

**Statement of Luis Navas-Migueloa
Local Long-Term Care Ombudsman, Baltimore City
Long Term Care Ombudsman Program**

**To the
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations**

**“In the Hands of Strangers: Are Nursing Home Safeguards Working?”
May 15th, 2008**

May 12, 2008



*Helping Older Adults
Live Better in Baltimore . . .
One Day at a Time.*

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Luis Navas-Migueloa, Long-Term Care Ombudsman
Commission on Aging and Retirement Education
City of Baltimore**

Good Morning Congressman John Dingell and distinguished members of the Subcommittee. My name is Luis Navas-Migueloa. I am a local Long Term Care Ombudsman with the City of Baltimore's Long-Term Care Ombudsman Program. I am joined by the manager of the Long-Term Care Ombudsman Program, Ms. Deborah Hamilton. We thank you for the opportunity to participate in today's hearing to discuss the advocacy role of the Long Term Care Ombudsman in nursing homes; and to give the committee first hand examples of cases in which the inability to access nursing home ownership has had a direct correlation to the resolution of the complaints and quality of life/care issues.

Commission on Aging & Retirement Education (CARE)

Background

The Baltimore City Commission on Aging and Retirement Education (CARE) is the designated Area Agency on Aging (AAA) for the Planning and Service Area of Baltimore City, which is the largest city in the State of Maryland. The City has the third largest senior population in the State, ranking behind Baltimore and Montgomery Counties. According to the 2000 Census, 110,961 or 13.85% of Maryland's over aged 60 population live in Baltimore City. The City's senior population tends to be somewhat older compared with that of Maryland as a whole; 9% of Baltimore's over 65 population is over age 85, compared with 8.4% statewide. Fifty-seven percent (57%) of seniors are members of minority groups; of these, 55% are African-American. Asian-Americans,

Hispanics and Native Americans each comprised less than 1% of the City's elderly population.

Baltimore City Long Term Care Ombudsman Program Background

Baltimore City's Long-Term Care Ombudsman Program is comprised of four (4) Long Term Care Ombudsman, one (1) program manager and volunteers.

It is my responsibility as a Long Term Care Ombudsman to visit residents in Baltimore City nursing homes and assisted living facilities. On a regular basis I investigate, receive and attempt to resolve complaints made by or on behalf of residents. Additionally, as Ombudsmen we are responsible for general advocacy activities on behalf of residents, observation of conditions in facilities, meeting with family and resident councils, and providing in-service training to staff.

Our local program provides advocacy services to 31 nursing homes and 323 assisted living facilities. In 2007 we handled 661 investigative complaints, 2013 information and assistance calls and conducted eighteen (18) in-service training sessions to area nursing home staff in an effort to increase staff empathy, reduce abuse and the violation of residents rights in area long term care facilities.

Complaint issues include but are not limited to, quality of life issues, resident to resident conflicts and abuse, which range from physical, sexual and verbal abuse to lack of linens in the nursing facility. Complaints are received from residents, facility staff, visitors and

families as well as complaints generated by a Long Term Care Ombudsman during deficiencies observed during facility visits.

As a Long Term Care Ombudsman I advocate for residents of nursing homes and assisted living facilities. I identify, investigate, and resolve complaints made by or on behalf of residents; I seek administrative, legal and other remedies to protect the health, safety and rights of residents; as well as represent the perspective of the residents in monitoring laws, regulations and policies.

Testimony

Statistics show that half of us who reach 65 years of age or older will, at some point, reside in a nursing home; therefore the incidents I am sharing with you could describe any of our experiences in the future.

As a Long-Term Care Ombudsman, I have observed the difference between nursing homes owned and managed by small employers, and those owned and managed by large corporate, unknown or business enterprises. In some nursing homes the owner is identifiable, reachable and responsive. In other nursing homes, the owner is hidden by layers of corporations, management companies and boards of directors, who may or may have not ever entered the nursing home. When posed with the question of which is better from my experiences, I can only answer with an analogy: If you are looking for the best dining experience, would you rather have dinner in a chain restaurant or in one where the chef is the owner?

When dealing with the less transparent nursing home, there usually is an obvious lack of personal contact which turns into a lack of personal care and concern. There seems to be a detachment from the purpose and mission of a nursing home, which should be to take care of the most vulnerable population: the elderly and physically and mentally disabled. This detachment translates to questionable practices such as reduced staffing, poor maintenance, limited pest-control contractors, and even discrimination against residents based on payee status.

The following is an example of decision making that can adversely impact the resident's quality of life. Nursing homes attempted to force Medicaid residents to move to the older part of the nursing home while reserving the newly opened wing of the building for private-pay residents. The residents that were compelled to move were initially unaware that the proposed move was due to their payee status. Nursing home staff admitted to me that the administration made a list of Medicaid residents. They then requested that these residents be moved to the older rooms of the nursing home because the beds in the newly built building were going to be used for private pay residents. The staff member also admitted that the residents and their families had to be told that their beds were no longer being used for long-term care.

When the administrations of these nursing homes were confronted by the evidence gathered by the ombudsman, the responses differed depending on the type of ownership. The nursing home with the identifiable owner admitted to the practice, and immediately stopped it. The administrator of the nursing home with the less transparent ownership completely denied the allegations, and instead interviewed staff members to find out who

gave the information to the ombudsman regarding their practice. This is an example of how the public's lack of access to the ownership of the nursing home serves as a shield, or buffer for the nursing home administration.

The following example will show that when there is no direct access to the owner, the nursing home can take greater liberty to cover-up blatant violations. Recently, while visiting a resident in his room, I noticed a strong odor of marijuana coming from the open window. The resident and I looked out the window and I saw four female staff members at the back door of the facility smoking what smelled like marijuana. When the staff members saw me looking at them, they immediately put out their smoking paraphernalia and ran inside the building through the back door, semi-adjacent to the resident's room. The resident informed me that "they do that all the time". Knowing that the building is equipped with security cameras, I went to see the administrator. He initially appeared receptive and responsive to the concerns regarding the dangers of having direct-care staff working under the influence of drugs.

The administrator then became pensive and said that the cameras were not recording and that I should call him the next day in order to find out details of their internal investigation. As requested, the next day I called the administrator; he declined to share any information regarding the incident. In addition, he stated that after having spoken with his corporate office he could "no longer believe the allegations made by me", and the incident was now considered a personnel matter. From that point on the Ombudsman no longer was privy to subsequent information deemed necessary to protect the quality of care in this facility.

This nursing home has changed ownership at least three times in the last few years. It has always had problems related to staffing. Additionally, unattended vermin infestations and building disrepair repeatedly have been issues addressed with the administration by the ombudsman. The complaints were responded to but not completely resolved because minimum efforts were expended. For example, in lieu of calling an exterminator, in-house maintenance staff put down glue traps which were ineffective.

One day recently, only 1 of the 4 floors had fully working showers. I screened residents on several floors, many of whom reported they had no access to working showers in three weeks. This is yet another example of how a problem could have been more appropriately addressed if the owners of the nursing home were more readily accessible to residents, families and the ombudsman.

In another nursing home, financial problems caused the nursing home to cease operations. The quality of care and life of the residents was diminished for over two years. Problems uncovered included: an unpaid water bill exceeding \$50,000, a malfunctioning boiler, and unpaid trash collection contractors. These debts resulted in the nursing home having to pay cash on delivery when food, supplies and other services were rendered on the premises. Overflowing outside trash collection containers and reduced staff became the norm due to mounting debts. The state regulatory agency and our program worked together and closely monitored the facility during this period.

In two and a half years of visiting this nursing home, the facility hired about six different administrators, a host of nursing directors, a handful of social work directors, and so on.

The only constant was the CEO who reportedly answered to a management company based out of Chicago and a local board of directors. This inconsistent and ever changing web of parties made it difficult and sometimes impossible to resolve some complaints.

At some point, out of frustration, the Nursing Home Administrators routinely gave a laundry list of complaints to the ombudsman. These administrators were frustrated because they also could not identify an entity to hold accountable; the Connecticut based management-company, the board of directors or the CEO. Unfortunately, the mounting problems were not resolved and the nursing home voluntarily ceased to operate August of 2007.

In conclusion, although the figure of the administrator does exist in all nursing homes, his or her role is apparently different depending on the ownership of the nursing home for which they work. Normally, the administrator is seen as the go-to person when change is needed. If I have a concern in a transparently owned nursing home and I am able to address my concerns with the administrator, it is not uncommon to have the problem solved or at least addressed prior to me leaving the facility.

When there is a problem in a nursing home with an absent owner it is difficult, and sometimes impossible to bring a resolution to problems. The administration becomes the buffer between the owners and the problems which occur in the facility.

Residents, families, and advocates in general, are limited to speaking with an individual who is either hiding problems from the ownership of the nursing home, or hiding the ownership from the people who end up suffering due to these problems.

I was not asked to offer solutions, describe the resolution process or possible sanctions. I am here to merely present the problems encountered in nursing homes by Long Term Care Ombudsman.

Again, half of us who reach the age of 65 will end up living in a nursing home.

Thank you for your time.