

Governor Quinn's Nursing Home Safety Task Force Hearing  
Testimony  
Office of the State Long Term Care Ombudsman Program  
Sally Petrone, State Ombudsman  
October 29, 2009

Chair Gelder and members of the nursing home safety task force, thank you for the opportunity to address the safety in nursing homes. My name is Sally Petrone and I am the Illinois State Long Term Care Ombudsman.

As mandated by the OAA, the mission of the LTCOP is to seek resolution of problems and advocate for the rights of residents of LTC facilities with the goal of changing the quality of life and care of residents. There are 16 Regional Long Term Care Ombudsman Programs that handle complaint investigations, provide systemic and legislative advocacy, provide education and technical assistance, and regularly visit facilities. Within the ROPs, there are 260 certified ombudsmen & of that number, 18% or 47 are full time paid ombudsmen. In FY08, Illinois ombudsmen received and worked to resolve over 9,700 complaints and handled over 22,000 consultations. Despite efforts to improve quality in NHs, complaints increase year after year and have become more complex. The most frequent issues brought to our attention are requests for assistance, help with discharges, accidents and improper handling, dignity and staff attitudes, assessment and care planning.

Ombudsmen are the eyes and ears of residents and sometimes, they may be the only ones trusted by residents. Ombudsmen visit facilities more than any other advocacy program -in FY08, they made 20,706 facility visits. We never proceed on a complaint investigation without first receiving resident consent. We've realized that we can't resolve problems & issues alone so we've built strong relationships with the ISP Medicaid Fraud units, county coroners, the local law enforcement, ICASA, hospital discharge planners, rape crisis centers, guardianship office, mental health professionals, states attorneys offices, private attorneys, & state agencies. Many of the ombudsmen have post graduate degrees in social work, education, psychology, gerontology, or nursing. We also have attorneys as ombudsmen.

Given this brief background about the program, it is fitting that I make the following recommendations to the nursing home safety task force:

1. Evaluate the entire process of criminal history analysis reports completed by IDPH and its contractors, VIP Security and Detective Services and private psychologists. My Office, housed at IDoA, receives a copy of every report. After reviewing, I forward to the designated regional program. After the law passed in 2006, (Public Act 94-752), there were more history assessments checked as "high risk" than what now comes across my desk. Here's a few composites, that I'd like to briefly relay: a 25 year old male, with convictions for public indecency in

2008, aggravated battery with firearm in 2006, domestic battery in 2005, retail theft in 2004, has a major mental illness was deemed at “moderate risk”. Another example is the 69 year old male with convictions for burglary and a murder. He has several medical disorders. Although the murder occurred in 1981, he was most recently in prison from 2006-2007. Plus, the assessment omits why the resident was sent to prison. I find it hard to believe that both residents were classified as “moderate risk”. I’m concerned that the scale has been lowered over time which ultimately elevates the imminent risk of being victimized.

2. Ensure the pre-admission screening is comprehensive and includes a review of the past resident’s medical records, drug history, mental health treatment, care plans, & criminal history. I do support the notion that the level II PAS screening and criminal background checks be completed simultaneously.

3. Stop mixing the high risk MIs with the frail elderly in NHs. The frail elderly need 24 hour nursing care; those under 60 with a primary diagnosis of mental illness need mental health services & not 24 nursing care. They need psychiatric rehab services, medication management, skills training, education and live in affordable alternative housing similar to the DD group homes. Using nursing homes to house the young mentally ill is inappropriate placement.

4. HFS should explore expanding the existing Illinois Medicaid waiver or develop a new waiver to cover community care for those with a primary diagnosis with mental illness.

5. Aside from the young mentally ill, there are young substance abusers living in nursing homes and they should not be mixed with the frail elderly residents. Some have a mental illness diagnosis, some don’t. Irregardless, they, like those with a mental illness, need supportive services and adequately, professionally trained staff and treatment specialists available 24/7. In essence, if the young MI & those with substance abuse history are making the NHs a permanent home for themselves, then make the home meet their needs.

6. Monitor the performance & outcomes of the psychiatric rehab services or psychotherapy sessions held in NHs. There are group and individual sessions conducted. Some NHs are bringing in teams of contractors. If it helps the resident cope with their illness, then it’s a good thing. Per Subpart S rules, those with a mental health condition must be provided with rehab services.

7. Develop an assessment tool to determine if a new resident is dangerous to themselves or others before being admitted. There are residents falling through the cracks & being overlooked. I bring up this problem to the task force because the numbers of suicides in NHs by older residents are happening at an astonishing rate. If we can “catch” those residents early on, hopefully, supportive services can be rendered and dangerous activities will decline.

8. Raise the Personal Needs allowance. We hope that the nursing homes and state agencies will work with us on passing legislation in the future. \$30.00 a month does not cut it to buy personal care items, birthday cards for their families, disposable undergarments, and the daily newspaper.

9. Increase funding for IDPH surveyors & the central complaint hotline. They have lost over 50 surveyor slots over the past couple years. Plus, consumers rarely get to talk to a live person when calling their central complaint hotline. Thus, we are seeing PH refer more complaints to the Ombudsman Program, an already strapped and under funded program.

And, finally, as you modify and transform the LTC system & improve safety in NHs, please recognize that 20 years ago, the typical NH resident was elderly, female, needed little help with their ADLs and lived in a NH as a “rest home”. Nowadays, we see the mix of populations happening more and more- we see the very frail, the young MI population, the substance abusers, & the identified offenders all living under one roof.

Thank you for the opportunity to draw attention to the important topic of safety in nursing homes. Regardless of age, payer, whether the residents has cognitive or physical impairments, every resident deserves access to quality care.