

KANSAS ADAPT



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835 EAST 800 ROAD – LAWRENCE, KS 66047
785-748-0832

Testimony in Opposition to HB 2306
Presented to the House Health and Human Services Committee
February 18, 2004
By Kevin Siek, Kansas ADAPT

Chairman Morrison and members of the committee thank you for the opportunity to appear before you today. My name is Kevin Siek and I am a disability rights advocate with Kansas ADAPT. ADAPT is a national grassroots disability rights group that fights for people with disabilities' right to live in the community with real supports instead of being locked away in nursing homes and other institutions.

When I first had an opportunity to give this bill a close look last week my initial thought was, "What are they trying to hide?" As it turns out it didn't take long to find out. That evening the CBS Evening News ran an expose on the ongoing problem of abuse and neglect in our Nation's nursing homes. In the report CBS cited a recent study by the Consumer's Union entitled, "*How Good are Your State's Nursing Homes?*" Amongst the findings of this study were the following:

The number of states in which 10 percent or more of facilities were cited for immediate jeopardy violations nearly doubled from 2001 to 2002. (Kansas made the 2002 list).

From 2001 to 2002, there was a 41 percent increase in the proportion of facilities that had more than 15 percent of their facilities receiving a citation for giving substandard care to residents. (Kansas made both lists).

There appears to be a "yo-yo" pattern of compliance for many facilities that have appeared on the Watch List. 78 facilities were on our first watch list published in 2000 in the Consumer Reports Complete Guide to Health Services for Seniors and on our latest one published in 2002.

The Consumer's Union Study came to the following conclusions:

Some nursing home administrators are doing little to correct deficiencies and problems in their facilities. Nearly one-fifth of the nursing facilities on our 2002 Watch List have been on all of our Watch Lists, indicating that administrators of those facilities and of those on the list for "yo-yo" compliance appear to be doing little to correct deficiencies and problems found by state inspectors working on behalf of the Centers for Medicare and Medicaid Services.

Given the widespread authority among states to fine questionable nursing facilities, many states are not using it to penalize homes with deficiencies in the care they deliver.

States and the Federal government make it hard for consumers to learn about penalties assessed against nursing homes, thus keeping consumers in the dark about vital information they should know before placing a loved one in a facility.

These findings echo those of a recent GAO report entitled, *“Nursing Homes: More Can Be Done to Protect Residents from Abuse.”* In addition to previous findings, this report found, in part, that “Allegations of physical and sexual abuse of nursing home residents frequently are not reported promptly. Local law enforcement officials indicated that they are seldom summoned to nursing homes to immediately investigate allegations of physical or sexual abuse. Some of these officials indicated that they often receive such reports after evidence has been compromised. Although abuse allegations should be reported to state survey agencies immediately, they often are not. For example, our review of state survey agencies’ physical and sexual abuse case files indicated that about 50 percent of the notifications from nursing homes were submitted 2 or more days after the nursing homes learned of the alleged abuse. These delays compromise the quality of available evidence and hinder investigations. In addition, some residents or family members may be reluctant to report abuse for fear of retribution while others may be uncertain about where to report abuse.’

Further, “Few allegations of abuse are ultimately prosecuted. The state survey agencies we visited followed different policies when determining whether to refer allegations of abuse to law enforcement. As a result, law enforcement agencies were sometimes either not apprised of incidents or received referrals only after long delays. When referrals were made, criminal investigations and, thus, prosecutions were sometimes hampered because witnesses to the alleged abuse were unable or unwilling to testify. Delays in investigations, as well as in trials, reduced the likelihood of successful prosecutions because the memory of witnesses often deteriorated.”

This legislation seeks to eliminate one of the few tools that vulnerable Kansans with disabilities have to defend themselves against the abuse and neglect that is pervasive within the nursing home industry. Rather than make it easier for the state to punish the “bad actors” in the industry, this bill actually benefits the worst offenders by limiting the scrutiny that courts can apply, particularly in cases where there is a pattern and practice of abuse and neglect.

It is this kind of legislation that keeps Kansas ranked among the top ten states that provide a substandard quality of care in their nursing homes (Consumer’s Union ranked Kansas 6th on the percentage of nursing facilities with citations for substandard quality of care). I strongly urge you to oppose HB 2306.

The reports cited in this testimony can be found online at:

How Good Are Your State’s Nursing Homes?

<http://www.consumersunion.org/health/nursing-rpt603.htm>

Nursing Homes: More Can Be Done to Protect Residents from Abuse

http://www.canhr.org/rights/rights_reports/Rights_pdfs/MoreProtection.pdf