S. HRG. 108–210

ELDER JUSTICE AND PROTECTION: STOPPING THE ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

ON

EXAMINING THE SERIOUS PROBLEM OF ELDER ABUSE, DETERMINING WAYS OF PREVENTION AND ENSURING THAT CRIMES AGAINST THE ELDERLY ARE REPORTED AND THOSE RESPONSIBLE ARE PROSECUTED

AUGUST 20, 2003 (ST. LOUIS, MO)

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C O N T E N T S

STATEMENTS

WEDNESDAY, AUGUST 20, 2003

ADDITIONAL MATERIAL

ELDER JUSTICE AND PROTECTION: STOPPING THE ABUSE

WEDNESDAY, AUGUST 20, 2003

U.S. SENATE,
SUBCOMMITTEE ON AGING, OF THE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in SE Courtroom, 27th Floor, Thomas F. Eagleton Federal Courthouse, 111 South 10th Street, St. Louis, MO, Senator Bond, (chairman of the subcommittee), presiding.

Present: Senator Bond.

OPENING STATEMENT OF SENATOR BOND

Senator BOND. Good afternoon. The hearing before the Senate's Committee of Health, Education, Labor, and Pension, Subcommittee on Aging will come to order.

I am Kit Bond, the Chairman of the Subcommittee and I welcome our witnesses and guests here today, and I thank you very much for joining us to talk about a subject which I think is of great importance and needs to have a lot more attention then it has had, and a lot more attention from the Federal Government.

Abuse, neglect and exploitation of seniors is all too tragic an issue, but we simply cannot afford to look the other way and sweep this problem under the rug. However, unthinkable these crimes against vulnerable seniors are, they really do occur and we cannot pretend that they do not exist.

Tragically, I fear these are not isolated incidents. And the number of victims will only continue to increase as our population ages unless we take decisive and effective steps to prevent this abuse from occurring in the first place.

Abuse and mistreatment of our seniors takes many forms. It can be physical, sexual, psychological or financial. The perpetrator can be a stranger, an acquaintance, a paid caregiver, a spouse, another family member, or a corporation. Elder abuse, I regret to tell you, happens everywhere. In poor homes, in middle class homes and in upper income homes. It happens in cities, in suburbs, in rural areas. It happens in homes, as well as in institutions.

Elder abuse does not discriminate. It knows no demographic or geographic boundaries. Now, some abusers are criminals who prey on the elderly. Others are caregivers or relatives who were pushed to the brink and are overwhelmed by the needs of their family members or their charge. Some are institutions that simply do not

provide residents the care they need. Then there are the scam artists who try to profit at the expense of seniors.

There are studies which report that 4 to 6 percent of America's seniors may at some time become victims of some form of abuse or neglect. Other estimates say between a half a million and 5 million elderly are victimized every year. The research is inconclusive. We just do not know how many seniors have been victimized. Somebody asked me how does Missouri compare to other States, well, we do not know how other states compare to other States. We do not have good information.

But we do know the issue has not received the attention it needs. Experts agree that we have only scratched the surface. One study estimated that 84 percent of all cases are never even reported. So we hear about horrific cases, but there are perhaps five or six more cases for every one that is reported.

Let me say up front, this is not an indictment in any way of the entire nursing home industry. I recognize, and this Committee recognizes, there are many fine nursing homes in Missouri and across the country that provide exceptional care.

However, the prevalence of abuse highlighted by several governmental accounting office investigations has forced us to come to grips with the fact that, in some instances, our Nation's public policy has been unable to ensure adequately the safety of nursing home residents. GAO's work confirms that significant gaps in Federal and State protection leaves some residents at considerable risk.

The GAO has amply documented years of abuse and neglect in too many of our Nation's nursing homes. In 1999, the GAO estimated that residents of one in four nursing homes in Missouri suffered actual harm from the care they received. That is simply unacceptable. It is worse than unacceptable. In many instances, it is a crime.

In July, the GAO revisited this issue to report that the shear magnitude of documented serious deficiencies that harm nursing home residents remain at an unacceptable high nationwide level despite some decline. For the most recent period reviewed by the GAO, one in five nursing homes nationwide, or about 3500 nursing homes, had serious deficiencies that causes residents actual harm and placed them in immediate jeopardy.

We can and we must do better. In large part, societies are judged by how well they care for those who cannot care for themselves, the young and the old. And right now, we cannot avoid the rather harsh judgment imposed upon us by these cruel statistics. We are not measuring up.

Most importantly, there is a moral imperative that drives us to look at the human beings behind these statistics, our mothers, fathers, grandmothers and grandfathers. We should not longer look away. In a modern humane society, we simply cannot sit idly by and let some seniors suffer harm and neglect instead of the attentive and protective care they need and deserve.

We cannot avoid the problem. We have to confront it and take the appropriate steps necessary to deal with the issues that touch every community. Abuse and neglect of an elderly, frail individual is no different than neglecting or abusing a child. Both are defense-

less and lack a strong voice. Both are vulnerable and suffer at the hands of those who are nothing more than cowards and criminals.

Abuse of the elderly should be treated no differently than abuse of children. A crime is a crime is a crime whether you are 5 years old or 85 years old.

Congress has embraced initiatives to guard against child abuse and domestic violence, and rightly so, but there has been no comparable effort to protect seniors from elder abuse. That is why we are here today. We want to ensure that crimes against the elderly are reported and those responsible are prosecuted. And most importantly, we need to do a better job in the first place to prevent this abuse before it has an opportunity to occur.

That is why I am an original co-sponsor of a bill called the Elder Justice Act, S. 333. The Bill is a first comprehensive Federal effort to address the issue of elder abuse. There have been hearings held on elder abuse in the Senate since 1979, and it is about time that we did something. Twenty Congressional hearings later we still do not have a Bill.

This measure, S. 333, combines law enforcement and public health to study, detect, treat, prosecute and prevent elder abuse, neglect and exploitation. It is based on the successful approach, it has been applied to combat child abuse and violence against women. It creates Federal leadership and resources to assist families, communities and States against elder abuse. It coordinates Federal, State and local elder abuse prevention efforts. And it establishes new programs to assist victims. It provides grants for education and training of law enforcement and facilitates criminal background checks for elder care employees.

The challenges we face in fighting elder abuse are formidable. The public, I regret to say, in large part, is unaware of the problem. State efforts to address elder abuse have not been adequately effective in the past. The perpetrators are seldom prosecuted and our front line responders often lack the training, the resources and the expertise to identify and address the problem. Various government agencies have failed too often to work in a collaborative and focused manner to protect seniors.

Without question, tackling elder abuse is not a simple problem. It is a complex one requiring a comprehensive solution. I look forward to the comments and testimony today to help us, as we try to navigate these complex areas. I see the Elder Justice Act as an important part of the solution.

Today I welcome the witnesses who have come to share their stories, and I thank you all for participating in the hearing. As I said earlier, most of the witnesses today will focus on abuse that occurs in some nursing homes. It is important to remember that elder abuse is not confined solely to some of the bad actor nursing homes or other institutions, the abuse occurs in the home as well.

I told several of you the heartbreaking story from the other side of the State, Ms. Quinilla Swartz. Yesterday, we heard about that in Clay County. Her husband had left this disabled person on the rug, covered in large infected bedsores unable to move She had been on the rug so long that the parts of the rug were stuck to her body, and she had many other problems as a result of the neglect.

Whether it occurs in a nursing home or in a home, elder abuse has been ignored too long. The purpose of the hearing is to bring awareness to the problem and provide an opportunity to hear people talk about what they have seen, the advocates who will speak about the causes and the possible suggestions for preventing the abuse.

I thank all of you for coming here today. I would say that, for all of you who are here, if you have further comments that you would like to share with us—and I will give the you number later on—this is Kara Vlasaty, on my staff; she can be reached at 202-228-4838, and we would welcome any thoughts or additional ideas you have.

Senator BOND. The first panel is family members who have seen first hand the abuse and neglect that can occur. Martha Ballenot will talk about her father, an Alzheimer's patient. I believe this the picture of him over here? And Steve Stevich will testify about the condition of his late wife, Patricia Stevich, who died in a Missouri nursing home.

We are sorry to hear about your tragic occurrences. We will include in full your statement in the record for all the Committee members and others to read. If you wish to summarize, I will have some questions later on.

And I call first on Ms. Ballenot.

STATEMENTS OF MARTHA BALLENOT, DAUGHTER OF BURTON REESE; AND FRANCIS (STEVE) STEVICH, HUSBAND OF PATRICIA STEVICH

Ms. BALLENOT. Thank you. Mr. Chairman and members of the committee. I am pleased to be here today to discuss with you the important issue of elder care in the United States.

Senator BOND. Ms. Ballenot, would you pull that microphone a little closer to you? I think that will help me and the Court Reporter.

Ms. BALLENOT. Is that better?

Senator BOND. Can you hear all right now? Thank you.

Ms. BALLENOT. My dad, Burton Reese, served his country in two wars, World War II overseas in China and the Korean conflict. He is now fighting the third war of his life, one my family calls Nursing Home Hell. After suffering a debilitating stroke in 1998, our Dad lived for the next year in two assisted living homes, four nursing homes, he was hospitalized 12 times. We kept thinking the next home would be better.

For the past 4 years, he has been in residential care with no hospitalizations. For a while, he lived in a locked Alzheimer's wing located in the basement of a St. Louis County nursing home. At Christmas, the residents of this wing were served leftovers of the meals of the rest of the nursing home residents as their Christmas meal.

The method of care here was to shoot the residents full of behavior control medication. This made the residents very manageable. One month we spent $3,000 on such medication.

One Sunday, while the two attendants on duty were talking at the nursing station, a resident emptied his colostomy bag down the hallway. I told the workers about it and could not get any of them

to clean it up. I had my 4 year old son with me. I had to choose between our Dad and getting my son out of there. I put my Dad in his room, picked up my son, left and went to the main office to complain.

Daddy eventually was hospitalized from this facility for malnutrition, dehydration, a blood clot in his leg, external bruising. A doctor who attended him said the bruising was the kind of injury often associated with physical abuse. When confronted with these diagnoses, the management at the nursing home decided he was the problem and they evicted him from the home.

The next move was to another local nursing home. We would visit him every day, sometimes twice a day. Daddy was very edgy there. He talked about being tried for murder and fighting in a war. We thought he was simply deteriorating. We know now this was his way of telling us he was being hurt. He especially hated the head nurse, he said she was a Nazi. We realized by calling the head nurse names, he was trying to point out to us who was hurting him.

He was constantly agitated. The doctors told us this was normal and we should keep trying different behavior control medication. We believed the doctors, and it turned out, yes, this was normal behavior for someone who was being brutalized constantly by the people we trusted to care for him.

One day, an employee reported to management that he had witnessed several other employees bribing another brain-damaged resident to beat our Dad as his caretaker stood by watching in amusement. He reported they had also dragged him on his knees, beat him with a belt on his bare legs as they were changing his clothes, hit him in the head with a book, locked him in a bathroom, and possibly overmedicated him, since one of the abusers was the med tech who dispensed medication.

The nursing home took prompt action calling the police and firing the accused employees and their immediate supervisor. But it took a front page story in the St. Louis Post Dispatch to convince the St. Louis County prosecutor to press charges. These assaults on our Dad were labeled third degree abuse.

This was not a career making case, so the assistant prosecutor assigned to his case did not feel it deserved his attention. He pressed on only after a letter writing campaign was mounted by my family. One of the abusers plea bargained for probation and the other had the charges dropped against him because the only witness, our Dad, was too demented to testify.

The original abuser could not be found. He defied his subpoena and did not appear in court. No warrant was put out for his arrest, there was not consequence for his failure to show up in court. The convicted abuser did not agree, as part of his plea agreement, to testify against the other person charged in the case. When asked about this, the assistant prosecutor simply shrugged his shoulders at me and asked me what good would have that done.

The med tech against whom the charges were dropped, was at work in another area nursing home within 2 weeks after being fired and charged with abuse. The Missouri Division of Aging decided that our Dad was a danger to the other residents and told

the nursing home to get rid of him or be in danger of losing their license.

It does not end here. Our lawyer, hired under the guise of being an activist, settled Daddy's case against the nursing home as soon as my sister, who holds our Dad's power of attorney, left town on vacation. He settled despite direct instruction from her, as well as an agreement with the nursing home and their insurance company, to the terms we had requested. Included in the terms was the implementation of a pilot project using surveillance cameras to monitor care.

Currently, we have to worry and wonder when the Missouri Division of Aging will intrude on our Dad's life again, always under the pretense of concern for his safety. Our Dad has lived for 4 years in a group home that specialize in the care of Alzheimer's and dementia victims. The State does not have a classification for this type of home, so they try to impose archaic rules, rules that do not work even in a tradition nursing home setting upon this home.

Even though our Dad has a condition where he will continue to deteriorate until he dies. The Division of Aging insists he be able to find a safe pathway out of the house, and that he be able to do that by walking without assistance of his care takers. In this setting, his care takers work at a ratio of three care takers to eight residents. In a nursing home, where the Division of Aging feels he would be safer, you have one care taker to 20 residents.

The Division of Aging, when questioned about these actions, always blame the State legislators. They always claim to be powerless. Since 1998, we have tried to get help to stop the abuse from the Missouri Attorney General's office. He could not help because our Dad was private pay, not on Medicaid. Our State senator filed our letter because he thought the matter had been taken care of, though he failed to ever ask us about it or contact.

The Missouri Department of Health took no action against the supervisor who did not know the abuse was happening on her shift. The list goes on and on. When Daddy first moved to his present facility in Creve Coeur, an eight bedroom residential facility, the other resident there was so demented that the only word he had been able to utter was coffee. And so the care takers at his previous nursing home gave it to him, cup after cup. When he arrived at the new facility, he was so dehydrated from drinking coffee, that he was blue. He died several weeks later.

At another home, I could not allow my son to sit in a chair while he visited his grandfather because it was so badly stained with urine. At the second nursing home, I watched as employees unplugged the electric keyboard of a nonmobile patient because they did not care to listen to her play the piano.

These are not isolated incidents, but daily occurrences in nursing homes across the country. What is the answer? Nursing home monitors for use by patients and their families and the Elder Protection Act are pieces of the puzzle, but not the entire picture. Personal responsibility is hard to legislate, but not so hard to demand.

We need to demand that the State agencies serve the people, not the special interest. We need to demand that all nursing home deaths are investigated. We need to demand that people do their jobs, that the elderly are recognized as valuable citizens and not

disposable nuisances. This will be you and me before too long. Is this how you want to live the final years of your life? Thank you.

[The prepared statement of Ms. Ballenot follows.]

Senator BOND. Thank you very much, Ms. Ballenot. That is a very difficult story and we appreciate you bringing it

Mr. Stevich.

Mr. STEVICH. Yes. Thank you, Senator. Mr. Chairman, members of the committee, I appreciate the opportunity to speak to you on behalf of my dearly departed, most precious wife of 40 years, who met her demise on Mother's Day in the year 2000.

She was a very delicate, lovely lady with a great warmth and love for all living things. She had many diseases that took their toll on her for over 20 years, and her last 7 years had been very hard on her, with extreme pain and loss of ability to get around. She had the advanced stages of arterial sclerosis.

She had a very difficult operation to enhance blood flow in her legs since it was shutting off all blood flow. She got gangrene in her little toe of that leg, and it had been finally healed, but without a toe nail. She remained in extreme pain since the nerves had been turned off in her leg and could not be turned off. She spent many days with many doctors trying to relieve the pain, with no success.

In April of 2000, she became very ill and I put her in the hospital. After 10 days, she had become stable enough to leave the hospital, but still in need of medical care at a skilled nursing home for further recovery. My son found the Florissant Skilled Nursing Home for her, which was on the way to my work, so I could drop off every day since I literally passed by the home on my way to work. She was in the nursing home for 20 days, and five of those days she had been taken back to the hospital.

As I look back on the care she received, I realize that she was not fed very well, nor did they even give her water. I brought in a child's sippy cup at the direction of our four-year-old granddaughter to help her be able to drink. It worked extremely well when I gave her water. I found at times the cup was not within her reach, and the lid was off when I would visit. When I talked to the nurses, they would tell me that she was on two-hour retraining program for input and output of body fluids, etc.

At that time, when I would visit her during evening hours, I found her off to the side in a special feeding room with others and only one person feeding them all. I tasted her food and some of it was cold. I would ask why and they would say that she had eaten all she wanted to. My wife went from 90 pounds down to 74 during her few days in that place.

On Mother's Day 2000, I received a call from the nursing home that my wife had passed away peacefully during the night. I went to see her immediately after I called our children with the news and they showed up shortly after I arrived. We got her out of the home that afternoon and my son picked up her personal items the next day.

We found quite a few items missing and complained about it to the home and the Division of Aging. The home literally did nothing, and one nurse's assistant yelled at me, saying my son had taken the items. The Division of Aging did nothing, as usual. I say that because they were informed about the illegal restraint that

the home had put on my wife and did nothing about it to ensure safety.

I assume that, since it was a professional staffed home, that all medical and safety procedures were followed. And since the Division of Aging was notified, that they would ensure safe use or removal of the restraint. When she was in the hospital, she had a restraint on her and all went well, so I assumed that all the care units followed a safe procedure. My wife did not have any type of device to alert anyone she was in trouble. The only method would be for her to yell.

Everyone at the home told me that she had died peacefully in the night. In about three or 4 weeks, a detective came to my house and spent over two hours asking me what I meant when I said my wife was violated. I kept telling him that she was violated after death by people at the nursing home taking her personal clothes and personal plants brought from our house that we put in her room, and her birthday plant her daughter had given her.

About 5 weeks after my wife's demise, I was informed that the governor had received information from the Division of Aging that a nurse had reported to them about the neglectful death of my wife by strangulation.

The Division of Aging never did tell me and I still wonder what their job is since everything is secret there and they never give you any answers. I still have no information or records that they have there. It is like fighting City Hall and a waste of the taxpayers' moneys.

I have found out that all nursing homes, by law, have a book of complaints that is readily available to new clients so they can read the record of the home's problems, enabling us to make a good decision in using that home. This book was never shown to me or told of its presence at the home. So, again, the law was there, but not enforced.

I also believe that the detective came to my house was investigating the strangulation death of my wife, wanted to see if I knew, and when he was sure I did not know, left and reported that I did not know so their municipality would not have it on their records.

I found out the night of my wife's demise she was calling out for Steve, and a nurse on that night closed her door since it was my wife's outcry was bothering her and possibly some other residents. The next morning, the next shift opened the door and saw my wife hanging out of the bed, the restraint hanging her on the side of the bed. My wife had been calling out for Steve, which my nickname is, so I could come help her, only I was not there to do so.

At home I was always there for her, especially during the last 7 years of her life. I took care of work, the house and her so she would at least be comfortable and safe and secure. I trusted her to the care of professional medical people and that is one I have with the rest of my life. I only think of how long she may have hung there struggling and I was not there for her. I am the one that put her in the home and literally signed her death warrant.

I feel deep guilt and pain so very often, and miss the love of my life. I feel the pain that my daughter and son feel when they talk

about her. I also feel that I let her down and denied my son and daughter of their mother's love in these later years of life.

Sometime before my wife went to the hospital, she told me she was nearly finished her project. I asked what the project was and she said it was me. My wife taught me well over the years, and instilled in me the cradle of life so, believe it or not, I have no animosity toward those that caused her death through neglect, and pray that their souls be forgiven and be at peace some day.

This is very difficult for me, and all of my emotions and feelings have peaked again, tears are running down my cheek. I am sad for my wife and have even a greater sadness for the human race, since a lot of us have forgotten how to speak from the heart. We have supposedly put procedures in place for the betterment of mankind, but only to twist the true solutions through our own ego, political gain, and pressure from the wealthy interest parties who give moneys to ensure the outcome, which benefits them rather than those procedures are put in place to protect.

I think you all should have all the homes on a—and grade them according to their resident care levels. You should audit them, without letting them know in advance you are coming, just like restaurants are audited for health. Insurance rates would come down if the level of service went up. You would get lesser complaints therefore lesser lawsuits and lesser moneys paid out by insurance companies, therefore lower premiums to the care takers and medical people.

This gives the elderly suburb care and cuts insurance expense. You can grade these homes just like restaurants, and at the same time also keep track of those that work at these homes so other homes can check their previous employment record prior to hiring them. This would keep those who should not work in the homes from going from home to home.

I have written a lot and I hope that I reached your hearts. I will say that I see a lot of violence and tragedy happening to our youth and more and more happening to our elderly, along with disrespect and lack of dignity for them. The elderly of the day were the ones that sacrificed so much in the Second World War. The men overseas and the women working on the home front.

If you have a less stable environment for our youth growing up, then less of them will be able to take over for the adult population, and you have lesser adults having anything to look forward in their so-called senior years, except lack of respect and dignity, then you have a society that is teeter tottering on becoming a tragedy and coming to an end just like so many other great nations before. I keep hearing more and more tragedies, but I ask but one question, why do you keep doing it to yourselves?

I end here, and I hope I have spoken from the heart and represented my wife well with respect, honor and dignity. Thank you very much, Chairman.

[The prepared statement of Mr. Stevich may be found in additional material.]

Senator BOND. Yes. You both touched our hearts. We appreciate very much your sharing your stories. I know how painful it is, but I hope that you can take some comfort that your willingness to come forward and lay out very clearly the trauma that your loved

ones went through and what it caused you will generate some action that will make it less likely that someone else's loved one will face what yours did.

This is a situation that, as I have said, once we started investigating this area, we found far too many cases like this. And it is a tragedy that has been below the surface. I know that we have some people who are dedicated to working on the problem. There are not enough people, there are not enough resources, there is not enough collaboration, but your testimony today will give us really a very strong motivation to try to get something done that can make a difference.

Let me start with Ms. Ballenot. In light of your experiences, if someone in Missouri, or across the country, is faced with placing a loved one in a nursing home, what advice would you give them?

Ms. BALLENOT. Call the Elder Advocate, and if there are any good nursing homes, they will know where they are at.

Senator BOND. Mr. Stevich?

Mr. STEVICH. I agree with the same thing, but a larger system has to be put in place across the Nation. And I am looking at some place all these homes are like registered and they are classified. And then they have a hotline if they—like I had nurses tell me things, and I thought they were telling me a real thing they were doing. I do not know. I am not a medical person. So if I had a hotline to call—like retraining program, I say great, they are retraining her. If I would have called somebody, there is no such program.

So there ought to be a hotline out there for the United States, there ought to be a place for the centralized computer site that all these homes on and all registered people that work there you know about, so if they go across the State line and work some other place, that home that hires them knows what they are getting.

Senator BOND. Well, I think the Center for Medicaid and Medicare Services has an information line. And, of course, I have heard some people say it is very helpful, others say that it is not.

Also, one of the things the Bill does is include required criminal background checks on employees of nursing facilities. We have heard stories of convicted violent criminals who are hired in nursing homes and beat a patient to death.

You were mentioning the elder abuse hotline. This is different, I believe, from the Elder Advocate—but the elder abuse hotline, for someone who suspects elder abuse, the number is 1-800-392-0210, and that is a place to report abuse.

What impact would you say that these experiences have had on your life, Mr. Stevich? Obviously, a great impact.

Mr. STEVICH. I have a lot of pain in the house. I have not left my home yet; I am trying to. There is a lot of memories there and I still feel—and I do not care—even my doctor and other people said, It is not your fault.

Senator BOND. That is clearly not.

Mr. STEVICH. I am guilty. I put her in that place. I did her—my mother, her father, her mother—over 13 years I handled it and I did not make a mistake until it came to the one person I loved the very most, my wife. And I failed her because I was not smart enough to know there was a—I am a very intelligent man, and I

was not smart enough, just stupid, and the most loved one I had died because of it. That lovely lady there.

And my children—my daughter only wants to tell you that things are different. That is all she wants to say, because she picks up the phone and tries to call her mother from work, and then she puts it back down. It has been over 3 years, and she still does it and she calls me up. And she does not want to give me her pain because it gives me more pain. So there is things that go on. My son is the same way. That is what affected me.

Senator BOND. I would think that their love is something that could be very valuable to you.

Mr. STEVICH. It is.

Senator BOND. We certainly hope that you find comfort in that knowing that there was no way that you knew about it, and, while this is a tragedy, you certainly—and we would say as outsiders, but it cannot be your burden solely. You are doing the best thing you can to help try to develop a system where this will not happen to someone else in your position.

Mr. STEVICH. I talk to a lot of elderly ladies, and that is what I am here for, because they all—men too—90s, 93—and I am out there with them. And they are scared.

Senator BOND. Good, good. Keep working, keeping helping them. Ms. Ballenot?

Ms. BALLENOT. Can I kind of elaborate on my previous comment also just for a sec?

You know, laws are all well and good and we have a lot of laws on the books, the problem is, that in this area no one is enforcing anything. Our prosecutors do not prosecute, our police do not arrest, our Division of Aging is near to useless. If people cannot follow the rules and the laws that are in place now, what is going to change to make new laws effective.

And as you are going down the road with the Elder Abuse Act and other things, we have to want to do it, and we do not want to right now. I have sat with the St. Louis County prosecuting attorney and he told me there is no problem. And I showed him a letter I wrote to his office that he was unaware of.

So the problem is, is the society, and including all of our public functions, does not recognize this as a problem and does not—you know, assault is prosecutable. My Dad was assaulted. But because my Dad all of sudden lives in this nursing home, he is a nonentity, he is a nonhuman being. You do the same thing to you or me, and somebody is charged. And it does not take a front page story in the Post Dispatch. And that is the dilemma. We were shocked to find that no one in the system cared. That my Dad did not exist anymore because he was an old guy in a nursing home.

Senator BOND. Well, that is one of the purposes of the hearing, is to let people know that this does happen. And it is a small step, but you both have taken, I know, very difficult steps. And coming forward and telling your story is a very powerful way to awaken a lot more people. We will certainly do what we can to make sure that the cause that you serve is carried on.

I think on the next panel you will hear that there are some things being done. We want to get behind and support those efforts, and I have talked to a lot of people the last couple of days

who are very seriously dedicated to eradicating this problem. Those people are out there, we want to provide the support for them, we want them to lead by example, we want to make sure that there are people in every area of the State who are concerned.

We thank you very much, again, for the great personal effort and the great strain that you have been through to be able to come forward and provide us with stories of the tragedies in your life. We thank you very much, and your pain will not go unanswered.

Ms. BALLENOT. Thank you.

Senator BOND. Thank you.

Mr. STEVICH. Thank you, Senator.

Senator BOND. Our second panel, I would like to call forward U.S. Attorney for the Eastern District of Missouri, Ray Gruender, to talk about the activities of the Department of Justice in this area. I also call forth Jim Gregory, First Assistant Prosecuting Attorney in St. Charles County, who's had experience with dealing with this kind of abuse and prosecuting it; and JoAnne Polowy, a Missouri representative of the Association for the Protection of the Elderly. Retired after a long career working in State government on aging issues, she is now an advocate for the elderly.

And we thank you very much.

Mr. Gruender, if you will begin.

STATEMENTS OF RAY GRUENDER, U.S. ATTORNEY, FOR THE EASTERN DISTRICT OF MISSOURI; JAMES G. GREGORY, FIRST ASSISTANT PROSECUTING ATTORNEY, ST. CHARLES COUNTY, MO; AND JOANNE POLOWY, MISSOURI REPRESENTATIVE OF THE ASSOCIATION FOR THE PROTECTION OF THE ELDERLY, NEW BLOOMFIELD, MO

Mr. GRUENDER. Mr. Chairman and members of the subcommittee, thank you for allowing me to participate in this field hearing to address the significant issues of elder abuse, neglect and exploitation. The elderly, especially nursing home residents, are one of the most vulnerable groups of individuals in our society because of their age, sometimes reduced mental faculties, financial status and medical conditions

While their experiences in life give them the wisdom to share with younger generations, the years take their toll and can make them physically and mentally vulnerable. In many instances, these individuals are unable to care for themselves and are unable to cry out for help when they are not receiving the care that they need.

Often they are the victims of abuse and exploitation, which can include neglect of the elderly's most basic needs for sustenance and medication. In many cases, this reprehensible conduct hastens or even causes death. In these instances, the elderly must look to others to protect them and to punish those who harm them.

As United States Attorney in the Eastern District of Missouri, I am keenly aware of the ongoing problem of elder abuse and neglect. On a regular basis, assistant United States Attorneys working in my office received deficiency reports on nursing homes within our district.

From these, we have been informed that, four residents died in a nursing home within 48 hours before the fire department removed the other residents from the home because of elevated tem-

perature. Another nursing home resident died of malnutrition, a diabetic nursing home resident died from elevated blood sugar levels because no insulin was given to that resident for 36 hours.

Another nursing home resident fell repeatedly and was seriously injured when the resident tried to get out of a wheelchair to go to the bathroom with no assistance. The falls occurred simply because the nursing home lacked adequate staffing. Another nursing home resident was found covered with ants.

Another nursing home temporarily employed unqualified individuals, some of whom had felony convictions. The nursing home did not conduct background checks on these temporary employees, and as a result, a resident was physically abused and subsequently died.

To prosecute abuse and neglect cases, U.S. Attorneys must demonstrate a Federal nexus, usually, some connection between the conduct in question and Federal payments. While U.S. Attorneys have successfully brought Federal criminal charges against those who abuse or neglect the elderly, and subsequently submit false statements or claims to the government concerning those incidents, these cases present unique challenges.

To use the criminal fraud statutes, the Federal Government must prove that at the time the nursing home officer sought payment, he or she knew that the services billed for were not being provided. To prove this, the government must often rely on circumstantial evidence, usually in the form of long standing and repeated pattern of evidence of abuse and neglect. That is, we have to show that they knowingly not provided services and yet billed for the services anyway.

Moreover, in these types of cases, the Federal sentencing guidelines look to a dollar loss to determine punishment. Unless the pattern of not supplying services occurs over a relatively long period of time, the loss is not likely to be enough money to result in a severe prison sentence under the Federal sentencing guidelines. Medicare and Medicaid paid the Nation's approximately 17,000 nursing homes an estimated 42 billion dollars in 2002 to care for its beneficiaries.

In an attempt to combat elder abuse and neglect, we at the Department of Justice use a Federal law, the civil False Claims Act, that allows for the imposition of civil penalties when false claims are presented to the government for payment through Medicare, Medicaid and other Federal programs. The False Claims Act does not, however, reach incidents that do not involve Federal losses or Federal false statements.

Under the Civil Rights of Institutionalized Persons Act, the Department of Justice has aggressively protected the civil rights of individuals that reside in State or locally operated governmental institutions. Under this Federal statute, the Department of Justice is able to investigate and redress patterns and practices of violations of these residents' civil rights. The Federal civil statute does not allow the Federal Government to examine private facilities. Nor does it allow us to address specific individual cases of elder abuse and neglect.

Where we have statutes that address a particular criminal offense, such as where the elderly are victims of fraud schemes, Fed-

eral prosecutors are reasonably successful in assisting the elderly and punishing the perpetrators through criminal prosecution.

Recently, in the Eastern District of Missouri, we prosecuted an individual who was responsible for a 2.5 million dollar investment scheme that caused a number of victims, many of whom were well into their retirement years, to lose their life savings. The Defendant, a financial adviser, pled guilty to one count of mail fraud and one count of embezzling from an employee benefit plan. Several of his victims, in their 60s and 70s and retired for a number of years, told investigators that they would be forced to return to work in order to meet their basic needs.

In that instance, Federal laws were in place that allowed us to criminally prosecute the individual responsible for the fraud scheme. Unfortunately, the perpetrator had squandered the money, but the Federal Government obtained, in part due to strict sentencing guidelines, including an enhancement for victimizing the elderly and vulnerable, a sentence of 87 months in prison without parole.

Elder abuse and neglect is a problem at all levels of our Nation. And it crosses all ethnic, racial and economic boundaries. We remain committed to working with local and State officials on this issue, and to continue to be an important participant in the fight against elder abuse and neglect.

Finally, I would like to thank the Chairman, Senator Bond, for allowing me to appear here today. I commend you, and the subcommittee, for your work on these issues, and I look forward to answering any questions you might have.

Senator BOND. Thank you very much, Mr. Gruender.

[The prepared statement of Mr. Gruender may be found in additional material.]

Senator BOND. Now we turn to Mr. Gregory.

Mr. GREGORY. Mr. Chairman and members of the committee, first and foremost, I would like to express my sincere appreciation to Senator Bond's office for extending an invitation to me to speak for this body regarding the prosecution of elder abuse that occurred at Claywest House Healthcare, LLC, located at 2840 West Clay, St. Charles, MO.

There are several individuals I feel it incumbent that I recognize before discussing the details of this prosecution. Individuals whose contributions were instrumental in the successful outcome. These individuals and their roles are as follows:

1. Jack Banas, prosecuting attorney of St. Charles County, MO, who authorized me to embark upon a prosecutorial endeavor that had never been embarked upon in Missouri;

2. Baue Funeral Home in St. Charles had brought a case of suspected abuse to the attention of Dr. Mary E. Case, St. Charles County Medical Examiner, whose policy required her office to be notified in case of suspicious deaths;

3. Dr. Mary Case and her assistant, Kathleen Diebold, who brought the suspected abuse to the attention of St. Charles City Police Department;

4. Detective Michael Miller of the St. Charles City Police Department who worked with me day and night interviewing witnesses;

5. Kathleen Sutton, a paralegal in my office who worked day and night assisting Detective Miller and I in obtaining documents and arranging witness interviews;

6. Ann Chambers, a CNA, a certified nurse assistant at Claywest House whose suspicions provided the link which led to a successful prosecution of the perpetrator of the suspected abuse and which ultimately led to the prosecution of the principal owners;

7. Jeanne Rutledge, former program manager of the Missouri Division of Aging, whose testimony regarding the required reporting of suspected abuse was crucial in the trial of the case involving American Healthcare Management, Inc, a Missouri corporation, Claywest House Healthcare, LLC and Charles B. Kaiser, III, the president of American Healthcare Management.

And last, but not least, Phil Groenweghe, the assistant prosecuting attorney of our office who helped me try the principal case.

This case had its inception on the evening of Wednesday, July 28, 1999, when certified nurse assistant, Ann Chambers, saw Karl Willard, a resident care assistant, in the hall of Claywest House with something on his shirt, and when inquired as to the cause of this, Willard responds with a vulgarity describing a resident, Marshall Rhodes, II, and tells Chambers and Fowler that Marshall Rhodes, II had thrown his medicine on him, Willard, and that he, Willard, is going to f——his ass up.

Rhodes was an Alzheimer patient incapable of communicating in a comprehensible manner. Between 8:00 p.m. and 8:30 p.m. on the evening of Wednesday, July 28, 1999, Chambers and Felisha Hunn observed Willard exiting Mr. Rhodes' room and closing the door behind him. And when Chambers and Hunn entered Rhodes' room, they find him in a defensive position with a scratch on his head that was bleeding and Rhodes complaining of being tortured.

Between 11:45 p.m. Monday, August 2 and 12:15 a.m. Tuesday, August 3, 1999, Marshall Rhodes is found in his room with open lacerations to his left side bottom lip; his sleeping gown ripped and bloody. The St. Charles City Fire Department was summoned; Mr. Rhodes was transported to the emergency room at St. Joseph Health Center in St. Charles where he was treated and returned to the Claywest House at approximately 3:00 a.m. on Tuesday, August 3, 1999.

Ann Chambers did not work on Monday, August 2 or Tuesday, August 3, but on Wednesday, August 4, when she returned to work, she observed Mr. Rhodes with his lip swollen and she and Felisha Hunn reported to the Administrator, Betty Via, and the Director of Nursing, Cheryl Davis, their suspicions regarding Marshall Rhodes' injuries and Karl Willard's actions. Chambers and Hunn were directed to provide written statements regarding their suspicions.

At approximately 6:45 a.m. on Thursday, August 5, 1999, Marshall Rhodes was found by nurse, Rhonda Brunner, unresponsive in his wheelchair, and Brunner summoned the St. Charles City Fire Department again to transport Mr. Rhodes to the St. Joseph Health Center. Claywest House officials attributed Mr. Rhodes' injuries to a fall from his bed, although this bed consisted of a mattress that was found—a mattress that was on the floor and no furniture in his room on which any blood was found.

On Saturday, August 7, Rhodes died at St. Joseph Health Center. His body was sent to the Baue Funeral Home for burial. Dr. Mary Case, the St. Charles County Medical Examiner, had instituted policies regarding the reporting of certain types of death, and Baue Funeral Home reported to Mr. Case's office that Marshall Rhodes' death involved a subdural hematoma. And on Thursday, August 12, 1999, Kathleen Diebold of Dr. Case's office contacted Cheryl Davis, Director of Nursing at Claywest requesting Mr. Rhodes' medical records.

During her conversation with Kathleen Diebold, Cheryl Davis never once mentioned anything regarding the suspicions expressed by Hunn to her and Via on August 4. On August 16, 1999, Jeanne Harper of the St. Louis office of the Missouri Division of Aging talked to Betty Via, the administrator of Claywest House, and Harper told Via that the incident involving Marshall Rhodes must be hotlined.

On August 17 1999, the administrator, Betty Via, emailed Charles B. Kaiser, III, the president of American Healthcare Management, the manager of Claywest House Healthcare and the operator of the facility, that the incident must be hotlined, that is, reported to the Division of Aging as suspected abuse.

Charles Kaiser responded to Betty Via's email, stating he personally spoke with Jeanne Rutledge at the Division of Aging who told him this was not something that needed to hotlined. This became crucial in the trial of the case, because Jeanne Rutledge testified unequivocally that Charles Kaiser had not conveyed the details of the incident to her.

On August 23 1999, Betty Via, the administrator of Claywest House Healthcare—received a page at the Lake of the Ozarks, where she was attending a seminar relating to skilled care facilities, and she was advised to return to Charles Kaiser's office, where she was then fired, ostensibly for not following budgetary policy.

Dr. Case contacted the St. Charles City Police Department and Detective Mike Miller was assigned to investigate the death of Marshall Rhodes. As a result of Detective Miller's investigation, numerous witnesses were interviewed and voluminous records were obtained regarding Mr. Rhodes' death and the operation at Claywest House.

Succinctly stated, it was determined that Claywest House was a limited liability company doing business as Claywest House, licensed pursuant to the provisions of Chapter 198 of the Revised Statutes of Missouri as a skilled nursing facility.

American Healthcare Management was a Missouri corporation organized and existing pursuant to the provisions of Chapter 351 of the Revised Statutes of Missouri and it had a management agreement with Claywest House whereby American Healthcare controlled the operation at Claywest House and received a substantial management fee. Charles Kaiser was the president of American Healthcare, corporate records of which indicate it was owned by a Robert D. Wachter and R. William Breece.

Records obtained from the Missouri Division of Aging disclosed that Claywest House had received numerous violations as a result of inspections and had been in danger of losing its State license as

a skilled nursing facility. This facility had also been assessed a fine of more than $300,000 for various deficiencies, but through the appellate process had been able to settle for a figure of approximately $100,000.

It became very obvious that the management of Claywest House felt they could not afford an abuse case in their facility with all the previous problems and an active cover up was engaged in. Evidence was presented to a grand jury and the following indictments were subsequently returned:

Karl T. Willard was indicted for elder abuse in the first degree as prescribed by Section 565.180 and subsequently sentenced to 10 years in the Missouri Department of Corrections.

Cheryl Davis, Director of Nursing of Claywest House, was indicted for failure to immediately report suspected abuse as prescribed by Section 565.188, a class A misdemeanor, but was acquitted by a jury.

Betty Via, the Administrator of Claywest House, was indicted for failure to immediately report suspected abuse pursuant to a plea agreement, or pro-offer, Via supplied the prosecution with certain documented evidence, including copies of email from administrators and Charles Kaiser and agreed to testify truthfully, whereupon the charge against her was nollie prosequied at the conclusion of the trial of American Healthcare, Claywest House and Charles B. Kaiser.

American Healthcare, Claywest House and Charles B. Kaiser, III were indicted for failure to immediately report suspected abuses prescribed by Section 565.188 and were jointly tried by a St. Charles County jury. The jury returned verdicts of guilty on each of three defendants and recommended a fine to be imposed by the court, and also recommended confinement in the St. Charles County Jail for a period of 1 year for Charles B. Kaiser, III, the maximum punishment that could be imposed.

On Thursday, August—February 6, 2003, the Honorable Ellsworth Cundiff sentenced the respective defendants as follows:

American Healthcare Management, Inc., a fine of $5,000, the maximum punishment that could be permitted under Missouri law.

Claywest House Healthcare, a Missouri limited liability corporation, the fine of 5,000, the maximum punishment permitted under Missouri law.

Charles B. Kaiser, III, president of American Healthcare Management, Inc., confinement in the County Jail for a period of 1 year, as recommended by the jury and a fine of $1,000, the maximum punishment permitted under Missouri law for this offense.

Now all three of these people, American Healthcare, Claywest House, Charles B. Kaiser have appealed their sentences and appeals are currently pending the Missouri Court of Appeals, Eastern District at this time.

In prosecuting this particular case, and investigating other nursing home practices, it is apparent that those investing in such facilities utilize various corporate entities to limit their individual liability. The corporate structure involved in the Claywest House case is rather common in the industry. It is obvious that operators take every advantage of ever possible loophole in the applicable statute to avoid reporting suspected abuse.

It is apparent that legislation requiring that suspected abuse be reported to law enforcement authorities, in addition to the State license authority, is needed. Those charged with licensing and inspection of facilities are not trained in criminal investigations and, therefore, many suspected abuses are just not reported. Thank you.

Senator BOND. Thank you very much, Mr. Gregory. We are—it is, I believe, reassuring to several of our witnesses to know that, while it takes a long time and it is not easy, their prosecutions can be possible.

[The prepared statement of Mr. Gregory may be found in additional material.]

Senator BOND. Turning to our final witness, Ms. Polowy, welcome.

Ms. POLOWY. As you said, I am here as the Missouri Representative of the Association for the Protection of the Elderly. I am sure you have heard of this, you have been involved in this area for quite some time, and quite a few of the members from across the country have testified at some of these 27 hearings that have been held since 19 whenever on asking the Federal Government to do something about conditions both in nursing homes and about elder abuse.

First let me say that I, and others I represent, strongly support the passage of your Elder Protection Act. We appreciate the fact that Senator Breaux and Senator Bond and quite a few others actually have signed on to this. And I understand there is a companion Bill in the House of Representatives and one of our Representatives from Missouri, Roy Blunt, is a co-sponsor of that.

By and large, as you have before and others have said, the public at large seems almost unaware that elder abuse is a national crisis. It is a major human rights issue. We talk about intervening with countries across this world about human rights violations and yet we have populations of people here in the United States that are extremely vulnerable, extremely frail, and nobody seems to be paying much attention to this at all.

The components of Senate Bill 333—and I am not going to go through the various points in that—but I have read and studied that Bill and you are certainly headed in the right direction. Now there are a few other things that could done, I am sure, but I think the fact that there can be a channel of funding to help publicize.

Mr. Gregory mentioned the fact that people are not calling local law enforcement. The public, staff in nursing homes, no one seems to be aware that when they actually witness cases, they call the State hotline number, that 392-0210 number that you gave before, but that is almost useless I have come to conclude in a case of serious abuse and neglect.

I worked in State Government for many, many years, was involved in the setting up of that reporting system, and really had not realized that across the State the State staff would essentially ignore, in most cases. Kind of general policy, which was, if there was a serious abuse case reported or violent case of rape or some such thing, they were to involve local law enforcement early on in the process.

In St. Louis, I think, they probably do this a little bit better than in other places. It is kind of like St. Louis is fortunate to have an

ombudsman office here that keeps a register of all the homes in St. Louis and does some good things. That is not true across the rest of the State.

And even in St. Louis I was involved in a case—I did not write this up in my testimony because it would get too long—but where a person actually got out of a facility—a skilled nursing facility—fell down a set of stairs, broke her neck. There was clear signs to me as a we looked into this case, of negligence on the part of the facility. The person was hospitalized, died.

The response to the call to the hotline by the St. Louis office was to not even go to that facility or interview anyone for 7 days. And when we inquired as to why the lengthy delay when the law says that you are supposed to investigate abuse and neglect within 24 hours, the law actually says, initiate the investigation. And the State workers and system has found a loophole there themselves to get out of going out and doing a proper investigation.

And so they can call the administrator of the facility, find out their version of what happened, and decide that, oh, it was really nothing. In that case, they went out in 7 days, by that time records were altered, alarms were fixed, all the things that—everything was in place, they called the case unsubstantiated. Because they called the case unsubstantiated, family members who tried to file suit lost the case in the court because the State testified that it was unsubstantiated case of abuse.

There are things like this that I find appalling. I have been doing this for about 7 years now since I retired. I knew we had a problem because the bureaucracy was increasingly becoming deaf to the pleas of families, and I decided that, when I retired, this is what I would do. I had no idea that I would be overwhelmed with the calls from family members—such as Mrs. Ballenot and the other gentleman who testified over and over and over.

Some of them have kept pictures, have kept documented records to get the bureaucracy to respond or do anything. This Claywest thing had been going on for 5 years with the State milling around blaming the law, but really it has to do with commitment and lack of involvement of law enforcement in this process.

The other issue that is connected with these cases is the losing of nursing staff. The professionals and paraprofessionals who are good people providing good care are leaving in droves the long-term care field. Much of it is because of the avarice of the corporate—for profit corporations.

My husband, for instance, was shocked when he read my testimony and I refer to the fact that the nurses who reported a case to me—that is probably my cell phone—anyway, it will stop in a minute, I guess—but this particular individual who owned this nursing home where some nurses actually witnessed a person being disciplined by taking them into a whirlpool room, hoisting them up, throwing them down into the whirlpool, having not attached the thing properly so he fell to the ground and bloodied his head and cut his head. He died 2 days later in the hospital. This nurse even saw this, called the State hotline and no one ever came to the facility to investigate.

But my husband was appalled over the fact that the man who owns or operates—and he is covered by all these layers of people

that are in this corporate maze—operates 53 facilities in the State of Missouri and who knows how many in Arkansas.

The fact that an individual can have that many facilities under their control—there are several corporations in the State of Missouri alone that control anywhere from 5,000 to 6,000 beds. You give them a dollar a day or a 50 cent per raise and their pulling in 2 million dollars.

So, when these corporations cry poor, when they go into these facilities by the month, cut the staff, make conditions unbearable—these two nurses actually went to this particular—and I noticed a thing in Mr. Gregory's testimony that said they have trouble dealing with it because these owners say they did not know that things were bad. Well, I may give him the name of this facility because in that particular case these two good nurses went to corporate headquarters, spoke to the owner before this incident occurred to tell him of the neglect of residents, and he said he would look into it.

In any case, I could go on and on, but I appreciate having the opportunity to be here and I am delighted that you are taking some effort in this behalf.

[The prepared statement of Ms. Polowy may be found in additional material.]

Senator BOND. Well, thank you. Thank you very much for your testimony. A little discouraging to hear that there is not action on the hotline number that we have just given out. We will pass along those suggestions to the State agencies. The number one for the serious kinds of abuse, I have talked to a number of law enforcement officials who strongly urge using the 911 where it is a matter of serious personal harm or life threatening injury to the patient. But it is troubling to know that the abuse hotline does not seem to be generating a response.

Let me turn back to Mr. Gruender. Yesterday, Todd Graves, the District U.S. Attorney was talking about the difficulty on the False Claims Act saying that some of the facilities were set up so there was one entity that did the billing and had no relationship to the service provider so that it was webbed through different corporations so there was a clear break in the chain. Is this one of the ways to get around the False Claims Act?

Mr. GRUENDER. It is one of many, Senator. By having a division between the two, you are not allowed or we have a difficult time proving a connection or knowledge by those who are billing. As you know, the False Claims Act is limited to the submission of bills. And by the way, it is a civil issue to begin with, so we are not even talking about a criminal prosecution.

It is a recovery of the funds. So without showing that they knowingly falsely submitted the bill, knowing that they were not providing the service, and since, of course, you have a separation between the service providers and the billing function, that creates proof problems for us. And that is partly the reference that I made during my testimony as well.

But there are certainly other problems. Some have been referred to here today about the difficulty of getting testimony available. And I saw one of the ideas of having video testimony as being a potential solution.

Senator BOND. I know that has worked well for child abuse video testimony. Well, Mr. Gregory, from the State's standpoint, you outlined a successful prosecution. Do you have the tools that you need in the prosecutors office, at the State level?

Mr. GREGORY. I think Ms. Pol——

Ms. POLOWY. Polowy.

Mr. GREGORY. —Polowy hit on the one thing that—the tools are in there on this hotline thing. But I found exactly what she was talking about. And I mean I have got a detective here, we set up, we had an informant inside this place that called and told these people what was going on. You could not get anybody down there.

Now, you have a million dollars and you can have a million laws in place, but if you do not have the people implement it, it is a waste of time. I do not know how to instill the morals. You cannot legislate morals. I do not know how to instill these people to take this at heart. And what Ray is talking about is exactly right. They use multiple corporations to insulate themselves from the knowledge on this stuff, and they hide behind it. We had to make—I had to make a deal with this person to get some interoffice email, you know, to where I could prove these things, that this was an active cover up.

That is your problem. Now you have got some stuff in your legislation, I think, will help if you have forensic training and geriatrics.

The big thing I see, there has got to be mandatory reporting of suspected abuse, but it has got to be resolved. So there ought to be a simultaneous reporting to the police. And if they are not involved and trained investigators are not involved, you are wasting your time on this stuff.

Senator BOND. What are the shortcomings in the State prosecution? Please share a little about the ground breaking nature of your case.

Mr. GREGORY. Well, this has never been prosecuted before. And I think probably what the problem is—she has hit on it—you can call this hotline—and these people know how to manipulate these people who work for the State. I am not saying they are dishonest, but you should have seen the type of investigation that they had done. For example, they hand the statement to Karl Willard and say, tell us what you know. He said, do not know nothing, saw nothing. That was his statement.

You are dealing with people that are not educated and not sophisticated and to get a good statement it takes a trained police officer, sit down and really question them right, because you cannot hand somebody a piece of paper and say, tell us what you know, because most people do not want to be involved and their scared of the court.

Senator BOND. Yes, Ms. Polowy?

Ms. POLOWY. Yes. I was involved in the Central Office level in this whole area, and it was appalling as you would review cases that had been reported into the hotline that were being just filed away because the staff did not ask those right questions. They had totally botched up the whole thing and so there was no way you could prosecute this.

Now I personally think that CMS right now, tomorrow, could issue a directive—and one thing they do do is seem to follow those directives that come, if they are clear and pointed. Now, usually, it is a bunch of munch, you know, general involved stuff——

Senator BOND. I have had some problems with CMS, yes.

Ms. POLOWY. —but CMS can issue a directive that tells them, just what he said, at the time that they receive a report of a death or a serious injury—or harm to a resident, they must simultaneously report it to the local law enforcement—to get a joint investigation.

Then some of these funds can be used that might be generated from your Act to do this cross training that is needed. Springfield in Green County, they have an absolutely wonderful prototype of a police department that has set up a special unit and that works very closely on the home and community side with Division of Aging personnel. But they are never called by the regulatory branch because they do not see it, within their tunnel vision, as their responsibility.

So that body that controls the purse strings for those State personnel salaries does have some leverage and if they can State this in some clear way that this is a mandatory thing—I have yet to be able to get State officials to make—if the Director of the Department of Health would make that commitment, if the governor of the State of Missouri would make that commitment and say it, they would probably do it. But if it is written as a little policy in the manual, they are not going to pay any attention.

Senator BOND. Yes, issuing an order is different from following up. But, let me go back to this—we are talking about the legislative branch here, and we will start with Mr. Gruender. What kind of structure is needed? Would you want to see a specific Federal statute on abuse of the elderly? You have had some experience looking at this, what is it that we need? Is there a Federal criminal statute specifically on this, would that work or is that a problem?

Mr. GRUENDER. Senator, I know the Department has not taken an official position yet and stands ready, I know, to work with you. But let me just point out, in the area of financial abuse of the elderly, or financial abuse of anyone, that has traditional been a Federal law enforcement rule. And I think we have been quite successful there. We have mail fraud and wire fraud statutes that are right on point and allow us to pursue those cases.

There is no Federal criminal elder abuse and neglect statute. So that makes it difficult to prosecute criminally on a Federal level. Now, traditionally, there are lots of State laws and traditionally those go to the States, but it makes it difficult for us to do that Federally.

On rare occasions, there have been some attempts by Federal prosecutors to sort of fit a square peg into a round hole by using a pattern of evidence to show that over a period of time they must have known that they were not providing the service and yet mailing or wiring in requests for payments, that sort of thing. But that really does not help us get to isolated incidents, and those are fairly rare.

Senator BOND. Let me phrase it this way, were there to be a Federal law, one you think that the U.S. Attorneys office could handle

this responsibility, how would it work with State prosecuting attorneys? What items would there have to be in it or what checks and safeguards would you want to see in it, if there were to be one? Not advocating one, but——

Mr. GRUENDER. Sure, Senator—I understand.

Senator BOND. What would be the outline?

Mr. GRUENDER. Well, resources are always an issue for us and it does help to have additional resources available to us. But be that as it may, we, in our office, assigned two AUSAs to review these deficiency reports and to attempt to see if we are developing those sorts of patterns that we might be able to shoehorn into the current Federal statutes as well, and/or use the civil statutes that are available to us.

There are frequently areas where there is overlap between State and Federal prosecution. For instance, gun crime. And we have had a great deal of success here in eastern Missouri prosecution gun crimes by literally having a meeting every week with the Circuit Attorneys office and going through and determining who best should prosecute each of these cases with criteria such as, you know, who has the best law for the facts of that particular case, and who would get the most severe punishment.

So, certainly, those sorts of things happen frequently and the coordination can be accomplished.

Senator BOND. Mr. Gregory, you are dealing with State laws, tell me, why could not Claywest be prosecuted for abuse?

Mr. GREGORY. Looking back, I think now I could have charged them with actual abuse, which is a felony under Missouri law. At that particular time, there had been a series of cases out of the Missouri Court of Appeals, Eastern District and then some in the Western District that said just exactly like the lady said where they had reversed convictions against administrators on the basis that you had not proved knowledge. I mean—so I took an unusual route that I felt that I could prove is not reporting. I felt like I had a good case on that.

Now, the abuse, it was a real difficult problem because the two ladies who saw this were not real articulate and they would get real confused because, quite frankly, the administrator and them were—it appeared to me—were trying to cover it up.

I wanted to go higher, I wanted to get the big boys, so I made a deal with the administrator. You almost have to do that on these things and flip—well, what we call flipping somebody to get them to testify.

Senator BOND. Well, that happens up and down the criminal prosecution ladder. That is you take the little fish and you give them a chance to either be swallowed by the shark or turn on the shark.

Mr. GREGORY. And what made it so difficult is this layer of corporations. We went to Jeff City; we had gone through secretary of State's office and you know you got a limited liability corporation, then you have got a management company and then you have got the actual licensee.

Well, this management agreement drained almost all of the profits from Claywest, the house itself. We found—when Mike Miller goes out there, ghost employees. They may have so many people on

the staff, but they just were not there. So I do not know whether we do not we have the facilities, whether or not they are billing this to Medicare and Medicaid.

Senator BOND. Yes. Well, that sounds like that is a regulatory question as well, and this is, you know, certainly an area to be pursued. We are supposed to vacate it here fairly shortly but one of the things they talked about yesterday or several places suggested was we also need to put more emphasis on finding out and stopping abuse before it happens.

I think we clearly need to have some more criminal prosecution tools where it occurs because it appears that it is very difficult to nail anybody. But the attorneys who are prosecuting these cases or pursuing these cases said there should be some means of alternative dispute resolution where if you had a problem, if you had suspected something like Mr. Stevich had, that you could go to a panel with some authority to say this is what appears to be happening to my loved one. We need somebody to step in. Part of it is the ombudsman role. Ms. Polowy, what——

Ms. POLOWY. Well, three or 4 years ago, we actually found a Senator or Representative who agreed with you, and we got put in—but it was only supposed to be pilot—an informal dispute resolution process for consumers, for family members and residents.

It was an absolute farce. The way the bureaucracy handled that with no regard for having it work and the report they gave back to the legislature was devastating. And there were people who I am sure you have heard of some of the names of the people who worked very hard. We tried to get them to cooperate with us, let advocates help develop your policy. None of that happened.

Since I spend a good deal of my time out of the State nowadays taking care of an aging husband, I do not have time to be hassling them as much as I used to, but during that time I was. And I was there, right in Jefferson City, 10 minutes away, and they could have asked me in anytime. And, you know, we are not included.

I hear from industry people, committees that are meeting, things that are going on, consumers are not involved, but they have no interest in this at all. And the bureaucracy—part of it is we do not have any power. We are not giving big money to them, the top level bureaucrats are totally under the control of the industry as far as I can see.

Mr. GREGORY. Could I just say——

Senator BOND. Let me ask——

Ms. POLOWY. OK. So that disappeared from Missouri law.

Senator BOND. This is a rather depressing picture. We have this Elder Justice Act. What do we need? Do we need to add things to it? Will this make a difference? Is this not enough? And let us just go down the line again.

Mr. Gruender? Anything you could suggest that we should consider?

Mr. GRUENDER. Nothing specific, Senator, except the Department, I know, is willing to work with your staff on anything they can to improve it and to work with you on it.

Senator BOND. Mr. Gregory?

Mr. GREGORY. My problem is, I may have the experience and the know how and the ability and, you know, the guts to go after some

of this stuff. These are not what I call sexy cases. It is not like when you have some elderly person dies or they strangled one of these things, they do not call out the major case squad and the major case squad people get out here and hold press conferences. This stuff is hushed up.

I think you need something to give Federal jurisdiction, where they can go anywhere, because, quite frankly—and you have been raised in the country, I was raised in Montgomery County, you were raised Audrain County—

Senator BOND. Yes, neighbors just up the road.

Mr. GREGORY. —and you do not get experienced prosecutors in those places. Sometimes you do not have really qualified investigators and stuff. If you have a Federal investigating team that can go in and look at this stuff and take jurisdiction in some of these places, or even assist, I think that is a big progress. Those cases are out there. I know dozens of them, but I do not have jurisdiction on some of them, but they are prosecutorial nightmares——

Senator BOND. Raw meat, yes.

Mr. GREGORY. —but they can be done.

Senator BOND. Ms. Polowy?

Ms. POLOWY. Well, I am interested that you are interested in prevention. That is a field of my interest. On the preventative side, you have got to do something in the nursing home world about staffing. And——

Senator BOND. Yes, as you know, there are provisions in there—some incentives for staffing—but requiring the money to——

Ms. POLOWY. I would like to have an opportunity to take a whole area unto itself to explain to somebody how they could do it and how they could force accountability. Right now, the State survey personnel do not have the information or the tools available to them to properly cause accountability. Medicare pours in the is money based on a formula and nobody tells the State personnel what that formula is and whether they should be checking it. It is ridiculous.

I will try to explain it all to your staff.

I think I tried once. And it takes three times to hear it.

Senator BOND. Well, if she can understand it in two or three times it may take me ten——

Ms. POLOWY. OK.

Senator BOND. —but once she understands it, then she can lead me through it.

Ms. POLOWY. Then maybe you can help.

Senator BOND. But this is an area we have been concerned about and there is obviously we have not gotten our hands on the whole problem.

Ms. POLOWY. On the community side of respite care until people are giving these family care givers more support and there can be some kind of real initiative in that direction, a lot of this home abuse is coming—just like in child abuse—I mean, I even grew up in the period when the child abuse world was just beginning to grow and the first articles appeared in mothers' magazines and all of that about if you are too tired, you are going to start beating on your kids and things like this. Well, the exact same thing is true here.

Senator BOND. Adult day care is——

Ms. POLOWY. And it is just not getting adult day care that would be the respite that they could use——

Senator BOND. But you are talking about the respite, yes, that——

Ms. POLOWY. —but I think there is also informal care givers who can come in and people who can provide respite, but most families do not have the wherewithal to deal with it, no agencies handle that, it is just a nonexistent difficult thing for people to deal with. So, on the community side, I see respite care as the big preventative measure.

Senator BOND. This has been a very informative, but troubling session. This issue is very personal and those of you who talked about family members, our hearts go out to you. The tragedies that the families have gone through is really unspeakable.

And yet we know we are seeing more and more that it does affect every community and the growing number of seniors, we are going to see more of it. We have to recognize and address this system and I look forward to following up, getting more ideas from all and any of you on how we have a multifaceted solution, public health, social services and making sure law enforcement works. And it appears that the regulatory side is adequately staffed is important.

And providing the respite care, providing taking some of the pressure off of the family that would like to keep the loved one who is suffering some disabilities at home, but cannot stay with them all the time.

I am hoping that the Elder Justice Act will get the Federal Government involved. We are looking for research and centers of excellence really to go through all these things and to work out all the details. Granted, we do not have all the answers here.

I thank you all for your time, and I very much appreciate it. And we do look forward to hearing from each of you. My sincere thanks to those of you who have come, especially those who talked about their family members, and we would welcome hearing from you.

With that, the hearing is adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF MARTHA BALLENOT

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss with you the important issue of elder care in the United States.

Our father, Burton Reese, served his country in two wars: World War II, overseas in China, and the Korean Conflict. He is now fighting the third war of his life; the one we fondly call "nursing home hell."

After suffering a debilitating stroke in 1998 our Dad lived in 2 assisted living homes and 4 nursing homes. He was hospitalized 12 times. We kept thinking the next home would be better. For the past 4 years he has been in a residential care center with no hospitalizations.

For a while he lived in a locked Alzheimer's wing, located in the basement of a St. Louis County nursing home. At Christmas, the residents of this wing were served leftovers from the meals of the rest of the nursing home residents, as their Christmas meal.

The method of care there was to shoot their residents full of behavior control medication. This made the residents very manageable. One month we spent $3,000 on such medication. One Saturday, while the two attendants on duty were talking at the nurses' station, a resident emptied his colostomy bag down the hallway. I told the workers about it and could not get any of them to clean it up. Because I had my 4-year-old son with me, I had to choose between our Dad and getting my son out of there. I put our Dad in his room; picked up my son, left and went to the main office to complain.

Our Dad eventually was hospitalized for malnutrition, dehydration, a blood clot in his leg and external bruising. A doctor who attended him said the bruising was the kind of injury often associated with physical abuse. When confronted with these diagnoses, the management at Clayton House decided that he was the problem and they evicted him from the home.

The next move was to another local nursing home. We would visit him every day, sometimes twice a day. Our Dad was very edgy there. He talked about being tried for murder and fighting in a war. We thought he was simply deteriorating. We know now that it was his way of telling us he was being hurt. He especially hated the head nurse. He said she was a Nazi. By calling the head nurse names, he was trying to point out to us who was hurting him. He was constantly agitated. The doctors told us this was normal and we should keep trying different behavior control medications.

We believed the doctors. It turns out, yes; this was normal behavior for someone who was being brutalized constantly by people we trusted to care for him.

One day an employee reported to management that he had witnessed several employees bribing another brain-damaged resident to beat our Dad (as they stood by watching in amusement.)

He reported that they had also dragged him on his knees, beat him with a belt on his bare legs as they were changing his clothing, hit him in the head with a book, locked him in the bathroom and possibly, over-medicated him, since one of the abusers was the Med Tech who dispensed medications.

This nursing home took prompt action by calling the police and firing the accused employees and their immediate supervisor. It took a front-page story in the St. Louis Post Dispatch to convince the St. Louis County Prosecutor to press charges.

These assaults on our Dad were labeled "third degree abuse." This was hardly a career-making case, so Assistant Prosecutor assigned to this case didn't feel it deserved his attention and, in fact, pressed on only after a letter-writing campaign was mounted by my family. One of the abusers plea bargained for probation and the other had the charges dropped because the only witness, our Dad, was too demented to testify. The original accuser could no longer be found; he defied a subpoena and did not appear in court. No warrant was put out for his arrest; there was no consequence for his failure to show up in court.

The convicted abuser did not agree, as part of his plea agreement, to testify against the other person charged in the case. When asked about this, the assistant prosecutor said to me, with a shrug of his shoulder, "What good would that have done?"

The Med Tech, against whom the charges were dropped, was at work on another area nursing home within two weeks after being fired and charged with abuse.

The Missouri Division of Aging decided that our Dad was a danger to the other residents and told Oak Knoll to get rid of him or be in danger of losing their license.

It does not end here: our lawyer, hired under the guise of being an activist, who settled Daddy's case against Oak Knoll as soon as my sister, who holds our Dad's

power-of-attorney, left town. He settled despite direct instructions from her, as well as an agreement with Oak Knoll and their insurance company to the terms we had requested including the implementation of a pilot project using surveillance cameras to monitor care.

Currently we have to worry and wonder when the Missouri Division of Aging will intrude on our Dad's life again, always under the pretense of being concerned for his safety. Our Dad has lived for 4 years in a group home that specializes in the care of Alzheimer's and dementia victims.

The State does not have a classification for this type of home so they try to impose archaic rules, rules that do not work even in a traditional nursing home setting, upon this home. Even though our Dad has a condition where he will continue to deteriorate, until he dies, the Division of Aging insists he be able to find a safe pathway out of the house and that he be able do that by walking. In this setting his caretakers work at a ratio of 3 caretakers to 8 residents. In the nursing home there was 1 caretaker to 20 residents. Where do you think he is safer?

The Division of Aging, when questioned about these actions, blames the State legislators. They claim to be powerless.

Since 1998 we have tried to get help to stop the abuse from the Missouri Attorney General's office. He couldn't help because our Dad was private pay and not on Medicaid. Our State Senator, filed our letter because he thought the matter had been taken care of. He never bothered to ask us or respond in any way. The Missouri Department of Health took no action against the supervisor who didn't know abuse was happening on her shift. The list goes on and on.

When Daddy first moved into his present facility in Creve Coeur, an eight-bedroom residential facility, the other resident there was so demented that the only word he had been able to utter was "coffee," and so the caregivers at his nursing home gave it to him, cup after cup. When he arrived at the new facility he was so dehydrated from drinking coffee that he was blue. He died several weeks later.

At another home, I could not allow my son to sit it a chair while he visited his grandfather because it was so badly stained with urine. At the second nursing home I watched as employees unplugged the electric keyboard of a non-mobile patient because they didn't care for the noise. These are not isolated incidents but daily occurrences in nursing homes across the country.

What is the answer? Nursing home monitors for use by patients and their families and the Elder Protection Act are pieces of the puzzle, but not the entire picture. Personal responsibility is hard to legislate but not so hard to demand. Demand that State agencies serve the people, not the special interests; demand that all nursing home deaths are investigated; demand that people do their jobs and that the elderly are recognized as valuable citizens, not disposable nuisances.

Ladies and Gentlemen, this will be us: you and me, before too long. Is this how you want to live the final years of your life?

Thank you for your time.

PREPARED STATEMENT OF FRANCIS M. STEVICH

Mr. Chairman, and Members of the Committee, I appreciate the opportunity to speak to you on behalf of my dearly departed and most precious wife of 40 years who met her demise on Mother's Day, 2000. She was a very delicate, lovely lady with a very great warmth and love for all living things. She had many diseases that took their toll on her for over 20 years and her last 7 years had been very hard on her with extreme pain and the loss of her ability to get around. She had a very difficult operation to enhance the blood flow in her leg since she was in the advanced stages of arterial sclerosis. She got gangrene in the little toe of that leg and it did finally heal but without the toe nail. She remained in extreme pain since the nerves had been turned on in her leg and could not be turned off. We spent many days with many doctors trying to relieve the pain with no success. In April of 2000, she became very ill and was put in the hospital. After 10 days, she had become stable enough to leave the hospital but was still in medical need of a skilled nursing home for further recovery.

My son found the Florissant Skilled Nursing Home for her which was on the way to my work so I could drop in every day since I literally passed by the home on the way to work. She was in the Nursing home for 20 days and 5 of those days she was taken back to the hospital. As I look back on the care she received, I realize that she was not fed very well nor did they even give her water. I brought in a child's "sippy cup" at the direction of our 4-year-old granddaughter to help her be able to drink. It worked extremely well when I gave her water. I found at times that the cup was not within her reach and the lid was off when I would visit. When I talked to the nurses, they would tell me that she was on a 2-hour retraining pro-

gram for input and output of body fluids, etc. At times, when I would visit her during eating time, I found her off to the side in a special feeding room with others and only one person feeding them all. I tasted her food and some of it was cold. I would ask why and they would say she had eaten all she wanted to. My wife went from 90 some pounds down to 74 pounds during her few days in that place.

On Mother's Day, 2000, I received a call from the Nursing home that my wife had passed away peacefully during the night. I went to see her immediately after I called our children with the news and they showed up shortly after I arrived. We got her out of the home that afternoon and my son picked up her personal items the next day. We found quite a few items missing and complained about it to the home and the Division of Aging. The home literally did nothing and one nurse's assistant yelled at me saying my son had taken the items. The Division of Aging did nothing as usual. I say that because they were informed of the illegal restraint that the home had put on my wife and did nothing about it to ensure safety. I assumed that since it was a professionally staffed home that all medical and safety procedures were followed and since the Division of Aging was notified that they would ensure safe use or removal of the restraint. When she was in the hospital, she had a restraint on her and all went well so I assumed that all care units followed a safe procedure. My wife did not have any type of device to alert anyone she was in trouble. Her only method would be to yell. Everyone at the home told us she died peacefully in the night. In about 3 or 4 weeks, a detective came to my house and spent over two hours asking about what I meant when I said my wife was violated. I kept telling him that she was violated after death by people at the nursing home taking her personal good clothes and the personal plants brought from our house that we put in her room and the birthday plant her daughter gave her for her birthday.

About 5 weeks after my wife's demise, I was informed that the Governor had received information from the Division of Aging that a nurse had reported to them about the neglectful death of my wife by strangulation. The Division of Aging never did tell me and I still wonder what their job is since everything is secret there and they never give you any answers. I still have no information on the records they have there. It is like fighting city hall and a waste of taxpayer's money. I also found out that all Nursing homes by law have a book of complaints that is to be readily available to new clients so they can read the record of the home's problems enabling us to make a good decision in using that home. This book was never shown to me or told to me of its presence at the home so again the law may be there but not enforced. I also believe that the detective that came to my house was investigating the strangulation death of my wife, wanted to see if I knew and when he was sure I did not know, left and reported that I did not know so their municipality did not have it on their records and looked better. I found out the night of my wife's demise, she was calling out for "Steve" and the nurse on that night closed her door since my wife's outcrys were bothering her and possibly some other residents. The next morning, the next shift opened the door and saw my wife hanging out of bed with the restraint hanging her on the side of the bed. My wife had been calling out for "Steve" which is my nickname so I could help her only I was not there to do so. At home, I was always there for her especially during the last 7 years of her life. I took care of work, the house and her so she was at least comfortable and safe and secure.

I trusted her care to the medical professionals and that is one that I have to live with. I often think of how long she may have hung there struggling and I was not there for her. I am the one that put her in that home and literally signed her death warrant. I feel deep guilt and pain so very often and miss the love of my life. I feel the pain my daughter and son feel when we talk about her. I will always feel that I let her down and denied my son and daughter of their mother's love in these later years in life. Sometime before my wife went to the hospital, she told me that she was nearly finished with her project. I asked her what the project was and she said, "It is you". My wife taught me well over the years and instilled in me the "Cradle of Life" so believe it or not, I hold no animosity towards those that caused her death through neglect and pray that their souls will be forgiven and be at peace someday. This is very difficult for me and all of my emotions and feelings have peaked again and tears are running down my cheek. I am sad for my wife and I have even a greater sadness for the human race since a lot of us have forgotten how to speak from the heart. We have supposedly put procedures in place for the betterment of mankind but only to twist the true solutions through our own ego, political gain and pressure from the wealthy interested parties who give monies to ensure the outcome which benefits them rather than those the procedures are to protect. I think you should have all the homes on file, grade them according by their resident care levels.

You should audit them without letting them know in advance you are coming just like restaurants are audited for health. Insurance rates would go down if the level of service went up. You would get lesser complaints therefore lesser law suits and lesser monies paid out by insurance companies therefore lowering premiums to the care-takers and medical people. This gives the elderly superb care and cuts insurance expense. You can grade these home just like restaurants and at the same time also keep track of those that work at these homes so other homes can check their previous employment record prior to hiring. This would keep those who should not work in the homes from going from home to home. I have written a lot and hope that I have reached your hearts. I will say that I see a lot of violence and tragedy happening to our youth and more and more of the same happening to our elderly along with disrespect and lack of dignity for them. The elderly of today were the ones that sacrificed so much in the 2nd world war. The men overseas and the women working on the home front. If you have a less stable environment for our youth growing up, then less of them will be able to take over for the adult population and less adults having anything to look forward to in their so called senior days except lack of respect and dignity, then you have a society that is teeter-tottering on becoming a tragedy and coming to an end just like all of the great nations before. I keep hearing more and more tragedies and I ask you but one question, "Why do you keep doing it to yourselves?" I end here and I hope I have spoken from the heart and represented my wife well and with respect, honor and dignity.

PREPARED STATEMENT OF RAYMOND W. GRUENDER

Mr. Chairman and Members of the Subcommittee: Thank you for allowing me to participate in this field hearing to address the significant issues of elder abuse, neglect and exploitation.

The elderly, especially nursing home residents, are one of the most vulnerable groups of individuals in our society because of their age, sometimes reduced mental faculties, financial status and medical conditions. While their experiences in life give them wisdom to share with younger generations, the years take their toll and can make them physically and mentally vulnerable. In many instances, these individuals are unable to care for themselves and are unable to cry out for help when they are not receiving the care that they need. Often, they are the victims of abuse and exploitation which can include neglect of the elderly's most basic need for sustenance and medication. In many cases, this reprehensible conduct hastens or even causes death. In these instances, the elderly must look to others to protect them and to punish those who harm them.

As United States Attorney in the Eastern District of Missouri, I am keenly aware of the ongoing problem of elder abuse and neglect. On a regular basis, Assistant United States Attorneys working in my office receive deficiency reports on nursing homes within the district.

From these, we have been informed that:

Four residents died in a nursing home within 48 hours before the fire department removed the other residents from the home because of the elevated temperature.

Another nursing home resident died of malnutrition.

A diabetic nursing home resident died from elevated blood sugar levels because no insulin was given to that resident for 36 hours.

Another nursing home resident fell repeatedly and was seriously injured when the resident tried to get out of a wheelchair to go the bathroom with no assistance. The falls occurred simply because the nursing home lacked adequate staffing.

Another nursing home temporarily employed unqualified individuals, some of whom had felony convictions. The nursing home did not conduct background checks on these temporary employees and, as a result, a resident was physically abused and subsequently died.

To prosecute abuse and neglect cases, U.S. Attorneys must demonstrate a federal nexus—usually, some connection between the conduct in question and federal payments. While U.S. Attorneys have successfully brought federal criminal charges against those who abuse or neglect the elderly and subsequently submit false statements or claims to the government concerning those incidents, these cases present unique challenges. To use the criminal fraud statutes, the federal government must prove that, at the time the nursing home operator sought payment, he or she knew that the services billed for were not being provided. To prove this, the government often must rely on circumstantial evidence—usually in the form of a longstanding and repeated pattern of evidence of abuse and neglect i.e., knowingly not providing services and billing for them anyway).

Moreover, in these types of cases, the federal sentencing guidelines look to a dollar loss to determine punishment. Unless the pattern of not supplying services oc-

curs over a long period of time, the "loss" is not likely to be enough money to result in a severe prison sentence.

Medicare and Medicaid paid the nation's approximately 17,000 nursing homes an estimated $42 billion in 2002 to care for its beneficiaries (GAO Report—July 17, 2003). In an attempt to combat elder abuse and neglect, we at the Department of Justice use a federal law, the Civil False Claims Act, that allows for the imposition of civil penalties when false claims are presented to the government for payment through the Medicare, Medicaid and other federal programs. The False Claims Act does not, however, reach incidents that do not involve federal losses or federal false statements.

Under the Civil Rights of Institutionalized Persons Act, the Department of Justice has aggressively protected the civil rights of individuals that reside in state or locally operated governmental institutions. Under this federal statute, the Department of Justice is able to investigate and redress patterns and practices of violations of these residents' federal civil rights. This federal civil statute does not allow the federal government to examine private facilities. Nor does it allow us to address specific individual cases of elder abuse and neglect.

Where we have statutes that address a particular criminal offense, such as where the elderly are victims of fraud schemes, federal prosecutors are reasonably successful in assisting the elderly and punishing the perpetrators through criminal prosecutions.

Recently, in the Eastern District of Missouri, we prosecuted an individual who was responsible for a $2.5 million investment scheme that caused a number of victims, many of whom were well into their retirement years, to lose their life savings. The defendant, a financial advisor, pled guilty to one count of mail fraud and one count of embezzling from an employee benefit plan. Several of his victims, in their 60s and 70s and retired for a number of years, told investigators that they would be forced to return to work in order to meet their basic needs. In that instance, federal laws were in place that allowed us to criminally prosecute the individual responsible for the fraud scheme. The perpetrator had squandered the money, but the federal government obtained, in part due to strict sentencing guidelines, including an enhancement for victimizing the elderly and vulnerable, a sentence of 87 months in federal prison without parole.

Elder abuse and neglect is a problem at all levels of our nation, and it crosses all ethnic, racial and economic boundaries. We remain committed to working with local and state officials on this issue and to continue to be an important participant in the fight against elder abuse and neglect.

Finally, I would like to thank the Chairman, Senator Bond, for allowing me to appear here today. I commend you and the Subcommittee for your work on these issues. I look forward to answering any questions you may have.

PREPARED STATEMENT OF JAMES G. GREGORY

Mr. Chairman and Members of the Committee, first and foremost, I would like to express my appreciation to Senator Bond's office for extending an invitation to me to speak before this body regarding the prosecution of elder abuse that occurred at Claywest House Healthcare LLC located at 2840 West Clay, St. Charles, Missouri 63301.

There are several individuals I feel it incumbent that I recognize before discussing the details of this prosecution, individuals whose contributions were instrumental in the successful outcome. These individuals and their roles are as follows:

1. Jack Banas, Prosecuting Attorney of St. Charles County, Missouri, who authorized me to embark upon a prosecutorial endeavor that had never been embarked upon in Missouri;

2. Baue Funeral Home who brought a case of suspected abuse to the attention of Dr. Mary E. Case, St. Charles County Medical Examiner whose policies required her office to be notified in case of suspicious deaths;

3. Dr. Mary E. Case and her assistant, Kathleen Diebold, who brought the suspected abuse to the attention of the St. Charles City Police Department;

4. Detective Michael Miller of the St. Charles City Police Department who worked with me day and night interviewing witnesses;

5. Kathleen Sutton, a paralegal in my office, who worked day and night assisting Detective Miller and I in obtaining documents and arranging witness interviews;

6. Ann Chambers, CNA, a certified nurse assistant at Claywest House, whose suspicions provided the link which lead to a successful prosecution of the perpetrator of the suspected abuse and which ultimately lead to the prosecution of the principals;

7. Jeanne Rutledge, former Program Manager, Missouri Division of Aging, whose testimony regarding the required reporting of suspected abuse was crucial in the trial of the cases involving American Healthcare Management, Inc., a Missouri corporation, Claywest House Healthcare, LLC and Charles B. Kaiser III, the President of American Healthcare Management, Inc.; and

8. Last, but not least, Phil Groenweghe, Assistant Prosecuting Attorney of our office who helped me try the principal case.

This case had its inception on the evening of Wednesday, July 28, 1999, when CNA Ann Chambers saw Karl Willard, a RCA, resident care assistant in the hall of Claywest House, with something on his shirt, and when inquired as to the cause of this, Willard responds with a vulgarity describing a resident, Marshall Rhodes II, and tells Chambers and Fowler that Marshall Rhodes II had thrown his medicine on him, Willard, and that he, Willard, is going to "f———his ass up." Rhodes was an Alzheimer patient incapable of communicating in a comprehensible manner.

Between 8:00 P.M. and 8:30 P.M. on the evening of Wednesday, July 28, 1999, Chambers and Felisha Hunn observe Willard exiting Mr. Rhodes' room and closing the door behind him; and when Chambers and Hunn enter Rhodes' room they find him in a defensive position with a scratch on his head that was bleeding, and Rhodes complaining of being tortured.

Between 11:45 P.M. Monday, August 2, and 12:15 A.M. Tuesday, August 3, 1999, Marshall Rhodes is found in his room with open lacerations to his left side bottom lip and his sleeping gown ripped and bloody. The St. Charles City Fire Department was summoned, and Mr. Rhodes was transported to the emergency room at St. Joseph Health Center in St. Charles where he was treated and returned to Claywest House at approximately 3:00 A.M. on Tuesday, August 3, 1999.

Ann Chambers did not work on Monday, August 2, or Tuesday, August 3, 1999, but on Wednesday, August 4, 1999, when she returned to work she observed Mr. Rhodes with his lip swollen, and she and Felisha Hunn reported to the Administrator, Betty Via, and the Director of Nursing, Cheryl Davis, their suspicions regarding Marshall Rhodes' injuries and Karl Willard's actions. Chambers and Hunn were directed to provide "written statements" regarding their suspicions.

At approximately 6:45 A.M., Thursday, August 5, 1999, Marshall Rhodes was found by nurse Rhonda Brunner unresponsive in his wheel chair, and Brunner summoned the St. Charles City Fire Department to transport Mr. Rhodes to the St. Joseph Health Center.

Claywest House officials attributed Mr. Rhodes' injuries to a fall from his bed, although his bed consisted of a mattress . . . (*balance of sentence unclear*).

On Saturday, August 7, 1999, Rhodes died at St. Joseph Health Center. Mr. Rhodes' body was sent to Baue Funeral Home for burial.

Dr. Mary E. Case, the St. Charles County Medical Examiner had instituted policies regarding the reporting of certain types of deaths, and Baue Funeral Home reported to Dr. Case's office that Marshall Rhodes' death involved a subdural hematoma, and on Thursday, August 12, 1999, Kathleen Diebold of Dr. Case's office contacted Cheryl Davis, Director of Nursing, requesting Mr. Rhodes' medical records. During her conversation with Kathleen Diebold, Cheryl Davis never mentioned anything regarding the suspicions expressed by Chambers and Hunn to her and Via on August 4, 1999.

On August 16, 1999, Jeanne Harper of the St. Louis Office of the Missouri Division of Aging talked to Betty Via, the Administrator of Claywest House, and Harper tells Via that the incident involving Marshall Rhodes must be "hot lined."

On August 17, 1999, the Administrator, Betty Via, emails Charles B. Kaiser, III, the President of American Healthcare Management, Inc., the manager of Claywest House Healthcare LLC, and the operator of the facility, that the incident must be "hotlined," i.e., reported to the Division of Aging as suspected abuse.

Charles Kaiser responds to Betty Via's e-mails stating he personally spoke with Jeanne Rutledge of the Division of Aging who told him this was not something that needed to be hotlined. This became crucial in the trial of the cases, because Jeanne Rutledge testified unequivocally that Charles Kaiser had not conveyed the details of the incident to her.

On August 23, 1999, Betty Via, the administrator of Claywest House Healthcare LLC, received a page at the Lake of the Ozarks where she was attending a seminar relating to skilled care facilities and was advised to return to Charles Kaiser's office where she was fired, ostensibly for following budgetary policies.

Dr. Case contacted the St. Charles City Police Department, and Detective Michael Miller was assigned to investigate the death of Marshall Rhodes II.

As a result of Detective Miller's investigation, numerous witnesses were interviewed and voluminous records were obtained regarding Mr. Rhodes' death and the operation of Claywest House Healthcare LLC.

Succinctly stated, it was determined that Claywest House Healthcare LLC was a limited liability company doing business as Claywest House, licensed pursuant to the provisions of Chapter 198 RSMo. as a skilled nursing facility (hereinafter referred to as "Claywest House").

American Healthcare Management, Inc. ("American Healthcare") was a Missouri corporation organized and existing pursuant to the provisions of Chapter 351 RSMo., and it had a management agreement with Claywest House whereby American Healthcare controlled the operation of Claywest House and received a substantial management fee.

Charles B. Kaiser III was the President of American Healthcare, corporate records of which indicated was owned by Robert D. Wachter and R. William Breece.

Records obtained from the Missouri Division of Aging disclosed that Claywest House had received numerous violations as a result of inspections and had been in danger of losing its State license as a skilled nursing facility. The facility had also been assessed a fine of more than $300,000.00 for various deficiencies, but through the appellate process had been able to settle for a figure of approximately $100,000.00.

It became very obvious that the management of Claywest House felt that they could not afford an abuse case in their facility with all the previous problems, and an active cover-up was engaged in.

Evidence was presented to a grand jury and the following indictments were subsequently returned:

Karl T. Willard was indicted for elder abuse in the first degree as proscribed by Section 565.180 RSMo. and subsequently was sentenced to 10 years in the Missouri Department of Corrections.

Cheryl Davis, Director of Nursing of Claywest House, was indicted for failure to immediately report suspected elder abuse as proscribed by Section 565.188 RSMo., a class A misdemeanor, and was acquitted by a jury.

Betty Via, Administrator of Claywest House, was indicted for failure to immediately report suspected elder abuse as proscribed by Section 565.188 RSMo., a class A misdemeanor. Pursuant to a proffer, Via supplied the prosecution with certain documentary evidence, including copies of e-mails, and agreed to testify truthfully, whereupon the charge against her was nolle prosequied at the conclusion of the trial of American Healthcare, Claywest House and Charles B. Kaiser III.

American Healthcare, Claywest House and Charles B. Kaiser III were indicted for failure to immediately report suspected abuse as proscribed by Section 565.188 RSMo., a class A misdemeanor, and were jointly tried by a St. Charles County jury. The jury returned verdicts of guilty on each of the three defendants and recommended a fine be imposed by the Court and also recommended confinement in the St. Charles County Jail for a period of one year for Charles B. Kaiser III, the maximum punishment that could be imposed.

On Thursday, February 6, 2003, the Honorable Ellsworth Cundiff sentenced the respective defendants as follows:

1. American Healthcare Management, Inc., a Missouri corporation, a fine of $5,000.00, the maximum punishment permitted under Missouri law for the said offense;

2. Claywest House Healthcare LLC, a Missouri limited liability corporation, a fine of $5,000.00, the maximum punishment permitted under Missouri law for the said offense; and

3. Charles B. Kaiser III, President of American Healthcare Management, Inc., confinement in the county jail for a period of one (1) year as recommended by the jury and a fine of $1,000.00, the maximum punishment permitted under Missouri law for the said offense.

American Healthcare, Claywest House and Charles B. Kaiser III have all appealed their sentences, and the appeals are currently pending in the Missouri Court of Appeals, Eastern District, at this time, with the briefs of the defendants being due August 25, 2003.

In prosecuting this particular case and investigating other nursing home practices, it is apparent that those investing in such facilities utilize various corporate entities to limit their individual liability. The corporate structure involved in the Claywest House case is rather common in the industry.

It is obvious that the operators take advantage of every possible loophole in the applicable statutes to avoid reporting suspected abuse.

It is apparent that legislation requiring that suspected abuse be reported to law enforcement authorities, in addition to the State licensing authorities, is needed. Those charged with licensing and inspection of facilities are not trained in criminal investigations, and therefore many suspected abuses are just not prosecuted.

PREPARED STATEMENT OF JOANNE POLOWY, MSW

Mr. Chairman, and Members of the Committee, I am appearing before you today in my capacity as an advocate for elderly and disabled persons who are dependent upon others for their care and protection from harm. Based on my many years of experience in State Government working on laws, regulations, policy and program development in the field of Aging, as well as personal family experiences with both home based and nursing home care, I want to let you know that I, and others I represent, strongly support the Elder Protection Act (S. 333) being considered for passage by the U.S. Congress.

The establishment of an Office of Elder Justice, an Elder Justice Coordinating Council, and an Intra-Agency Elder Justice Steering Committee within the Department of Health and Human Services to coordinate efforts at a Federal level to prevent, detect, evaluate and intervene on behalf of elderly people who are victims of abuse and neglect, are essential first steps in the public policy process of addressing the issues in Elder Abuse. By in large, the public is unaware that this is a national crisis and a major Human Rights issue in the United States.

Large numbers of helpless and dependent elderly and disabled persons are being victimized each year, particularly in nursing homes, as the for-profit corporations and operators are reaping enormous financial gain at the expense of the helpless, by not having to be accountable to government as they are given taxpayers money and provide sub-standard care. The current approach of not involving law enforcement in the investigation of serious complaints of abuse and neglect must stop as State personnel responsible for monitoring nursing homes and home care agencies are not trained investigators and consequently many deaths can be covered up by unscrupulous operators and staff.

I would like to share with you now a story of a case recently brought to my attention that illustrates the flaws in the system. It is typical of hundreds that others and I who advocate for victims of abuse hear over and over. This is a little different, however, as the case was brought to my attention not by a family member but by two ethical nurses who were stymied and frustrated by "the State system" that seems to protect operators more than victims. These nurses worked in a small nursing home in southeast Missouri. The home had been operated as a community facility for many years and was considered both a good place to receive care, and a good place to work. A few years ago, however, a corporation that now owns 50–60 facilities in Missouri and Arkansas purchased the facility. Shortly thereafter the whole philosophy of care changed with the appointment of a new Administrator and Director of Nursing. Staff hours were reduced, and the focus shifted from care to profit. The two nurses ultimately even traveled to the corporate headquarters to complain to the owner about the deteriorating conditions and the lack of staff. They told him of their concerns and that residents were being neglected. He listened and told them he would look into it, but nothing changed.

Then one day a resident with Alzheimer's disease, admittedly difficult to handle, started acting up. The Director of Nurses called the janitor and with his help dragged the man into the whirlpool room. They put him on a hoist, but did not strap him on properly. They then dropped him into the whirlpool, but when they were pulling him out he fell off the hoist onto the concrete floor and gashed open his head. There was blood everywhere. The LPN who told me this story was called in to help and to call for an ambulance. Other staff helped clean up the blood and the man was taken to the hospital. He died two days later. The LPN, herself, called the State Hotline and recorded the incident in the nurses' notes. To her knowledge, however, no one from the "State" ever came to investigate and her notes "disappeared." The staff was told to forget about the incident . . . but these nurses could not. Both ultimately were fired, and since the Regional Office apparently classified the report as unsubstantiated, it is not a public record unless there would be a lawsuit filed. In this case, there was no family member interested in pursuing it. The reason, I believe, that there was no investigation is that State policy for a number of years has allowed regional staff to initiate an investigation by calling the facility rather than going on-site. Since the administrator probably told them that the resident "fell" by accident, they apparently decided to believe him and therefore did not bother to interview staff or look into the matter further.

Unfortunately, the public and staff in health care facilities do not think to call law enforcement in cases such as this, and, even if they do, the police think this is not their jurisdiction and funnel the report on to the State. It is essential that Federal and State laws address this issue, and that the appropriate agencies and prosecutors cooperate in these investigations. Nursing home owners fear this step and do not want this to happen.

Another aspect to consider is that the nurses who were involved in this case are typical of good caregivers no longer working in long-term care. Large numbers of nursing professionals and paraprofessionals no longer work in nursing homes due, in large part, to the avarice of the owners and the benign neglect of State Government regulators. Many are so disillusioned with the abuse and neglect of residents being sanctioned by government and the breakdown of the regulatory system that they are leaving the long-term care arena. This, too, is a critical public policy issue that must be addressed.

I have volunteered my time since my retirement seven years ago to speak up in behalf of the frail elderly who were being abused and neglected, particularly in nursing homes, and to assist and give moral support to their family members. Even when I was working for the State I could see that the bureaucracy was increasingly becoming indifferent to the cries for justice coming from families and victims themselves. Although I originally thought that the nursing home leaders would be helpful in addressing the problem of abuse in their facilities, I eventually learned that this really was of no importance to many of them. Their interest was in covering up wrong doings and keeping from being sued for wrongful deaths. I also saw top-level politically appointed administrators whose jobs depended on placating the industry passively resist enforcing policies and laws developed to address flaws in the system. Laws were strengthened with the help of advocates, but often it was the State regulators themselves who found the loopholes to avoid appropriate implementation. The influence of the for-profit industry has expanded to an unconscionable level in recent years and their control of both the Legislative and the Executive branches of government is extremely disturbing. Hopefully you will do all in your power to respond to the public's repeated pleas for change before you and I are helpless, infirm, and dependent on others for our care.

In summary, let me once again express my strong support of the Elder Justice Act and the efforts of Senator Breaux, Senator Bond and others of you who are coming to understand the need to address the crime of Elder Abuse.

Thank you for allowing me to testify.

PREPARED STATEMENT OF BETTY WILLSON

Dear Committee Members: I appreciate this opportunity to tell about my experience with nursing home abuse. My mother, who passed away in April, 2003, spent six years in our local Beverly, Inc. facility. It was a nightmare for both of us. It's not that we didn't make our problems known to State; we even formed a family Council to deal with the suffering and death we saw (see enclosed copy of a letter we wrote to State just last year). As usual, the State cited them for these serious problems, let the facility "correct" them, and did nothing else, even though the facility had a long history of being out-of-compliance and should have been shut down.

When my mother suffered two broken ribs and a chipped elbow, it could have been prevented by the facility which allowed trainee aides to transfer her and other residents over the objections of the CNA who reported it to his superiors. Since a monitor was in the facility at the time (because of many previous violations), they did not report my mother's injuries either to me or to the State. They tried to explain to me that she screamed and cried because she had osteoporosis or arthritis.

I finally took her to the hospital myself for X-rays. They had plenty of time to send a nurse over to the "facility friendly" ER doctor to tell him what they had told me, so he told me that all he saw on the X-rays was "some arthritis". That evening, I got hold of Mom's family doctor. He saw the X-rays and made an appointment for Mom the next day with a bone specialist. He found two broken ribs and a chipped elbow. By this time, Mom had suffered seven pain for over 30 hours, with no treatment other than Tylenol.

Later, a team from State came in, determined what had happened, validated my claim of abuse, cited the place for not reporting the injuries, and (guess what?) did nothing else. Even the monitor buried the incident in her weekly report with only eight words: "One resident received multiple fractures of unknown origin". We later discovered that this "neutral" monitor was a former employee of a Beverly facility.

Most abuse is rooted in neglect, and neglect is exacerbated by understaffing, undertraining, and the nursing homes' blatant cover-ups because they do not fear getting penalties or fines. Facilities are almost always aware of imminent inspections, so they have time to bring in extra staff, cover up problems, and re-do records, in order to obtain good surveys.

As for abuse, I have seen residents given the wrong medications, sitting or sleeping for hours in wheelchairs, falling and suffering injuries and even death, not being fed at mealtime, choking to death, going for days or weeks without showers or hav-

ing their teeth brushed, teeth rotting out, eyeglasses and dentures lost but not replaced, etc. (See our Family Council letter enclosed.)

The answer to abuse lies in having consistently and strictly enforced laws addressing minimum staffing, required training of aides, and penalties that fit the crime of elderly abuse. Until we achieve those goals, the suffering will go on and on and on . . .

CAREGIVERS FAMILY COUNCIL,
NEOSHO, MO 64850-1726,
July, 3, 2002.

Mr. H. DAVID MORGAN,
Jefferson City, MO 65102-0570.

DEAR MR. MORGAN: Your letter of June 7 to Janet Clayton was recently shared with me because my name was mentioned in it. Since I am Chairman of our Family Council here at Beverly Healthcare of Neosho, I would appreciate it if you would review with me some of the statements made in the letter.

In their May 2 survey, this facility was given two "J" tags for federal violations, which were dropped to "H"s. Since they received two of these, plus an "E" and a "G" (plus yet another "G" for an accident investigation just two months before), we believe these violations warrant being moved to "K"s rather than being dropped back to "H"s. When nine out of 14 residents (60%) were assessed with Stage IV bedsores acquired after being admitted, and when the facility has a long history of being out of compliance (7 out of the last 8 years), we believe it is time to stop giving them more chances to "correct" their problems, only to repeat them again and again.

All of their violations also received a State rating of Category II, which requires penalties of varying severity. We hope each of these violations will receive a penalty, with daily fines being imposed for the "H"s. This facility has had several less stringent penalties in the past, but, to our knowledge, has never been given a fine. Such a monetary penalty would be the only way to get the attention of a huge corporation such as Beverly, Inc. As caregivers, we are convinced that daily fines would bring about faster results in obtaining better care for our loved ones.

In paragraph three you stated that "the pressure sores did not show signs of infection". In the survey, they were described as "growing", "tunneling", "sloughing", "undermining tissue", "macerated", "containing dead tissue", etc. A Stage IV pressure sore is described on page 22 of the Survey as "A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone". Pressure sores are treatable and preventable and should never be allowed to reach this stage where they can cause agonizing pain, shock to the body, and death—whether or not the wounds are infected. This week, one resident died from the effects of her horrible Stage IV pressure sores. This is not the first time this has happened here, and we feel the facility should be held accountable.

In paragraphs 7 and 8, you mentioned the list of concerns I presented to a surveyor on behalf of our Family Council at the January 25 survey. You stated that "we could not prove the allegations contained within Betty Willson's list, except to a sink having lukewarm water." Why, then, was the facility cited for two of the concerns—cold water not only in the dining room sink, but also on one hall of the facility for weeks, as well as a lack of activities for residents. Five more of our concerns on the list became proveable and were cited on the 4/2 survey just 10 weeks later. (These were (1) understaffing, with aides working 12, 16, and 20 hour shifts; (2) Charts and records in disarray: (3) visible sores on patients (especially my mother), (4) Bottlenecks of wheelchairs after evening meals, causing late bedtimes for patients, and (5) Aides not using rubber gloves and/or handwashing between patients to prevent infection.

I presented our other concerns also: (1) understaffed kitchen causing late meals and unbalanced menus consisting mainly of starches: (2) numerous serious injuries from falls; (3) wrong medications being given; and (4) the facilities apparent foreknowledge of the times of State visit plans. We felt that these complaints were evident at the time (1/25) we reported them. We do not understand why some could not be proved until 10 weeks later.

At I left the surveyor, I told her CONFIDENTIALLY that there was a nurse who was willing to be contacted to verify, or add to, our list of concerns. I gave her telephone number, and the hours she could be reached. She waited for a call, but was not contacted during the entire time of the visit. After the team left, the administrator called her "on the carpet" where she was accused of "talking to state and to residents' caregivers about confidential matters". Her hours were cut to only 8 per

week and she was so upset she almost quit, even though she had been a loyal employee for over a decade. This incident undermined what little faith we had in our confidentiality being preserved.

On January 30, I received a letter from Julie McCarty, the surveyor who recorded our list of concerns, stating that "several residents, family members, and staff were interviewed" (regarding our list). However, no member of our Family Council was interviewed, except myself. Nor was the nurse who volunteered to be interviewed. The letter said, "records were reviewed", but if they were, why didn't they discover how chaotic they were until 10 weeks later? The letter said that "all shifts were observed", but members of our Family Council were in the facility during the entire time (except for some of the late-night shifts) and none of them saw a surveyor in the facility after 7 p.m. The after-supper bottlenecks continued.

PREPARED STATEMENT OF JOE MAXWELL

Thank you Senator Bond and Members of the Subcommittee on Aging for allowing me to submit written testimony in conjunction with the hearings held in Missouri to discuss the issue of nursing home reform and efforts at the federal level to pass legislation.

As the state of Missouri's official advocate for the elderly, I would have appreciated the opportunity to testify in person at the hearings in Kansas City and St. Louis. In the future, please feel free to contact my office when you need assistance in addressing policies affecting Missouri seniors and their families.

I have long advocated and fought for nursing home reform in our state. Unfortunately, it is long overdue. As Elderly Advocate, my office handles inquiries and concerns from seniors and their families on a daily basis. In the last two years, my staff and I have dealt with some horrific abuse and neglect cases—far too many of which have resulted in death. We've seen seniors who have suffered from severe bums or have choked to death due to a lack of proper supervision. We've seen far too many cases of sexual abuse. And we've seen bedsores so bad that amputation was the only remedy.

This year, after three years of trying, we were finally able to pass meaningful nursing home reform with the passage of The Senior Care and Protection Act of 2003 (SB 556/311). This important legislation was the product of a bi-partisan effort that included a lot of hard work and negotiation on both sides of the aisle.

The Senior Care and Protection Act of 2003 sought to rid our state of the "bad actors" in the nursing home industry by holding them accountable and making them pay the price for non-compliance, while at the same time creating provisions that support the majority of homes that do provide good, quality care. The major provisions in SB 556/311 include:

Increasing fines for violations and making them stick for the most serious violations (prior to this legislation, fines had not been increased in Missouri since 1979 and state regulators had not been able to collect fines that were levied)

Increasing accountability for nursing home administrators by making it a Class D felony for those who conceal abuse or neglect

Requiring criminal background checks for all employees, whether they live in or out of state

Requiring background checks for owners by allowing the state to consider compliance history in other states before granting them a license to do business in Missouri

Protecting nursing home employees from employer retaliation for reporting abuse and neglect

SB 556 passed both houses of the general assembly with overwhelming bipartisan majorities, and enjoyed the strong support of senior advocates throughout the state. At the end of the day, the nursing home industry was divided among those who could support the bill (some reluctantly) and those who finally agreed they could "live with the bill."

Missouri's new nursing home law goes into effect next week on August 28. I am confident that the laws enacted in this legislation will provide our seniors residing in nursing homes with greater protections against abuse and neglect.

I encourage Members of the Committee to take a close look at nursing home reform legislation passed in Missouri and other states in order to ensure that any federal legislation supports, rather than hinders, reform efforts at the state level. I have attached a copy of SB 556/311 for your review and would be happy to respond to any questions you may have.

MISSOURI COALITION FOR QUALITY CARE,
JEFFERSON CITY, MO, 61502,
August 21, 2003.

Hon. KIT BOND,
U.S. Senate,
Jefferson City, MO, 65101.

SENATOR BOND: As a citizen of Missouri and officer of the Missouri Coalition for Quality Care (MCQC), I applaud you on your testimony before the Committee on Finance on July 17, 2003.

This past week I was called by your staff to inquire if I would be interested in testifying at your field hearings in Kansas City on August 19. I was looking forward to this opportunity to express my opinions on the subject of elderly abuse and neglect but obviously the quota had been reached.

I have over 15 years experience as a volunteer ombudsman, both in Iowa and Missouri. I resigned from the Missouri Ombudsman Program in 1997 because my reports on serious complaints were not addressed and facilities were allowed to dictate the ombudsman's role and participation. I joined MCQC in 1998 and find that I can accomplish far more than being confined to an unsuccessful ombudsman program.

The Long-Term Care Ombudsman Program was initiated in 1972, and today—31 years later—Missouri only has ombudsmen assigned to 312 nursing homes out of 1,232 facilities. It is appalling that 920 facilities (75%) are without an ombudsman who is defined as the primary facilitator throughout any complaint or grievance process on the behalf of residents. THIS IS A TRAGEDY!

In your testimony you spoke of the tragic deaths of four elderly residents at Leland Health Care Center in University City, MO., in April of 2001. I am well aware of this catastrophe and the failure to prosecute those responsible. We at MCQC wrote many letters appealing for accountability measures. You know the outcome, you spoke of it in your testimony. A special MCQC recognition award was presented to the paramedics and fire-fighters who responded to the Leland call. It was chilling to hear the details of that tragedy. We were sorry you were unable to attend the ceremony.

I've also encountered many heartbreaking, unresolved problems while serving as an ombudsman. It is incomprehensible that no one wanted to get involved when an elderly couple lost their substantial life savings, when they were forced to sell their last possession of 40 acres for a measly sum of $3,000 so they could receive Medicaid, when the wife's guardian failed to enter funds from—sale of property into her records, when the gentleman had to wear the same colostomy pouch for three days and tie candy wrappers around it to prevent leaking, when the gentleman expressed a desire to move to another facility he was threatened that he would never see his, wife again because her guardian refused to let her move with him—and on, and on, and on. However, we took the guardian to court, the judge ruled that the wife of 65 years should be with her husband, and we moved this couple to another home. They have both passed away within the last two years. We saw to it they were not buried in a pauper's grave. They are buried at a beautiful country cemetery in Yarrow, MO., with a large granite headstone bearing the family name. This gentleman and his wife saved their money and planned well, never dreaming they would be so victimized.

Senator Bond, I am proud that you represent us in the U.S. Senate and was delighted to hear you comment that nursing home residents and their families have suffered and been victimized by problem nursing homes for far too long.

The Missouri Coalition for Quality Care will continue with our mission and goal to improve the quality of care and quality of life of residents in Missouri's long-term care facilities and recipients of in-home care.

Sincerely,

MRS. PHYLLIS KRAMBECK,
Vice President.

TWO AREAS FOR CONSIDERATION—HENRY KRAMBECK

1. Shortage of Volunteer Ombudsmen and Suggestion for Remediation.

With the recent move to limit state inspections of nursing home facilities in Missouri from two per year to one (and in same instances none) it is crucial that all facilities have volunteer ombudsmen on board. However, recent statistics indicate that 75% of the nursing homes in Missouri do nat have ombudsmen serving in their facilities! This is a tragic situation. I believe the student ombudsman program implemented at Truman University in Kirksville, MO. (now in its third year) would

dramatically impact the ombudsman program if duplicated state-wide. The accompanying materials explain the program and detail its success in this area: "A Student Ombudsman Project—An Overview", "Need An LTC Ombudsman? Consider This . . .", "Local Ombudsmen Highlighted in National Publication" and "A Success Story". I hope you would have time to peruse these materials.

2. Nursing Home Bill Needed.

It is a truism that some nursing home administrators do not want volunteer ombudsmen in their facility. This attitude immediately suggests that the facility is not operating efficiently. It is also a fact that some ombudsmen have been terminated by administrators despite the fact they were doing a good job of advocating for the residents. In many instances these terminations were without due process or just cause. Last year I suggested a Bill to Mr. Sam Berkowitz that would remedy this situation. Mr. Berkowitz was anxious to sponsor this Bill but lost his bid for a Senate seat. The Missouri Coalition for Quality Care (a non-profit advocacy group) of which I am a member, is currently looking for someone to sponsor the Bill. The Bill would make it mandatory for a nursing home to accept an ombudsman if one were. available. Further, the ombudsman could be recalled only by the regional ombudsman coordinator and only after due process and just cause.

Thank you for your attention to these suggestions. I firmly believe that, if implemented, the two ideas stated above would have a profound, positive impact on the Missouri state ombudsman program. This would result in better care for nursing home residents as well as to provide a training vehicle for students planning a career in health services.

TRUMAN STATE UNIVERSITY—"A STUDENT OMBUDSMAN PROJECT"

Eta Sigma Gamma is a national professional health education honorary established in 1967. There are approximately ninety-nine chapters nation wide. The only Missouri chapter is located at Truman State University in Kirksville and is coordinated by Dr. Carol Cox of the University. The three elements forming the basic purpose of the organization are teaching, research and service. The organization is designed specifically for professionals in health education. During the year 2001 Dr. Carol Cox came across an article in a periodical relating to the ombudsman program. Realizing this was a program that would fit well with the objectives of the Honorary, she called the toll free number listed in the article. After several subsequent calls she was put in contact with the Mark Twain Legal Services in Canton, Missouri which is the office of the Regional Ombudsman Coordinator for the area wherein the university is located. Arrangements were made for training the student participants and this was accomplished.

On March 14, 2001 I received an email from Clare Wheeler of the Canton office requesting that I interact with the eight trained students and attempt to place them in suitable facilities in the local area. Realizing that time was of the essence (the school year was coming to a close) I decided on a plan that would result in maximum student placement and one that would provide an ongoing source of future participants. It was decided to place student ombudsmen in teams of two, preferably a male and female and to initially utilize juniors and seniors for obvious reasons. After gaining some experience and with the end of the school year in sight, it would be the responsibility of the "experienced" student ombudsmen to select and indoctrinate their successors. We used the analogy of a relay team on a track squad. This plan not only made use of a maximum number of students but afforded the chosen facilities an opportunity for increased resident/patient contacts. It should also be mentioned that some of the students were already certified CNA's. Initial placements were made at Northeast Regional Health Center and the Twin Pines Adult Care Center Both facilities were eager to participate in the program and placement was affected following a brief training session with the students and a placement staffing involving the students, myself and administrators/staff of the facility. Although of short duration because of the school year, the plan worked well and one of the students elected to remain on the job during the summer. I prevailed upon my wife to act as ombudsman of the Twin Pines facility during the. summer. She was successful to the point that I was considering adding additional student ombudsman to that facility under her supervision this school year. Placing a student in each wing would make possible a contact with every resident once each week - an optimal situation. Unfortunately, recent events at Twin Pines relating to staff and communication problems with the facility Board of Directors has undermined this unique opportunity.

Twelve students are participating this school year, four returning students and eight new candidates. They have completed training and we are in the process of placement. Recently I place two students with Mr. Karen Stone, administrator of the LaPlata facility. A few weeks after placement I followed up with Mr. Stone to determine if he was satisfied with the program and his reaction was immediate. He declared it a wonderful program not only for the facility and the residents but for the students as well. It is cooperation such as Mr. Stone's that result in approaching optimum care for our nursing home residents and hospital patients. Dr. Cox and I also have high praise and appreciation for the following people who eagerly participated in the initial program: Marilyn Powell, former administrator of Twin Pines; Louise Smith former social services coordinator of Twin Pines and=Beverly Howard on the staff at Northeast Regional Health Center.

Finally, it should be evident to all concerned that this "pilot program" is deserving of further implementation and analysis. Dr. Cox, my wife and I have contended from the outset that such a program would be worthy of implementation state-wide if not nation-wide. Students would not necessarily have to be members of a health honorary. Most colleges and universities in Missouri have health programs or service programs from which these students could be selected. It would provide an ongoing source of young, energetic people who are interested in the health field for the ombudsman program. Students would benefit significantly from the experience, facilities would benefit from the additional help and, most of all, the residents/patients would be assured of receiving the highest level of care possible. Programs such as described above in conjunction with continuing improvement of the state-wide ombudsman program could result in significant benefits for all citizens.

NEED AN LTC OMBUDSMAN? CONSIDER THIS . . .

Are long term care ombudsman volunteers difficult to recruit in your area? Would a continuing source of trained ombudsmen volunteers be welcome in your community? If your answer to the above questions is a resounding "yes" you might consider developing a program similar to the one currently functioning in Kirksville, Missouri and the surrounding community.

Based on the Truman State University campus in Kirksville, MO is a group of students who are members of Eta Sigma Gamma, a national professional health education honorary established in 1967. Totaling ninety-nine chapters nation wide, only one chapter is located in Missouri. Dr. Carol Cox of the university coordinates the program that is comprised of three basic elements i.e., teaching, research and service. Realizing that the Missouri State Ombudsman program would be a perfect vehicle to realize the basic purposes of the honorary, Dr. Cox made provisions for her students to receive the necessary training for placement as ombudsmen in the surrounding community. Assistance was provided by the Regional Ombudsman Coordinator housed in Canton, Missouri. Administrators of local Nursing Home facilities, Residential Care facilities and the N.E. Regional Health Center were contacted for possible placement opportunities. In almost every instance administrators were eager to participate in the program. Following a pre-placement orientation by a representative of the Canton office, students were presented to the facility administrator and staff for a placement orientation meeting. A supervised facility tour was then undertaken and arrangements made for continuing service. After the student ombudsmen achieve some experience a follow-up meeting is usually held to discuss any problems or concerns. Students are placed in teams of two where possible. Juniors and seniors are placed first for obvious reasons. The analogy of a relay team on a track squad is used in that student ombudsmen who graduate from the University have the responsibility of indoctrinating their successors thus creating a continuing source of trained student volunteers. At this date, all of the students in the program have been placed and are functioning successfully in local facilities within Kirksville and in the outlying communities of LaPlata and Queen City.

It should be stated that the above program could be implemented anywhere in the country. Students would not necessarily have to be members of a health honorary. Most colleges and universities have health or organized programs that are service oriented. Projects similar to that described above would tend to keep interested students in the health field. (It should be noted that some of the students in the Truman project are already CNA's). Students would benefit significantly from the experience, facilities would benefit from the additional help and, most of all, the residents/patients would be assured of receiving the highest level of care possible.

Finally, the following people should be acknowledged for their eager cooperation that led to the initial success of the Truman project: Marilyn Powell, former administrator of Twin Pines Adult Care Center; Louise Smith, former Social Service Direc-

tor of that facility; Beverly Howard, Administrator with the N.E. Regional Health Center; Nan Blickhan, Director of Social Services for that facility and Karen Stone, administrator of the LaPlata Nursing Facility in LaPlata, MO.

LOCAL OMBUDSMEN HIGHLIGHTED IN NATIONAL PUBLICATION

Sara Clouse, Alan Toigo, Henry Krambeck BSwD, MA and Carolyn C. Cox PhD,CHES have recently published an article entitled, "The Student Ombudsman Model" in the nationally recognized journal, "Annals of Long-Term Care - Clinical Care and Aging" from the American Geriatrics Society May 2003 edition. Sara and Alan are both enrolled in the Health Science program at Truman University and are members of the national professional health and science honorary Eta Sigma Gamma. They currently serve as ombudsmen at the LaPlata Long-Term Care facility in LaPlata, MO. Mr. Krambeck is it former educational administrator and has functioned as an ombudsman in Iowa and Missouri since 1989. He currently assists Dr. Cox with the Student Ombudsman Program and serves as liaison person for MCQC (Missouri Coalition for Quality Care). MCQC has formed a partnership with the twenty member student group. Dr. Carolyn Cox is faculty advisor for the award winning Eta Sigma Gamma honorary. Dr. Cox originated the Student Ombudsman Model two years ago with assistance from Mr. Pat Wheeler and Clare Wheeler, regional ombudsman coordinators from Canton, MO. Now in the second year of the program, sixteen student ombudsmen serve all facilities in the area with one exception including LaPlata, Schuyler County, N.E. Regional Health Center, Manor Care and Kirksville Residential Care Center.

A SUCCESS STORY

MCQC's alliance with the Truman University Student Ombudsman Model continues along successful lines. The program, now in its third year, has received local, state and national recognition. Some recent accomplishments include: Student participation with the Coalition in legislative advocacy activities in Jefferson City; Conclusion of a state-wide study, "Long-term Care Administrators' Perceptions of the Ombudsman Program in the State of Missouri" (in review by the journal, The Director; Publication of the Model in the national professional journal, "Annals of Long-Term Care". In addition, the number of area ombudsmen increased six-fold over a two year period with volunteers making over two hundred visits to each area facility (Adair and surrounding counties), impacting 450. residents. All of the participating students have been trained and certified by the Arthritis Foundation as PACE (People with Arthritis Can Exercise) Instructors and teach senior exercise classes in the area (Adair County). Interestingly, some student ombudsmen have changed their major emphasis to Health Care Administration in hopes of becoming a nursing home administrator after graduation!

Sadly, approximately 75% of nursing homes in the state do not have ombudsmen. With the recommended reduction of state nursing home inspections from two visits per year to only one it is critical that an ombudsman be an integral component in every facility. A statewide adoption of the Student Ombudsman Program as utilized in Kirksville could solve the problem. The student volunteers have enjoyed a unique bond with residents while positively impacting that individual's life. In the process, the students amass that body of knowledge necessary to become successful in their chosen career. These students are our health providers of tomorrow!

[Whereupon, at 4:10 p.m., the committee was adjourned.]

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