AARP Kansas
555 S. Kansas Avenue
Suite 201
Topeka, KS 66603

T 1-866-448-3619
F 785-232-8259
1-888-687-2277
TTY 1-877-434-7598
www.aarp.org/ks

March 20, 2013

The Honorable Mary Pilcher-Cook, Chair
Senate Committee on Public Health and Welfare Committee

Reference: In support of SB 236 (With balloon) - relating to the reporting of adult care home/medical care facilities resident deaths

Good afternoon Madam Chair and Committee Members. My name is Ernest Kutzley. I am the Advocacy Director for AARP Kansas. We represent more than 335,000 members in Kansas. Thank you for this opportunity to express our comments in support of SB 236 as drafted and the opportunity to offer a balloon to the bill due to an error in the review of the draft language.

AARP Kansas has long been a proponent of long-term care services and assisting the state in achieving the highest quality of care possible for nursing home residents. We believe that, when families make the very important and difficult decision to admit their elderly loved ones into a nursing home, they should have confidence that their parents, grandparents or loved ones are in good care.

Investigation of Resident Deaths:

Currently no national policy requires the investigation of nursing home resident deaths to determine whether abuse or neglect may have played a role. Arkansas, however, has a unique law that requires coroner investigations of all nursing home resident deaths. Coroners who find reasonable cause to suspect that the death is due to neglect or other "maltreatment" report their findings to the state survey agency and the state Medicaid Fraud Control Unit. Referrals may also be sent to a local city or county prosecutor. The state survey agency treats the coroner reports as complaints and investigates them accordingly.

We believe that Kansas regulations should require that in all cases of death of a resident in adult care homes and medical care facilities, the facility shall immediately report the death to the appropriate coroner. Also, in all cases where death of an individual who was a resident of a long-term care facility occurs in a hospital within five (5) days of entering the hospital, the hospital shall immediately report the death to the appropriate coroner. These reports shall be made regardless of whether the facility or hospital believes the death to be from natural causes or the result of abuse, negligence, or any other cause.

If the coroner, upon investigation, finds reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, he shall report his finding to the police and the appropriate prosecuting attorney. If the institution making the report is a hospital or nursing home, the coroner shall report his findings to the hospital or nursing home unless the findings are part of a pending or ongoing law enforcement investigation (providing a modicum of protection to responsible facilities against frivolous accusations and unwarranted claims).

In testimony given on March 2002, Mark Malcolm Coroner of Pulaski County, Arkansas reported that:

> "Since July 1, 1999 my office conducted approximately 2400 nursing home investigations. In the majority of these cases we have found the level of care provided to be adequate. In 56 death investigations we have uncovered a much different story. We have seen dinner plate-sized bed sores with infected and dying tissue, infected feeding tubes, rapid and unexplained weight loss, dehydration, improperly administered medications and medication errors that resulted in death. We have found basic needs such as general hygiene and dental care neglected, urine and fecal matter dried on bed linens and in diapers left unchanged for hours. We have seen a patient whose care had been so poor that a mucous growth formed on the roof of her mouth and when it finally sloughed off, she asphyxiated and died. When we arrived at the facility to examine this woman, ants were crawling on her bed and body.
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> Without this law in place, these cases would go unreported and unnoticed, and the decedents would simply be released to funeral homes with families left none the wiser. In sixteen years at the Coroner's Office, I have been active at my State legislature on a variety of issues but none more important that Act 499 of 1999. The intention of the legislation was solely for the protection of the long term care patient. However, independent oversight such as that provided by my office can also provide a modicum of protection to respectable, responsible facilities against frivolous accusations and unwarranted claims. Facilities staffed by competent,

conscientious professionals welcome an independent confirmation of good care in the currently litigious atmosphere of their industry.

SB 236 should create a process comparable to the Kansas Children's Death Review Board which examines trends and patterns that identify risk factors in the deaths of children, from birth through 17 years of age. The State Child Death Review Board has developed the following three goals to direct its work:

- To describe trends and patterns of child deaths, identifying risk factors in the population;
- To improve inter-agency communication so recommendations can be made regarding recording of actual cause of death, investigation of suspicious deaths, and system responses to child deaths;
- To develop prevention strategies including community education and mobilization, professional training, and changes in legislation, public policy and/or agency practices.

Why would we propose these changes?

We are not targeting long-term care providers. We are merely asking for a process to protect long-term care residents, support their families, identify adult deaths that occur due to abuse or neglect that now may go undetected, and place adults who live and die in adult care homes on equal footing with adults who live and die at home as it relates to health and safety standards.

Caregiver Support:

The decision to place a loved one in a long-term care facility can be emotionally painful and is based upon expectations that the nursing home will provide a safe environment and the level of care that their loved one requires. Some will and some will not. Unfortunately, gaps in state laws that regulate nursing homes and understaffing have led to deficiencies, abuses and death. Family members and caregivers must monitor their loved one's care and look for any potential signs neglect and poor levels of care including dehydration, malnutrition, and bedsores, infections, and even death.

When a nursing home resident is hurt or neglected, passes unexpectedly, family members wonder why and where to turn to for answers. With care homes in almost every House district, we believe they will turn to you and that support and passage of HB 236 by you

and this committee will be a giant step towards supporting them and protecting this vulnerable population.

Staffing Levels:

In 2010, 32.2 percent of Kansas nursing homes received deficiency ratings for actual harm or jeopardy to their residents. Between April 2009 and November 2012, 106 Kansas nursing facilities received 131 deficiencies specifically for failure to provide adequate nurse staffing.

In Kansas, the current required minimum staffing hours, by law, is 2 hours of direct care by nursing staff each day. There has been no increase in the minimum care requirement for more than 30 years, while the longevity and level of frailty of persons living in nursing facilities, and the assistance they require, has climbed steadily upward. The current level of two hours of care per day does not meet the level of care necessary prevent harm or to maintain functional ability of elders residing in Kansas nursing homes. These findings indicate a serious need for improvement that can be addressed through increasing staffing hours.

No fewer than four national studies have researched and recommended increased resident care by nursing staff in nursing facilities. Those same studies have concluded that residents have improved outcomes when receiving levels of care from 4.13 up to 4.85 hours per day.

Racial Disparities:

Disparities in care exist when underserved communities access both nursing home and home and community- based services. Recent studies show that poorer quality of care in nursing homes is linked to racial segregation. African American residents are more likely to live in poor-quality nursing homes marked by significant deficiencies on inspection reports, substantial staffing shortages, and financial vulnerability.

In a 2007 report by Kathleen Fackelmann, USA Today revealed that a system of separate and unequal nursing home care for black Americans exposes seniors to substandard care. Also, a new report reveals a system of separate and unequal nursing-home care for black Americans, one that could expose frail seniors to substandard care. The study, in the

September/October issue of Health Affairs, found that 60% of blacks in nursing homes ended up in just 10% of the facilities — typically ones that had been cited for quality problems. This report also found that blacks were nearly 1½ times as likely as whites to be in homes that had been cited for deficiencies that could cause immediate harm.

SB 236, as drafted, would require administrators of adult care homes and medical care facilities to report any resident death to the coroner of the county in which the death occurred, regardless of what caused the death. The bill would also make technical changes to update state agency names and identify the state agency with which certain reports are to be filed to conform to Executive Reorganization Order No. 41.

We would ask the committee to support SB 236 and to allow the addition of a balloon to empower the coroner to investigate the reported deaths of care facilities.

> **(4) If the coroner, upon investigation, finds reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, he shall report his finding to the police and the appropriate prosecuting attorney. If the institution making the report is a hospital or nursing home, the coroner shall report his findings to the hospital or nursing home unless the findings are part of a pending or ongoing law enforcement investigation.**
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> **And that all facilities report "Immediately."**

Therefore on behalf of the over 18,000 residents living in Kansas nursing homes and our 350,000 Kansas members, we thank you for your support and hope that you will allow the balloon to empower the coroner to investigate deaths of care facilities residents and that you will support passage of SB 236.

Respectfully,
Ernest Kutzley

AARP Kansas Balloon:

AARP would offer a balloon amendment SB 236 to include the following bolded/underlined text:

> **(4) If the coroner, upon investigation, finds reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, he shall report his finding to the police and the appropriate prosecuting attorney. If the institution making the report is a hospital or nursing home, the coroner shall report his findings to the hospital or nursing home unless the findings are part of a pending or ongoing law enforcement investigation.**
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> **And that all facilities shall report "Immediately".**

AN ACT concerning social welfare; relating to the reporting of adult care home resident deaths; amending K.S.A. 2012 Supp. 39-1431 and repealing the existing section.
Be it enacted by the Legislature of the State of Kansas:
Section 1. K.S.A. 2012 Supp. 39-1431 is hereby amended to read as
follows: 39-1431. (a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a licensed clinical psychotherapist, the chief administrative officer of a medical care facility, a teacher, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a licensed dentist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, licensed professional counselor, licensed clinical professional counselor, registered alcohol and drug abuse counselor, a law enforcement officer, a case manager, a rehabilitation counselor, a bank trust officer or any other officers of financial institutions, a legal representative, a governmental assistance provider, an owner or operator of a residential care facility, an independent living counselor and the chief administrative officer of a licensed home health agency, the chief administrative officer of an adult family home and the chief administrative officer of a provider of community services and affiliates thereof operated or funded by the department of social and rehabilitation services Kansas department for aging and disability services or licensed under K.S.A. 75- 3307b, and amendments thereto, who has reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services shall report, immediately from receipt of the information, such information or cause a report of such information to be made in any reasonable manner. An employee of a domestic violence center shall not be required to report information or cause a report of information to be made under this subsection. Other state agencies receiving reports that are to be referred to the department of social and rehabilitation services Kansas department for children and families and the

appropriate law enforcement agency, shall submit the report to the department and agency within six hours, during normal work days, of receiving the information. Reports shall be made to the department of social and rehabilitation services Kansas department for children and families during the normal working week days and hours of operation.

Reports shall be made to law enforcement agencies during the time social and rehabilitation services Kansas department for children and families are not in operation. Law enforcement shall submit the report and appropriate information to the department of social and rehabilitation services Kansas department for children and families on the first working day that social and rehabilitation services the Kansas department for children and families is in operation after receipt of such information.

(b) (1) Any operator or licensed adult care home administrator shall **immediately** report any death of a resident to the coroner or deputy coroner of the county in which the death occurred, regardless of whether such operator or licensed adult care home administrator has reasonable cause to believe that such death occurred as a result of natural causes, abuse, neglect or any other cause.

(2) Any chief administrative officer of a medical care facility shall **immediately** report any death of a resident kept, cared for, treated, boarded or otherwise accommodated in a medical care facility to the coroner or deputy coroner of the county in which the death occurred, regardless of whether such chief administrative officer has reasonable cause to believe that such death occurred as a result of natural causes, abuse, neglect or any other cause.

(3) As used in this subsection, "operator" and "resident" shall mean the same as in K.S.A. 39-923, and amendments thereto.

(4) If the coroner, upon investigation, finds reasonable cause to suspect that an adult has died as a result of abuse, sexual abuse, or negligence, he shall report his finding to the police and the appropriate prosecuting attorney. If the institution making the report is a hospital or nursing home, the coroner shall report his findings to the hospital or nursing home unless the findings are part of a pending or ongoing law enforcement investigation.

(b) (c) The report made pursuant to subsection (a) shall contain the name and address of the person making the report and of the caretaker caring for the involved adult, the name and address of the involved adult, information regarding the nature and extent of the abuse, neglect or exploitation, the name of the next of kin of the involved adult, if known, and any other information which the person making the report believes might be helpful in the investigation of the case and the protection of the involved adult.

(c) (d) Any other person, not listed in subsection (a), having reasonable cause to suspect or believe that an adult is being or has been abused, neglected or exploited or is in need of

protective services may report such information to the department of social and rehabilitation services Kansas department for children and families. Reports shall be made to law enforcement agencies during the time social and rehabilitation services Kansas department for children and families are not in operation.

(d) (e) A person making a report under subsection (a) shall not be required to make a report under K.S.A. 39-1401 to 39-1410, inclusive, and amendments thereto.

(e) (f) Any person required to report information or cause a report of information to be made under subsection subsections (a) or (b) who knowingly fails to make such report or cause such report not to be made shall be guilty of a class B misdemeanor.

(f) (g) Notice of the requirements of this act and the department to which a report is to be made under this act shall be posted in a conspicuous public place in every adult family home as defined in K.S.A. 39-1501, and amendments thereto and every provider of community services and affiliates thereof operated or funded by the department of social and rehabilitation services Kansas department for aging and disability services or other facility licensed under K.S.A. 75-3307b, and amendments thereto and other institutions included in subsection (a).

Sec. 2. K.S.A. 2012 Supp. 39-1431 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.