working in a nursing home. Let's not criticize these nurse's aides, but rather develop educational programs to more adequately prepare them for this important vocation, and I might add, reimburse the nursing homes in a way that will allow them to pay these nurse's aides an equitable wage for the service they are providing.

Thank you.

Senator Moss. Thank you, Mr. Olufson.

Is the Good Samaritan Society a proprietary organization or a nonprofit organization?

Mr. Olufson. Nonprofit.

Senator Moss. Is the rate of turnover rather high despite the training program you described with nurses and nurse's aides?

Mr. Olufson. In my own facility?

Senator Moss. Yes.

Mr. Olufson. I think this varies with the size of the area. We hire a lot of younger girls, we feel these are good for the patients, and consequently there is possibly a higher turnover than you would find in a rural area.

Senator Moss. That remains one of the problems, doesn't it, in getting adequate care, that there is this high turnover rate of both nurses and nurse's aides?

Mr. Olufson. This I cannot answer, except in my own city.

Senator Moss. Thank you.

Do you have any questions of Mr. Olufson?

Senator Mondale. Do you know what percentage of the personnel working in nursing homes in Minnesota, that is, nonprofessional help, not doctors or L.P.N.'s or R.N.'s, in your opinion, have adequate training for the jobs that they are doing? You say half of them, two-thirds of them?

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[1] See Part 19B, p. 2420.

Mr. OLUFSON. You are referring specifically to the nurse aides now?
Senator MONDALE. Yes.
Mr. OLUFSON. What percentage of them have adequate training?
Senator MONDALE. Yes; in your opinion.
Mr. OLUFSON. Well, my opinion, for what it is worth, I think in my own facility, as that is the only place I can really give you an example, I feel they are pretty well trained. We have an on-going program that consists of weekly sessions with our aides. Both our director of nursing and the inservice director work 1 hour each day for a total of 2 hours hand-in-hand with the nurse aides.
Senator MONDALE. Are you in a position to comment on the level at which the other nursing homes have trained their nursing aides?
Mr. OLUFSON. In the Good Samaritan Society?
Senator MONDALE. No; statewide.
Mr. OLUFSON. I don't believe I would be in a position to answer that.
Senator MOSS. Thank you very much, Mr. Olufson. We appreciate your testimony.
Mr. GREEN. I would now like to call Mr. Jerome Huset, administrator of Summit Manor in St. Paul. He will describe a very innovative and excellent program that they are using in his facility.
Senator MOSS. Mr. Huset, your entire statement will be placed in the record, and you may highlight it in any way you see fit to enable us to get the gist of what you are going to tell us.

STATEMENT OF JEROME HUSET, ADMINISTRATOR, SUMMIT MANOR NURSING HOME, ST. PAUL, MINN.

Mr. HUSET. Mr. Chairman, Senator Mondale, for the expediency of time here, I have passed these out,[1] we will not go through them in depth, I think that I will just explain the overview of the situation. I would like to get to section F on it, being this was dealt with to a greater extent this morning.

I feel that the most important is the section A, the patient care policies section, as well as the financial statements that go out to the board. I also feel that a patient care policy for the nursing home should be directed, voted upon, and OK'd by the board of a nursing home.

That is the foundation for section B, the schema for action. I intentionally left out the upper portion of this. We have this documented on the same basis as the remaining part of it. The part that is interesting is the involvement in the resident care conference, section C, and how this grows. The resident care conference is a group of individuals under the direction of the director of nursing service, and the physician. All of the department heads are members thereof, and this is a recommending body, and this is done on section D, which involves the patient's needs individually, not collectively.

Each resident's name, room number, and their needs are put down there and they are reviewed as to whether they are being fulfilled; if they are being fulfilled, how did we fulfill this, so that we can become successful again at doing this. If we are not, why did we fail and how can this be corrected.

[1] Retained in Committee file.

Now, as a result of this, some needs have come up relevant to the individual patient and that is what we call a reality or a patient-to-patient system. We have four to five individuals sitting in with a therapist, with an OTR, that takes and brings a reality orientation system where the individual is having difficulty finding his room because he is disoriented when he comes there, or as sometimes we fail to recognize that in the aging process we forget once in a while, don't we. We even do that when we are young. But it is terribly demeaning to us when it happens, and at that age group, because it confirms to us that we are losing our mind. So before doing certain things we try to educate them or bring them into perspective.

In the other part of this, this ties in with the resident care conference, where the orientation group moves into a remotivation group setting. You say what value has this to the employees. Well, one of the main problems with, you might say, aides and orderlies is they get bedpanitis, there is not very much incentive, and if they are involved on a 1 to 1 or a group setting like this their motivation is a lot greater.

The optimal nursing care cycle, which parts of it are duplicated from Wayne State University's Public Health Department, this is a system of live audit and closed audit system. I would like to turn back in this system to about page 4 where it goes to the in-depth portion of the control, such as is the call-light in easy reach, is the armband readable, is the drinking water available. These are functions performed by the nursing service. This is an interdepartmental system. They hand this report in to us accumulated. And if you look toward the back part of it there, we can then start to imagine the system.

There is also standards of nursing care, section 1, application and execution of physicians orders; is the medical diagnosis complete, is it clear and in correct terminology; are the orders complete; is the nature, the amount, the frequency and method noted, observations, supervision of the patient; is the family included, does the patient understand the problem, does the family understand the problem. These are then summarized and grouped, and at the end you can see that they are grouped and value assessed accordingly. This is not done by the administrator; this is done by the resident care conference. And on the appendix there you can see the overall summary as to what standing each individual nursing home has.

Also, I feel the relevancy of this is that today there has been a lot of discussion on nursing homes. I think we would have as many definitions of a nursing home as there are individuals in this room. So for clarity for those individuals who are interested in our nursing homes, I clarified all the lines that are necessary and all of the things that we can possibly do. Are there any questions?

Senator Moss. Well, I can see this is a very detailed and well worked-out analysis of how to evaluate problems and deal with them so you have management in nursing homes. I think this is a fine piece of work. I haven't had time to go through it in detail, of course, but I am impressed with it as I have looked at it here and as you have explained it rather briefly. Are you actually using this system now at your nursing home?

Mr. Huset. Yes, we are. In the resident care conference section there, we are also utilizing that as an evaluation point of the total facility as well. As you would go through the residential care conference, you will see that.

On section B there, the upper portion, the administrators and their departments are the brains of the operation and the resident care conference the heart of the operation. The decisions are made in the upper echelon of management; yes, the director of nursing service and the department heads, but the recommendations come from the needs of the individual patient accumulated on up through this system.

It is not as formidable as it happens to sound, but I do feel that through use of documentation it is unnecessary for a situation like today.

Senator MOSS. Is this quite a new thing, or are there other nursing homes that are using this sort of evaluation?

Mr. HUSET. I think the newness is not that other nursing homes are or are not. There are many, many of them that probably are doing it, but do not have it down to this depth and probably coordinated in an overall picture.

Senator MOSS. Would this evaluation, when it is completed and filled out, be available to, say, a State inspector or somebody of that sort if he wanted to look at it?

Mr. HUSET. I would appreciate if they'd come and help us with some of these, definitely, or even as far as on the opposite, to some extent the physical facilities and things, we would even like to include some of the relatives of the patients who exist there. In fact, on the section of the resident care conference there it includes the resident and family on there, so that we do include them in our conference when it does pertain to, for instance, their specific mother or relative.

Senator MOSS. Yes, I noticed that. I think that is a great step forward in trying to evaluate and improve the nursing home internally, and I am impressed to have that in the record. Thank you.

Do you have any questions?

Senator MONDALE. No questions.

Mr. HUSET. Thank you very much.

Senator MOSS. Mr. Green.

Mr. GREEN. I now call on Mr. Dennis Layer, director of education for the association; then Mr. Schumacher will summarize.

STATEMENT OF DENNIS LAYER, DIRECTOR OF EDUCATION, MINNESOTA NURSING HOME ASSOCIATION

Mr. LAYER. Thank you, Senator Moss and Senator Mondale.

It is a privilege for me to be able to speak to this group. I am the director of education for the Minnesota Nursing Home Association and have been in that position for approximately 18 months.

I think the fact that the association has a full-time education director speaks very highly for the concern that the administrators have toward education, not only toward education of the key staff people, but also education of the aides and orderlies who work in the nursing homes. If I might, I would like to talk to you briefly about a program that we have started through the association that is being used by some 57 homes right now who are members of the organization.

Realizing that training funds are not readily available to the nursing home, funds for purchases of training equipment, audiovisual aids, and so forth, the Nursing Home Association Education Committee has decided that we would purchase, for use by the nursing homes, various types of visual, audio, and audiovisual aids, and these aids would be,

at least in our first instance, primarily directed toward the training of the nurses' aides and the orderlies, because, of course, they have most of the direct contact with the patient, more so than the professional staff, and therefore we feel that they need this type of training.

Principally, the visual aids are involved in skill training, how to train, which is, of course, an important aspect. We have also tried to develop programs to teach them the other types of training; that is, the understanding of the aging process.

Briefly, what we did is this. We went out and we purchased what we considered to be some of the finest training vehicles, and we developed that into a training package. The package consists of 20 hours right now, for the basic orientation of the nurse's aide, 20 film strips and records of approximately 45 minutes in length. We developed for these a set of lesson plans. They can be used by each inservice instructor or director of nursing in each facility. Along with this we have developed a standardized set of quizes if they would like to use them that can be given to each student as they attend the course.

Then we have also developed along with this an individualized training record that they can keep on file for each employee which indicates, No. 1, when they attended the classroom session, who the instructor was, topics covered, and so forth; how well he did on it, and also a section to indicate the clinical experience, so that we can find out if, in fact, there is some carryover from the classroom, from the formal training, into actual on-the-job experience.

As I say, the entire program is approximately 20 hours long. It is available to the nursing homes. We mail it out in a package just like you mail films back and forth.

We have 57 homes, as I mentioned, that have signed up for this program in the short time we have had it. We have had three nursing homes who have completed the program and have graduated classes, classes from six to 12 students. The certification for the graduation is handled in the nursing home by the inservice director or the director of education, and we provide as an additional incentive a small pin that indicates that they have completed the 20 hours of instruction.

Of the three homes that have graduated students from this particular program, the feedback to me is that it has been very successful. Of course it is not easy, because with this type of inservice training oftentimes the employees must come in on their own time. Some nursing homes reimburse for this, pay the employee for the hour or 2 a week that they come in for inservice training, some do not, and so it becomes a difficult problem to get people to come for training, but we are trying.

We have purchased six 16-millimeter motion pictures called "Patients are People," which is again a series that deals with "how to" type training, and so forth, "How to Give a Proper Bed Bath," "How to Handle the Bodily Needs of the Individual Resident," and so forth.

So as an association we have been actively involved in providing different types of education. We also have a road show approach to seminars and so forth but because of time I won't go into detail on this.

We do realize that the ultimate solution to these problems in the nursing homes, if they exist, are going to come about largely through education and through training. Of course it is axiomatic the more a person knows about his job the better able he is going to be to perform that job, and this is part of our function as we see it as an asso-

ciation, to provide this type of service to our members, something that they really couldn't do because of financial restriction.

As has been alluded to before, vocational technical schools are now taking an interest in training of nurses' aides and orderlies. Up until this time the hospital orientation or the acute care orientation has not been particularly effective toward getting this type of employee into the nursing home. We have some nursing homes in the Twin City area that have opened themselves up and are allowing these students to come in for a portion of their clinical experience while they are attending the session in the vocational technical school, and, of course, we hope to expand that type of program to include professional students such as R.N.'s and L.P.N.'s.

That basically concludes my formal presentation. I will be happy to answer any questions that you might have.

Senator Moss. Well, thank you, Mr. Layer, for that explanation of what the training program carried on is.

How widely is this being done?

Mr. Layer. Within our membership—which program are you talking about now, sir?

Senator Moss. The film strips and so forth.

Mr. Layer. We have approximately 57 homes, individual homes, that are on the program. The program is this. They send us their schedule and we schedule them, and then we schedule the films to be shipped to them on a regular basis. So to complete the entire 24-hour session may take up to 6 months for an individual facility.

Senator Moss. Thank you.

Do you have any questions?

Senator Mondale. What is your medical background?

Mr. Layer. I have no medical background. I have a bachelor's degree in the biological sciences and I have a masters degree in educational psychology.

Senator Mondale. The course you have developed goes for 20 hours, is that right?

Mr. Layer. Yes, sir, the basic course.

Senator Mondale. And that is basically designed for nurses' aides?

Mr. Layer. Yes, sir.

Senator Mondale. At this point there are three nursing homes in the State that have completed that program, is that right?

Mr. Layer. Yes, sir.

Senator Mondale. A total of 57, including those three, have signed up or are in the process.

Mr. Layer. Now, of course, some of the homes have purchased this type of program on their own and are not using the one necessarily that we have.

Senator Mondale. Are there many that have adequate programs of their own, in your opinion?

Mr. Layer. I would say that this is one of the serious problems that the nursing homes face. They may not have an adequate training program through no fault of their own because they either do not have the resources financially or personnelwise to conduct one, and this is where I see the role of an association or a group like ours to fill in that gap.

Senator Mondale. Do you think 20 hours is adequate?

Mr. LAYER. No, sir, I do not, and, of course, as I mentioned, this is a basic program and we have expanded this program. We are continually adding new films to the program as they are available.

It is interesting to note that not only are the films hard to come by, there aren't that many companies that are producing good visual aids for long-term care or chronically ill patients. Most of them, again, are for the acutely ill or oriented toward the general hospital or acute hospital approach. So this becomes another problem as far as training is concerned. You can show a lot of similar things, but then it has to be somehow fitted into the nursing home picture.

Senator MONDALE. This morning one of the witnesses testified that she took a job as a nurses' aide and that very day, without any training at all, was giving medication and drugs and the rest. Is that possible?

Mr. LAYER. Yes, that's possible.

Senator MOSS. Thank you very much, Mr. Layer, for that explanation of the training schedule that is carried on.

Mr. Green.

Mr. GREEN. I will now call on Philip Schumacher, president of the association, to summarize.

Senator MONDALE. I would like to introduce him. He is an old friend of mine, or used to be until these hearings began. Possibly, this is my last act of friendship.

Mr. SCHUMACHER. Thank you, Senator.

Senator Moss, Senator Mondale, friends, I did want to quote Daphne but I can't find her, and the TV cameras are gone. She quoted me this morning. I thought I would reciprocate in a kindly manner, but since she is gone or I don't find her and the TV cameras are gone, I will have to pass that one up.

Sometime back I heard Mr. Halamandaris say that someone was going to get a toothache out of this, and believe it or not I had an emergency trip to the dentist last night at 10 o'clock and I have had a toothache all day.

Frankly, I don't envy your committee. You've got a tough job. But I did make a few notes on some of the things we went through and I will quickly go through them.

Certainly, as far as we are concerned, we think that peer review is something that has to come in addition to the governmental inspection type of services that are essential to the nursing home.

We further believe that these departments, the health departments, must have more funds in order to function as they should.

I would like to challenge the subcommittee to assist us in locating Federal or private funds for seed money for a peer review program.

You have heard some idea of what the Minnesota Nursing Home Association is doing. I think we are all proud of what we are doing. I am proud to be president of the association, and we have had a very good program for the last several years.

We have had problems in dealing with HEW, as it was pointed out, but I think these are certainly no discredit to the individuals. There are restrictions placed on staff people in HEW, fund restrictions, and so forth.

You have heard of the problems that nursing homes are confronted with in dealing with physicians. This is very common and I think it is worse in the big cities. I don't know how you people on the committee can solve this, and I will refer that one right back to you.

You have heard of how we are educating our staffs. We are doing, I think, a good job where the nursing home administrator takes advantage of this service. I think we can do that.

We also participate with mental health centers throughout the State, and these people have been very helpful in training staffs for nursing homes.

You have heard of a patient care program that's in writing, and we work toward this sort of thing and commend the nursing home that has brought this out.

On the national level we have been concerned with reimbursement, as was mentioned earlier today. We are not interested in regressive reimbursement programs, and we have actively participated with other States in our area, our neighboring States, in working with HEW to try to revamp some of the existing reimbursement programs. So far we have met with no success and again I think this is due to restrictions that are placed on HEW staff, the lack of flexibility in the programs.

At a national level we have been interested in and helped sponsor and promote chronic care, which, I am sure, your committee is familiar with. This is a program which calls for complete revamping of the national policy on health care of the aged.

I would like to say that I think that as participants in this hearing we should be given an opportunity to have a copy of the testimony which was submitted this morning in order that we might be able to have a team, an impartial team, perhaps with the help of the health department, an impartial team to check some of these matters out within the next 30 days. I certainly don't question the integrity of anyone who submitted evidence, but I think things can get out of proportion.

The statement was made about a patient jumping out of a third-story window. I know of a fully accredited hospital within this State that within the last 6 months had a patient jump out of the third-story window and no one is running around screaming that this hospital is substandard.

Senator MOSS. Well, I thought the complaint was that nobody went out even to see the patient. A nurses' aide finally went out, wasn't that it?

Mr. SCHUMACHER. That could be.

I know the complaint was registered and I missed that part of the comment. But I think that things have to be put in the right perspective and I would think that we could be allowed an opportunity to respond to some of the affidavits that have been presented to your committee.

Finally, we as an association have requested the Governor and responsible legislators in this State to investigate fully the state of care in our nursing homes, not only in our member homes but in all types of homes, regardless of ownership. This request was submitted to the Governor recently, and we intend to follow up with cooperation and further insistence that he do this.

I would also like to comment to you people who do work with Mrs. Krause. We are concerned with problems that exist and we know that you are, also. I believe that Mrs. Krause is properly motivated, but I think that we have to work together on things such as those complaints that were brought up here. I think you have to work with the health department. This is the first time we have had any public

admission of places and persons and times, et cetera. Evidence from 1967 was brought out today. This should have been reported to the proper parties in 1967, not in 1971.

I would like to close by quoting Senator Moss from an address he gave in October of 1970, because to me it expresses what I also think about the nursing home field. He said:

> Thankfully, nursing homes have begun to come out from under the imposed shroud. Thankfully nursing homes are now attractive buildings in centers of the city. Thankfully a nursing home owner is becoming more and more a professional and an accepted member of society. But the day still appears to be far away when children will be heard to say that they want to become nursing home administrators when they grow up. This must change. Change in priorities are the hallmarks of the 1970s. Excellent nursing homes must become better. New methods must give way to still newer and better methods. As a society we must adopt our priorities so that care for the elderly in our society ranks ahead of questionable defense spending and building of supersonic transports.

Thank you.

[Applause.]

Senator Moss. There is little I can quarrel with since you quoted me at the end there. I do appreciate very much your testimony, and I am sure what you say is correct and proper. We all are seeking the same goal. It is just a matter of cooperative effort rather than being at swordpoints on these problems. It is a matter of understanding, and I do believe the testimony we heard this morning, which was quite shocking and startling, just brought into focus the number of things that we have to find out about.

I want to assure you that the record will be available; in fact, as soon as it is prepared it is available and you are entitled to have a copy. We would be very pleased to have you submit any additional information in writing that you would like to have in. We always leave the record open for a period of time after hearings so that any matters that were overlooked or to which there could be a response, the data can be put in the record to make it complete before it is all buttoned up. So I want to assure you that will be done, Mr. Schumacher.

We appreciate having you come to testify for us today, and we recognize that you men have a hard job and that you are doing your very best with it. What we want to do is be helpful, not in any way to impede your progress.

Mr. Green, does that complete your testimony?

Mr. Green. Yes.

A Voice. Could I say something, please?

Senator Moss. We will see if we can get to you at the end, if we have time.

Thank you very much.

We will now hear Dr. Warren R. Lawson, secretary and executive officer of the Minnesota Department of Health.

Very glad to have you, sir, and we will be glad to hear your testimony, anything you'd like to say. If you want to put it in the record and highlight it, you may do so, or however you want to proceed.

STATEMENT OF WARREN R. LAWSON, SECRETARY AND EXECUTIVE OFFICER, MINNESOTA DEPARTMENT OF HEALTH

Dr. Lawson. Senator, I don't think this will take too long, I would like to read it.

Senator Moss, Senator Mondale, ladies and gentlemen, of the 409,000 persons in Minnesota who are 65 years or older, approximately 41,000 are cared for in licensed nursing homes and boarding care homes in Minnesota today. This 10 percent of this population group does not include patients in the State mental hospitals or persons in foster homes which provide housing for one to four well older individuals without being subject to State licensure.

More than 100 years ago, in 1864, the Minnesota State Legislature made it mandatory for the county boards to provide suitable places for the "reception," "proper accommodation," and "support" of all poor persons dependent upon the county. Twenty years later, based upon this law, Minnesota had 24 so-called poorhouses with a capacity of 651 beds. Men outnumbered the women in these facilities by 4 to 1.

By the end of the century, counties were becoming increasingly sensitive to the needs of the growing number of county assistance recipients and this concern resulted in 1900 in the State board of corrections and charities, which then existed in the State, adopting plans for a 23-bed so-called model poorhouse. This action provided for particular requirements then believed necessary. Among them, solidity of construction, complete separation of the sexes, and a separate apartment for the overseer. Attention was also given to problems that they called circulation, and to avoid waste of time and effort, and to eliminate some of the undesirable features that were observed in the existing homes at that time, such as the carrying of soiled articles through the food preparation areas of these facilities. This 1900 decision, then, represents the State's first attempt to regulate construction and operation of facilities for the care of the aged in this State.

The passage of the Federal Social Security Act in 1935 had a tremendous impact upon the county poorfarm system. Under the Social Security law, persons living in public institutions were ineligible to receive the new old-age assistance and as a result many aged persons moved from the county homes in order to be eligible for these aids or pensions, as was the preferred term at that time.

Under the terms of the 1935 act it was soon discovered that it was possible for residents in homes to receive their social security pensions providing the county facility leased its operations to a private operator. The lease was usually awarded to an applicant who promised to provide care at the lowest rate. This meant that a county poorfarm filled with infirm and often ill persons was turned over to an individual wholly inexperienced in the care of the sick. The successful applicant, however, usually quickly learned that he was unable to provide even a minimally acceptable service at the rate agreed upon in the contract.

The 1935 Federal law, in effect, gave impetus to the development of proprietary homes for the aged, as is evidenced by the fact that by 1942, the first year that the Minnesota State Hospital and Nursing Home licensing law was in effect, there were already 90 proprietary homes with a bed capacity of 4,000 in the State. By 1959 there were 312 licensed proprietary homes in the State with a bed capacity of over 6,000 beds. These latter data represent 71 percent of the total number of licensed homes in the State (442), and 37 percent of the total licensed bed capacity in the State (14,583). In more recent years there has been a reversal of this trend in that today proprietary homes represent only 46 percent of the total homes in the State (318 of 684), and 42 percent of the total bed capacity, or (17,406 of 41,313).

The majority of homes conducted by nonprofit associations originally operated primarily as simple homes for the aged. Although most provided nursing care to persons who became ill or incapacitated after admission, only in relatively recent times have these homes received persons who were in need of nursing care at the time of admission.

Frequently when a new hospital was constructed in a community the old hospital was converted to a long-term facility. We are now seeing the second and third generation of specific facilities and many of these original conversions have been replaced with new structures specifically designed for their purposes. A substantial number of these are now physically connected with a hospital and are designated in Minnesota as convalescent and nursing care units. There are now 71 such units in the State with a total bed capacity of 4,040.

Prior to the 1941 State licensing law in Minnesota there was little to prevent an unscrupulous or incompetent person from establishing a facility for the aged and chronically ill and advertising it as such to the public. Many unsatisfactory conditions existed and this prompted the Minnesota State Hospital Association and the Minnesota State Medical Association to support legislation for State licensure. It was through their efforts, and that of Mr. Ray Amberg, for many years the administrator of the University of Minnesota Hospitals, that a comprehensive licensing law was enacted in Minnesota in April of 1941.

This was the first comprehensive licensing law for hospitals and related institutions in the United States and it was necessary for the writers of the bill to begin almost from scratch in designing this extremely progressive legislation.

Few new homes were opened during the period from the depression of the 1930's through the Second World War, although it was becoming increasingly apparent that more facilities were urgently needed to care for the growing numbers of the aged and infirm.

During the next decade several additional events occurred which affected the development of nursing home facilities. In 1949 the State Legislature enacted a law which permitted the sale or lease of tuberculosis sanatoria which were no longer needed for the treatment of tuberculosis. The Social Security Act was amended in 1950 to permit the Federal Government to share in grants paid to persons in public institutions. And in 1951 a State law was passed which permitted counties to establish county nursing homes.

Since 1950 essentially all new nursing homes in the State have been constructed specifically for their purposes and are fire-resistant structures. In the last 21 years more than 35,000 beds have been provided in new or remodeled facilities or additions to existing facilities. In Minnesota no nursing home has been newly established in a converted dwelling for over 12 years.

All licensed facilities are visited approximately twice each year with additional visits as the need arises. All visits are unannounced except for the initial visit. Findings are recorded in memoranda——

Senator Mondale. Would you yield there?

Dr. Lawson. Yes, sir.

Senator Mondale. Did you hear the testimony earlier today?

Dr. Lawson. No; I was not here this morning.

Senator Mondale. There was at least one, and I think two, witnesses who said that the nursing home knew that the inspector was coming

and that the nursing homes would then get ready to pass the inspection. Is that possible?

Dr. LAWSON. I don't believe that is correct, sir. There are strict orders to all of the staff exactly to the contrary.

A VOICE. Senator Mondale.

Senator MOSS. No comment from the audience.

Senator MONDALE. Proceed.

Dr. LAWSON. Orders are issued when findings indicate deficiencies. Administrative procedures have been established for the conduct of informal hearings where the licensees are afforded an opportunity to discuss deficiencies and plans to correct them. Agreements are reached for compliance with minimum regulations or, where this is not feasible, for reclassification to a lesser level of care facility or closure.

This procedure has been successful in most cases, and during the period of 1958 through July 1, 1971, 100 nursing homes in this State, with a bed capacity of 1,877, were reclassified downward to boarding care homes; 183 nursing homes and boarding care homes with a bed capacity of 2,800 have been closed, for a total of 283 facilities with 4,676 beds which have either been reclassified down to a lower level of care or have been closed.

When these informal procedures fail, it is then necessary to initiate formal proceedings to revoke the license of a facility as provided by State law.

Senator MONDALE. Would you yield there.

How many revocation proceedings are underway now?

Dr. LAWSON. None.

At the request of local health departments, the State board of health deputizes the local health officer, for the surveillance responsibilities involving the visits and issuance of orders with respect to licensing and, more recently, certification standards. At the present time these surveillance responsibilities have been assumed by the cities of Minneapolis, St. Paul, and Bloomington, and by St. Louis County.

Regulations for nursing homes and boarding care homes first became effective in 1952 and were among the first in the country. These were revised in 1962. A proposed new revision of the regulations has now been in process for approximately 2 years and it is anticipated that they will be formally adopted by the State board of health in the relatively near future.

All written and signed complaints are thoroughly investigated. The recent unfavorable publicity has precipitated a substantial increase in the number of telephone complaints, most of which have been anonymous.

The 1941 State licensing law appropriation provided for a licensing staff consisting of two inspectors and one clerk and has remained the same for the past 30 years——

Senator MOSS. Two inspectors and one what?

Dr. LAWSON (continuing). Clerk—even though the total number of licensed facilities now exceeds 800 and the total number of beds involved exceeds 70,000.

Senator MONDALE. I'm not sure I understood that. You mean that even though the number of patients in the nursing homes have risen to 41,000 as compared to something like 4,000, you have the same number of inspectors?

Dr. LAWSON. That is correct.

Senator MONDALE. Do you think you can keep up with that?

Dr. LAWSON. The number of inspectors is determined by the legislature. In 1959 licensing fees were more than doubled by the State Legislature in anticipation that this increased revenue to the State would be used to authorize the employment of additional inspection staff, but unfortunately no additional personnel have been authorized.

In regard to the certification of facilities under title XIX and title XI of the Social Security Act, the Legislative Advisory Committee, on December 18, 1969, granted six of the 12 positions requested by this Department for the certification of facilities. The remaining six positions were again requested from the 1971 legislature. These were included in the Governor's budget, but the legislature only funded two of these six additional positions requested.

Following a recent review by Federal representatives of the department's certification procedures, the department was advised that the number of staff employed is grossly inadequate to perform the required certification functions. In addition, the Federal representatives indicated that it is improper for the department to undertake certification surveys in any instance where a facility is currently deficient in meeting State licensing requirements. This means, of course, that considerably more licensing staff is necessary so that the benefits to patients under these Federal programs are not jeopardized.

It is estimated that a total of 45 professional employees will be required for licensure and for the certification for titles XIX and XI. We are presently funded for eight personnel for certification and three for licensing. This means 34 additional full-time professional staff plus four or five clerks for the certification of all facilities in the State, excluding Medicare, will be required.

Upon this background historical sketch of Minnesota's efforts to assure quality of care in nursing homes, I now wish to present my views on the five items enumerated in Senator Moss' letter dated November 17, 1971, which, as the letter stated, are the matters upon which this hearing is focused.

1. The lack of a clear national policy with regard to treatment of the infirm elderly, including the absence of supportive services.

We would agree that one of the basic difficulties is the lack of a well-defined and consistent national position in dealing with the problems of the infirm and elderly. At the State level we see several kinds of evidence of this lack of a firm national objective, including problems of fragmentation of authority and responsibility between various Federal agencies, a lack of communication and coordination between Federal programs, and vacillation and inconsistency in Federal program policies, interpretation of Federal regulations, and Federal program objectives. All of these matters directly and seriously hamper the ability of the State agencies to function effectively.

One simple example will illustrate several aspects of these problems. The Life Safety Code was adopted as requirements in both the Medicare and the Medicaid programs. However, the timetable for compliance and for the interpretation of the code were different for each program, and in situations where a facility was certified for both programs the result was only confusion and frustration. At the State level we believe it is imperative that the Federal Government establish firm

Federal objectives and a consistent Federal commitment throughout its entire program structure.

2. The absence of the physician from the nursing home setting.

Certainly all patients and residents in nursing homes should receive adequate medical supervision. The difficulty is to define the word "adequate" in this context. No system of rules, from my viewpoint, which arbitrarily establishes a specific frequency for physician visits will assure "adequate" medical care considering the wide range of the requirements of individual patients. As has been suggested by some, facilities could be required to contract with a physician to provide the medical surveillance for all patients in a facility, but this proposed system would probably be unacceptable to many of the residents who would wish to continue to be cared for by a physician of their own choosing.

In Minnesota nursing homes are required, as part of the licensing process, to have a specific independent arrangement for medical care for circumstances where an individual's private physician cannot be contacted and for those patients who have not designated a specific physician as their personal physician. In addition, of course, in the Twin Cities metropolitan area there are well-developed public medical services and public emergency ambulance services that can be readily obtained at any time that acute medical care or hospitalizaton is required.

3. The consequences of relying on inadequate and untrained personnel.

The State department of health has recognized for many years that training is one key to assuring the provision of high quality service to patients in nursing home facilities. In the early 1950's the department was successful in obtaining a grant from the U.S. Public Health Service for a project to provide in-service training for nursing home personnel. Continuation funding was not available, but because of the importance of this program it has been continued, utilizing in the earlier years Federal categorical allotments, and in recent years the Federal block grant allotment for public health services.

4. Lax enforcement of existing standards by States and the Federal Government.

The matter of enforcement of standards is a complex issue. Further, regulatory agencies are frequently burdened by excessively cumbersome enforcement procedures written into the law. The Minnesota State Legislature recognizes the difficulty, and an interim committee has been considering this question with the department. It is expected that new legislation will be considered at the next legislative session to attempt to provide a more flexible system for assuring compliance with existing nursing home standards.

In considering this issue, however, it must be recognized that a summary revocation of a license in many instances is not a reasonable procedure, particularly in those situations where there is not bed capacity available in the area that can suddenly absorb 100 or 200 additional patients. We are observing in Minnesota a phenomenon relative to extended care facilities under the Medicare program which bears upon this problem.

Nursing homes throughout the State are requesting voluntary decertification as ECF's. The reason given usually by both proprietary and nonprofit facilities is that the costs of complying with staff-

ing and the very stringent fire protection standards of the Life Safety Code are simply financially unfeasible.

What is happening as a result is that there are developing large areas of the State where there are no ECF's, and Medicare beneficiaries are unable to avail themselves of these services when needed. And it is understandable that many older persons are just unwilling to be shuffled 100 or 150 miles from home with the resultant total disconnection from their family and friends and their local professional medical care arrangements.

High standards are important in every field of public health, and Minnesota has a long tradition of high expectations. Nonetheless, the imposition of any standard presumes that those affected by them will be able to comply. We might, for example, adopt a standards of zero ionizing radiation dose for X-ray procedures. While this is a desirable ideal, it is an impossible standard.

The word "laxity", to me, is a subjective term which editorializes but does not elucidate upon the problem of standards or their enforcement. A complicating factor is that the simple facts are that we do not know, with any degree of certainty, what standards are the real determinants of quality care. Further, if it can be presumed that any measurement of the quality of care is a medical matter, it would seem that it reasonably follows that this determination is the proper responsibility of persons qualified in the medical sciences.

5. The existence of financial incentives in favor of poor care in our programs of long-term care.

It is obvious that this allegation can be made, and that it is probably true in some instances, just as the question also arises in any other circumstance where payment is made for any service or for any commodity. The remedy——

Senator MONDALE. Would you yield there. Isn't this a special problem——

Dr. LAWSON. A very important problem.

Senator MONDALE (continuing). In that, first of all, these people can't defend themselves. Many times they are abandoned by their relatives. So it is not like you or me complaining about a bad car purchase or something; they are defenseless.

Secondly, as I understood it, there is a shortage of beds, so that it is a seller's market, that is, the nursing home people can say, well, if you don't like it here, you can go out and walk the streets if you want. Isn't that right?

Dr. LAWSON. Right.

Senator MONDALE. So that when we say they have the power to defend themselves, it is a pretty theoretical proposition, isn't it?

Dr. LAWSON. I'm not suggesting they have the power to defend themselves.

Senator MONDALE. You are saying, don't revoke the license; then what remedy is there?

Dr. LAWSON. I think it is a complicated remedy. I am simply saying you cannot close beds when beds are not available to put people in. You can't put them out on the street. We are going to have to devise systems that assure quality care within these facilities without having to be revoking licenses and displacing patients. I think that's the point.

The remedy, of course, is legislative, and I am certain that all regulatory agencies would be most pleased to have the opportunity to work with legislative bodies at all levels of government with the objective of establishing systems that would assure that this does not occur.

As additional information for the committee I would like to refer to two studies that demonstrate that Minnesota has been and is actively concerned about the quality of medical care in nursing homes.

The first of these is a report of the findings of the Institute for Interdisciplinary Studies of the American Rehabilitation Foundation entitled "Policy Issues Regarding Nursing Homes."[1] dated June 1969. The Minnesota survey, financed by the Department of Health, Education, and Welfare, examined several aspects of the total problem of nursing home care, and copies of this report will be submitted to this committee by a separate mailing. However, for purposes of this statement several quotations from this independent study seem appropriate.

On page 2 the report states, "In Minnesota the Department of Health has played a major role in upgrading nursing homes by setting standards, licensing, and periodically reviewing all nursing homes. * * * The Department of Health appears to have been unusually influential, due, in part, to a strong legislative mandate and relative independence in enforcing standards."

On page 18, "The Department of Health was ranked first of several organizations (* * * including * * * Federal agencies * * *) in contributing leadership and improving nursing homes in Minnesota * * *."

Page 29, "This study has shown how elusive a phenomenon is 'quality of nursing home care.' Compared with 15 years ago, homes in Minnesota are better housed, larger, more frequently physically attached to hospitals, and more often run on a nonprofit basis."

The second investigation is that undertaken by the Minnesota Medical Association in 1970 in cooperation with the Minnesota Department of Health and Minnesota Blue Cross, aimed at an assessment of the quality of medical care in hospitals and nursing homes in the State in a project entitled "A Feasibility Study of the Quality of Medical Care."

The study involved the analysis through a statewide external audit procedure of the quality of care rendered for 20 common disease entities in randomly selected facilities throughout the State, for which there is general agreement among physicians as to appropriate case management.

Review of these cases was at three levels: Nursing personnel, peer review physician, and finally an independent project director. Anonymity of patients and institutions was assured to permit objectivity in the evaluation. Participation in this study was voluntary on the part of the institutions and the reviewers.

Sponsoring agencies included the State department of health, Northlands regional medical program (heart, cancer, and stroke program), Minnesota Blue Cross, Minnesota Blue Shield, the Minnesota Hospital Association, and the Minnesosa Department of Public Welfare. In addition, the Minnesota Nursing Home Association assisted in providing a critique of the nursing home portion of the study protocol.

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[1] see p. 2195.

Following completion of the hospital portion of the study the Social Security Administration funded a more comprehensive analysis of the data collected. The study has been conducted under the auspices of the Minnesota State Medical Association Subcommittee on Standards of Medical Care. After the final reports of the project have been presented to the sponsoring agencies, they will be available in published form and copies will be on file with the Federal agencies and will be submitted to this committee for their review.

The studies represent a singular and unique melding of private and public sectors in investigations into the health care delivery system in this State.

In conclusion, it is my sincere hope that these hearings will provide the basis for a more systematic integration of the role of the Federal agencies and their counterparts in the State of Minnesota. In my view, we must begin to seriously face the problem of fragmentation of health services and functions at all levels of government, and I sincerely believe this phenomenon is directly and indirectly responsible for much of the confusion and indecision that is evident everywhere today in the health care field. Layer upon layer of structure and the disconnected specific programing of health services without any relationship to a total plan or a total objective are only two facets of this extremely serious problem.

In addition, as I have repeatedly noted in my statement, Minnesota has never been slow to recognize its obligation to assure quality medical services for its citizens. Problems obviously still remain. The regulatory processes of government in our political system are always imperfect, but as we all reach for this ideal we must identify the imperfections in a constructive context so that remedies can be designed which will continue the record of progress that has been made to date in promoting quality care for the elderly and the infirm.

Thank you.

Senator Moss. Thank you, Dr. Lawson, for your statement.

You indicated that by law you are required to inspect nursing homes twice a year.

Dr. Lawson. Not by law.

Senator Moss. Not by law. Are you able to carry that out twice a year?

Dr. Lawson. Not using the licensing personnel. We plan to have at least two contacts with every hospital and nursing home facility in the State, using three techniques, primarily. One is the licensing personnel, and they are mighty few.

Secondly is the staff that we use Federal grant allotments for in the program called "Improving Patient Care," which is actually a quasi arrangement that we have that performs some licensing functions as they go in to their facilities, providing consultation and assistance in improving quality care on a person-to-person basis.

The third is through the Medicaid program and certification procedures. Obviously we are forced into the old game of doing the best you can with inadequate funding and staff and we have to put the pieces together as we can best do so.

Senator Moss. You consider those, then, inspections?

Dr. Lawson. Yes. They all relate very closely together. One of the confusions, Senator, I think that may be involved in this question of

whether hospitals and nursing homes are notified prior to inspection is a confusion in the Medicare program as contrasted to licensing operation. In the Medicare program by policy, they are notified of Medicare certification surveys. They are not notified of any investigations relating to licensing except for the first license they receive.

Senator Moss. What department of State government is responsible for inspection of the nursing home facilities for fire, for example?

Dr. LAWSON. The State fire marshal. We do not license a facility that does not have clearance from the State fire marshal.

Senator Moss. Do you know what number of inspectors he has for that purpose?

Dr. LAWSON. No, I do not. I do know that the State fire marshal operates under a fairly complicated system that relies, to the extent possible, on local fire inspection resources, too.

Senator Moss. One reason I asked that, in a report that I have seen made by HEW, it indicated that of the number of homes surveyed here in Minnesota 25 percent hadn't had an inspection for fire protection in 3 years. Now, would that be possible?

Dr. LAWSON. We insist that there be an inspection on record every 2 years.

Senator Moss. So you would think that there would be one at least every 2 years?

Dr. LAWSON. There is supposed to be one every 2 years.

Senator Moss. Did you tell me only 42 percent of your nursing homes are proprietary now?

Dr. LAWSON. That's correct.

Senator Moss. I thought that that's what I heard you say. What are the prospects of your getting some additional personnel out of the legislature? You were talking about the number that were authorized and then only part of them were funded. Are you making efforts for the next session of the legislature to get some additional authorization?

Dr. LAWSON. Yes, we make efforts at every session, sir. I don't really think one can criticize the legislature. I think the legislature is as confused as everybody else is about the multifaceted Federal approach to these problems, and I think that it is not unwillingness, but I think it is simply confusion on their part.

Senator MONDALE. Do you think the case for more inspectors is doubtful?

Dr. LAWSON. Oh, no.

Senator MONDALE. Then what is the confusion?

Dr. LAWSON. The confusion is about what the Federal requirements are.

Senator MONDALE. Even agreeing on those things that can be agreed on, don't you need more inspectors?

Dr. LAWSON. Oh, absolutely.

Senator MONDALE. Can't that be done, then? Shouldn't that be done?

Dr. LAWSON. Yes, that should be done.

Senator Moss. Now, when you talked about the number of nursing homes that were reduced to what, intermediate care facilities?

Dr. LAWSON. Under the State law we have two licensing categories, a nursing home and a boarding care home. A boarding care home is a home where a person is presumably well but simply needs personal care in dressing, undressing.

Senator MOSS. These, then, didn't basically change they just changed their licensing name, is that right?

Dr. LAWSON. The patients are different. A patient in a boarding care home does not require nursing care, and the number I quoted has been the number of which by voluntary agreement, with some coercion obviously by the Department, have agreed to reduce the level of care, their level of care licensing, so they are no longer eligible, then, to take care of patients who require nursing care.

Senator MOSS. How many licenses have been revoked by the formal procedure? You talked about that informal procedure. How many by formal procedure, say, in the last 5 years?

Dr. LAWSON. Dr. Knutson, do you have a figure in your mind?

There haven't been very many, about 12. The difficulty is one of extremely difficult procedures to go through. An actual process of revocation may require up to as much as 3 years to accomplish. And, as I indicated, the legislature is concerned about the problem and a legislative committee of the House is considering this matter, and I am sure that there will be new legislation proposed and we have several suggestions how this might be done.

Senator MOSS. You do have recommendations on how that could be accelerated?

Dr. LAWSON. Yes; we have an alternate way we think that could be handled.

Senator MOSS. Is the reimbursement formula unrealistically low now for nursing home patients?

Dr. LAWSON. Of course, you must understand, Senator, that we are not, by law, authorized to be involved in the medical payment part of it. I can tell you this, that, as we have been holding public hearings on our proposed nursing home regulation, the principal issue that comes up over and over again is what the effect is going to be on the cost of care when these new regulations are adopted. Where is there going to be any indication that there is going to be reimbursement for the additional costs. So I am sure it is a problem.

Senator MOSS. Well, I take it from that you think it is too low.

Dr. LAWSON. Yes.

Senator MOSS. Because the people in the industry are saying that they can't meet the standards?

Dr. LAWSON. This is the most constant comment that we get.

Senator MOSS. Do you have any figures at all on return made on proprietary homes, return on investment or profits?

Dr. LAWSON. I do not, sir.

Senator MOSS. One of the witnesses said earlier today that there was no communication, or imperfect communication, between the health department and the department of public welfare. Is this so, and if it is, are there plans to change that?

Dr. LAWSON. Well, I think there is communication between the two departments. I think the general attitude in the department of welfare has been that we are the regulatory agency, we are to set the health care standards; they are the reimbursement mechanism, and these two ought to proceed relatively independently.

Senator MOSS. Your function, then, is to see that the standards are adequate on care from the health standpoint. You shouldn't be inhibited, then, really, by these other complaints, saying it is going to make it too expensive.

Dr. LAWSON. No; we do not feel that the regulations adopted by the State board of health can be considered on the basis of what the cost of care is.

Senator MONDALE. Just one question. What kind of people go into the private nursing home business? Is there a tendency on the part of, say, doctors to set up nursing homes? What kind of people go into it? Is there any regulation as to that or possible conflicts of interest?

Dr. LAWSON. Well, of course, Senator, I can speak only personally on that subject. I do not know what kind of a person goes into the nursing home business. I do know that there is one very curious facet to this whole question of profits in nursing homes, and that question has never been answered to me satisfactorily, and I presume it is the basis for your inquiry, and that is I don't quite understand why, if there are such great profits in nursing homes, why the nonproprietary nursing home charges should not be much less than what the proprietary rates are. If someone can explain that inconsistency to me, I'd feel a lot more comfortable about the question of profits.

Senator MONDALE. Do you see any difference in the care provided by a nonprofit nursing home and a for-profit nursing home?

Dr. LAWSON. I don't think basically that you can make a distinction, if you examined a large number of homes and the quality of care provided, whether they were proprietary or nonproprietary, and again for a rather independent evaluation of this question I refer you to the Institute of Interdisciplinary Studies that I referred to in my statement. This addresses this issue directly, and I think as an independent study you should take that judgment.

Senator MONDALE. Getting back to my original question, what kind of people go into nursing home proprietary operations? Is there any regulation on that?

Dr. LAWSON. There is no regulation on that. The regulations require that the licensee be of a good moral character. I, Senator, believe that all kinds of people go into the nursing home business. I think some of them go in with the idea there is going to be large profits.

Senator MONDALE. But I mean wouldn't it probably make a difference if, for example, a doctor went in the nursing home business in the sense that he is trained and has the background? Or, say, if a registered nurse went into the business, would it be better than someone with no medical background at all?

Dr. LAWSON. That's correct.

Senator MONDALE. That does make a difference.

Dr. LAWSON. That would seem like a reasonable assumption. The facts are, I guess, from what I know, there are probably more people who have a religious background than any other.

Senator MONDALE. That's in the profit or nonprofit side?

Dr. LAWSON. Profit.

Senator MONDALE. You don't keep records?

Dr. LAWSON. I suspect we do have, we could pull out of the files, if the committee wanted, what the background of the people are.

Senator MONDALE. If you can, I would appreciate that.

Dr. LAWSON. I'd be glad to do that.

Senator MOSS. Are your standards in Minnesota equal to the Federal standards on nursing homes? There are certain requirements for those that have Federal patients in them.

Dr. LAWSON. Well, let me put it this way, Senator. No; they are not exactly compatible, but I think the evidence that you should take into account is that at the beginning of both the Medicare and the Medicaid programs, nursing homes did not have a difficult time complying with additional requirements stated in the Federal regulations. It was a fairly simple change. Basically the structure, basically the staffing patterns, basically the ancillary services were there. Specific details may have been somewhat different, but they had no difficulty in translating to be eligible for certification under either program.

Senator MOSS. But in Minnesota you use what the State standards are when you certify a nursing home, you do not refer to the Federal standards, is that right?

Mr. LAWSON. Oh, no; the certification procedure requires conformance with the Federal standards, plus holding of a valid State license.

Senator MOSS. I understood the Federal HEW study indicated the Federal standards were not being used as required in the certification here in Minnesota but you say there is no truth to this?

Dr. LAWSON. Oh, yes.

Senator MOSS. Thank you very much, Mr. Lawson, for your testimony. We were glad to have you. We appreciate it.

Mr. Douglas Ewald, executive director of the Minnesota Hospital Association.

Senator MOSS.

We are glad to have you, sir, and sorry that it has come right at the end of the day. We are still fighting that clock and an airplane schedule, so we will appreciate your making your presentation but ask you to tailor it as best you can for length of time. Anything that you have prepared in writing will be placed in the record and be part of the record.

STATEMENT OF DOUGLAS EWALD, DIRECTOR OF GOVERNMENTAL RELATIONS, MINNESOTA HOSPITAL ASSOCIATION; ACCOMPANIED BY FRED N. SHRIMPTON, ADMINISTRATOR, GLENHAVEN NURSING HOME, CHAIRMAN, MHA CONFERENCE ON GERIATRIC CARE, TRUSTEE, MINNESOTA HOSPITAL ASSOCIATION; AND EINER SOBERG, ADMINISTRATOR, CHAPEL VIEW

Mr. EWALD. Senator Moss, Senator Mondale, members of the committee staff, and ladies and gentlemen:

My name is Douglas Ewald and I represent the Minnesota Hospital Association. I would like to clarify for the record that I serve it in the capacity of director of governmental relations and not as its executive director. And I hasten to add that although there are four of us here, we will make two rather brief presentations and should not take really more than 15 minutes of your time.

I would like to introduce, however, on my right, Mr. John Weigel, who is assistant director of the Minnesota Hospital Association's Conference on Geriatric Care, and on my far left, Mr. Fred Shrimpton, who is the present chairman of our conference on geriatric care, and on my near left, Mr. Einer Soberg, who is the immediate past chairman of the conference on geriatric care.

If I may, at this time I will turn it over to Mr. Fred Shrimpton.

Senator MOSS. Thank you.

Welcome, gentlemen. We are glad to have all of you.
Mr. Shrimpton, we will hear from you, sir.

STATEMENT OF FRED SHRIMPTON, ADMINISTRATOR, GLENHAVEN NURSING HOME, GLENCOE, MINN.

Mr. SHRIMPTON. Thank you, Senator Moss. I shall be the more long-winded of the two presentations.

I appreciate this opportunity. I am administrator of the Glenhaven Nursing Home in Glencoe, Minn., also Glencoe Municipal Hospital at Glencoe, Minn. I do represent the Minnesota Hospital Association, which I serve as a member of the board of trustees, and also, as Mr. Ewald has indicated, as the current chairman of the conference on geriatric care, which is our nursing home and boarding care home membership.

The Minnesota Hospital Association was organized in 1917 and our membership currently consists of the 200 hospitals in the State, 72 of which also operate attached nursing home units, and 117 freestanding, nonprofit and publicly owned nursing homes and boarding care homes. The freestanding nursing homes and hospital units, numbering 189, comprise the MHA Conference on Geriatric Care.

The addition of nursing home members came about, when in 1966, the Minnesota Association of Geriatric Homes, an association of voluntary homes founded in 1945, contacted the Minnesota Hospital Association to discuss membership in the association. This was finalized when the former association officially disbanded and its membership joined the Minnesota Hospital Association Conference on Geriatric Care. The criteria as established for membership in our association stipulates that the nursing home or boarding care home (1) be licensed by the Minnesota Department of Health, (2) be under nonprofit or public ownership, and (3) have in effect a written patient transfer agreement with a hospital. These criteria were established because the association felt that the voluntary homes are leaders in the care of the aging and that association membership would foster closer relationships with hospitals to effect improved continuity of patient care.

I quote from our association bylaws as part of the language which defines our purpose: "The purpose of this association shall be to promote the welfare of the people by helping to make available services of hospitals, homes, and related health care institutions of highest possible quality and in such quantity to best benefit the citizens of Minnesota and the United States." Striving to meet this purpose has been made easier by the dedicated efforts and involvements of many agencies, organizations, and individuals in the State. I wish to recognize the Minnesota Department of Health, which early established a program to license health care facilities and over the years has established standards that have resulted in nursing homes and hospitals in Minnesota that are among the finest in the Nation. During the past year and one-half, our association has worked diligently with the Minnesota Department of Health in revising licensing regulations for nursing homes and boarding care homes. We feel that these regulations, when adopted, will serve to further improve the quality of long-term care facilities in the State.

As an association concerned with high standards and quality of care, we have established and promoted a practice accreditation visit pro-

gram for long-term care facilities which was the first of its type to be established in the country. The Joint Commission on Accreditation of Hospitals is generally recognized as the ultimate standard-setting agency for health care facilities. Our practice accreditation visit program, which has the endorsement of the Minnesota Department of and assist the nonaccredited home in complying with the joint commission on Accreditation of Hospitals, was developed as one of the mechanisms whereby our membership can achieve and attain the goal of improving patient and resident care exemplified by accreditation. Briefly, the program operates by utilizing the staff from an accredited home to review the program, standards and survey procedures of the joint commission with the staff of a nonaccredited home to encourage and assist the nonaccredited home in complying with the joint commission standards and becoming accredited. Presently, of the 74 accredited long-term care facilities in Minnesota, 57, or 77 percent, of them are members of our association. Because a number of nursing home facilities have been subject to a first-time review by the joint commission within the past few weeks, we expect when the results are in that this number and this percentage will be increased.

Other activities and programs we have established and encouraged include educational meetings, workshops, and institutes, a management engineering program for health care facilities, "meals on wheels" and day-care centers based at nursing homes to serve the aging in the community.

A pioneering attempt to measure the quality of care in nursing homes was developed by the Subcommittee on Standards of Medical Care of the Minnesota State Medical Association, which conducted a feasibility study.

You heard this study referred to just a little while ago by Dr. Lawson.

This study was sponsored and funded by the Minnesota Hospital Association, Minnesota Blue Cross and Blue Shield, Northlands Regional Medical program, and the Minnesota State Medical Association. The study is to be published soon, and we will see that copies are made available to the committee if it so desires.

As an association with a membership of 189 nursing homes and nursing home units of hospitals, with a total of approximately 15,000 beds, which represents 70 percent of the voluntary beds and 40 percent of all long-term care beds in the State, we feel it vital that we attempt to assure the highest standards attainable for health care facilities. It is in this respect that we offer our continuing cooperation to the Minnesota Department of Health and other standard-setting agencies.

It was announced that this hearing was for the purpose of gathering evidence of abuse of nursing home patients and poor nursing home conditions in Minnesota. Up to this point my comments have focused on some of the positive programs with which the nursing home members of our association have been involved.

When and where such instances occur, we ask for, and support, immediate correction of such deficiencies or that such facilities be closed. Minnesota has many outstanding nursing homes. They, and more importantly, the people of this State should not tolerate poor ones. Again, we offer our continuing willingness to the Minnesota Department of Health and other agencies to cooperate toward the goal of achieving uniformly better nursing home care.

There are several concerns that we feel need to be expressed if nursing home conditions are to be improved, both statewide and nationally. First, steps must be taken to correct instances of poor nursing home care. We fear that the lack, or refusal, of accountability to the public and governmental agencies is a prime cause of poor conditions. The public, through governmental programs including Medicare, Medicaid, and public assistance related intermediate care, pays for a large share of nursing home care.

The following is quoted from the position paper on reimbursement adopted by the Conference on Geriatric Care membership in 1969:

> By virtue of their service to the public, and since payment comes largely from public funds, all long-term care facilities are quasi-public and should be willing to make full disclosure of their operating costs to the appropriate officials concerned with the reimbursement programs

This clearly indicates the intent of our membership. A survey by the American Association of Homes for the Aging, the national association for nonprofit homes, reveals that nearly 100 percent of all nonprofit homes in the country favor a statement similar in intent. It is clear that voluntary homes favor accountability for their performance. This should include uniform cost reporting and access to financial and other pertinent records of the home by appropriate officials.

Secondly, we believe there is an acute need to coordinate, on both the State and national levels, the increasing demands for higher standards and consequently higher operating costs to comply with such standards and the need to assure that private and public moneys are available to finance such requirements and standards. We have seen in this State and across the country the imposition of the Life Safety Code, the standards for skilled nursing home participation, and the like, all of which admirably are designed to further enhance the quality of care rendered by the Nation's long-term care facilities. At the same time, we have seen State and national cutbacks in budgets and financing by the public sector. Obviously, if nursing homes are to provide quality service, they must be paid to do it. We recommend that standard-setting agencies coordinate their work with reimbursing agencies to alleviate this problem.

Thirdly, with the implementation in recent years of the Medicare and Medicaid programs, we have witnessed an increasing fragmentation of the long-term care field. In Minnesota, homes must first be licensed by the Minnesota Department of Health as a nursing home or a boarding care home. Then the nursing home is fragmentized into levels of care consisting of extended care facilities, meeting Medicare conditions for participation, skilled nursing homes, meeting title XIX standards for participation, or intermediate care facilities class I, meeting standards for that program. Consequently, a nursing home may provide one, two, or three levels of care. The boarding care home licensed as such is classified as an intermediate care facility type II, providing essentially room and board with no professional nursing services. While we in Minnesota have this fragmentation into four levels of care, other States have developed as many as six, and possibly more, different levels of care. This fragmentation has caused chaos and confusion both within the long-term health care field and among the general public.

We are concerned that whereas the different programs and standards are fine in theory, in practice it is quite a different story. We have a concern that the individual human needs of the patients/residents of long-term health care services are not being fully considered. There is a danger in moving people from bed to bed, room to room, unit to unit, and facility to facility as their needs for care change. This is what is required by these programs when they are enforced in the very strictest sense.

A primary example of the chaos imposed on the field was the establishment of standards for participation in the extended care, skilled nursing home and intermediate care facility programs. These standards address themselves only to what the facility must provide by way of staffing and services. They have in no way, with some exception in the extended care facility program for Medicare, defined standards or developed any guidelines as to the type of patient or resident that is to be served by these various facilities, a consideration certainly equally as important as defining the conditions for participation. Recognizing this serious problem, our association organized a committee in June of 1969 at the request of the Department of Public Welfare in an attempt to address this particular problem. The end result of this effort was the development of a form entitled "DPW 1503, Level of Care Evaluation Form and Guidelines for Interpretation of Skilled Nursing Care and Intermediate Care." The purpose of this form and guidelines is to inform and assist physicians and nursing home personnel in understanding the differences between the various programs so that a proper determination of the level of care can be made. We realize this form and guidelines have not adequately conquered the lack of understanding of the various levels of care among physicians, health care personnel, and the public. This remains a problem for Minnesota and the country if the intent of these various programs is to be properly carried out.

Therefore, we strongly recommend that uniform guidelines for level of care evaluation under title XIX and other programs be established on a national basis. We express caution and concern that any such guidelines for skilled nursing homes not be established to be synonymous with guidelines for the extended care facility program under Medicare as we have a strong conviction that the concept of the skilled nursing home differs from the extended care facility despite the standards for participation being quite similar. The skilled nursing home must be considered as a long-term care facility providing skilled care to patients on a long-term basis, while the extended care facility must be considered as a relatively short-term rehabilitative facility. We note with alarm that some States reclassify patients in need of skilled nursing care to intermediate care as a means of saving money.

The American Association of Homes of the Aging recognized this same problem and in testimony before the Senate Finance Committee made the following recommendations:

> AAHA urged the creation of a task force to examine the health care programs for the aged, excluding hospital programs, presently provided, with a view to developing a single program of care for the aged, which program would provide total comprehensive care short of hospital acute care and for which reimbursement would be based upon the actual reasonable costs of the care and services provided to the individual patient, whether such reimbursement were retrospective or prospective.

A second charge to this task force should be that of defining a facility which would provide the care and services meeting the needs of this single program, looking not to a host of facilities, each of which could provide only a part of the care, but to a galaxy of facilities, each of which would provide all of the care for a patient mix which would not only permit operational efficiency in the delivery of care, but which would present to the taxpayer a true economy in the cost of care.

The proposed task force should be composed of geriatric nurses and other specialists in geriatric care, medical economists, and consumer representatives, provided that these latter have experience in programs for the aged and that they have no financial interest, direct or indirect, with institutional providers of care and services to the aged.

That's the end of the quotation from AAHA.

Such a single program as outlined here could eliminate the current fragmentation of nursing home care about which we have serious concern. We believe the charge to this task force is attainable. We believe that a single, all-encompassing, well-defined program is necessary. We believe there will continue to be confusion among physicians, nursing home and boarding home personnel, officials of the various programs, the public and the patient until such a program is established. And we believe that the person who suffers the most is that individual we are here to serve, that individual who puts his trust and confidence in us, our patient or resident.

I thank the committee for the opportunity to express the views of our association.

Senator Moss. Thank you, Mr. Shrimpton.

I agree with you about the various levels of care. I don't think there is anything to prohibit it now, though. Couldn't one institution give different kinds of care?

Mr. Shrimpton. Oh, yes, as we do. I have three levels of care in my institution but they are subject to different regulatory bodies.

Senator Moss. That is true, they have different regulations to meet for different levels of care, but it is possible to break them out.

Mr. Shrimpton. Yes, sir.

Senator Moss. Thank you very much. I wish really time was not too restricted, that we might have had some questions, but I think we must move on.

Who will be your other witness?

Mr. Soberg.

STATEMENT OF EINER SOBERG, ADMINISTRATOR, CHAPEL VIEW NURSING HOME, HOPKINS, MINN.

Mr. Soberg. Mr. Chairman, Senator Mondale, I am very appreciative of the opportunity to testify today, particularly in view of the fact that I was not scheduled to be on the program. I will make my remarks very brief.

My name is Einer Soberg, and I am administrator of Chapel View, a 128-bed nursing and boarding care home in Hopkins, Minn., about 5 miles west of Minneapolis.

I have just completed a 2-year term as chairman of the Conference on Geriatric Care of the Minnesota Hospital Association, an organization which represents the nonprofit and publicly owned homes in the State of Minnesota. I was Mr. Shrimpton's immediate predecessor in that position.

I am well aware that the purpose of this committee is to investigate the quality of care in nursing homes in Minnesota and not the method

of reimbursement, but the fact remains that the method and the amount of reimbursement that the welfare department provides for the care of welfare patients in nursing homes not only is directly connected to the quality of care but it does, in reality, actually determine the quality of care. Therefore, I believe it is worthy of consideration by this committee.

The Conference on Geriatric Care has developed and made public a position paper on reimbursement in which we advocate that reimbursement for nursing care for welfare patients be based on the actual operating costs of the providers of the care. We also advocate full disclosure of costs to the appropriate local, State, and Federal agencies. I have personally been involved quite extensively in the matter of reimbursement, since I was chairman of the committee that developed the position paper on reimbursement that I referred to a moment ago. I am also at the present serving as chairman of the Subcommittee on Nursing Home Reimbursement, and this subcommittee is developing a proposed method of reimbursement which embodies the principles of payments based on costs and full disclosure of costs.

As a first step toward this goal we are presently working on a uniform accounting system which we propose will be used by all providers of nursing care and boarding care in the State of Minnesota. We feel that this is a necessity if accurate cost comparisons are to be made between different homes.

It is our position that since well over half of the patients in nursing homes today are having at least a part of the cost of their care paid for out of public funds, the providers of that care should be accountable to the taxpayers by means of disclosure of their operating costs. We believe that the taxpayers have a right to know how their money is being spent.

It is my personnel opinion that the best way to eliminate poor quality nursing home care is to make it unprofitable to provide that kind of care, and that can best be done by paying for nursing home care on the basis of costs with full disclosure of such costs.

The proprietary home operator is unquestionably entitled to a fair return on his investment and a fair profit, but since both of these come in large part from public funds, the public is certainly entitled to have some control over them. We in the nonprofit segment of this field stand ready to provide such information and to accept such controls.

Thank you for your attention.

Senator Moss. Thank you, Mr. Soberg, very much, for your statement here today, and we do appreciate your keeping it brief because of the time factor.

Does that complete your presentation?

Mr. Ewald. That concludes our presentation, Senator Moss.

Senator Moss. We appreciate very much having you come and give us the point of view, the added point of nonprofit nursing home people, and we think that out of this record today we will be able to add to the record from other hearings, and hopefully we can implement some of the things that have been suggested for improvement so far as the Federal involvement in nursing homes is concerned. The States and the Federal Government must work hand-in-hand, of course, if we are going to continue to improve our nursing homes and to offer the service to which our elderly and infirm citizens are entitled.

This will complete our witnesses today. We had hoped to hear from Mr. Frank Franz of HEW about a study that he had made here but obviously we won't have time this afternoon. We will ask Mr. Franz if he could supply us with a copy of his study and any other information he might like to have in the record.

I know there were a few other people who would like to have testified today, and we wish we could accommodate those of you who would have liked to testify. I will be glad to receive and place in the record any written statement that any person wants to enter so long as it is on the subject that we have been talking about today. The record will remain open for 30 days, and so there is time for preparation of a written comment or statement for any of you who wish to send it in, and this would apply to the witnesses who have testified orally here today. They may want to make some amplification of their testimony by reason of other testimony that was offered today, or by other information that they feel ought to be before the committee.

A record before a committee should be as complete as possible and should cover all sides of any subject matter. We do welcome any comment that our citizens wish to make.

I want to thank my colleague, Senator Mondale, for his attendance. I want to thank all of you who have been here all day long and have listened so attentively. We have had a large audience here today, indicating the interest and concern there is about the subject matter. I certainly want to thank the university here for permitting us to use this fine facility which has been so well adapted for the purposes that we had today.

If my colleague has any comment, I will entertain that. When he finishes, we will start our dash for the airplane.

Senator MONDALE. Let me say, Mr. Chairman, that I am most grateful to you for coming to Minnesota and holding these really historic hearings on nursing home care in Minnesota, and for your leadership in this field nationally. I think that from these hearings, we can conclude that many of our nursing homes are providing excellent care but, unfortunately, some of them are not.

Second, it is clear that a nursing home occupant often finds it hard to defend himself or herself from bad care. There is a shortage of nursing home beds. Many nursing home occupants are unable to defend themselves, they don't have the money to look for alternatives, and it is difficult for them to protect themselves and, thus, it seems to me all the more important that, recognizing there are problems, we move swiftly to prevent them.

Speaking as a Minnesotan, I don't think it is just good enough to say that we may be better than other States. I think with our tradition of good health standards we shouldn't rest until every person in a nursing home has the finest care possible. That ought to be our minimum objective and we ought to be at it right away.

I thank the Senator from Utah for being here, the Minnesota Nursing Home Association for their critiques, the Minnesota Hospital Association, Mrs. Krause and her panel of witnesses, and particularly all of you who sat here all day long, thank you very much.

Senator MOSS. We are adjourned.

(Whereupon, at 4:45 p.m., the subcommittee adjourned subject to call of the Chair.)

ADDITIONAL MATERIAL SUBMITTED BY WITNESSES

PREPARED STATEMENT OF STATE SENATOR ROBERT J. TENNESSEN,[1] MINNEAPOLIS, MINN.

Mr. Chairman, Senator Mondale.

Thank you for permitting me the opportunity to address you on the important topic of care of our elderly in nursing homes. As a freshman state senator I have had an opportunity to offer some minor legislation in the regulation of nursing homes and have learned the political power of the Minnesota Nursing Home Association, Inc. What you will learn in testimony today will indicate the extent and gravity of the problem and make clear that there is a roll for both the state and federal government in rectifying a national disgrace.

The public will be outraged when it learns the conditions existing in *some* nursing homes, especially since two-thirds of all nursing home revenue is paid by the taxpayer. I believe the public will demand that these disgraceful conditions be ended, that proper and decent care be provided our elderly and that a public accounting be made of the nursing homes cost, expenditures, ownership, debt and internal control in handling of drugs.

Minnesota has existing statutory authority to establish all reasonable and necessary standards for facilities, patient care, staff, control of drugs, and other matters as the appropriate agencies deem necessary. By statute the State Board of Health has licensing power over hospital, rest homes, nursing homes and boarding homes. M.S., Section 144.50. The power of the State Board of Health is very extensive. It has the power to inspect hospitals, rest homes, nursing homes, and boarding care homes prior to granting a license. It has rule making authority and may detail the requirements the particular licensee must meet. The Board may refuse to grant, refuse to renew, or may suspend or revoke a license on any of the following grounds:

(1) For any violation of Minnesota statute, Sections 144.50 to 144.56, or any of the Boards rules and regulations; (2) permitting, aiding or abetting the commission of any illegal act in such institution. (3) conduct or practices detrimental to the welfare of the patient; or (4) obtaining or attempting to obtain a license by fraudulent means or misrepresentation. M.S., Section 144.55. The Board has further authority to adopt rules and regulations applicable to the sanitation and safety of the building, the construction of the building and to the health, treatment, comfort, safety and well-being of the patients. M.S., Section 144.56. Results of inspections by the Board of Health are to be kept confidential.

County nursing homes are regulated by the Department of Public Welfare. M. S., Section 144.583. Typically the rules and regulations applicable to county nursing homes are copied verbatim from those published by the State Board of Health for other nursing homes. The State Fire Marshal has a responsibility for inspection and enforcing compliance with fire and safety codes and rules and regulations. An additional state body, the Department of Public Welfare, prescribes the maximum rates to be paid by counties for care in nursing and boarding care homes.

Even with the apparent broad statutory authority, the State Board of Health has not promulgated sufficiently tough rules and regulations to insure proper patient care nor has it properly enforced the rules and regulations currently existing. Part of the Board's failure may be the lack of political strength neces-

[1] See statement, p. 2086.

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sary to carry out its mandate, or in my opinion, the simple unwillingness to carry out its responsibilities. In any event, inadequate care remains a grave problem in many of our nursing homes.

The inadequate care results from insufficient and untrained staff, poor physical plans, inadequate medical supervision, lack of patient programs, sketchy auditing of accounts and pricing structures, questions of ownership and other factors.

Selection, education and training of staff must be improved. Only licensed medical employees must be permitted access to patient's medicine and only they may be permitted to administer them. Patient-staff ratios must be adopted and enforced appropriate for the care required. The employees must know the importnace of cleanliness, kindness and respect for individual human beings.

Minnesota has been spared the tragedy of deadly fires which have occurred in many other states. Apparently the State Fire Marshal has been quite diligent in requiring appropriate measures for fire protection and safety and has enforced his rules and regulations. However, some physical plants require greater efforts to keep them sanitary and to prevent communicable diseases.

Nursing homes must be more than simply bins for the storage of old people awaiting death. Their mental, emotional and physical needs are not being met. Nursing homes must be required to provide suitable reading materials, programs, arrangements for religious counselling and worship, and facilities for physical exercise and therapy for those able to benefit from them.

Some of the other problems I outlined are of the "we don't know" variety. We do not know whether we are overpaying or underpaying for patient care. We do not know the pricing structure of nursing homes, who owns them, their debt structure, whether all patients are receiving adequate care, whether homes have adequate staffs, since nursing homes generally refuse to provide financial information necessary to make such decisions intelligently. Also, the state lacks sufficient investigatory staff to determine such facts on its own. We do not know whether inadequate care results from inadequate reimbursement by the state or simply inefficiency or unscrupulousness on the part of operators.

Obviously not all nursing homes are inadequate. The problems I listed apply principally to those classified by the federal government as "intermediate care facilities" which under Minnesota law are also classified as nursing homes. Federal standards for such facilities should be improved. Since the establishment of the immediate care facility classification, public assisted nursing home residents have been shifted from Medicaid to Old-Age Assistance and Aid to the Disabled resulting in a partial disqualification of some residents. Also some institutions have voluntarily down-graded from "extended care facilities" to "intermediate care facilities." State enforcement of its own rules and regulations have been inadequate. In cases where nursing homes have been inadequate, the State Board of Health has often obtained voluntary reduction from nursing home status to boarding care home status with often no change in the patients. Until 1969, no formal action had been begun by the Minnesota Board of Health to revoke a nursing home license. At that time, approximately three license revocation procedures had been instigated. Since then I am unaware of any additional actions. Because the political power of the Minnesota Nursing Home Association and the American Nursing Home Association is great, federal help is necessary to overcome the use of political power by nursing homes. It took twelve years to repeal the so-called state Mayhood Act, named after former state senator (who also owned nursing homes and continues to have interest in nursing homes). That law prevented the city of Minneapolis from adopting or enforcing any standards and singled Minneapolis out for treatment different from that of any other part of the state. In the 1971 session of the legislature, the Minnesota Nursing Home Association ostensively supported the repeal of the Mayhood Act. Yet later in the session under the veil of expressing concern for state-wide standards, it supported a bill which would have prevented local control of nursing homes in addition to state regulation. That bill was introduced late in the session and the hearings on it were held when it was apparent that the Senate Finance Committee would not approve any additional investigators for the State Board of Health. Had it become law, nursing homes would have been left unregulated.

The state can adopt and enforce effective standards with federal help. If after learning the pricing practices and ownership techniques of nursing homes, subsidiary and related corporations, and if we learn that payments are inadequate we believe that the federal government should assist in improving financial support for nursing home patients.

However, the federal roll should be one of cooperation with the state, it should not preempt all rule-making and enforcement powers. States must be able to set up and enforce more rigid standards, not inconsistent with those established by the federal government, particularly for programs.

ADDENDUM

After listening to the testimony of other witnesses, particularly Dr. Warren R. Lausen, Secretary and Executive Officer of the Minnesota Department of Health, I believe the state should provide more flexible sanctions for use against non-complying nursing homes. However, the Department of Health has authority to revoke or suspend licenses and within the broad authority granted it—the ability to devise some other types of corrective measures. Had sanctions been of particular concern to the Department of Health during this recent session of the legislature, I would have expected it to present its request for desired change.

Not once during the recent session did the Department even raise the question.

I have little faith in the Department of Health enforcing any new powers the legislature might give it. Private causes of action with punitive damages may be necessary.

NEWS RELEASE AND MAGAZINE ARTICLES SUBMITTED BY J. I. GREEN, MINNESOTA NURSING HOME ASSOCIATION, MINNEAPOLIS, MINN.

MINNEAPOLIS, MINN.—Philip K. Schumacher, President of the Minnesota Nursing Home Association, after having talked personally with Mr. Val Halamandaris, Chief Investigator for the Subcommittee on the Long Term Care, Senate Select Committee on Aging said "The Minnesota Nursing Home Association pledges its full cooperation regarding the hearing set for November 29. Schumacher added that he was pleased to learn from Mr. Halamandaris that the Hearing would address itself to many of the issues involved in the delivery of Long Term Care and that hopefully the information obtained would be translated into a meaningful, uniformly administered national policy on Long Term Care, replacing the current hodgepodge of programs, policies and regulations."

Mr. Schumacher who owns two nursing homes in Eveleth and Virginia, Minnesota, today again restated the Association's positive program to upgrade the quality of care in Minnesota nursing homes. "Education has been our major focus during the past three years. The Association has conducted or co-sponsored many programs. Among them, seminars on inservice education, housekeeping, food service, activity programs, volunteer services, management, mental health, community relations, decision making, podiatry and utilization of community resources. He also referred to the Association's film library and teaching guide that is being used by members to improve their inservice education programs."

In addition to educational activities, the Minnesota Nursing Home Association has been active in the Legislative arena, Schumacher said. MNHA drafted and worked vigorously for the passage of the bill that required the licensure of nursing home administrators. It supported requests by the Minnesota Department of Health for additional staff persons to be used in the inspection of nursing homes and enforcement of regulations governing them. MNHA also supported legislation that would insure uniform administration of licensing and fire safety regulations.

MNHA joins with officials of Minnesota government in the hope that all concerned will work together to identify problems and seek solutions, and that the Hearing will not turn into a "witchhunt". MNHA earnestly desires that legitimate concerns be responsibly discussed to insure quality total care for all nursing home residents. Schumacher also stated "I hope that MNHA will have an equal opportunity to review the files of the State Health Department and the Health Department of Minneapolis and St. Paul. This is important if nursing homes are to have an opportunity to honestly identify and evaluate any problems which may exist."

Over the past two years, persons who purport to be "friends of the aged" and concerned for their welfare have made many allegations about the quality of care in Minnesota nursing homes. These persons have no regulatory authority and have admitted such. However, they have not been concerned enough to act in a responsible manner and to turn over the alleged evidence to the State Department of Health. In my opinion, Schumacher said, "These persons who have

failed to properly inform the authorities are grossly negligent and have done a great disservice to those they are purporting to help".

Finally Schumacher said, "If it can be proven that the allegations of abuse, neglect, poor food, poor care and personal indignities are true, the Minnesota Nursing Home Association will insist that the facilites involved correct their deficiences or close their doors".

Guilt by Association

(By J. I. Green)

Now I know how Broadway Joe Namath felt—guilt by association. I own no Bachelor's III, but I am associated with nursing homes. Charges have been made that numerous substandard conditions exist in a majority of nursing homes. Since my life's work is with nursing homes, that makes me a bum—guilt by association. The charges also imply that all nursing homes and administrators fall in the same category. I have given the best years of my life to nursing homes and the aged. I am proud of this and will give my remaining years, if the profession wants me.

In assessing any problem, one must be objective, must be knowledgeable, competent to evaluate, and of course must be sincere in his approach. Quite frankly, I feel that the charges made constitute quite a pile of Baloney Slices. In any profession, business or occupation, some always do a better job than others. This has always been the case, and of course, it always will be. To say that there are no substandard conditions in Minnesota would be folly, and just as ridiculous is the statement that substandard conditions exist in a majority of facilities.

With 28,000 nursing home beds in Minnesota, there are then potentially some 10,220,000 patient days per year. Considering the volume of care being rendered, complaints are sure to be made. An official from the Minnesota Department of Health, recently stated that "Our office receives an average of five nursing home complaints per working day. Among them are complaints about food, refunds, care, doctor's charges, Medicare, etc. Some of these are by telephone and some by letter—some valid and some not." To me, five complaints per working day compared to 10,220,000 patient days is not cause for undue alarm.

The primary sources of complaints come from residents, relatives, and employees. Now, let's examine each category. First, the resident—Complaints by residents are sometimes valid, and yet due to processes of aging, they all cannot be accepted as fact. The unfortunate presence of guilt complexes among some relatives can cloud their interpretations of comments made by those whom they visit. And at the same time, their evaluation may be correct. Employees, due to their presence in the facility, are in a good position to observe conditions. However, the testimony of former employees (especially those leaving under unfavorable conditions) it is not always credible. What I have been saying is that the matter of charges and substantiation of such has many facets.

The much discussed matter of the quality of care provided as it relates to proprietary or non-proprietary ownership leaves me a little bored. Both types of ownership have definite places in the long-term care profession. Nationwide, proprietary facilities represent approximately 85% of the total beds. Minnesota is unique in that it has a substantial number of non-proprietary beds. Free enterprise is probably the dominating factor in the rapid growth and sophistication of this great country of ours—I hope it will continue. Church related facilities probably comprise the majority of nonproprietary beds. To many persons, their church is very important to them—and they want to spend their later years in a church related nursing home. They should have this opportunity! As I see it, the determining factor in the delivery of quality care lies with the philosophy, dedication and competence of ownership and management, not whether it is proprietary or non-proprietary.

The operation of a nursing home is a very complex one. It is many things to many people. To the resident it can mean life removed from familiar settings, medical problems, social problems, and loneliness. To the nursing home, it means the staggering responsibility of trying to provide a full life for the resident, meeting all of his needs—medical, social, physical, emotional and spiritual—needs that can no longer be met by relatives. It means trying to provide "The Better Life Through Total Care."

When substandard conditions do exist, it is my opinion that they must be corrected within a reasonable time or the facilities closed. Nursing homes are in a service profession. If a facility cannot render quality service, it is failing in its responsibility. Since the welfare of our aged hangs in the balance, a strict quality control must be maintained.

As I stated recently in a television interview, I too am concerned and so is my Association. We will work to identify problems and seek solutions with any person or organization that is sincere, knowledgeable and will conduct themselves in a responsible manner.

I have always been concerned for the welfare of our aged, for I believe that "old age is an accomplishment, not an affliction, and that it must be treated with kindness, understanding, and dignity."

Executive Director's Comments

(By J. I. Green)

Eight months have passed since I became a part of Minnesota Nursing Home Association. I feel now would be a good time to reflect on those months.

First, I think it would be appropriate to restate some of my personal philosophy that was mentioned in my brief address to the general assembly of the convention last October.

"I am not at all concerned whether a home is proprietary, or non-proprietary, large or small, or whether it is old or new—but I am vitally concerned that the home delivers quality care and that it is adequately reimbursed for such care."

"I personally believe in making things happen—good things seldom come about by accident. Realizing this, I will constantly be striving to make good things happen for the MNHA and its membership."

I have always hung my hat on these two philosophies. To me, they are absolutely essential to a good performance on my part and for a well managed organization.

Now, let's look at the past eight months. They have been extremely busy, and also productive. Much time has been devoted to re-organization and actually to my personal adjustment to a new State, people, government, Association, etc.

Part of my orientation began with a quick trip around the state with President Phil Schumacher, attending regional meetings—two a day. Then came the search for additional staff and new office space. Both searches were successful. Arvid Larson was employed to direct our Education and Membership programs. A full-time secretary was obtained and on March 1, we moved into new office space.

The new space is attractive, adequate in size, and conveniently located. While all this was going on, we were also dealing with problems akin to the Legislature and rate freeze.

There was a definite need to beef up communications to the membership. We designed a HOT LINE, and as you know, it has appeared in your mail quite frequently. Early in the year we talked about computer services, a purchasing program, and an insurance program for the membership. The computer program is off the ground, the purchasing program will probably be finalized by July 15, and the insurance program is about ready for delivery. The Association's Constitution and By-laws were evaluated and a completely revised edition will be presented for your adoption at the convention in October.

On January 9 I mailed a memo and survey relating to the educational needs of nursing homes in Minnesota. From this, and with the fine help of our Education Committee and Avid Larson, we have developed an excellent Education program.

One of the points stressed in my presentation during our swing around the state was that each and every member has a responsibilty to offer constructive criticism of his association and its staff. No association can grow in the proper fashion unless it is meeting the total needs of its membership. Help us grow properly, by informing us how we can do a job better, and provide more benefits to you.

The balance of 1969 promises to be big too. Planning for the convention is well under way. Already 35 exhibits have been sold. The program content and speakers promise to be outstanding—plan now to attend.

Our strength, effectiveness, and member benefits are in direct proportion to the size and dedication of our membership. If you are not yet a member of the team, join now. Go to where the action is—to MNHA!

LETTER FROM J. I. GREEN, EXECUTIVE DIRECTOR, MINNESOTA NURSING HOME ASSOCIATION, TO SENATOR FRANK E. MOSS, DECEMBER 6, 1971

DEAR SENATOR MOSS: A week has passed since your committee's hearing in St. Paul, Minnesota, November 29, 1971; and the smoke has begun to clear.

I want to thank you very much for permitting the Minnesota Nursing Home Association to offer testimony at the Hearing, and for giving us the amount of time that you did. Although the smoke is clearing, I can't seem to see the outcome of the Hearing. That is, I cannot seem to see the meaning the Hearing had for M.N.H.A., the profession, the State of Minnesota, or the Federal Government. What is the result? What happens next? What benefits do you see being derived from the Hearing, and when might one anticipate receiving them?

I would appreciate it if your office would keep me informed of any new developments.

Thank you for your concern for America's aging. I remain,

Very truly yours,

J. I. GREEN.

LETTER FROM J. I. GREEN, EXECUTIVE DIRECTOR, MINNESOTA NURSING HOME ASSOCIATION, TO SENATOR FRANK E. MOSS, DECEMBER 28, 1971

DEAR SENATOR MOSS: As a result of the allegations made at your Hearing on November 29, 1971, the Minnesota Nursing Home Association has restructured its Standards and Ethics Committee to address itself to the matters presented. Actually, what was done was that we formed a metropolitan subcommittee involving some fourteen persons, of whom about 50% are Registered Nurses. The remainder are experienced, dedicated administrators. This subcommittee has developed its policies and procedures, and will soon be making on-site investigations to determine the validity of the allegations.

Where necessary, outside professionals, physicians, dieticians, therapists, etc. will be called in to assist in making the final determinations. We feel that the concept is a professional approach and will become a very meaningful part of the Association's activities. You can rest assured that our investigative teams will be critical in their appraisals, and that their findings will be legitimate and fully documented. This same metropolitan group will also be responsible for investigating complaints that might be made in addition to those presented at the Hearing.

We are treating this effort as an interim measure—interim until we can secure funding for a comprehensive professionally staffed department of the Association. This department would develop meaningful standards, in addition to those prescribed by governmental agencies, and would function on an on-going basis, including the inspection of facilities to insure that those standards are consistently being met.

As you can see, Senator Moss, from the above measures being introduced, we are vitally concerned with the quality of care being provided to our aged. Knowing that the Federal Government is equally concerned with nursing home care, we must appeal to you for assistance in learning where and how we may turn for help in funding these measures. Any thoughts of yours with regard to obtaining grant monies would be most gratefully received and implemented. We hope to hear from you soon.

Thanking you in advance for your assistance, I remain,

Very truly yours,

J. I. GREEN.

PREPARED STATEMENT BY MISS KIRSTEN FLESCHE, RN, ASSISTANT EXECUTIVE DIRECTOR OF MINNESOTA NURSES ASSOCIATION

Mr. Chairman, I am Kirsten Flesche, Assistant Executive Director of the Minnesota Nurses Association, the professional organization of approximately 5000 registered nurses in the state of Minnesota. The MNA is a constituent of the American Nurses Association.

On July 30, 1969, Mr. Chairman, you heard Miss Mary E. Shaughnessy speak for the American Nurses Association expressing our concerns about the number of persons requiring long-term care. The nature and complexity of their health and social problems indicates the need for a wide gamut of institutional community services. You may recall Miss Shaughnessy spoke about concerns of the professional nurses in ANA related to the proposed standards for skilled nursing homes. She pointed out the problems of organizing and administering effective nursing service in a typical nursing home. She described the activities the nursing profession was carrying out to meet the needs of the long-term patients.

One of these activities was the establishment of a Division on Geriatric Nursing Practice in 1966 for members of the profession interested in this field. In 1969 membership was approximately 30,000 registered nurses. Their primary function was the development of standards for geriatric nursing practice and a program of certification. Twenty-four geriatric conference and special interest groups have been formed by state associations to assist nurses in upgrading their practice. In 1968 the Minnesota Nurses Association established such a group. At present there are about 600 members. They have held four programs in 1970 and 1971 to assist nurses in upgrading their practice.

On August 27, 1969, the Minnesota Nurses Association appeared before the State Senate Public Welfare Interim Committee and expressed concern regarding nursing home problems in the following areas:

"I. Need for licensed nursing personnel to be in attendance 24 hours a day,

II. Need for orientation and in-service education for nursing personnel,

III. Current reimbursement policy which provides more money for patients who are bedridden thus discouraging restorative rehabilitative care."

In July of 1971 MNA stated that:

I. Supervisory responsibilities, unexpected emergency situations, patient and family education needs which could arise at any time all require a minimum of 24 hours coverage by a licensed nurse and preferably a registered nurse whose background prepares her for such responsibility.

II. Positioning of bed patients, baths, and the frequency of checking patients are matters of nursing judgement and *should not* be spelled in the regulations which could become obsolete with new scientific developments and advances in nursing care.

III. In the regulations, the terms "adequate staff", and "disturbed patient" need to be clarified.

The Public Health Nurses Section and the MNA Board of Directors oppose the Social Security Administrations interpretation of "skilled nursing" as used by the fiscal intermediaries and urges a definition consistent with what constitutes good nursing practice.

Mr. Chairman, Senator Mondale and members of the committee, we are concerned. As a Profession we are working to improve our contribution to care. However, no matter how capable the registered nurses are in providing care, the patient will still be deprived of care if registered nurses are not employed to provide that care or are prohibited from practicing nursing because of job description or lack of available funds.

POLICY ISSUES REGARDING NURSING HOMES FINDINGS FROM A MINNESOTA SURVEY, SUBMITTED BY WARREN R. LAWSON, SECRETARY AND EXECUTIVE OFFICER, MINNESOTA DEPARTMENT OF HEALTH

I. INTRODUCTION

In The Year 2000, there will be 100,000,000 elderly persons among the population of this country. A great many of them will be living in nursing homes. or whatever substitute facilities are develped in the next three decades. They will

be joined by a large group whose qualification for nursing home type services is measured in terms of chronic illness rather than in chronological age. Many members of this large consumer group will, of course, qualify on both counts.

Across the country, expansion of nursing home facilities has already begun to serve the increasing numbers of people who have need of services. Nursing home operators, health services planners, public agencies who pay for care of nursing home patients, family and friends of patients—each represents a concern for assuring that the special services required are provided in a fashion appropriate to the best interests of the patient and society.

Three major policy issues emerge from these combined concerns:

1. The effect on the kind of services available caused by the increase in the number of nursing home facilities.
2. The role of state agencies and professional associations in formulating and enforcing public policies regarding nursing homes.
3. The quality of nursing home care—how it should be defined and measured.

This report reviews these policy concerns and suggests areas for emphasis and action, using data from a survey of Minnesota nursing homes as a framework of facts for analysis.

Nationally, expansion of nursing home facilities has been tremendous, as has been the accompanying increase in the number of nursing home patients. This report describes changes in Minnesota nursing homes over a 15-year period, documenting not only the doubling of institutions and the tripling of beds, but also changes which can be regarded as qualitative: changes in fire protection, size, and hospital attachment. These findings are reported in chapter II.

The increased importance of nursing home care has prompted greater attention to protecting the public interest. In Minnesota, the Department of Health has played the major role in upgrading nursing homes by setting standards, licensing, and periodically reviewing all nursing homes. As described in chapter III, the Health Department seems to have been unusually influential, due in part to a strong legislative mandate and relative independence in enforcing standards.

Chapter IV considers the question: how can "good" nursing home care be defined and measured? Relationships between home characteristics and selected measures of quality are tested with correlation techniques. The findings—that high quality, as measured in the Minnesota survey, is associated with having a small percent of patients in a home on welfare and that ownership for profit has little measurable impact of quality—demonstrate how much there is to be learned about protecting the nursing home patient.

Chapter V points out the elusiveness of achieving good care and identifies forces at work which might have further ameliorative effects, including professional ethics, public regulation, business ethics, and consumer representatives. Suggested next steps are proposed for health services researchers, comprehensive health planning programs, and associations of proprietary nursing homes.

The survey on which this report is based involved the collection and analysis of various types of data. Most importantly, a random sample of nursing homes in Minnesota was selected. One fourth of the state's 392 institutions for the elderly which, in 1966, provided some nursing care—as opposed to personal care—were visited. Their administrators or owners were interviewed regarding nursing home characteristics, patients, programs, and costs, and their opinions and attitudes toward nursing homes were solicited.

In addition, a series of informal interviews with knowledgeable persons throughout the state were conducted. Data on the distribution of nursing homes since 1952 were obtained from the *Directory of Licensed Hospitals and Related Institutions*, issued annually by the Minnesota Health Department. Payments by county welfare departments to nursing homes over a 14-year period were determined from records maintained by the Department of Public Welfare.

The study was funded under contract with the U.S. Public Health Service and was directed by Nancy N. Anderson. R. Hopkins Holmberg shaped the study design and served as consultant throughout. Lana Stone assisted in every aspect of data collection and analysis. Statistical analyses were performed by Robert Schneider.

Special thanks are due to staff of the former Health Economics Branch of the U.S. Public Health Service and to the many nursing home operators and public officials who patiently answered questions.

This report was prepared after contractual obligations to the U.S. Public Health Service were completed. The authors take responsibility for its content.

II. Changes Over Fifteen Years

Description of changes in Minnesota institutions for the elderly from 1952 to 1966, taken from data reported yearly in the state's *Directory of Licensed Hospitals and Related Institutions.* In addition to substantial increases in the availability of facilities, there have been changes in the age, fire protection status, size, and type of homes, many of which are felt to be desirable.

CHANGES IN THE MINNESOTA NURSING HOME SCENE

The number of institutions for the elderly in Minnesota has doubled since 1952, and the number of beds has tripled.

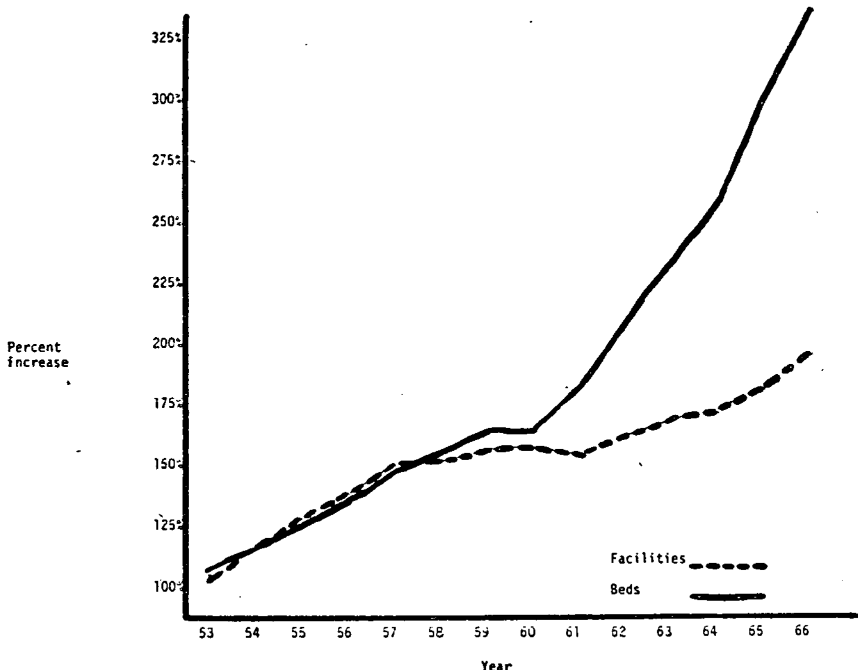

FIGURE 1.—Percent increase in facilities and beds since 1952

In 1952, there were 291 nursing homes, convalescent and nursing care units, combined nursing and boarding care homes, and boarding care homes.[1] By 1966, the total number of institutions climbed to 563. From 9,023 beds in 1952, the total grew to 29,981 in 1966.

Besides the increased quantity of available facilities, there have been changes that might be characterized as *qualitative.*

NEW HOMES

An increasing proportion of the state's nursing care patients are housed in new facilities. Sixteen percent of the existing facilities opened within the year preceding the Minnesota survey. Thirty-eight percent of the institutions have been open five years or less. It may be assumed that many of these new homes are housed in facilities especially constructed for nursing home purposes (although beneficial consequences to the patient can only be inferred). The reported number of new homes is inflated, however, by the practice of regarding any change of ownership the start of a "new" home for purposes of licensing.

[1] In Minnesota, institutions giving skilled nursing care are classified as nursing homes. Those providing personal care only are designed boarding care homes. Convalescent and nursing care units are defined as hospital-attached nursing homes.

MORE FIRE PROTECTION

Another change that might be considered a qualitative improvement is the increase in facilities having a fire protection system. The number of homes neither built of fire resistive materials nor protected by sprinkler systems has decreased from nearly three out of five in 1952 to only one out of five in 1966. This change reflects the substantial increase in the number of homes constructed of fire resistive materials.

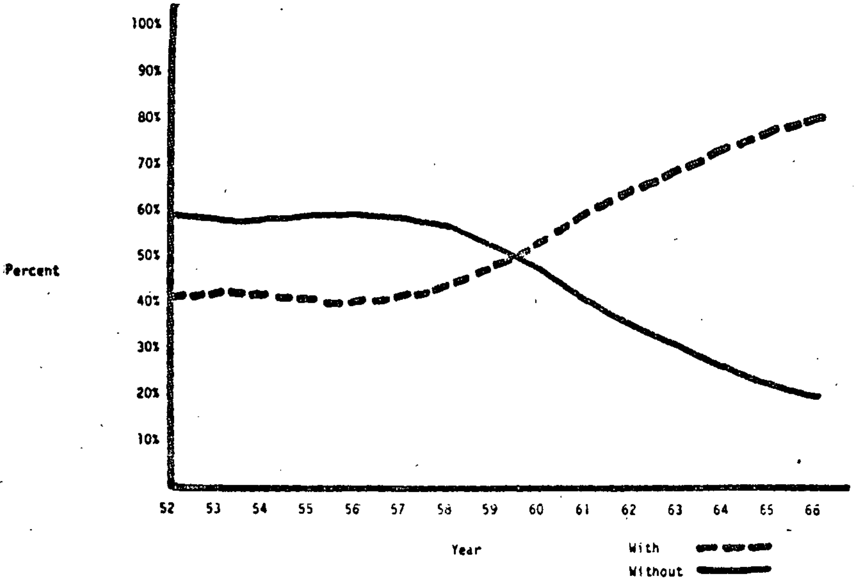

FIGURE 2.—Percent of total institutions with and without fire protection,* 1952–1966

LARGER HOMES

It is generally believed that larger homes offer patients advantages which are lacking in smaller facilities, especially those having fewer than 25 beds. Over the 15-year period, the average number of beds per institution has increased from 31 beds per home in 1952 to an average bedsize of 53 in 1966.

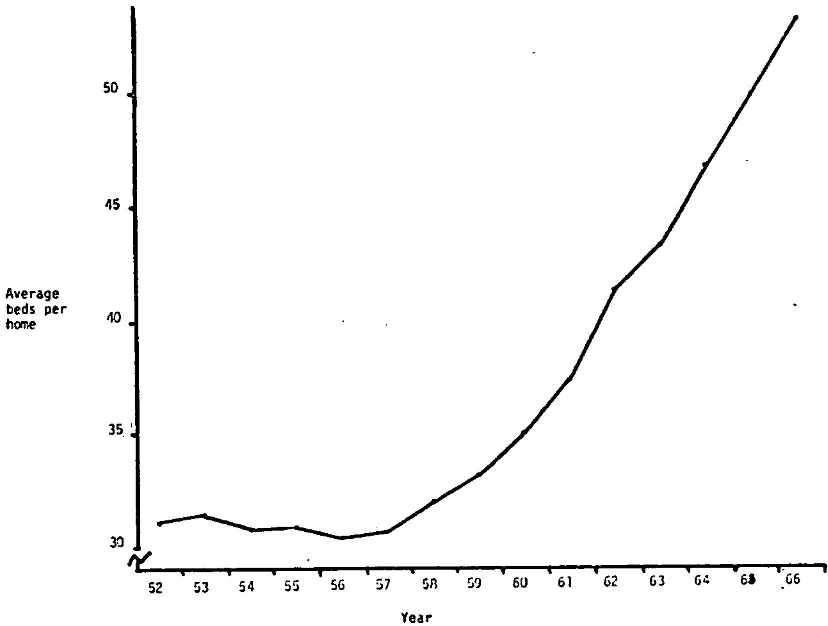

FIGURE 3.—Increase in average bedsize, 1952–1966

RECLASSIFICATION OF FACILITIES

Over the years, the proportionate distribution of different types of homes has changed. These changes are regarded by many as overall qualitative improvements. For example, boarding care homes represented a larger proportion of the total institutions in 1966 than they did in 1952. Proportionately, they doubled, from 15 percent of the total to 30 percent.

This increase represents largely the reclassification of old nursing homes to boarding care homes. When a nursing home was determined to be substandard, often its license would be changed to permit it to provide only boarding care. One hundred ninety-five such reclassifications have taken place since 1952.

INCREASE IN HOSPITAL-ATTACHED HOMES

The nursing home that is physically attached to a hospital is thought by some people to be superior because it can share the hospital's staff and program. In Minnesota, there were many more convalescent and nursing care homes (C&NC home is the official Minnesota term for chronic care units of hospitals) in 1966 as campared with 1952 when hospital-attached homes were almost non-existent.

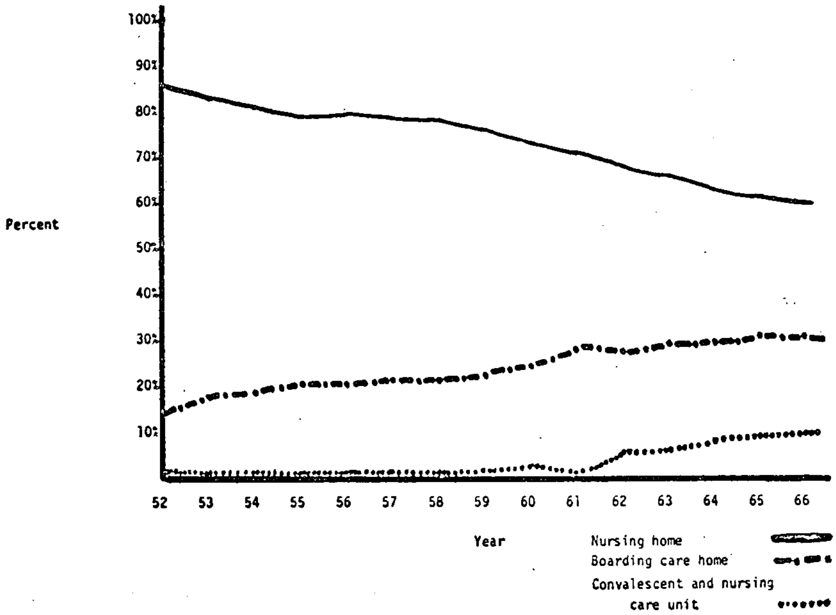

FIGURE 4.—Percent of total institutions represented by each type of facility, 1952–1966

MORE NON-PROPRIETARY HOMES

The proportionate distribution of proprietary and non-proprietary institutions has also changed over 15 years. The number of non-proprietary homes increased greatly—from 84 in 1952 to 252 in 1966—the non-profit and governmental homes now represent 45 percent of the total institutions.

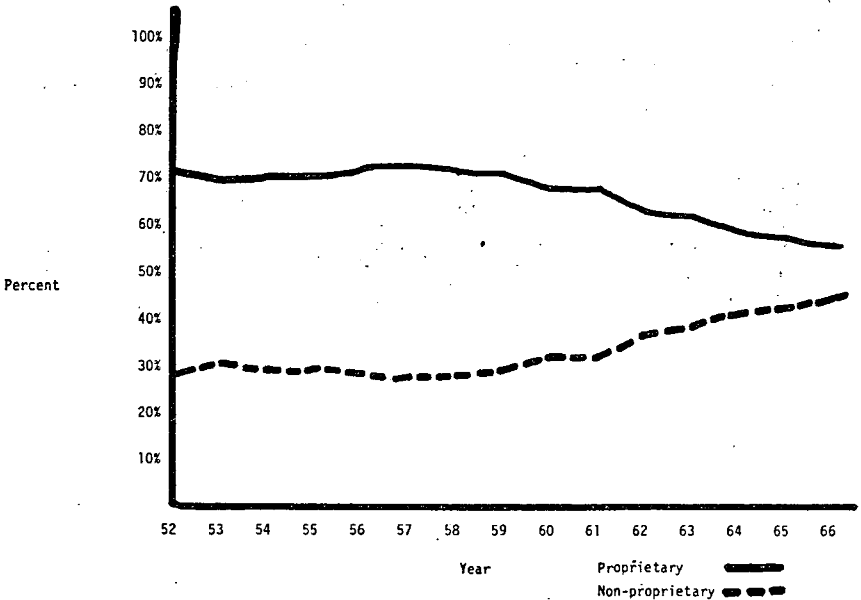

FIGURE 5.—Percent of total institutions represented by proprietary versus non-proprietary facilities, 1952–1966

If only nursing homes and C&NC units are considered (excluding homes that provide only boarding care), the trend toward more non-proprietary facilities is even more marked. In 1952, only 28 percent of all nursing care facilities were non-proprietary, but in 1966, 58 percent were thus classified.

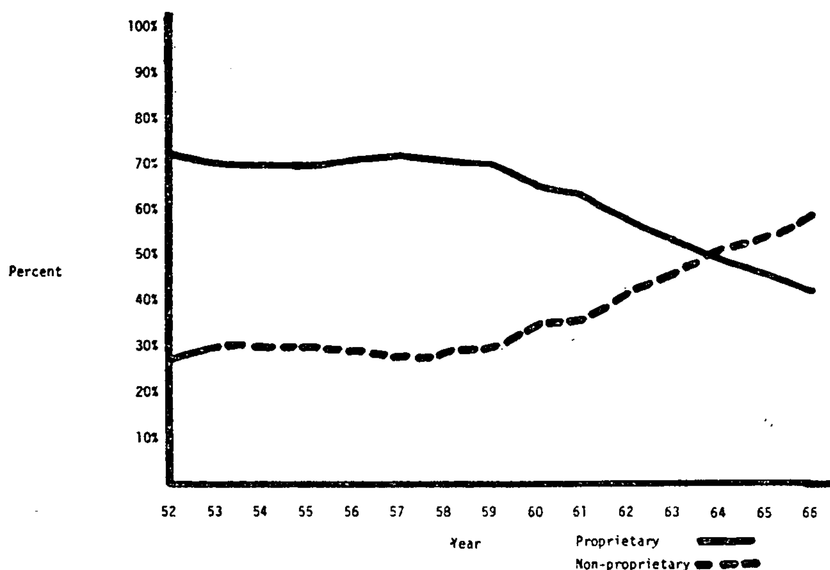

FIGURE 6.—Percent of nursing care institutions (excluding boarding care homes) represented by proprietary versus non-proprietary facilities, 1952–1966

Although non-proprietary homes are often more highly regarded than those operated for profit, interpretation of the increase in non-proprietay homes as a qualitative impovement is questionable in view of the Minnesota survey findings reported in this monograph.

III. REGULATION OF NURSING HOMES

Description of regulation of nursing homes by the Minnesota Department of Health. One of the first to license nursing homes, the Health Department has not only licensed homes that concurred with statutory requirements, but has also enforced additional policies through prelicensing contacts with applicants and informal hearings. Fifteen-year trend data, reported in the preceding chapter, are in consonance with the changes the Health Department attempted to bring about. Other influences on nursing homes have been exerted by the Department of Public Welfare and the nursing home associations. Data come from interviews with informed persons throughout the state and from review of public documents.

The Minnesota Department of Health, as the delegate of the Board of Health, has responsibility for licensing "all institutions offering care to the sick" including, as early as 1941, nursing homes.

The legislature not only delegated enforcement of the state's 1941 Hospital Licensing Law to the Health Department; more important, it gave the Department authority to set "reasonable standards" as "found necessary and in the public interest" in order that legislative action would not be required for changes in regulation. A 1951 act further strengthened the Health Department to make its regulations mandatory for purposes of licensing.

Thus, the Health Department received authority to set standards as well as to enforce them.[2]

The seemingly unusual autonomy of the Department originates also in the structure of state government. The executive officer of the Board of Health is appointed by the Board, a nine-member body appointed by the governor to three-

[2] McClure, Ethel, *Homes for Aged and Chronically Ill Persons in Minnesota: Their Development and Licensure*, Minneapolis, Minnesota State Health Department, 1959, p. 29.

year, overlapping terms. The Board serves without pay and appears to have normally been a political and composed of professionals. The Department of Health is responsible to the Board of Health, and is administered by the Board's executive officer. This arrangement leaves the Department less directly responsive to the governor than are other state agencies which are headed by commissioners appointed by the governor with the consent of the senate.

Relative freedom to regulate nursing homes is enhanced by the relative abundance of nursing homes in the state. The Department is not constantly faced with the prospect of either ignoring broken standards or pushing the patients in substandard beds out in the cold. There has been a proportionate increase in the number of nursing home beds per senior citizen; in 1952 there were 28 beds per 1000 persons over 65 while in 1961 the ratio was 35 beds. Although there seems to be no validated method of determining bed need based on population, when compared to the 1961 national ratio of 21 beds to 1000 population over 65, Minnesota seems to have a comparative abundance of nursing care beds.[3]

Many new beds were added in 1958 and the years immediately following. Availability of Hill-Burton, Federal Housing Administration, and Small Business Administration funds to finance nursing home construction were among the several influences encouraging building around this time.

REGULATION OF NURSING HOMES

Requirements for licensure, similar to those of many states, have to do with physical plant, personnel, equipment, sanitation, reports and records, and handling of medication. The personnel requirements are noteworthy. "A supervisory nurse shall be in charge of the nursing service. She shall be either a registered nurse or a licensed practical nurse." Further, "in homes licensed for the care of 12 or more persons there shall be at least one person dressed and on duty during the night.[4]

Since 1951, it has been required that a licensed nursing home have a dayroom. Fire protection standards, administered by the Fire Marshal of the state, became effective in 1959. They called for use of fire resistive non-combustible materials in construction of new facilities.[5]

INFORMAL DEPARTMENT OF HEALTH POLICIES

In addition to official regulations, the Department of Health has instituted a number of informal policies in its efforts to upgrade nursing homes.

ENCOURAGEMENT OF LARGE FACILITIES

In October 1958, the Department of Health, in its annual Hill-Burton State Plan, issued a statement entitled "Problems Concerned in the Operation of the Small Nursing Home." A major problem discussed was the difficulty of employing competent full-time nursing staff. It was pointed out that income from patients is often inadequate to pay salaries beyond that of the owner, and that even when the operator is herself a nurse, other duties detract from her practice of nursing. A shortage of nursing personnel across the state further suggested to the Department of Health that larger facilities could better utilize—as well as afford—nurses.

Another problem with small nursing homes is inadequate physical facilities. According to the Department of Health statement: "From the standpoint of long-range planning, it is not economically feasible to require all of these small existing homes to invest in making the necessary changes in the physical plant to meet minimum standards . . . As soon as an adequate number of beds is provided in modern, fire resistive nursing homes, many of these homes presently licensed as nursing homes will serve very effectively as boarding care homes or foster homes for persons needing some personal supervision but not requiring nursing care or medical supervision."[6]

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[3] Speir, Hugh B., *Characteristics of Nursing Homes and Related Facilities: Report of a 1961 Nationwide Survey,* Washington, D.C., U.S. Department of Health, Education, and Welfare, 1963, p. 40.

[4] *Minnesota Statutes and Regulations of the Minnesota State Board of Health for the Construction Equipment, Maintenance, Operation and Licensing of Nursing Homes and Boarding Care Homes,* Minneapolis, Minnesota State Board of Health, 1963.

[5] *Minnesota Regulations Relating to State Fire Marshal: Nursing and Boarding Care Homes,* St. Paul, Minnesota, Division of Insurance, Fire Marshal Section, 1959, p. 10.

[6] *Minnesota State Plan for Hospitals, Public Health Centers and Related Medical Facilities: 1962–1963,* Minneapolis, Minnesota Department of Health, Division of Hospital Services, 1962, p. 175.

At this time (1958) the Department asserted that a desirable home would have 25 beds or more.

ENCOURAGEMENT OF SPECIALLY-CONSTRUCTED FACILITIES

In 1959 the Department of Health adopted an informal policy that no more converted frame dwellings would be licensed as nursing homes. Preference would be given to facilities specifically constructed as nursing homes. Institutions in converted facilities were not encouraged to remodel, and many were reclassified to boarding care homes or closed.

ENCOURAGEMENT OF HOSPITALS TO BUILD C&NC UNITS

Another informal policy of the Department of Health, as noted in its Hill-Burton Plan, has been that "approximately one-third of the (Minnesota) nursing home beds should be constructed as units of Hospitals." The advantages the Department saw in these convalescent and nursing care units are enumerated as follows:[7]

1. Closer medical supervision;
2. More efficient utilization of existing nursing and other personnel who are in short supply;
3. Common utilization of basic facilities and services such as kitchen, laundry, and boiler plant;
4. Ready avialability of x-ray, laboratory, and other diagnostic facilities and services when needed;
5. Joint utilization of specialized personnel such as social service workers, doctors, dieticians, medical record librarians and others;
6. A smoothly operating mechanism for the transfer of patients from the hospital to the nursing home or the reverse as the needs of the patient change;
7. More flexibility in the administration of the hospital by freeing acute beds now occupied by long-term patients not requiring hospital care;
8. The advantages of joint purchasing and a single administration;
9. Opportunities for training all types of hospital personnel in the care and rehabilitation of the long-term patient; and
10. Joint utilization of rehabilitation facilities and personnel by the hospital and the nursing home on both an in-patient and out-patient basis.

ENCOURAGEMENT OF COMMUNITY SPONSORSHIP

A theme espoused by the Health Department, though never written as were the above informal policies, is the importance of community responsibility in the sponsorship of nursing homes. A statement of the health officer before hearings of the 1961[8] session of the United States Senate explicates this point of view:

Senator: I have a question I would like to ask you . . . You mentioned in your statement and in your remarks a moment ago that a large percentage of your beds, 65 or 70 percent, that have been added since 1950 were non-profit and federal and you indicated that was a trend and I understood you to think that in the course of time that privately-owned nursing homes of that type will be passe.

Health Officer: I think so. Senator, years ago we had the same trend in hospitals and gradually the hospitals became non-profit because of the recognition that the provision of hospital services is a public responsibility and should not be placed on a single individual or group of individuals.[9]

ENFORCEMENT OF REGULATIONS AND INFORMAL POLICIES

Nursing home regulations and policies have, of course, been enforced and encouraged by licensing procedures. In addition, the Department of Health has exercised some other means of enforcing standards, both formal and informal.

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[7] *Ibid*, pp. 90–91.

[8] Recent interviews suggest at least informally that these statements still reflect informal policies.

[9] United States Senate, 87th Congress, 1st Session, "Nursing Homes: Hearings before the Subcommittee on Nursing Homes of the Special Committee on Aging, Part 5, Minneapolis, Minnesota, Dec. 4, 1961," Washington, D.C., U.S. Government Printing Office, 1962, p. 634.

PRE-LICENSING ACTIVITIES

One way of upgrading nursing homes is to prevent new homes of questionable character from opening. According to Ethel McClure, an historian of Minnesota nursing homes: "It is obvious that from the standpoint of procedure it is simpler to prevent an undesirable institution from opening than it is to close one after it has been licensed." [10]

Potential nursing home operators are screened by means of a "preliminary information questionnaire" developed by the Department of Health for "prospective owners, managers, individual corporate officers, partners and persons in charge of care facilities." The form inquires into the applicant's qualifications and background, including formal education and previous employment. Since Minnesota's 1941 licensing law requires the applicant to have appropriate "character and responsibility," the questionnaire also inquires into personal history of tuberculosis, mental illness, epilepsy, physical disability, arrests, use of intoxicating beverages, and addiction to habit forming drugs. The Department of Health has stated that "No final commitment for purchase, construction, remodeling or affiliation with an existing or proposed care facility should be made until clearances on the information questionnaire have been made by the Department." [11]

Preliminary plans for construction, prepared by an architect or engineer registered to practice in Minnesota, must be submitted for Department of Health approval.

An individual or corporation contemplating opening a home may be required to obtain information regarding local need for the proposed facility. A conference with the applicant is conducted by the Department of Health to go over forms and discuss the potential for success of a nursing home. According to one Department official: "We want to talk to people before they start building—tell them that profit will not be too high, that it is hard to get staff, that many regulations need to be met.[12]

INFORMAL HEARINGS

After an institution has been licensed, revocation or refusal to renew is "quite complicated, involving the preparation of a 'complaint,' the provision for a hearing with the taking of testimony, and possible court action. The hearing must be authorized by the State Board of Health and witnesses may be subpoenaed." [13] In order to avoid some of these complications, in 1958 the Department instigated the procedure of holding informal hearings. Orders for a hearing were issued by the Department when observed failings of a home were left uncorrected over a period of time. Such informal hearings provided an opportunity for Department officials to get together with the administrator or owner of the home to discuss problems and the question of continued licensure.

Unannounced visits by Department of Health officials also provide the impetus for scheduling informal hearings. (Surveillance of Twin Cities nursing homes has been delegated to the health departments of Minneapolis and St. Paul.)

Some homes retain their license after improving the conditions questioned by the Department of Health. Often a nursing home is reclassified to a boarding care home. Informal hearings also result in voluntary withdrawal of applications for renewal or new licenses.

IMPACT OF DEPARTMENT OF HEALTH ACTIVITIES

There is much evidence that the Department of Health has effectively enforced its regulations and encouraged its informal policies. The changes in Minnesota nursing homes since 1952 are in consonance with what the Department hoped to accomplish. The Department has worked for especially built facilities, larger homes, units attached to hospitals, and institutions run by non-profit or governmental associations. Trends since 1952 are all in this direction, although it is impossible to isolate the influence of the Department from other factors such as new federal legislation and market influences.

(The proportionate decrease in the number of proprietary institutions could reflect the impact of several informal departmental policies. Proprietary homes

[10] McClure, *op. cit.*, p. 76.

[11] "Preliminary Information Questionnaire," Minnesota Department of Health, Division of Hospital Services, mimeographed, 4 pp.

[12] Interview with a representative of the Minnesota Department of Health.

[13] McClure, *op. cit.*, p. 79.

have tended to be smaller and more frequently housed in converted frame dwellings.)

Since 1952, 208 institutions have closed. One hundred forty-six of these occurred after 1958 when the informal hearings were inaugurated. Similarly, reclassification of nursing homes to boarding care homes increased rapidly after 1958.

While a variety of factors could account for the reclassifications as well as the closings, reasons cited by operators of reclassified homes contacted by questionnaire point to enforcement of Department of Health regulations and informal policies. Of 32 responses (60 questionnaires were sent), 14 cited age of the physical plant (and five of these, the fact of a converted frame dwelling) as the reason for reclassification. In addition, five gave as reasons the small size of their facility. Eight of the 32 reclassifications had occurred when the home underwent a change of ownership.

OTHER INFLUENCES AFFECTING MINNESOTA NURSING HOMES

There seems little question that the Department of Health has been the most influential maker and enforcer of nursing home policies in Minnesota. However, the Minnesota Department of Welfare and the nursing home associations also have some influence on public policy.

MINNESOTA DEPARTMENT OF PUBLIC WELFARE

The Minnesota Department of Public Welfare has played an important role in the Minnesota nursing home scene by virtue of its responsibility to administer the state's public assistance program. Since some 60 percent of Minnesota's nursing home patients have their care financed by public assistance programs, rates at which homes are reimbursed are very important, at least to the extent that financial arrangements influence the care provided. The Department of Public Welfare also has responsibility for licensing the state's 20 county-run nursing homes, although the licensing is done according to Department of Health standards.

NURSING HOME ASSOCIATIONS

The two dominant associations of nursing home administrators and owners in the state are the Minnesota Association of Geriatric Homes (MAGH)—which limits its membership to administrators of non-profit homes and public homes—and the Minnesota Nursing Home Association (MNHA), whose members are predominantly—but not exclusively—proprietors.[14]

While these associations play important roles for their members, a major influence on public policy has not been discovered in this study. The MNHA attempts to show "that proprietary nursing homes can furnish their facilities at less cost than public or publicly-sponsored institutions, and consequently can provide good nursing home care at a substantial saving to private families and welfare agencies." [15] In addition to its concern for representing the proprietary home to the public, MNHA has been active in trying to improve reimbursement rates provided by county welfare agencies.

MAGH has forced perhaps more on standards than on reimbursement, working closely with the Department of Health in several educational activities. Its focus has been the "retirement center" or "geriatric care center" and it has emphasized the implications of a term applied to many of its members in the early days—that of "benevolent." MAGH has by policy avoided political activities, though in the past several years some members have urged a more active use of political techniques in upgrading income.

HAVE NURSING HOMES BEEN UPGRADED?

The Department of Health was ranked first of several organizations (including county welfare agencies, federal agencies, individual nursing homes, and nursing home associations) in "contributing leadership and improving nursing homes in Minnesota" by 62 of the 118 nursing home operators interviewed. Certainly, generally desired characteristics are more frequently found among Minnesota nursing homes now than in 1952.

[14] The Minnesota Association of Geriatric Homes has since evolved into the Conference on Geriatric Care of the Minnesota Hospital Association. Seemingly, few changes in policy toward nursing homes have resulted, although it must be noted that study of the two associations was completed before the merger took place.

[15] United States Senate, 87th Congress, 1st Session, *op. cit.*, p. 667.

The impact of public policies cannot be rigorously evaluated, however, without examining their effect on the nursing home patient.

IV. Correlates of High Quality

Analysis of relationships between selected nursing home characteristics and measures of "quality of care" defined in terms of desirable facilities, staff, and program. There are only low statistical relationships between "quality" and size, hospital attachment, and home ownership. The most important is the percent of patients in a home on welfare: the more welfare patients, the lower the quality. Cost per day and monthly charge are also related to quality. Data were gathered in structured interviews with 118 nursing home administrators or owners.

Quality of nursing home care—like quality of other health and welfare services—is an elusive phenomenon. It is perhaps easiest to look at it by dividing nursing home characteristics, nursing home care, and nursing home consumers into three phases or levels. These would include (1) whether the patient gets better and stays as healthy as possible, (2) whether the program of care provided him is in accord with accepted standards of patient care, and (3) whether the home has available to the patient for his care certain desirable resources in terms of facilities and staff. Though each of these levels plays an obviously important part, the ultimate test of quality of care is in what happens to the patient—the outcome.

In the Minnesota survey, it was possible to use only measures of resources and program—changes in patient status or outcome measures were beyond the research design, and previous work in this area has yielded little in the way of generalizable outcome measures that could be adapted.

The quality indicators, then, are actually measures of factors which are assumed to be characteristic of nursing homes where patients improve as much as possible and receive good care. The indicators have been used separately, not combined into an index, in order to determine whether each was an independent descriptor or an aspect of one inclusive quality construct.

PATIENTS PER ROOM

The number of patients per room is one indicator of quality. Generally older persons enjoy having a single or double room; a low ratio of patients per room signifies a physical facility allowing for greater privacy and accommodation to patients' individual desires. Space is used as one criterion for accreditation of nursing homes.

PATIENTS PER BATHROOM

A second indicator is the ratio of average number of patients to number of bathrooms, both public and private, in the nursing care section (including bathrooms where access is through a patient's room as well as through the hall). Again this provides a measure of the adequacy of pleasantness of the physical facilities.

ORIGINAL USE

Whether the home was constructed as a nursing home or convalescent and nursing care facility as opposed to being converted from a private home or other use roughly indicates the appropriateness of the physical plant to its present purposes.

STAFF HOURS PER PATIENT

The number of staff hours per week per patient is an indicator farther along the continuum from resources to patient outcome. It is obtained by dividing the reported total hours worked per week by all staff members (excluding clerical maintenance personnel) by the average number of patients in the home. This ratio is a measure of the amount of attention the patient could receive.

REGISTERED NURSE—OTHER NURSING STAFF HOURS RATIO

The mainstay of the medical nursing home staff are the nurses, and of them, the registered nurses bring the most sophisticated medical expertise to the patient. Accordingly, another indicator of quality is the proportion of total number of nursing hours worked per week attributable to registered nurses, as opposed to licensed practical nurses or nursing aides.

PHYSICIAN HOURS PER PATIENT

Another aspect of the patient's medical treatment is the amount of physician care he receives. Homes vary greatly in the provisions made for having M.D.'s see patients; some have a specified physician on call, while others make use of the patient's private physician on all occasions. The physician hours per patient indicator is obtained by dividing the reported number of hours per week spent in the home by medical doctors by the average number of patients in the home.

STAFF VARIETY

Some nursing homes provide only medical care; others offer a variety of psychological, social, and even vocational rehabilitation. The staff variety measure is the number of employee categories represented on the home's staff. A high staff variety score indicates the presence of professional personnel offering therapeutic services: occupational therapy, physical therapy, activity programs, social work services, and services provided by volunteers.

PATIENT PARTICIPATION

Rather than a measure of environment or staff, this indicator concerns participation by patients in home programs aimed at social or psychological rehabilitation, including entertainment, self-government, hobbies, and home maintenance. A total of the percentages of patients participating in each home activity was obtained for this indicator.

THERAPEUTIC ORIENTATION

Ideal nursing home care might well be that which rehabilitates the patient to independent living. Whether this goal is even held in mind by administrative personnel may indicate the quality of care provided in a nursing home. Accordingly, administrator attitudes regarding the purposes of nursing homes were measured, and responses combined into a scale of orientation toward rehabilitation.

The variables correlated with the quality indicators are measures of characteristics which are believed to be related to the kind of care a nursing home gives.

Location.—Urban physical location vs. rural.
Hospital-attachment.—Hospital-attached nursing homes—convalescent and nursing care units—vs. free-standing non-proprietary homes.
Ownership.—Free-standing proprietary vs. free-standing non-proprietary homes.
Estimated cost per patient day.
Average charge per month.
Average rate of reimbursement by the county in which the home is located.
Occupancy.—Average number of patients in home divided by the number of beds.
Size.—Number of beds in the home.
Accreditation.
Percent of patients having white collar, proprietor, or professional backgrounds.—The total percent of patients falling in these categories.
Percent of patients on welfare.
Percent of ambulatory patients.—Percent of patients walking unassisted or with a cane or crutch.

Data for all these measures were obtained in interviews with the administrators or owners of homes.

A stepwise regression analysis was performed to relate the quality indicators to the home characteristics. This procedure involved the selection and ranking by computer of the fewest number of home characteristics which together had the highest multiple correlation coefficients with the quality indicators. It identified with partial correlation the magnitude of the relationship between each home characteristic and every quality indicator, while holding the influence of all other variables constant.

The 12 home characteristics are listed in order of their importance with regard to quality of care—the magnitude of the average partial correlation of the home characteristics with the quality indicators described earlier is given in parentheses.

1. *Percent welfare patients.*—The higher the percent of patients receiving welfare in a home, the lower the quality of care in the home. (.2762)

2. *Cost per day.*—The higher the cost per day of care, the higher the quality of care provided in the home. (.2735)

3. *Charge per month.*—The higher the average monthly charge, the higher the quality of care. (.1707)

4. *Location.*—Rural homes are more likely to have higher quality care, except in regard to registered nurse hours to licensed practical nurse and nurses' aide hours per week. (.1085)

5. *Size.*—The larger the home, the higher the quality, with the exception of staff hours per week per patient. (.0974)

6. *Hospital-attachment.*—Hospital-attached nursing homes—convalescent and nursing care units—are more likely to have higher quality care. (.0894)

7. *Percent ambulatory patients.*—The percent of patients in a home who are ambulatory is inversely correlated with quality of facilities, but with the exception of variety of staff, directly correlated with quality of staff and program. (.0855)

8. *Accreditation.*—Accredited homes are more likely to have higher quality care. (.0687)

The remaining variables are simply listed in order of importance; no conclusions can be drawn about the nature of their relationship to quality since the correlations are so small.

9. *Reimbursement rate.*
10. *Percent middle class patients.*
11. *Occupancy.*
12. *Ownership.*

None of the average partial correlations is very large. The miniscule correlations between quality and size, hospital-attachment, accreditation, and ownership are surprising, as these home characteristics are generally thought to be related to good patient care. Accreditation is also taken to be a symbol of high quality care.

One possible explanation of these unexpected findings is the salutary effect of public policies toward nursing homes in the State. In the case of ownership, for example, had proprietary and non-proprietary homes been compared 10 or 15 years ago, differences might have emerged—possibly in favor of non-proprietary institutions, since many apparently substandard proprietary facilities have since been closed thus upgrading the proprietary homes as a category. The same may be true of size as a factor. The closing of the very small homes may have resulted in making size above a certain minimum a relatively unimportant correlate of quality.

The nature of the measures used in this survey might be an additional explanation for some of the unexpected findings. The assumptions about characteristics of facilities, staff, and program as indicative of quality of care, for example, are not based on proven foundations with demonstrated relationships.

Consider the fact that hospital-attachment ranked sixth in the correlations. It has been contended by some that physical proximity does not guarantee the nursing home patient superior treatment by hospital staff, and that hospital-attachment encourages emphasis on the patient's medical needs to the detriment of concern with social and psychological aspects of patient care. Probably the pros and cons of hospital-attached homes—and hence the unexpected findings of their relatively low correlation with quality indicators—can be resolved by devising measures of quality of care related to the incoming health status of each patient, his predicted potential for improvement, and his measured attainment of such improvement (outcome). It may be, for example, that hospital-attached nursing homes give better care for some patients, but that for others, the characteristics of the free-standing home's program may be more appropriate.

The Minnesota survey findings, therefore, bring into question some popular assumptions about good high quality care—that large, hospital-attached, accredited, and not-for-profit homes are necessarily better than homes lacking these characteristics.

Further Analysis of Hospital-Attachment, Ownership, and Quality

Analysis of variance was used to further examine the effects of hospital attachment and of ownership on quality. This statistical procedure determines whether there is more variation between categories in regard to the test variable than

there is within categories. Analysis of variance also allows isolation of the effects of one variable from the effects of others being examined.

Only three significant effects of hospital-attachment on quality emerged, suggesting that in most cases there was just as much variance among hospital-attached and among free-standing homes as there was between the two categories. The significant effects all relate to staff: convalescent and nursing care units have higher ratios of staff hours per week to patients, physician hours per week to patients, and a greater variety of staff.

When *non-significant trends* are also taken into account, convalescent and nursing care units tend to have consistently more desirable staffing patterns. In contrast, free-standing nursing homes tend to have better facilities. The greater availability of medical staff to a hospital-attached unit is to be expected, although the data do not assess the amount of attention given nursing home patients. Perhaps less expected was the finding the C&NC units also tend to have a greater variety of staff—reflecting non-medical as well as medical personnel—as well as a tendency toward a larger number of activity programs participated in by proportionately more patients.

In short, the data suggest the relative superiority of hospital-attached nursing homes on the measures of quality used, but do not allow definitive investigation of the criticisms made of such homes—namely that staff do not give as much attention to nursing home patients as their availability and numbers would suggest, and that programs over-emphasize medical care to the neglect of social and psychological treatment.

In contrast to the three significant effects of hospital-attachment, there is only one in regard to *ownership:* non-proprietary homes report more physician hours per week per patient spent in the home than do proprietary nursing homes.

The trend of the differences is similarity less conclusive than that for hospital-attachment. There seem to be no patterns. Five of the contrast values favor non-proprietary homes; four favor proprietary homes. Inconsistencies occur with regard to both facilities and staff.

The relative unimportance of ownership in regard to quality of care could be explained by the variation between sub-categories within the proprietary and non-proprietary categories. The latter lumps together both non-profit and governmental homes. Since homes run by county governments reputedly give poor care, it may be that non-profit homes do have an advantage over proprietary homes which is canceled by the inclusion of county and other governmental homes in the non-proprietary category.

Contrary to popular opinion, there is little evidence in these data that non-profit homes provide better quality care than do governmental homes. There are only three statistically significant differences: non-profit homes have lower patient to room and patient to bathroom ratios; government homes report more physician hours per week per patient. When non-statistically significant contrasts are included, five are in the direction of non-profit homes, four in the direction of governmental homes.

The comparability between these two sub-categories of non-proprietary homes would suggest that the new breed of community owned not-for-profit homes, as well as improvements in the old county-run homes, has improved the quality of care provided in governmentally-sponsored homes.

The lack of statistically significant effects of ownership on quality of care is *not* modified when governmental homes are excluded from the non-proprietary category, so that non-profit homes may be compared with proprietary homes. There is only one statistically significant effect: non-profit homes have a higher ratio of registered nurse hours to licensed practical nurse and nurses aide hours per week per patient. The trend of the differences, however, does favor non-profit homes, with seven being in the direction of non-profit homes and two to the contrary.

The downfall of the myth that non-proprietary homes are superior may be due in large part to the recent emergence of a new breed of proprietary homes—those owned by corporations. "Private nursing home" is no longer synonymous with "converted frame house run by Ma whose kids have left." Instead there are growing numbers of new, specially-constructed proprietary nursing homes owned by corporations and run by professional administrators.

This hypothesized superiority of corporate proprietary homes is somewhat upheld by the findings. There are two significant differences between corporate and non-corporate homes. Corporate homes have a greater variety of staff and a more therapeutic orientation. Furthermore, six of the differences are in the direction of corporate ownership.

There are three statistically significant effects of ownership when non-corporately owned proprietary homes are excluded, allowing corporately-owned proprietary homes to be compared with non-proprietary homes. Non-proprietary homes have lower patient to room ratios; corporate proprietary homes have a greater variety of staff and a more therapeutic orientation.

The trend of the differences does not consistently favor either corporate proprietary or non-proprietary homes.

IMPORTANCE OF THE PATIENT'S ECONOMIC STATUS

The finding that the largest correlate of quality (as measured in this study) was the percent of welfare patients in the home was startling. There is apparently a trend for the "better" homes to have fewer patients on welfare.

This relationship could be explained in two ways: 1) welfare patients predominate in homes where care is less expensive (and hence of lower quality, since quality indicators used were directly correlated with cost and charges) because of low reimbursement rates by county welfare departments; or 2) welfare patients—or those who act in their behalf—pay less attention to quality when selecting a nursing home than do prospective patients who pay for their own care.

Both of these explanations are supported by the findings. Homes having a higher percent of patients on welfare tend to be those having relatively lower costs and charges, suggesting that welfare patients are more likely to be in homes where care is cheaper—presumably because of low reimbursement rates.

The relationship between high quality and a high percentage of patients on welfare is not entirely explained by low reimbursement rates, however, because the correlation reported is the magnitude of the relationship with all other variables held constant, including cost, charge, and reimbursement rate of the county in which the nursing home is located. So it would appear that welfare patients pay less attention to quality when selecting a nursing home. Perhaps when a third party is paying for the care, the consumer himself (or his family) has less to say about choosing the home.

This latter explanation is further supported by the interrelationships between percent of patients on welfare, percent of patients having been employed in white collar jobs, and the quality indicators. The relationship between the first two home characteristics would suggest that economic characteristics of the patients are being measured. Further, the small but positive relationship between white collar patients and quality suggests that this group of supposedly more powerful and better informed consumers tend to land in "better" nursing homes than do welfare recipients.

V. NEW POLICIES FOR BETTER NURSING HOME CARE

Findings from the Minnesota survey have shown the elusiveness of good nursing home care. Factors such as non-profit status and accreditation seem to be relatively unimportant to good care. The study has revealed four forces for improved quality: professional ethics, business ethics, consumers of nursing home services or their representatives, and public consumer protection agencies. Specific suggestions for new policies are directed to health services researchers, comprehensive health planning agencies, and associations of nursing home proprietors.

Interrelationships among the three policy issues brought forth in this Minnesota survey have not always been obvious. What do the answers that have been suggested by the data imply regarding a concern common to many: higher quality nursing home care?

WHAT IS GOOD NURSING HOME CARE?

If nothing else, this study has shown how elusive a phenomenon is "quality of nursing home care." Compared with 15 years ago, homes in Minnesota are better housed, larger, more frequently physically attached to hospitals, and more often run on a non-profit basis. These are generally thought to be positive changes. Yet it was found that some of these characteristics were unrelated to the measures of quality used in this study, particularly the quality of the home's staff and its psycho-social program. For example, on the 12 home characteristics studied, whether the home was run for profit or not was least related to quality of care. Additionally, the relationship of hospital attachment and quality was equivocal. And according to measures used in the study, homes that are accredited were not necessarily of higher quality.

According to study findings, the usual means of public regulation do not seem uniformly effective. Licensing of nursing homes by the Department of Health was pioneered in Minnesota, and the Department seems to have shown a strong, and generally positive, influence. Yet, in recent times its impact has been strongest when it supplemented the more traditional licensing activities (once given, seldom revoked) with informal hearings and other attempts to actively upgrade nursing homes. The study points up the need for continually updating standards and policies: the Department's early emphasis on community ownership of nursing homes apparently was associated with the closing of many substandard proprietary nursing homes. The lack of consistent qualitative differences between proprietary and non-proprietary homes found in the 1966–67 data reported here suggest that continuing this emphasis possibly might not be in the best interest of the people in Minnesota.

The role of welfare departments in assuring quality of care to their clients or constituencies has always been somewhat ambiguous. The Minnesota Department of Public Welfare has not had an official mandate to license the majority of nursing homes since 1941, and it is currently hoping to transfer responsibility for county homes, a vestigial charge, back to the Health Department. The study suggests that greater concern with quality on the part of the public financers of service may be in order, however. The finding that welfare patients seem to be clustered in homes providing poorer quality certainly demands further investigation.

Cost of nursing home care affects public regulation. Welfare departments are justifiably anguished about the large proportion of their budgets represented by the bill for public assistance recipients in nursing homes. (Indeed, the relationship between a home's proportion of welfare patients and its quality had a third dimension: costs of care. Welfare patients tend to be in the cheaper homes, although this relationship does not completely explain what appears to be an independent relationship between welfare patients and quality.) Public clamor encourages welfare departments to pay more attention to cost than quality, partly, one would suspect, because dollars spent are more visible than patients treated poorly.

Cost is a concern of professional associations of nursing home administrators and owners. Proprietary associations have worked toward higher reimbursement rates for a number of years. Associations of non-profit homes seem to be broadening their focus on professional education, common problems, etc. to include encouragement of higher rates.

HIGH QUALITY AS A PUBLIC POLICY

Morally, there seems to be no question that the nation should make quality of health and residential care for the aged a matter of public policy and action. Questions do arise as to what quality is, how it can best be achieved and how the expenditure of scarce resources can be made more efficient. The study has suggested some tentative answers.

1. It would appear that high quality care involves maintaining individual functioning as long as possible by delaying or compensating for the deterioration of aging; then providing humane protective care.
2. Such care can be provided most effectively by arraying a variety of institutional settings, medical and psycho-social activities, and supportive services to encourage individuals to function themselves, and to provide them with special roles as appropriate.
3. Care of the aged will continue to be expensive. Fortunately, high quality care has characteristics which can promote cost savings.

(*a*) The encouragement of individual functioning may produce cost savings such as allowing residents or patients to help run the home. Indeed, there are many who feel expensive medical staffs tend to "overtreat" the patient and thus make him more dependent.

(*b*) There are less expensive alternatives to nursing home care. Provision of support and medical services to persons living independently but concentrated spatially, as in a public housing unit, offers one such alternative. Legislation providing for levels of care (extended care facilities, intermediate care facilities, and the like) has had as its objective linking patients with the most appropriate kind of care, hence avoiding providing the most expensive kind of care when it is unnecessary.

MEASUREMENT OF QUALITY

Formulating public policies for high quality care and then enforcing them depend on the extent to which "quality" can be defined and measured. Although current policies are generally compatible with the considerations enumerated above, operationalizing such concepts as "individual functioning" and "appropriate levels of care" requires additional effort.

These specific ventures seem to hold promise.

1. Development of methods to assess functional capacity of individuals.

There have been a number of studies over the past 50 years undertaken to define functioning and to apply the techniques of medical and behavioral science to its measurement. While a great deal of basic research has been completed, techniques for placing nursing home patients according to functional capacity are still experimental.[16]

2. Development of predictors of functional gain.

If care of the elderly is to have restorative, as well as protective objectives, it will be necessary to develop methods of predicting whether an individual can achieve functional gains. Then care can be prescribed judiciously and its results evaluated fairly. At least one study has taken stroke patients and developed statistical predictors of response to rehabilitation. It is now possible to select the prognostic techniques most effective for deciding whether expensive rehabilitation services are in order.[17]

3. Development of indicators of quality.

Accreditation of health services often suffers from not knowing what indicates good care. Traditionally attention has focused on buildings, staff qualifications, occasionally even a concern with how often the board of directors meets. The relationship of these characteristics to what actually happens to the patient (how much time does an RN really spend directly benefiting patients?) and how he responds to this treatment is unknown. This study suggests assumed relationships may not be valid. On the other hand, examining each patient before and after treatment to assess whether as much progress as possible has been made appears prohibitively expensive. We need valid quality of care indicators that can be economically applied as well as automatically revised as new information is available.

FORCES FOR IMPROVING NURSING HOME CARE

The study has illuminated the issue of quality of care: largely what it is not, and how what it is might be discovered. The Minnesota survey has also identified some forces that might be engaged in improving nursing home care.

PROFESSIONAL ETHICS AND PUBLIC REGULATION

For a long time the public has relied on a combination of professional ethics and public regulation to assure that high quality health services are provided to all ages, including the elderly. Health professionals receive special training and practice according to ethical codes which qualify them to be public servants. These qualifications have exempted health professional from certain checks and balances applied to providers of goods (as opposed to services). Little attention has been afforded competition, informed choice, or other ways to safeguard the consumer so often employed when tangible goods are being consumed on the open marketplace.

When professional services are being consumed (used), the major augmentation of the professional ethics and training has been accreditation—actually an extension of professional ethics, since accreditation has been the responsibility of professionals—though within public agencies.

Findings of the Minnesota survey have, in part, affirmed the value of this technique of consumer protection in regard to nursing home services. If one state's experience is instructive, a public health unit of state government does play an important role in the upgrading of nursing home care and the protection of consumers.

However, a close examination of the nursing home scene uncovers trends that suggest other forces for improving nursing home care may be at work.

[16] Such studies are summarized in Anderson, Nancy N., and Stone, Lana B., NURSING HOMES: RESEARCH AND PUBLIC POLICY, October, 1968, to be published in *The Gerontologist*. This paper was originally presented at the Twenty-first Annual Meeting of the Gerontological Society in Denver.

[17] "A Study of Rehabilitative Predictors in Cerebrovascular Accidents," ongoing project at Kenny Rehabilitation Institute, Minneapolis, Minn., sponsored by Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, December 1964–May 1969.

The following changes are occurring:

1. An increase across the nation in the proportion of proprietary nursing homes whose operators may consider themselves businessmen rather than professionals;
2. A possible tendency of professionals within public health units which regulate nursing homes to favor like professionals in institutions and to protect them from competitors;
3. Increasingly insistent demands which result from high costs, encouraging both professionals and public officials to care less about quality and more about economy;
4. A consumer revolt against professional providers of health, welfare, and educational services, as evidenced by campus revolts, uprisings at professional health meetings (such as at the most recent National Health Forum), and strikes of AFDC mothers; and
5. Demands that the politics be put back into professionally dominated public agencies to make them more responsive to democratic processes. An example of this is the requirement that 51 percent of the members of councils advisory to comprehensive health planning agencies be representatives of the consumers or, as often phrased, "the public."

These trends, along with the findings of the Minnesota survey, point to some new forces for improving nursing home care.

BUSINESS ETHICS, A FORCE FOR CHANGE

In the providing of goods (rather than health and welfare services) business ethics have been held responsible, at least in part, for good performance. For one thing, the businessman wants to make a profit and his success therein depends on pleasing the customer (as illustrated by the phrase, "the customer is always right").

In recent years good business sense has required an even greater concern with the public interest because demonstrating social concern has become almost indispensible for good public relations and hence successful business.

The nursing home field is increasingly predominated by businessmen and large corporations. In showing little difference between proprietary and non-proprietary nursing homes, this study has questioned the assumption that business concerns are necessarily detrimental to high quality nursing home care. Could it be that business ethics and concern over pleasing the customer might be a force for improving nursing home care?

CONSUMER POWER TO ASSERT DEMAND

The answer could be yes—providing there can be some checks to assure that the businessman's self-interest is consonant with the best interests of the customer and the public. To encourage such consistency of interests, it seems in order to give the nursing home patient greater bargaining power. Were he not facing a shortage of nursing home beds and insufficient information about the services he is buying, it might be more possible for him to assert demand that influences the providers.

The patient will need additional assets, however, weak and sometimes senile that he is. Advocates of his rights are readily available: his family, the social worker, and the physician. Also, groups of concerned older people and consumers unions are occasionally developing to defend the rights of the nursing home patients.

Consumer power requires the following:

1. Information to patients, families, social workers and physicians about what services are available and can be purchased;
2. Freedom of choice regarding what kind of care the patient wants and which home he desires;
3. Freedom from retribution from institutional management if complaints about nursing home services are made by patient or family; and
4. Open door policies by nursing homes so that family, friends and the community are aware of what is happening in nursing homes.

CONSUMER PROTECTION

Even with a combination of professional and business ethics, balanced by consumer power, there would still be need for public efforts toward consumer protection. These should have three important attributes:

1. Adequate measures of quality to assure that requirements are actually related to the kind of care received and patient responses to it;

2. Some independence from the providers of service in order to assure impartial judgments, still allowing for benefit from professional expertise; and

3. Independence from political bargaining while maintaining responsiveness to democratic processes and elected officials.

HOW DO WE GET FROM HERE TO THERE?

These dimensions of quality and the forces for implementing them—so briefly identified—appear to be pie in the sky, when compared with our current shortage of nursing home facilities, intense demand for the quickest available service, overburdened public health agencies, and uncertainty about how to define and measure quality.

There are some specific steps which can be taken that promise to improve the quality of care now available to the consumer to more nearly approximate the more ideal situation (whose dimensions have been enumerated). These suggestions are directed toward parties having new and perhaps fresh concern over nursing home care.

HEALTH SERVICES RESEARCH TO MEASURE QUALITY AND EVALUATE FORCES FOR CHANGE

Resources for research and development to solve problems related to organizing and delivering health services are becoming more abundant. Of special note is the establishment of the National Center for Health Services Research and Development, whose section on Health Care Institutions has now assumed responsibility for research on nursing homes, formerly sponsored by a variety of sections within the Public Health Service.

It is suggested that research and development be undertaken to:

1. Develop measures of quality as specified above; and
2. Test the effectiveness of forces for change.

For example, there are nursing homes characterized by professional ethics and the hospital non-profit ideology, those run for profit, and those run by public agencies. These could be compared.

Similarly, the effects of incorporation of numbers of small nursing homes could be studied longitudinally to further assess the impact of the business ethic.

COMPREHENSIVE HEALTH PLANNING FOR IMPROVED CONSUMER PROTECTION

Comprehensive health planning agencies, established by the Partnership for Health Act, have given some attention to nursing homes—at the state level because of the concern of many state welfare departments and governors with the cost of nursing home care, and at the areawide level as part of an attempt to broaden the traditional planning emphasis on hospitals to include other kinds of health facilities and services.

Comprehensive health planning agencies might attempt to protect the nursing home consumer in the following ways:

3. Gather and publish information about nursing homes in the state;

Initially information could be largely descriptive, telling what services are given, the nature of the facilities and program, staffing patterns, and patient characteristics. As more knowledge is gained, some evaluative comments would be in order, indicating the type of patient for whom the home might best be suited, following the model of guides to hotels, motels, and restaurants. Health department licensure divisions would want to cooperate in such a venture.

4. Develop legislation to provide for alternatives to skilled nursing care and incentives for nursing homes to rehabilitate patients to levels of less intensive care.

Presently the nursing home operator receives more reimbursement for bed patients than for ambulatory ones. Consequently, "good business" results in keeping nursing home patients in bed at higher rates of income. Since the public hopes for rehabilitated patients, public and private interests might be more compatible were there financial incentives to the nursing home operator to rehabilitate patients, rather than the current incentives to keep them in bed. For example, a bonus could be paid for patients rehabilitated

to another level of care. (Demand being so high, there should be little difficulty replacing bed patients.)

The comprehensive health planning agency might also encourage local groups to obtain federal and state grants in order to provide health and supportive services in public housing units to avoid institutionalization of semi-independent older persons.

PROPRIETARY NURSING HOME ASSOCIATIONS PROMOTING CUSTOMER SATISFACTION

Proprietors of nursing homes appear to be uncertain as to how they should respond to public pressures toward professionalization (such as the new legislation requiring administrators be accredited), and how to use professional associations. Associations of proprietary nursing home owners have tried in the past to promote the idea that good care can be provided more efficiently in a for-profit home. This message might be communicated more effectively if associations promoted customer satisfaction quite openly through some of the following actions:

5. Assume an open-book, open-door strategy:

If for-profit homes do measure up to non-profit facilities, it should be to the advantage of the proprietors to tell their story to the public. Open books and open doors can *show* in a way a thousand public relations releases cannot.

Proprietors, themselves, could publish more information about their homes than is now readily available.

6. Adopt professionalism.

Training and ethics are important aspects of business as well as voluntary, non-profit agencies. "Professional" managers are being promoted more actively as professional teachers or physicians. Nursing home associations can supplement their concern with reimbursement programs with a concern for upgrading the qualifications of their members. They can also promote the role of impartial bodies in installing and evaluating professionalism.

LETTERS AND MATERIAL FROM DAPHNE H. KRAUSE, EXECUTIVE DIRECTOR, MINNEAPOLIS AGE AND OPPORTUNITY CENTER INC., TO SENATOR FRANK E. MOSS, JAN. 12, 1972

DEAR SENATOR MOSS: I feel compelled to comment on a recent letter of January 6, 1972, sent to you by Mr. John Broeker, who represents the Minnesota Nursing Home Association. In particular I would like to direct your attention to the enclosed article from the Minneapolis Star dated January 7, 1972. The discussion of the remarks made by Margaret Christison, Inspector for the St. Paul Health Department, is of special significance.

The St. Paul Health Department has gone out of its way to defend the Capitol View and Lexington Nursing Homes which featured so prominently in your hearing on November 29, 1971. Without an extra effort on the part of Miss Christison to defend these homes, their rebuttal to charges would have remained very weak.

There was much publicity over the testimony of one witness, Mrs. Ellen Marx, following the Minnesota legislative subcommittee's hearing on December 30, 1971. While it is true that there were statements in her affidavit that were not clearly stated as hearsay when they should have been, much damage was done to Mrs. Marx's testimony and her reputation as the result of statements by Miss Christison that turned out to be highly misleading. Mrs. Marx said in her affidavit that a patient died from a drug overdose. To rebut Mrs. Marx, Miss Christison quoted from the death certificate to show that the patient had not died from a drug overdose. As the enclosed news article points out, the death certificate by no means clears up the possibility of a drug overdose.

In addition, on her own and not in response to any question, Miss Christison felt compelled to further discredit Mrs. Marx by stating that 10 years ago the Health Department had "closed" the nursing home owned by Mrs. Marx because of bad conditions. This is false. There is no record in the Health Department of such a closing. In fact, there is a record in the Health Department files of good patient care given by Mrs. Marx.

I submit that it is very difficult for fearful, unsophisticated witnesses to prove their points against the expertise of someone speaking with the authority and

aura of the St. Paul Health Department—especially when such an inspector twists the facts.

As you probably know, Senator, there has been criticism leveled at your committee because some officials believe that this whole problem should have been handled locally. The folly of that argument is made clear by the testimony of January 6, 1971. Miss Christison said her office would have acted vigorously for closure of the Lexington had complaints been made known two years ago. Mrs. Kippels testified that the St. Paul Health Department would not accept her complaint two years ago because she was not a relative.

To imply that all our affidavits are false or are being so proven is a gross exaggeration, hardly worth comment—especially when so much of the testimony remains either totally unrefuted or simply denied.

One final comment. We find the apparent position of the St. Paul Health Department in support of bad nursing homes curious, when Dr. William R. Lawson, Secretary and Executive Office of the Minnesota Department of Health, in his prepared statement for the State Senate Committee on Health and Welfare declared:

"We know many nursing homes are cutting corners and literally going out of their way to avoid consistent compliance with the regulations.

"The Department takes the position that there are faults within the industry which require serious attention."

Yours very truly,

JOHN A. EDIE,
DAPHNE H. KRAUSE.
Attorney for M.A.O.

[From the Minneapolis Star, Jan. 7, 1972]

'SERIOUS DEFICIENCIES' NEARLY CLOSED NURSING HOME IN ST. PAUL

(By Joe Blade, Minneapolis Star Staff Writer)

The much-criticized Lexington Nursing Home was almost closed in 1969 by the St. Paul Health Department, it was revealed Thursday before a Minnesota legislative subcommittee.

"Serious deficiencies" led to a decision that the administrator must be replaced if the home were to remain open, said Margaret Christison, St. Paul nursing-home inspector.

"We probably would have conducted a very vigorous campaign" to close the home, she said, if complaints of severe abuses had come to light then.

But Lorraine Kippels, a former nurse's aide, testified that Miss Christison's office would not accept a complaint from her.

In 1969, the Ramsey County Welfare Department would not refer patients to the Lexington, Miss Christison stated in a letter, because of "poor nursing care, cold food and staff's apparent lack of concern for patients."

Referrals now are being made to the Lexington because it is felt that deficiencies have been corrected, Jim Abts, welfare supervisor of nursing-home units, said later in a telephone interview.

Laurence Trana, one of four partners who own the Lexington and the Capitol View Nursing Home, replaced Louis Thayer as administrator. Now the Lexington needs "no more surveillance" than any other nursing home, Miss Christison said.

However, a report from the Minnesota Department of Health dated Dec 28, 1971, reported "continual deficiencies" at the Lexington concerning the building, sanitation, nursing care, training and records, food and handling of drugs.

Although legislators asked repeatedly whether the home still is deficient in these areas, the question was not answered.

The Lexington now is "meeting minimum licensing requirements," finally, said Anthony Kist, the state's chief of licensing and certification for hospitals.

Miss Christison, who attacked the credibility of a critic of the Capitol View last week, found herself on the defensive yesterday.

Rep. William Ojala, Aurora DFLer, referred to an earlier comment by Miss Christison that a patient did not die of drug overdose as a Lexington critic charged. Ojala said that a doctor did not view the body before signing a death certificate.

Also, Ojala said, records do not show that St. Paul closed a four-patient nursing home run by Mrs. Ellen Marx in 1961, as Miss Christison had said.

In fact, said Ojala, the file stated Mrs. Marx gave patients "excellent care." Mrs. Marx stood up in the audience and said she closed the home only because her husband insisted on it.

Miss Christison did not respond to either statement. As she did last week, she devoted most of her remarks to defending the nursing homes being discussed.

Yesterday's testimony was the first revelation that inspecting agencies were aware of problems at the Lexington.

Four former employees spent more than an hour criticizing almost every aspect of the Lexington's operation in a Nov. 29 hearing in St. Paul of a U.S. Senate subcommittee.

Three of the witnesses plus two others repeated many of their comments for more than two hours yesterday before a subcommittee of the Minnesota House Health and Welfare Committee.

Trana, his attorney, the personnel director and two nurse's aides began rebutting the testimony but ran out of time when the committee had to adjourn. It will reconvene next Friday.

JANUARY 18, 1972.

DEAR SENATOR MOSS: As a follow-up to our letter to you of January 12, 1972, we would like to make available to you the recently acquired affidavit from Mrs. Mae Tarnow, a former patient at the Capitol View Nursing Home.

She personally witnessed one Ana Bustamante beating up on an aide by the name of Francisca. She also swears that several other people witnessed this incident. The Minnesota Nursing Home Association has made much of this incident as a prime example of our "false" statements and "outright perjury." They claim that none of the purported witnesses ever saw such a beating.

It is our feeling that the enclosed sworn affidavit serves to disprove their claims, and to re-emphasize the problems present at the Capitol View with Mrs. Bustamante as Head Nurse.

Yours sincerely,

DAPHNE H. KRAUSE.
JOHN A. EDIE,
Attorney for M.A.O., Inc.

AFFIDAVIT OF MRS. MAE TARNOW

STATE OF MINNESOTA, COUNTY OF HENNEPIN

Mrs. Mae Tarnow being first duly sworn deposes and states the following:

My name is Mrs. Mae Tarnow and I live at 550 NW. 8th Street in New Brighton, Minnesota. For almost seven years I was a patient at the Capitol View Nursing Home in St. Paul, Minnesota. I left there on January 15, 1972.

Several months ago when I was living on the first floor in room 115, I heard a commotion in the hallway. At the time I was sitting on a chair in my room next to the door. I heard shouting and hollering coming from the hallway just outside my door. I got up from my chair and walked to the door to see what was going on. Mrs. Bustamante, the head nurse, was having an argument with another member of the nursing staff named Francisca. I always called her Frances. Francisca did not speak English very well. They were arguing and yelling at each other very loudly. They moved closer together and Mrs. Bustamante started to hit Francisca. I did not see Francisca hit Mrs. Bustamante at all. She just tried to guard herself. I did see Mrs. Bustamante hit Francisca in the face. I did see Mrs. Bustamante scratch Francisca's arms. There was some bleeding.

I saw Mr. George Peterson, one of the owners, coming down the hall. I stepped back into my room. I guess he tried to break it up. The next thing I saw was Francisca running upstairs and Mrs. Bustamante running after her. Some of the patients on the second floor told me that they fought more upstairs.

Marilyn Wahls, a nurse, saw the beating on the first floor, and I would say at least four patients saw it, including Mrs. Bump who was my roommate at the time.

Later on I saw Francisca crying. She went home, and I have never seen her since then.

Marilyn Wahls told me that Francisca lives with her.

MRS. MAE TARNOW.

Subscribed and sworn to before me this 17th day of January, 1972.

LOIS A. LOOMER,
Notary Public, Hennepin County, Minn.

REPORT OF FINDINGS ON CULTURES TAKEN FROM LEXINGTON NURSING HOME, ST. PAUL, MINNESOTA; REPORT MADE BY LIA OZOLS, M.T., A.S.C.P., ABBOTT HOSPITAL, MINNEAPOLIS, MINN., COLLECTED AND SUBMITTED BY MRS. DAPHNE KRAUSE, R.N.

ABBOTT HOSPITAL

MICROBIOLOGY, MAO CULTURES

Date Cultured: November 17, 1971.
Date Reported: November 18, 1971.

Source	*Result*
Jars of Ointment:	
Mycolog	No Growth.
Salicylic acid	Do.
Benzoin	Do.
Vial	Cimex lectularius (bed bug).
Soiled Linen	Pseudomonas aeruginosa.

LIA OZOLS, M.T., A.S.C.P.

Statement made to Lois Loomer by Lia Ozols, M.T., A.S.C.P., November 24, 1971. Soiled Linen, *Pseudomonas Aeruginosa.*[1]

BACTERIOLOGY REPORT

Date Cultured: November 23, 1971.
Date Reported: November 25, 1971.
Source: MAO swabs culture.
Isolated: *Klebsiella*, a Proteus species and *Pseudomonas Aeruginosa.*[2]

LIA OZOLS, M.T. (ASCP),
Chief Administrative Technologist.

Report given to Lois Loomer by Lia Ozols, M.T. (ASCP), November 26, 1971.

PREPARED STATEMENT OF LORRAINE KIPPELS, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME[3]

I worked at the Lexington Nursing Home from March 6, 1969 to March 23, 1970. The building is three stories, first floor, second floor, and third floor. The first floor has the ambulatory patients; the second floor has the sick and medicare patients; and the third floor has the senile and confused, though not all of them are senile and confused. Mr. Thayer was the administrator at the time I worked there and Mr. Lawrence Trana was the assistant administrator and Mrs. Lucia O'Connell was the supervising nurse. I have never worked in a nursing home before and I have no license for nursing of any kind. There were three shifts. I worked the 3–11 shift as a nurses aide. The first day I started working at the Lexington Nursing Home a nurse told an aide to orient me. All she did was walk me down the hall, introduce me to a couple of the patients, show me where the supply room was and where the linens were kept. From then on I was on my own. By the second week I was doing all the treatments, such as bed sore care, impactions, enemas and so on. I also passed medications on the second floor when they were short staffed. This floor was the medicare floor. I heard later that on a medicare floor it was against the law to pass medications. I then stopped passing meds on that floor. I floated on all floors. I was later transferred to the third floor where the senile and confused are kept. This floor just reeked of urine. The main reason was that we didn't have the supplies to keep it in good condition. There were two mops kept on the third floor. Those mops were so full of urine, it was like mopping urine with

[1] Pseudomonas Aeruginosa is a bacterial infection—upon notice of this infection, it should be immediately cultured. If the Culture is positive, the patient should be treated *immediately*. If the patient is not treated the infection will go into the bloodstream and the patient will die. The infection spreads rapidly.

[2] The patient cultured has three (3) very infectious bacterial infections. They are all very contagious, transmitted by anything that touches them. This patient needs *immediate* medical attention. The three infections eat away at the tissues, then into the blood and if not treated, death.

[3] See statements of Mrs. Lorraine S. Kippels, p. 2122 and Part 19B, p. 2291.

urine. Soap was doled out to us an ounce at a time. The toilet paper and light bulbs were given out in small quantities as well. If a light bulb burned out we had to bring the burned out bulb to Mr. Thayer before he would give us a new one. We couldn't use Dutch cleanser as Mr. Thayer said it was against the health regulations to use cleanser. Therefore one patient after another was put into a room uncleaned regardless of what kind of infectious diseases or skin infections they had. Disinfectants used on the floor were watered down. The supplies were kept locked up. Mrs. Thayer and Mr. Trana were the only ones who had keys. Since they went home, it left the 3–11 shift without any access to the supplies whatsoever.

When I worked on the second floor I did treatments. I didn't have a scissors to cut the gauze and tape, so I stopped Mr. Thayer one day in the hall and asked him for a scissors. He said if I wanted a scissors that he would buy one and charge me 50¢ for it. After I returned it he would give me my 50¢ back. I said: "no", that I couldn't do the treatments without a scissors, so he said: "that's too bad," and walked away. I did do the treatments though, as I brought my own scissors from home. The patients were the ones who suffered from the lack of supplies. I made many, many lists for Mr. Thayer and Mrs. O'Connell as to what we needed on the third floor, listing such things as toothpaste, clothing, toothbrushes, deodorant and so on. I also suggested to him that one way they could do this was to use the Welfare money allotted to the patients each month and then buy the things and charge them for it. I did this at four different times. The only thing we ever got was toothbrushes, and they fell apart in a few weeks.

The linens came up from the laundry in terrible shape. I knew one of the aides that worked in the laundry room. I asked her how the laundry was done. She said it was not sorted out. It all came down one chute. The only thing that was taken out of the laundry was the colored clothes that belonged to the patients. Otherwise everything was thrown into one wash. They used one cup of soap, three tablespoons of bleach, and were told to pack the machines as much as they could.

The food there was a big joke. Patients were always complaining of being hungry. One night they had a meat loaf. This meat loaf was made out of cottage cheese and cereal. Mrs. Finney and I ate the meat loaf and spit it out, it had such a bad taste. We told the cook about it and he just laughed. The meat was also very tough. Many of the patients choked on the meat. There was no pork served in the home since it was run by Seventh Day Adventists and they do not believe in serving pork, although this was not told to the patients when they came into the home. Many of the patients asked many times for bacon or ham. They also used a stamp scale in the kitchen to weigh the meat. Everybody used to laugh when they saw the stamp scale because it was dirty and no one could figure out how they could weigh the meat on a small scale like that. There were no special diets. Almost all of the patients were given the same thing regardless if they were diabetic or on pureed food. They were given a lot of things like pancakes and high carbohydrate foods also a lot of wieners which most of the patients on the third floor choked on. This was because they didn't have their teeth in their mouth to chew them. We also had to set up the meal trays on the third floor. This was done many times after cleaning up stool and emesis from patients. We were required to go into the kitchen, take the pieces of bread out of a loaf and set them on the trays with milk and set the coffee on the trays. Many of the glasses were so dirty that we'd throw them out or else we would rewash them before using them on the trays. They got one small juice glass of milk at each meal. They also had what they called a "refreshment cart". This cart mostly consisted of watered down kool-aid and peanut butter sandwiches. At one time Mr. Thayer said that he was going to discontinue the refreshment cart. He did for a couple of weeks until there were so many complaints that he finally set it up again, and we got the same things on it, watered down kool-aid and peanut butter sandwiches.

The heating system in the building was a big mess for a fairly new building. The thermostats had been broken off so there was no way to regulate the heat. Some rooms were cold and some rooms were very warm. One night the heat went off completely. We had to wear gloves and coats and went around to the patients and wrapped them in anything we could find. The place also had pipes that leaked. They were continually breaking. We had buckets sitting on the floor to catch the water leaking down into the third floor. Mr. Thayer told us we should keep the buckets empty so that the patients would not slip and fall in the water.

The whole process of passing meds was not properly supervised. This led to several bad abuses including stealing of meds from patients and some patients not getting their meds at all. After I had been on the third floor for a short time Mrs. O'Connell picked certain aides to set up and pass medications. She said this was perfectly legal. I did check with the Nursing Association and they said it was alright. We did receive class training before we were allowed to pass meds. I went to eight classes, one hour each. The class consisted mostly of things regarding the nervous system. We didn't learn about the actions and reactions of certain medications that were used on that floor. In fact, some of the aids didn't know what Digitalis was, or that the pulse was to be taken before Digitalis was given. They also didn't know that Panwarfin and Coumadin are blood thinners and that patients should be watched very cautiously after it is given. I passed medications on the first floor and on the third floor; and I relieved Evelyn Ryder on the first floor on her days off; and I relieved Mrs. Finney on the third floor on her days off. Mrs. Finney had no training in passing meds. I had the keys to the medication room and also to the narcotics, but not for the supplies. This seemed kind of ridiculous to me that we had access to the narcotics but could not get at the supplies such as toilet paper, light bulbs and so forth for the patients. There was also a lot of stealing of medications on the third floor. This has been recorded by Mrs. Finney and I several times. It was completely ignored by Mrs. O'Connell and Mr. Thayer. After quite a length of time, we decided to set up a trap. We told the R.N., Mrs. Corey, in charge about it. That night an order for Chloral Hydrate came in for Clarence Beglinger. We counted them, there were 30 in the bottle. The next night we came to work and there were 13 left in the bottle. This was reported again to Mr. Thayer and Mrs. O'Connell. Nothing was ever done. They didn't believe what we were telling them. We had proof as to who was doing it but they didn't do anything about it. I went down to Mrs. O'Connell's office on different occasions when I had run out of medications. She kept medications and salves in her drawer. She took some of the medication out and handed it to me and told me to use that and if I did need medications when she wasn't there to borrow it from other patients and to try to borrow it from the Welfare patients.

I had also understood that infectious diseases should be isolated, and sterile procedures used. In this home they made no attempt to do either. I'd like to tell you of one patient, Dixie Alford. He had tuberculosis. We found this out two weeks after he died. This was found out purely by accident as one of the patients had heard Mrs. O'Connell and Dr. Johnson talking in the hallway, and heard it said that he had died from active tuberculosis at Midway hospital. They did not tell us about it so I went to her and she said: "Yes, he had," and she suggested we go down and have a mantoux test. As we had cared for this patient, cleaned his teeth, and done most of his care, we were very upset that they hadn't told us that he had active tuberculosis. The room had never been cleaned after his death. Another patient was moved into his bed right after he left. We went to the Health Department and had a mantoux test. While I was there I discussed with the health department their going out to the nursing home and taking tests of the other patients. They said "No, the mantoux tests would not show up on elderly people because of the condition of their skin." I then suggested that they take an X-ray unit out and they said no that this was not their procedure. Therefore they never did check to find out where the tuberculosis came from.

Another patient, Edwin Johnson, had a confirmed staph infection. He had the staph infection from the day I started working there. I'd been there one year and he had that staph infection quite actively for the whole year. He walked around barefoot with the seepage running down his legs and onto the floor. Other patients would step in this seepage. There were no sterile procedures used on this man. There were very seldom treatments done as we did not have the supplies to do his treatments. He was also not isolated. He was put in the room with two other men. The nurses never seemed to want to call a doctor on our shift. In fact they had been told on occasions not to call them after certain hours. Consequently some of the patients went through some very unnecessary suffering.

One patient in particular who couldn't swallow, Violet Carlson. She came in as an apparent stroke victim. She did have a little hard time swallowing at the beginning but she could get food and medications down. As time progressed her swallowing got much worse. It got to the point where she couldn't swallow anything, including medications or water. We had written this on the day book many, many times. All the aids on the day shift and on our shift had discussed her condition. This was written on the day book. The day book is the book used for

aids and orderlies to write anything pertinent about a patient. No doctor was ever called for Violet Carlson. One day I came to work and there was an aid and orderly in the room with her and they said that she was dying and that they had orders from Mrs. O'Connell to push fluids. By this time it was too late.

She had gone at least a month to six weeks without medications, water or food. Mrs. O'Connell had a meeting shortly after this woman died. She was confronted and asked why nothing had been done for Violet Carlson. She got kind of red in the face and said that the doctor had seen her but that he saw her in the hallway therefore she wasn't charted on. We know this wasn't true because we had looked at her chart and nothing had been charted on her. A few days after she died we returned to her chart and there was charting on her that the doctor had seen her. There was another patient, Clyde Crosley. I came on the floor and as usual, I walked down the hall. I would look in the rooms of the patients to see if any of them needed any help. When I came to his room I found him in a geriatric chair sitting beside his bed. He was laying on the tray of the geriatric chair with his arm hanging over the side. I walked up to him. At first he appeared to be sleeping so I walked to the desk and asked Mrs. O'Connell who happened to be on the floor at that time (she rarely was on the floor, but at that time she was). I asked her if it was alright if I got an orderly and put Mr. Crosley to bed. She said: "No", it was almost supper time and to wait until after he had eaten and then we could put him to bed. Well this was three o'clock in the afternoon and supper was served between five and five-thirty. I went to check the other rooms and came back to Mr. Crosley's room. He was still in the same position. I walked up to him and looked in his face. His eyes were rolled back in his head and I knew there was something wrong immediately so I went back to Mrs. O'Connell. She came down and we put him to bed. His blood pressure was very high and he had a high temperature. He was then sent to Midway Hospital. He had had a stroke. He then came back to the Lexington Nursing Home was put back on the third floor and was kept in a geriatric chair almost the whole time he was there. He was constantly sitting in urine when our shift came on. We would take him out of the chair, clean him up and put him into bed and let him rest for awhile and then get him up again for supper. This was done every day. He was very raw and sore on his bottom from sitting in urine all the time. Apparently it looked as if he had been sat in the chair in the morning and left there until our shift came on. Anyway, this man got sick again and started running a high fever. In fact his temperature was about 105 and 106. Mrs. Finney and I were in the room taking care of him. He was dying but he was conscious. We went down and reported this to the nurse and she said: "Yes, but there is nothing we can do for him". They did not call a doctor and they did not call his relatives. We begged the nurse to please try and give him something so that he would be more comfortable. She said: "No, there was nothing we could do for him". She had no doctors orders. It is terrible to sit by and watch a patient die and knowing that there is nothing you can do.

They have a Death Certificate Book in the nursing home. The book is signed by the nurses after the patient dies. There have been a few occasions when doctors have been there, but these are very rare. There is no proof of what a patient dies of when a nurse signs the Death Certificate Book.

The use of tranquilizers was the most alarming thing to me. If a patient walked too much or talked too much they would give him a tranquilizer. It got so bad that a patient had to be sent to a hospital to be awakened from an overdose. There was one patient, Mr. Charlie Fricken, he was an ex-boxer, and a very gentle and well mannered man. He would get up at night and pace the floors. Some of the aides didn't like this; they felt that he was a bother to them. Mrs. Finney and I would sit him down in a chair when he got up at night and give him crackers and peanut butter sandwiches and milk. We would also give him magazines to read. He was a very nice person, so he really didn't bother us too much. There were other aides who didn't agree with this. They had called the doctor and they had gotten a order for Thorazine for this man. The orders were to give it for seven days and then call the doctor back and let him know how he was reacting. These orders were not followed. He was given Thorazine for 15 days. At that time it was stopped only because the man became very violent. Mrs. Finney will tell you about the attack on her. This turned a nice man into a very violent man. He also had to be tied into bed. I've seen him tied down with five posey belts. I also have talked to a nurse about Thorazine. She said that Thorazine can have a reverse action and that evidently this is what happened to Mr. Fricken.

There was another patient, Ed Foster. On March 15, 1970, eight days before Mrs. Finney and I were fired, this man had been found asleep in the morning by the day shift. He could not be awakened. They had to send him to St. Paul Ramsey Hospital to have him brought to. At this time we told Mrs. O'Connell we would not pass medications anymore because of patients being overdosed and because of stealing of medications.

Another drug used in extreme amounts is Darvon. Susie Johnson was one of these patients. She was a Welfare patient. She used approximately $80 worth a month for over 2 years. It said on the day-book that it was given for headaches, yet they never checked into what was causing her headaches. There were also several others getting close to the same amount of Darvon on that floor. I read in the Physicians desk reference about Darvon and it said there that side effects of Darvon could cause headaches yet they continually gave it to her.

There were occasions when the nursing home experimented on patients without permission or notifying the families. Mrs. O'Connell came to the floor and said that five patients from the third floor were picked to take a drug called Derefil. This is an internal deodorant. After this medication was given to the patients all five of them got loose runny green stools. One patient in particular, Irene Spearbeck, had quite a loss of weight. She lost approximately 40 pounds in a month. She also had had green, runny loose stools. We would walk down the hall and mop up after her and almost everytime we would take her into her room her underclothing would be full of stool. The family was very concerned about her losing so much weight and she was getting very black under the eyes. They came up and asked me about it and seeing that there was no nurse on the floor I felt it was up to me to tell them that she was on a drug called Derefil and that since she had been on that she had loose stools and that she had been losing weight. I'm not sure as to whether it was this or not, but it seemed to me it was since all of the other five patients had loose stools. The family said they had not given permission to use this on her, they then took her out of the home and had her placed in a Boarding and Care home in Hastings.

Living in a nursing home at its best is not easy when you mix normal patients with confused patients. This can cause pure havoc. One patient in particular, Oscar Nelson, was moved from the first floor to the third floor. When he was on the first floor he was very nice; he used to talk to us a lot; he used to go to the store for other people in the home and buy them cigarettes and candy and so forth. He was allowed to come and go almost as he pleased. Why he was moved to third floor we do not know. After three days of being on the third floor he was a completely different person. One day I walked in and as I had told you before I checked the rooms of all the patients. The door was closed to his room. I opened it and found him sitting in a geriatric chair with a nightgown on and bare feet. He was talking to himself and tearing up paper. There was shredded paper all over the floor. I walked up to him and he didn't even know that I was there. He acted like he had completely "flipped his lid"! I was so mad at this, as I liked this patient so well when he was on the first floor, and my temper flared up. I went down and told the nurse about it. I said: "Who the hell put that man in that chair?" She said, as usual: "I don't know." Well we knew it had to be the day shift. They were constantly putting people in geriatric chairs. I then went down and found Mr. Thayer and Mr. Trana on the first floor hallway. By that time I was so mad the tears were coming down my face and I was hollering at them for putting this man in a geriatric chair. I told them that he didn't belong on the third floor anyway. Mr. Thayer only said: "Well, I don't like geriatric chairs either." He never did anything about it. I then returned to the third floor. The man was running a high temperature. They called the doctor and he was sent to the hospital. He had pneumonia. When he came back they put him on the first floor. I think it was a blessing that he did get sick and did get pneumonia because he did get to go back to the first floor. He can now come and go as he pleases and is looking much better. He also appears much better as first floor patients do get better care than those on third floor.

There is also another patient, Lorraine LaMonte. She was a very very confused patient when she came in. She used to slap other patients around and she would get up at all hours of the night. She would drink from the toilet and she would smear stool on the walls. She thought that the other patients were babies and she would go over at night and pull the blankets off of them to cover them up. She kept the patients awake most of the time. After I left the home I heard that she was sent to Hastings. It is specifically against the State Health

regulations to have mentally disturbed patients in a nursing home. The administration paid no attention to this.

There was one patient who was very noisy. This was Marie Dimitz. She had some kind of a thing about people trying to take her money from her. According to most of the aides she didn't seem as confused and senile, as she did appear to have a type of psychiatric problem. She was very very noisy, upsetting everyone on the floor. They moved her to three different rooms, they tried three different tranquilizers on her, nothing helped. They gave her no help whatsoever on that floor. This kept on for quite a long time. In desperation one day we heard that Mrs. Christison was coming to the home. She is the investigator from the State Health Department. This Mrs. Dimitz, a patient, didn't like to sit in the hallway. We thought the only thing we could do to get attention for her from Mrs. Christison was to put her in the hallway in a chair and she would start hollering. Then the investigator would probably check her. Well it did happen that way. She started screaming and really putting up a tantrum, so Mrs. Christison walked over and looked at her chart, talked to the patient. The next day when I came to work she was sent to Mounds Hospital for psychiatric care. There should be an easier way to get a patient some psychiatric help than going through something like this.

Apparently it is legal to renew prescriptions for patients without a written order from the doctor just as a matter of convenience. This practice is often abused by the nurses. We had a patient by the name of Mamie Davidson. Before she had come to the nursing home she had fallen and hurt her hip. She was sent to Midway Hospital. Her family doctor, Dr. Bolinski, was out of town at the time. They called in Dr. DeRauf. He was her doctor for two days only. She was then sent to the Lexington Nursing Home. Then her own doctor was in charge of her. Yet for two and one half years prescriptions were written out and re-ordered from Dr. DeRauf. I talked to her sister and we have proof that all these prescriptions were renewed by Dr. DeRauf and yet Dr. DeRauf was NOT her doctor. Dr. Bolinski was. Dr. Bolinski had only made out one prescription for this woman in the two and one half years that she had been there. I want to make it clear and stress again that he was not her doctor. That he had only been her doctor for a few days in the hospital and that was all. So, as you can see, the nurses had prescriptions refilled many many times without ever notifying a doctor or getting phone orders from him.

As a taxpayer, I was appalled to discover that one of the pharmacies that supplies the home occasionally charge more for Welfare patients as a matter of policy. There was one patient on first floor who had a order for a humidifier. This order came late at night. So we could not get it from the usual druggist, Grant Street. It had to be gotten from Desnick Bros. Drugs around the corner from the home. When the humidifier came in on the box it said "Sale price $9.95," yet on her bill it was marked $14.95. I took the bill to Mrs. Corey, the R.N. on the floor. She said she would call Desnicks and ask for an explanation as to why it was $14.95 for this patient. Desnicks told her that from Welfare patients they get five dollars more thus she would have to pay $14.95. Mrs. Corey then asked if she could buy it and how much she would have to pay. They said that she could buy it for $9.95.

It was almost impossible to maintain the general everyday hygiene of the patients because of lack of supplies, lack of help and bad procedures in the home. The patient's glasses which fell on the floor were often taken and simply laid around. They would never get back on the same patient. Often they were thrown in the drawer. The third floor desk drawer was always full of glasses. We tried to fit them on patients, but unless we knew the prescriptions for their lenses this was almost impossible. As I have also said before there were toothbrushes, but we got no toothpaste. The brushes were not really much good, they fell apart after two weeks. I asked for toothpaste, for deodorant and so forth. We never did get it. Consequently the teeth were never taken care of in that nursing home. We did start checking on some of the teeth. We took out the false teeth and were going to brush them with soda. Some of the teeth were stuck in their mouths so badly that we had to pry them out. Well, some of the skin and blood came along with their teeth. After this happened to one patient, I decided that I would not try to take their teeth out to clean them. If they weren't going to supply us with what we needed to keep them clean, there was nothing we could do about it. Also when the false teeth were taken out they were mislaid and ultimately thrown in a box and kept in the med room or in the side supply room. They were kept like this dry so they did shrink up and could not be re-fitted back in to the patients mouths.

Their fingernails and toenails were also in very bad shape. One of the patients, Gertrude Johnson, was limping down the hall one day. Mrs. Finney and I noticed her limping so we took off her shoes and socks to see what was wrong with her. We expected to see a sore, but instead we found that her toenails had grown so long they had curled around and grown into the skin under her toe. We then decided to check the other patients. They were all in very bad shape. Most of them had grown so long they were almost impossible to cut. Mrs. Finney would soak the feet and then I would do the cutting. I brought my own supplies from home as the nursing home had no clippers for these patients. We also did the same thing to the fingernails. When we soaked the fingernails most of them were full of stool and other dirt. To cut them I brought my own supplies for them too. The hearings aids were done the same way. We had one patient who had a hearing aid that was broken shortly after he got to the third floor. The hearing aid was never fixed. This man would go around hollering: "Help Help"; all the time and people were wondering what was wrong with him. His problem was that he could not hear. If he could hear he would have been practically a normal patient and could have been down on the other floor.

I have already told you about the bad oral care at this home. I would like to give you a good example of the end result of this neglect. There was a patient named Rosella Bun. When you walked to the door of her room the odor was atrocious. We looked the room over from top to bottom trying to find what was causing the bad odor. When I was sitting down talking to her I discovered it was coming from her mouth. I checked in her mouth and it was just green thick covering her teeth. The smell was so rotten you could not stand it. I reported this and wrote it down on the day-book several times. Well, Dr. Johnson did come over to see the patient and he diagnosed it as pyorrhea. He told us to wash her mouth out three times a day with peroxide. We did this for several months and nothing helped, her mouth was still just as bad if not worse. During that time I had changed my shift and was working on the day shift for approximately two weeks to a month. Dr. Johnson was on the floor at that time. He was talking to the nurse and asking if he should see any other patients. The nurse said: "No", I then walked up to him and told him about Mrs. Bun and her pyorrhea that hadn't gotten any better. He said: "Who was that patient?" and I said: "Rosella Bun". He said: "Well, she's just a crab anyway and there is nothing we can do for her so just leave her alone." Therefore there was nothing we could do. When a doctor gives an order we have to stand by it so she did and to this day I think she still has the pyorrhea and the thick green mouth.

Some of the aides at the nursing home, in order to avoid doing any extra work, put patients in geriatric chairs and shut the doors to their rooms so that the patients would not bother them. This often led to very dangerous situations. There was one patient by the name of Rose Kline. It was a very hot summer afternoon and I came on the floor and as I told you I check the different rooms. The door to her room was closed. I opened it and found her sitting in the geriatric chair with her feet against the heater. They had a floor heating system in that room. The thermostat had been turned way up so the room was stifling hot. She was also sitting by a window that the sun was coming in. She was bright red, sweaty and very hot. She was crying out that her feet were burning and that someone was trying to electrocute her. After I took her out of the room, I went down to the desk and told them about it, again nothing was done. As I told you before they keep the patients in geriatric chairs all the time to keep them out of their way. She then became much worse. She constantly hollered and screamed about being electrocuted. She was then tranquilized. She was getting a tranquilizer by the name of Haldol. This was a fairly new tranquilizer so it could not be gotten at a drugstore. We had to get it from St. Paul Ramsey Hospital. She later started turning very yellow. She was a bed patient by this time. We were very concerned about her as we thought she was jaundiced. After approximately a week or two they sent her to the hospital. She was operated on at St. Paul Ramsey Hospital and later died.

Incontinence is a problem in most nursing homes, if not in all. If patients are not kept clean and dry their incontinence becomes a very serious problem such as bed sores, bladder and kidney infections, and often gangrene. There was one patient, Mary Whelen, who was very incontinent. She was on the third floor. At first she was allowed to go down to the dining room for meals; then they asked if we would keep her up on the third floor as she was constantly leaving a trail of urine on her chair and on the floor. The smell was so bad that they didn't want her in the dining room. She was not kept clean or dry. She started breaking down and got what is called "urine burn." I had reported this many many times in the day-book. Nothing was ever done.

Consequently she got much worse. In fact she was so bad that from her waist down to her ankles she was like raw beef steak. She was purple, yellow, green. Every color you could think of. There was a nurse by the name of Mrs. Bruckner there at the time. I showed her her condition. She said too that it was the worst thing that she had ever seen. We did get orders to give her oatmeal baths which we did on our shift. We also had made pads for her so that on our shift we kept her changed and dry. But if this isn't done 24 hours a day it does not help. And it was not done 24 hours a day and she did get worse. She got so bad she started having chills and running a temperature. She was later sent to Midway Hospital, then to a different nursing home. When the family came in to get her clothing they said they had never seen such neglect and that they would never bring her back to that home again. She also bled from the vagina. I had reported this. Mrs. O'Connell had come up and checked her, other nurses had checked her and nothing was ever done for this patient. As far as I know no doctor had ever been called. One of the ways to treat incontinence was the use of catheters. Unfortunately, like everything else, it was done poorly and under unsterile conditions. I had been taught by a nurse when I worked on the second floor how to irrigate catheters properly. Since there were no training classes there, the teen-agers or the on-the-job training students, the young aides and even some of the older aides that came in had never learned how to irrigate catheters correctly. This consequently left many bladder infections in patients as they would inject the sterile solution into it and then draw it back out into the syringe. The next time that they injected sterile solution they were putting the unsterile solution right back in. Some of them were also left in too long, even up to three months to a point where they were rotting when they came out. Some of them would fall apart. Many of them were blocked and by-passing. By-passing is when the urine does not go into the catheter, it instead goes around the catheter. One of the patients in particular who had trouble with her catheter was Mabel Giese. One night her catheter had come out. The balloon was not deflated. The nurse got kind of mad about it. She inserted a new catheter under very unsterile conditions. She then pumped the sterile water into the balloon to fill it up. The balloon was in her bladder. Then she pumped three or four times the normal amount of air into the balloon and then she said: "Well, this catheter will never come out." After I left the home one of the aides that still worked there told me that she had to be sent to the hospital to have this catheter removed.

The day Mrs. Finney and I were fired from the nursing home a patient on the third floor went out the window to her death. This patient was named Clara Kubecheske. She had only been on the floor a few days. She was one of the worst diabetics in the building, yet we had not been told that she was a diabetic. We found out a couple of days before she died while talking to one of the nurses. We all said that we didn't know that she was a diabetic. The only medication that she got was an insulin shot in the morning. We gave her no medications at night. She was put in a room with a very confused roommate; the one who slapped patients around. She would go over and keep this patient awake. The patient did not seem to be very confused so she was very upset all the time. She couldn't get her proper sleep at night. She was slapped and the covers were pulled off of her constantly. She was so upset with this patient that she had asked many times if she could be moved or if she could go home. They told her: "No; she was to stay there."

PREPARED STATEMENT OF ROBERT SHYPULSKI, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME[1]

My name is Robert Shypulski. I worked at the Lexington Nursing Home for about three years from June 1968 as an orderly. I worked the day shift 7:00–3:30 and also the second shift 3:00–11:30 P.M. Here are some of the conditions I saw. The people who do the laundry, they have got to be blind. The linens come up from the laundry as dirty as they went down. They are torn, raveled, and stained with urine and medications. They are run through a mangle with dried feces in them. There is also a shortage of linens. Patients are put to bed with their clothes on or naked because there are no linens, no draw sheets, no diapers and no gowns. There is also a pathetic shortage of clothes. It gets

[1] See statement of Robert A. Shypulski, p. 2124.

so bad that men's pants have to be held together by a chain of safety pins. Sometimes 10 or 12 pins.

In the last 6 months there have been cockroaches on third floor. I remember one instance when I was going to give a whirlpool bath and I went in, opened the door and turned on the light and the cockroaches were running wild. I must have killed or stamped on 15 of them before I could turn on the water in the tub.

The food at the Lexington Nursing Home is a complete disgrace. One good example is jello. They served lime jello one evening and it was so hard it bounced off the floor like a ball. I couldn't even cut it with a spoon. None of the patients ate it that evening. The patients don't get enough to eat. I remember one patient when I first started working at the home; he was like a giant. Now his skin just hangs in layers. I'd say he has lost one hundred and twenty pounds. Another instance I'd like to bring out is a patient who was very sick and we had to feed him with a syringe. We were feeding him Sustagen, which was ordered by a nurse, Mrs. DeMar. The Sustagen is a complete, nutrious liquid diet. It is very expensive I understand. When we ran out of it, the cook came up and told us we could no longer use Sustagen since it was too expensive and we used too much of it. Instead he gave us Kool-aid. And he said: "put a lot of that in a glass, it's just as good." So I tried it and he wouldn't even drink it. The patient lost weight and he went without food again. So we ended up grinding apples and feeding him orange juice for a diet.

I was a witness to an incident with medications that upset me very much. About 4:30 one afternoon, Mrs. DeMar called me into the med room. Here in the med room waste paper basket were the medications in the bottom of the basket. She told me to go get a brown paper bag and call Mrs. Clay, the R.N. to witness it. She came up and she looked at the medications. They were daytime medications. Mrs. Bruckner was the nurse who was responsible for the medications during the daytime. Mrs. DeMar was awful upset about this because this was not the first time this had happened. Mrs. Clay called Mrs. O'Connell that evening, and told her what had happened and that they had found the medications in the waste basket. Mrs. O'Connell sounded upset Mrs. Clay told me. She said she was going to speak to Mrs. Bruckner about it. A couple days later I asked Mrs. DeMar what Mrs. O'Connell had said about the medications. Mrs. O'Connell had talked to Mrs. Bruckner and had said she had a very plausible excuse. The excuse was that Mrs. Bruckner didn't want to chase the patients. She didn't see any sense in it so they did not get their medications. This was told to me by Mrs. DeMar.

At the Lexington Nursing Home the residents keep their eyeglasses for only about a week. They are taken off at night and put them in a drawer or sometimes on the dressers. When we come back they are gone. They are thrown in a cardboard box and they never have any names on them. Once in awhile we take tape and put names on them if we have white masking tape. That was a very unusual thing to do. Many times I've sat patients down and tried to remember which glasses were theirs, because they were stumbling in the dark.

Patients at Lexington Nursing Home have no oral care whatsoever. If they have their teeth, they are lucky. After begging on my hands and knees I finally got tooth brushes. I went to brush two people's teeth and their gums just bled. They asked me to stop so I did. I couldn't stand it. I was told that if you don't brush your teeth at least once a day the gums get soft and they bleed. When then I rinsed their mouth out with mouthwash and I noticed that the bristles from the tooth brush were stuck in between the teeth. They were very cheap toothbrushes. Another patient on third floor had teeth and gums that were rotten and very red and inflamed, and swollen. He had a gold tooth around which all the gums were rotted. I'm not a dentist, but this man had big black holes in his teeth. I think they are cavities. One time I went to the 'dentist shop' where we keep all the old teeth and spare teeth. One patient told me that he was tired of eating pureed food. He ate this type of food because his dentures were lost. Well I went to the dental shop to try to find some teeth that would fit him. Then Lola Finney told me it was no use because they were dry, they had shrunk. I guess all those teeth were all broken up and shrunk. I don't think I could have ever scrubbed any of them clean, so I said "I'm sorry Chester I'll try to get you better food than the pureed."

There were numerous times when the patients should have been sent to the hospital and were not. One time a woman fell and had a 3½" cut on her hand. Within 2 days, it was swollen, puffy and very inflamed. I remember we used to soak it every night, to see if it would do any good. It didn't, so I called Mrs. Jeske down and she said: "The only thing you can do is soak it. You should

have gone to the hospital and had stitches when the incident happened." The same poor woman has a very painful hip condition. She sat in a chair and leaned to one side because her hip hurt her so bad. She used to kind of hobble along the rail holding her one leg up because it hurt so bad she said. We reported it and about two weeks later she was sent to the hospital. She had a broken hip. I think I know a broken hip when I see one. Her foot lay very twisted in when she laid on the bed. The same poor woman was tied in a chair. No one would take her to the bathroom. I was working with the women one evening. We took her to the bathroom and she sat on the toilet and she must have urinated for a good five minutes and I'm not kidding. She sat and she went to the toilet for a good five minutes because she was too proud to wet her pants and no one would take her to the bathroom. This happened all to that same woman.

Arnold Nash was another patient who came to third floor. He had a penis that was grossly enlarged. On second floor there was a feud between two orderlies. One insisted on using a condom catheter (a catheter that is on the outside of the penis and is tied around the waist) and the other orderly said: "no, that is the reason why the penis is swollen." The evening orderly used ice packs and the day orderly kept a condom catheter on. When he was sent to third floor he said he had to go to the bathroom so I took him to the bathroom and I noticed his penis. It was at least 2" wide and very swollen and inflamed and filthy around it. The skin in the area was rubbed raw. There were sores on his scrotum, his penis and in between his legs. There were a number of sores around the edge on the head of the penis. I called the nurse immediately. She came and said: "Elevate it and keep ice packs on it." That was about the only thing one could do.

There was another patient who had trouble walking to the bathroom. He was not incontinent when he came. He had no problem urinating, he just needed some assistance walking to the bathroom. One day the day shift decided to catherize him anyway. The day shift orderly put a catheter in him. The first catheter drew blood instead of urine. So he took it out thinking there was something wrong with the catheter. So he tried another one. The same result happened. He told me personally to watch the patient because he was bleeding a little bit from the penis. Later on that evening a clot came through his penis that filled the whole bottom of the bed pan. I'd say it was about a foot long, a foot wide and three inches high. Two or three days later he was sent to the hospital. He died there.

Even in emergency situations aides and orderlies are left without supervision. About a year and a half ago a husband of this patient brought her fruit cocktail for dinner. A short time later she started to vomit. She was taken to the whirlpool bath to be cleaned up. They put her in the whirlpool and she started to vomit again, only this time it would not come up. It was as if it was going down into her lungs. She started to rattle and that. She was having trouble breathing. I was notified and the aides and orderlies asked me what I would do. I said call the nurse immediately. So I called her on the intercom and I said: "Mrs. Corey please come to third floor, it's an emergency," and I repeated it. She came up and she bawled me out. She said: "Don't you ever order me to a floor." I said: "Will you please just come and look at the patient". She told us to get the suction machine and the oxygen. We did. She told an untrained aide to administer oxygen, and to suction the woman's throat. The suction tube was put down her throat at least nine inches. Then she would take it out and apply oxygen. This continued for about 45 minutes until the woman was blue, cold and clammy and very unconscious. All the time Mrs. Corey was sitting in the break room. The patient was sent to the hospital and died the next day.

Finally there is a classic example of inhuman treatment that I cannot disregard. This is an example of bad care. The best way I can characterize this is torture. Torture by failure to give care. When I started to work at Lexington Nursing Home 2½ years ago, this patient was an ambulatory. He was on second floor, used to walk to the bathroom and putter around. He became less and less ambulatory. He sat in the chair all day; he laid in the bed all night; he started to get mean; he would fight people when they came near him. Then he was moved to third floor. He was completely ignored when he got to third floor. He was never shaved, never. We had to cut his whiskers with a scissors. His teeth were never brushed and his bath days were skipped. He was never fully dressed. He sat in a chair with a blanket. They never bothered to dress him. At this time he became very incontinent. He sat in the chair all day in urine and feces. The staff hesitated to go near him. Because of his incontinence they only gave him a gown and a blanket. Each day they restrained him in the chair.

I remember we put him to bed one night and I touched his leg and there was a lot of pain with it. It was around that right ankle that there was a dark area and the foot was swollen. We reported it several times and nothing ever happened—as usual.

On March 8, 1971 Mrs. Finney saw this patient for the first time since she had been reinstated. I showed her this patient and she touched his leg and the patient screamed. We called Mrs. DeMar, our nurse (the best nurse Lexington Nursing Home has ever had). She cared about the patients. The next day he was sent to Midway Hospital where his leg was amputated between the knee and the hip. He came back from the hospital he was in good condition. He was clean, his teeth were clean, he was shaven. He looked unusual. In a week he was looking bad again. He needed a shave. Sometimes we could cut his beard with a scissors. His teeth were filthy his finger nails began to get long and stool was underneath them. He had 'urine burn'; 65% of the patients on third floor had urine burn. He had catheter burns. He was awfully mean again. Because he was mean they gave him a lot of Librium. They gave him so much Librium during the day that he couldn't even hold his head up. He couldn't eat or drink. He just sat in the chair. His strength . . . it was more like the chair was holding him up. His skin began to break down. The coccyx area was first. We kept him off it. We took him out of the chair. We put him on his side. He was left on his side until we came to work the next night. His other side began to break down. We had orders from Mrs. O'Connell to give him tincture of benzoin treatments. Then we were giving the treatments to his sores. In a little time his other side broke down. He's broke down on both sides, the hip and the shoulder and the foot and the coccyx. He became very sore. We treated him every night. We were like the only shift that would go near him. We were like private nurses to him on our shift, Lola Finney, Mrs. DeMar, and me. As time went on we began to speak of staph. His wounds became very drippy, open and very ugly looking. You could have put a golf ball in one of them. The one on his hip began to look like a mound and there were three openings that were always seeping. It was very sickening looking.

I would like to mention that one day when I came to work at 3:00 P.M. I came in the room and that man was the first I always used to look at because I knew he was in the same position I left him in the night before. The day shift said to me: "I'm sorry we just didn't have time to do him today." He was sitting up in the chair, he was sitting in stool. I got furious. I went out to the desk and I asked who put him up in the chair. Mrs. Roady, the L.P.N. answered: "She said to me that he had only been up since before dinner and that was only about four hours ago." So he was up sitting for 4 hours in his condition in stool. We had to clean the stool out of his sores nearly every day. We used sugar and peroxide treatments at this time. It was very painful for him to go through this. He used to scream and bang on the bars. On top of all this, one day I came to work in early September. I said: "I've had it Mrs. DeMar. I will not take care of him. I'm scared of him like everyone else. We're all scared of staph." She said: "I know: I'm going to call Dr. Johnsons this evening after Mrs. O'Connell leaves". She did that because Mrs. O'Connell didn't want anyone calling the doctors. So she called Dr. Johnsons. He said: "No", on the hospital. But he did give a prescription for Elase and Garamycin ointment. The next day Mrs. O'Connell came to the floor and she said there will be no Elase used on this man, and no Garamycin ointment. We will continue with sugar and peroxide. About two weeks later Dr. Johnsons came in and saw this patient. Three or four days later it was confirmed that this patient had a staph infection. He was moved into a private room 317.

I think the only way I would have found out that the patient had staph was one evening when I came on duty Mrs. Jeske had said do not take the treatment cart into Mr. Gabrielson's room. I asked why. She said: "Because the patient has a confirmed staph infection." I said: "I had thought so." The only way we found out anything about the patients was if we looked in the charts. He was moved into room 311. This so called "isolation room" was a farce. The gloves never fit the men's hands. They used to split down the sides. These were cheap plastic gloves so I never used them. They had one paper mask in all the time that I did treatment in this home. They never had proper prescriptions. He slept on just an air mattress. But there was no air in it because there was no motor. He laid on that hot piece of plastic for a long time before we got a motor. If we used gowns for the isolation room for ourselves, then the patients had to go without, so I looked at it this way: I've been taking care of him this long and I haven't got

it so I probably never will. There were constant violations of the isolation procedures. Hydrogen peroxide went in and out of the room. Patients wandered in and out. The treatment staff came in and out with the supplies. There was no disinfectant. Sometimes there wasn't even any soap to wash your hands with. The door was left open and patients walked in and out constantly. People were always in and out of that room. No one listened, dishes were taken in and out there was really no sense. He had laid in a room with staph with two other patients, one an ambulatory patient who used to walk around and another a bed patient. Well, since I have been suspended from the home, this patient has died, and so have many, many more. Fifteen patients died on third floor alone. So I don't know what goes on at that home. I'm sorry to see patients have to be tortured like this at that home, but I also want to add—he's not the only patient. There was another patient who had worse bed sores than this man will ever have. Thank you.

PREPARED STATEMENT OF LOLA M. FINNEY, FORMER EMPLOYEE OF THE LEXINGTON AVENUE NURSING HOME[1]

My name is Lola Finney and I started working at the Lexington Nursing Home on October 21, 1968, approximately a month after this new home opened. The following are some of the things I saw. There is a beauty parlor in the basement of the Lexington Nursing Home. They do not practice sanitation and sterilization procedures as I understand the laws of Minnesota to be. I am a licensed beautician of 33 years with a current manager-operators license. It is a state law that there be sterilizers in a beauty parlor. If they have them in this beauty parlor in the nursing home, they do not use them. I see towels on stools and chairs. I do not see combs, brushes, curlers and so forth in a sterilizer. The state law is that you must have a dry and a wet sterilizer. Combs, brushes, towels and so forth must be sterilized before you can use them again. I have seen combs, brushes and so forth used on patient after patient without sterilization. There are patients in this home who are unable to sit under the hair dryer. So the operator wraps their hair and sends them back to the floor until their hair dries. When the operator's work is over for the day she comes to the third floor and combs out the hair and sets it. She uses the same comb and brush on all of these patients. The men get their hair cuts from an orderly named "Mr. Clem". He cuts their hair very close and they look like convicts. He said he was paid for cutting their hair by Mr. Tranna, the administrator. There was a patient on the third floor named Mabel Geise. Her hair hadn't been combed for weeks. She slept in bed with some kind of a dust cap or something on her head. One day we were able to take her to the beauty parlor. I took her down and when they combed her hair out she had some sort of a scalp disease. Her hair was shampooed and the same comb was used on another patient.

I want to talk about the Med classes (instruction in how to give medications). I did not want to be a Medical Aid because I did not feel I would be qualified after those few lessons to pass meds and set them up. I did not feel as though I would like someone to administer meds to me that did not know what they were doing. They were short of R.N.'s and L.P.N.'s and I knew we would be replacing them. I attended two, at the most, classes and I did not go to any more. High school kids who were in on-the-job training were passing meds, also the orderlies. One day Mrs. Moe the R.N. asked me if I would consider setting up and passing meds because they were so short of help. The only reason I even considered it was because I felt I was more qualified than these kids or teenagers. So I did it. Mrs. Moe showed me how to take the card and compare it with the medicines in each patients cubicle and then put it on the tray. I didn't know an aspirin from a moth ball. I proceeded to set up these medications. She had to go and do other things. When she came back she looked at my tray and said: "Great". This is all the training I had for setting up meds and passing them.

We had a lot of trouble with the bacon they served in this nursing home. They were Seven Day Adventists so they did not serve pork, they served beef bacon. It looked more like corned beef bacon. It was very tough and very stringy. The patients used to choke on it. They would come to the desk and you would have to put your finger down their throat and drag it out. We complained so much about this bacon that they finally stopped serving it on the third floor. One Sunday they served for the dinner meal baked chicken with mushroom gravy. What

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[1] See statement of Mrs. Lola M. Finney, p. 2124.

was left over they refrigerated. The next day, Monday, when I came to work on the 3–11 shift I saw they had taken it out for the supper meal. They did not use it that night for some reason and they did not refrigerate it again. It was served to the patients on a Wednesday for the supper meal. Many patients got sick. Staff also that ate that night got sick. I was one of the victims.

One night I was working in the med room when the patient Charlie Fricken appeared. He started to slug me. He was an ex-prize fighter, but a very gentle man. He started slugging me and accusing me of going with his wife. There was only one other aid on the floor, a Jenny Hayes, and she was sent to second floor to help out. When he slugged me I screamed, she screamed. The more we screamed, the more he slugged us. The night orderly came on, Billy Price, he called to him gently because he knew him. He said to him, "Charlie, come with me." And he sat him down in the hall and he gave him a peanut butter sandwich and some milk. This calmed him down. I called second floor to speak to Mrs. Corey the R.N. She came to the third floor and she called the police. The police came, strapped him on the stretcher, took him to St. Paul Ramsey Hospital and from there Mr. Fricken was taken to Hastings.

Letter From Senator Moss to Witnesses

The following letter, from Senator Moss, was sent to all witnesses prior to the hearing:

U.S. Senate,
Special Committee on Aging,
(Pursuant to S. Res. 27, 92d Congress),
Washington, D.C., November 16, 1971.

Mr. James Green,
Executive Director, Minnesota Nursing Home Association,
Minneapolis, Minn.

Dear Mr. Green: As you know the Subcommittee on Long-Term Care of the U.S. Senate Special Committee on Aging has scheduled hearings for the Minneapolis-St. Paul area on November 29, Monday, at 9:30 a.m. in the auditorium of the O'Shaughnessey Education Center at the College of St. Thomas, St. Paul, Minnesota.

The hearing will focus primarily on the following issues which I believe are the root causes of the many problems in the field of Long-Term Care.

1. The lack of a clear national policy with regard to treatment of the infirm elderly including the absence of supportive services.
2. The absence of the physician from the nursing home setting.
3. The consequences of relying on inadequate and untrained personnel.
4. Lax enforcement of existing standards by States and the Federal government.
5. The existence of financial incentives in favor of poor care in our programs of long-term care.

The witnesses for this hearing will be Mrs. Daphne Krause with her associates, the State Department of Health and the Minnesota Nursing Home Association. Accordingly, it is a pleasure to invite you to testify.

The format of the hearing calls for a written statement which can be read or summarized orally by the witness who then will be required to answer the questions posed by the Committee.

The following is a list* of nursing homes that will receive some mention, whether favorable or unfavorable, at the hearing. The Lexington Nursing Home will be singled out for some special attention. I request that this list of homes not be released to the press in advance of the hearing.

I am looking forward to your attendance at the hearing.

With best wishes,

Sincerely,

Frank E. Moss,
Chairman, Subcommittee on Long-Term Care.

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*List retained in committee files.

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