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1. Prescreening: The PAS level II preadmission screen needs to be an honest evaluation of an individual's physical and mental health status, the need for nursing home care (e.g., "needs medication supervision" doesn't mean "needs nursing home care,") and appropriateness for nursing home placement (including dangerousness, the need for "specialized services," the need for a greater level of care than a nursing home.) For this to happen, there needs to be supervision and quality control of the level II PAS screen process, to insure that the screen is not a pro-forma everybody-gets-in farce. In other words, the screener cannot have an implicit or explicit requirement that "everybody gets in, because otherwise where will they go?" Right now, to the best of our knowledge -- we think the data from IDHFS will show this -- virtually everybody with a level II PAS is screened in, that is, determined to need nursing home services, and no more than nursing home services.

The PAS screen should be coordinated with criminal background screening, so admission of potential residents most likely to be a danger to other residents is not allowed until after all screening is completed.

We have discussed among ourselves, how to require preadmission screening for some people, so that they are not admitted until the entire PAS/criminal record evaluation is completed, an appropriate care plan is developed, IDPH and/or DMH determines the nursing home has the resources to follow it, and the nursing home has agreed to follow it*. One way is just to require that if somebody needs a level II PAS, they can't get in without the "identified offender" assessment. Another would be to require that the "identified offender" assessment be completed for anybody entering a nursing home who was not on Medicare. Yet another would be to refine this even further, and say that the complete screen/assessment would have to be completed for anyone (or anyone not on Medicare) who (as shown by the criminal background check,) had been in custody, or been arrested, within a given period. We're thinking maybe 3 years, because we have seen data that people who do not "reoffend" within this period, are unlikely to in the future, but we defer to IDOC's expertise on this issue.

While we think the first approach we have suggested may have equal protection/disability discrimination problems; the second and third should not. There are other possibilities, each of which has its advantages/disadvantages; the main point, however, is that for at least some people, the full identified offender assessment needs to be completed prior to admission.

(*It is critical, of course, that IDPH follows up to make sure the nursing home is meeting its commitment.)

2. The "identified offender" evaluation also needs to become more than a pro-forma waste of paper.

This means:

a. We have been given to understand by IDPH that the clinical psychologist doing the "dangerousness assessment" uses one tool with mental health/clinical subscales (the HCR-20,) and another (the V-RAG) based heavily on an evaluation tool (the Psychopathy Checklist-Revised) that is considered valid when administered by an experienced clinician. Except for the very few sex offenders, the psychologist has no personal contact with any person he is evaluating. We were told by IDPH that the assessment done by the psychologist considers only criminal history; that is, his evaluation is not based on the mental health/clinical parts of the tools he uses.

We do not believe it is possible to assess "dangerousness" without evaluating the person's medical history, behavioral history while being treated for a mental illness, current diagnoses, medication and other therapy recommendations, and the person's history of and current compliance with those recommendations.

The Corrections Code, 730 ILCS 5/5-4-1, requires the clerk of the court to send to IDOC, among other things,

- (e) (3) any presentence reports;
- (3.5) any sex offender evaluations;
- (3.6) any substance abuse treatment eligibility screening and assessment of the defendant by an agent designated by the State of Illinois to provide assessment services for the Illinois courts;
- (4.1) any finding of great bodily harm made by the court with respect to an offense enumerated in subsection (c -1);
- (6) any medical or mental health records or summaries of the defendant,

Assuming these documents are being provided to IDOC, they should be made available to whoever is doing both the "identified offender" assessment and the PAS level II screen. And these persons should use them.

We don't know if the records sent pursuant to 5/5-4-1(e) include records from other criminal proceedings which did not result in commitment to IDOC. In other words, we don't know if the records are cumulative. If they are not, the task force should get expert clinical advice about whether these records would likely be too old to be useful, or whether IDOC should pursue getting them, either by agreement with the county clerks, or through a statutory change.

b. The screener should be considering the history of arrests as well as convictions for any "identified offender." This doesn't mean you have to assume they are guilty of everything they have been arrested for, but somebody who has been arrested 40 times in the past few years (and there are some of those,) obviously has more difficulty adjusting to societal norms, than does somebody who hasn't been arrested since his conviction 40 years ago. (There are some of those, too.)

c. In order to consider the history of arrests, the criminal background history needs to be complete. The Tribune reporters found that [prospective] residents might have literally dozens of arrests that were not mentioned on the assessment forms. We don't know if this is because the State Police check is missing them (in which case the questions are why, and how to fix this,) or the State Police are not telling the people doing the identified offender assessment about all arrests, or the people doing the identified offender assessment just aren't mentioning them. To the extent the background check is incomplete, the process needs to be fixed.

d. At least one of the level II PAS screen and the "identified offender" evaluation, should include a face-to-face interview with the person, by somebody with professional mental health training, with the results of the interview available to whoever is doing either/both assessments.

3. There needs to be some common sense injected into the evaluation process. A resident with a history of violent felonies, arson, and repeated violations of orders of protection, is not "medium risk." This would be true even if he had not told the person doing a pre-sentencing evaluation of his desire to put his sister "in a pine box," and that the only way he kept himself from acting on this desire was to sometimes "pop a pill." The person doing the evaluation knew nothing of the resident's statements, which are publicly available in his court record. This resident was determined to be "medium risk," with the caveat that the assessment was done without knowledge of his meds orders or meds compliance. If this were a Gene Wilder movie, it would be funny. As reality, it is not.

Another example: The Evanston resident who stabs Troy Warfield in his eye with an ice pick. This scenario happened one of two ways: either the perpetrator carried the ice pick with him all the time, or he brought it for the specific purpose of stabbing Mr Warfield. Either way, his reliance on a deadly weapon for protection or to lash out, and the degree of forethought that may have preceded the attack, would raise questions about his future suitability as a nursing home resident to anybody giving any thought to the issue. Yet the assessment -- which rated him "medium risk" -- made no mention of his past use of a deadly weapon in a nursing home on another resident. When he moved into a sister facility in Evanston,

and again uses a deadly weapon to almost kill [incredibly] the same resident he had attacked before, what is shocking is not what he did, but the stupidity that allowed him to do it.

4. The rote recommendations on the identified assessment forms are useless.

a. For residents determined to be "moderate risk," every nursing home is told the following:

"The resident requires closer supervision and more frequent observation than standard or routine for most residents in an open facility. Regular monitoring should be attentive to behavioral changes that may signal a need for closer observation or sustained visual monitoring on a time-limited basis. Periodic assessments should ascertain whether the level of supervision is sufficient."

"Regular monitoring" and "periodic assessments" are required for every nursing home resident in Illinois. So these prescribed extra precautions are meaningless.

b. For residents determined to be "high risk," every nursing home is told the following:

"The resident requires a single room in close proximity to the nursing station to permit ongoing visual monitoring."

This appears to assume that the resident is not going to leave his room, or the vicinity of his room, and that there will always be nurses watching him if he does. And presumably following him if he goes anywhere. No nursing home in Illinois -- probably anywhere -- has the staffing necessary to perform this degree of monitoring.

Nursing homes are also told, with respect to all "high risk" residents:

The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated.

Again, this degree of "observation" and "assessment" is required for every nursing home resident in Illinois.

Recommendations for all residents should be individualized and realistic. If an individual needs a level of supervision a nursing home cannot realistically be expected to provide, the individual should not be admitted into the nursing home.

5. From the records we have seen, and the experiences of those who have contact with them, we believe that the majority of younger residents with chronic mental illness going into nursing homes -- certainly the ones with criminal records, and almost certainly the rest -- have serious substance abuse problems. * Sometimes alcohol, sometimes illegal drugs, often both. The assessments barely touch on this issue, other than stating -- this is probably the most common statement in the "identified offender assessment" -- "The resident is a mentally ill substance abuser."

The assessment process needs to include an explicit evaluation of the [prospective] resident's need for substance abuse treatment. A resident who needs substance abuse treatment should be allowed to enter only a nursing home which offers such treatment. IDPH should work with DASA to create real substance abuse treatment programs in the m.i. facilities, and in any other nursing home that wants to accept residents with substance abuse problems.

To confirm this, IDPH needs to do a more thorough demographic review of the identified offender assessments than is possible for us. We are happy to assist with this review.

6. IDPH needs to create database of residents who injure other residents or staff, so IDPH can track them facility to facility, and use the results for quality control: is the current screening working, what did they miss, could they change the screening to catch it. Incident reports need to be supplemented with police reports, which the Department should start getting, at least in the largest jurisdictions, and for specific identified facilities. To do this, of course, IDPH LTC needs to hire IT staff, since they don't have any.

7. With respect to getting police reports to IDPH: This is an issue on which the Attorney General might be helpful.

8. IDPH should revisit the issue of what incident reports should be filed with the Department immediately, rather than being filed at the facility and made available to surveyors during surveys. The new IDPH incident report rule, among other things, does not require a facility to report that a resident is missing until the resident has been found and determined to be seriously injured. And it entrusts to the judgment of the facility, the determination of when a resident has been injured seriously enough (including by another resident) to warrant filing an incident report with IDPH. We think this is purely a staffing issue with IDPH: they didn't have the staff to read the reports they were getting before the rule change.

9. Just as the IDPH should be getting more information about what is going on in the facilities they regulate, the coroners/medical examiners should be told about all resident deaths, so they can decide whether to perform or arrange for an autopsy. IDPH has been unsuccessful in persuading the coroners/medical examiners that they should be getting this information. This is another issue on which the Attorney General might be helpful.

10. To negate the effect of the **Rosewood** decision (making the maximum state fine for nursing home violations \$10,000,) there should be legislation to immediately allow IDPH to levy fines commensurate with seriousness of injury to residents. The legislation should provide that when a nursing home does not file a mandated incident report (i.e., when a resident injures another resident or staff,) falsifies an incident report, or submits false information during a survey, the otherwise applicable fine is doubled.

It is really important to remember that right now occupancy rates for Illinois nursing homes open at least one year is 78%. There are a lot of empty nursing home beds. The concern that if regulation is too harsh, that facilities will close and people will have no place to go, is not based in reality. If we start doing vigorous, intelligent nursing home regulation in this state -- including imposition of receiverships and license revocations -- people who make a business decision to do the least they have to do, and "take the hit" if they miscalculate what they can get away with, are likely to recalculate the odds and act accordingly.

11. There needs to be increased funding for IDPH so it can do more than deal with the worst of the worst superficially, go through the motions on a lot of the rest that they see, and hope for no more bad newspaper headlines. For a start, this means more surveyors (70 - 75 more,) surveyors with a mental health background; technical staff to track data, read and respond to incident reports and police reports, instead of just piling them on a desk. They also need IT staff (see above.) They need clerical staff, so they are not using nurses to file incident reports, inter alia. They need division chiefs. They need lawyers, so they don't have to settle so many cases because they don't have the staff to litigate appeals of fines and citations.

12. With respect to the nursing home ombudsman program

a. The program should be funded so it can be staffed up to federal staffing standards, and all ombudsmen can do meaningful work on behalf of all residents, including those under 60 years old. Most of the ombudsmen never go into the kind of nursing homes the Trib is writing about, because representing residents younger than 60 is optional, and they don't have the time or the training .

b. All 16 programs should have or hire volunteer coordinators, instead of laying them off or changing their job descriptions, as they are now doing because of funding cuts.

c. As a matter of state policy, the ombudsmen should be directed to continue to work on cases in which a resident has died. (Current policy, based on the program's understanding of the federal mandate, is that when a resident dies, the ombudsman no longer has a client, and the case is closed.) Among other things, the ombudsmen should be able to assemble documentation, and pursue remedies such as IDPH and ISP involvement, on behalf of dead residents. Without additional funding, however, it would be unconscionable to impose any additional workload on the ombudsmen programs.

13. IDPH should make easily available to the public (this means on-line,) more information about nursing homes, including all violation reports, incident reports, and police reports. Again, the Department need the staff to be able to do this. In addition, nursing homes should be required to give residents/resident representatives, a copy of any incident report involving the resident, and any notice of violation involving the resident. This would both increase pressure on facilities to fix themselves up and, with respect to incident reports, increase the likelihood that IDPH would find out about false reports.

14. The Department of Financial and Professional Regulation and IDPH need to cooperate to increase the likelihood that licensed professionals working in nursing homes, who cooperate with or cover up the abuse or neglect of residents, lose their professional licenses. For example, the administrator cited in the Tribune story and the IDPH survey as falsifying an incident report to cover up the rape of a 69 year old woman by a 21 year old resident, by saying the sex was consensual, should lose his license.

15. As best we can tell, there has never been a prosecution of a mandated reporter, for failing to report abuse or neglect of a nursing home resident. The Attorney General could be helpful, in educating state's attorneys and local police about mandatory reporting requirements, and in helping with or actually initiating prosecutions. If the law is not being implemented because it is unenforceable as it is now written, it should be amended. Again, the Attorney General could be helpful on this issue.

16. One of the reasons SIR Management facilities -- cited in the Tribune story -- have so many corporate owners/management, is to avoid liability. If they had to have insurance to meet liabilities, the premium cost would be a real incentive to keep bad stuff from happening. IDPH would need legislation to require this. It should happen.

17. It isn't a coincidence that the rapist in the Trib story 11 years ago at the Arc of Jacksonville (placed there by DCFS) was 20, and the rapist at Maplewood was 21. The state needs to have a particular plan -- and carry it out -- geared to the needs of our really young adult seriously mentally ill citizens. We think this means 18 to about 25, which is the most likely time for schizophrenia to first hit, but are happy to be corrected about a better target age range. Putting these young adults in a nursing home is just crazy: it's the same as saying "your life is over." They may need intensive mental health services (including limited guardianships, if necessary,) education, vocational training; in non-jargon, they need hope and a plan, just like any other young adults. This isn't something IDPH can do, or Mental Health, or DOC, or any agency by itself, but it is something they could accomplish together. Until this is done, we're just going to be feeding these places more fodder.

18. Apart from the very youngest, Illinois needs to stop supplying politically powerful nursing home owners with a limitless supply of nursing home residents as a cash crop. That means nursing homes need to stop being used as housing of last resort for every population, no matter how unsuited for nursing home life. Most persons with chronic mental illness don't "need" nursing home care. The state is picking up 100% of the cost of their "care*" in the majority m.i. facilities, places where they have no life and no hope, and which exacerbate their misery and increase the likelihood that they will do bad things to themselves or others. Helping them move to places they want to live, with supportive services that Medicaid will actually match, needs to become a priority. In short, **Olmstead** them out.

*There is federal match for person 65 and over, even in the majority m.i. facilities.

19. With respect to the really "dangerous" people:

People who are a danger to themselves or others are not supposed to be admitted to a nursing home in the first place. If they become "dangerous," they are supposed to be discharged. The Nursing Home Care Act says that now, and allows for immediate emergency discharge. If they are dangerous because of a mental illness, they are committable. The medical expertise for dealing with such people is not ours, and it is not IDPH's (certainly not alone,) since, at a minimum, we are probably talking about using limited guardianships and other forms of supervision and behavioral control to do one's best to keep both them and the people with whom they come in contact, safe. You may also want to consider opening or converting small units in existing IDMH facilities.

To say that these people can be cared for safely by putting them in a room nearest the nurses' station -- as is currently the recommendation for all residents deemed "high risk" -- is simply ridiculous. Nor is it acceptable that when a resident attacks another resident, there is no criminal prosecution because the resident is probably not competent. An individual living in the community who attacks his neighbor, is not sent home to do it again, because he may not be competent to stand trial. This would, we think, be a good issue for IDMH to take responsibility for, with help from the Attorney General, in conjunction with the state police, the local chiefs of police, and the state's attorneys' association.

Under no circumstances, the care of "dangerous" residents be entrusted to the same people who are paid to house them now in large private institutions. And in deciding where they should go, it is important to remember that people may become significantly less "dangerous" over time. Illinois absolutely must not create new large institutions that there is then pressure to keep filled because that is the only way they are cost-effective, because it is politically more safe to send somebody there whenever there is any doubt about them or because they piss off the nursing home staff where they are currently living. Moreover, if the outcome of the task force is an emphasis on creating permanent institutional settings, the fight for the next 5 years is going to be "what town should they be in?" We guarantee the answer is not going to be Lake Forest or Winnetka or Glen Ellyn or Northfield. (The Certificate of Need that was approved for the "prison nursing home" when this was proposed last time, was for Robbins. No surprise there.) Making such a "solution" a proposal of the task force, would waste the energy and intelligence that has been brought to bear thus far on this subject.

We hope this is helpful.

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