Opponent Testimony on SB 453
House Committee on Health & Human Services

Submitted by:
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Madam Chairwomen and members of the House Committee, thank you for allowing me the opportunity to offer opponent testimony on behalf of SB 453 – related to certified aides working in adult care homes.

My name is Dustin Baker. I come to you with over 20 years of diverse healthcare and nursing expertise. My journey in nursing was not a traditional one. I started as a Certified Nursing Assistant in long-term care serving our seniors. Then earning my LPN, associates, baccalaureate, and master's in nursing. I am an Advanced Practice Registered Nurse, Family Nurse Practitioner, and a Nurse Educator with experiencing in teaching nursing students and our aides both in long-term and in the hospital. I have been a lifelong advocate for seniors.

I come to you in opposition of SB 453 for one simple reason, our seniors deserve better! While I understand the workforce shortage firsthand, this bill would simple be bad business for Kansans. The COVID-19 pandemic shined light on what occurs when we lower the bar for our seniors. In the last week it has been brought to my attention of the abuse and neglect that has occurred because of the relaxed laws during the pandemic.

Through Executive Order (EO) 22-02 and HB 2477 our Governor and Legislators created the Temporary Nurse Aide Training Program (TNA). This program allows an individual to complete an 8-hour unsupervised or timed training course completely online. Upon completion, they will receive an additional 20 hours of skills training in a long-term care facility. This shortened training course that allows them to perform the same duties of a Certified Nursing Assistant (CNA) who has had 90 hours of training in the state of Kansas is absurd. Our nursing homes do not need more "warm bodies" in them taking care of our grandparents. They need highly trained and educated folks. Someone who has been trained to handle the challenges that occur in our most vulnerable population.

The work of a CNA is difficult. They are required to perform highly skilled task, such as transferring residents; feeding residents; promoting resident independence; dress/undress a resident living with dementia who is having communication difficulties who is swing their fist at them; reposition residents at a minimum of every 2 hours; recognize when a resident is at risk for skin breakdown to prevent damage to tissues and bedsores; demonstrate accurate

measurements of vital signs, recognize reportable conditions and values; keeping residents free from abuse, neglect, exploitation, and report it when suspected; demonstrate feeding techniques to prevent a resident from choking; and perform lifesaving skills, such as CPR and abdominal thrust, previously known as the Heimlich maneuver. These are skills that require more than just 40 hours of training to understand the science and skills behind it. In accordance with CMS definition 483.35 "competency" is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. It requires clinical judgement, discernment, effective communication skills, and a comprehensive understanding of the aging process.

The creation of the TNA position is one example that has placed our seniors at great risk of abuse and neglect already. This position was created to help elevate the workforce shortage, but what in fact it did was created a pathway for seniors to be subjected to crimes against them. A prime example is what occurred at a Kansas nursing home during the EO. CMS and KDADS report obtained from public records shows a corporate owned long-term care facility in Richmond, KS, where an agency CNA whiteness a facility TNA abuse a resident. The report goes on to reveal that the TNA smacked the resident five to six times across the mouth. It was reported to the facilities administrative personnel who dismissed the CNA concerns and the charge nurse in fact shrugged her shoulders when she was informed. It was not the facility who reported the crime, but rather the agency administrative personnel who filed the report to protect the residents. The facility allowed the TNA to continue to work for 15 hours and 20 minutes after the abuse occurred. Placing the 39 residents in the facility at risk for additional abuse and crimes from this TNA. Is this the type of "trained" staff you want taking care of you?

Kansas currently has 324 licensed adult care homes in the state. There are 114 who are currently on the watch list for serious deficiencies, with 67 who have had payments suspended from CMS. Kansas has 169 facilities who have been banned from participating as a clinical site for CNAs because of their severe deficiencies and low quality of care to their residents. As of today, we have not received answers from KDADS if these facilities would be permitted to train these nurse aides. Are these really facilities we want training individuals who are going to be caring for our seniors?
In closing, I urge you to vote NO with regards to SB 453. Our seniors deserve to receive high quality long-term care from their services providers. Remember it's not the seniors who get to choose who care for them. By allowing this legislation to move forward it would place all of them at risk for abuse and neglect, just like the resident from Richmond, KS.

References

ProPublica. (2022). Nursing Home Inspection Report, Kansas. Retrieved from https://projects.propublica.org/nursing-homes/state/KS
CMS. (2022). CMS Form 2567 for Richmond Healthcare & Rehab Center. Retrieved from https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/175444/health/complaint?date=2021-01-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175444	A. Building B. Wing	01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Healthcare & Rehab Center	340 E South Street Richmond, KS 66080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0608 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 39 residents. Based on interview and record review, the facility failed to report suspicion of a crime against Resident (R)4 to the State Agency and one or more law enforcement entities after notification received of an allegation of abuse. The facility received notification from a nursing staffing agency on 12/24/20 at 03:30 PM that a Certified Nurse Aide (CNA) had witnessed Temporary Nurse Aide (TNA-staff member that has completed a shortened training course to be able to do the duties of a CNA during the COVID-19 pandemic) hit R4 in the mouth multiple times. Findings included: - The Physician Orders, located in the electronic medical record (EMR), dated 11/02/20, included diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The Admission Minimum Data Set (MDS), dated [DATE], assessed R4 as having clear speech, she could sometimes make herself understood, and she could sometimes understand others. Her Brief Interview of Mental Status score (BIMS's) had an answer of not applicable on the MDS due to her being rarely/never able to make herself understood. The staff assessment for mental status indicated R4 had short and long term memory problems, no memory/recall ability, and severely impaired decision making skills. She had no behaviors but did wander four to six of seven days in the assessment period. She required supervision and set-up for bed mobility, walking in room and corridor, locomotion on and off the unit, and eating. She required limited assistance of one staff member for transfers and extensive assistance of one staff for dressing, toilet use, and personal hygiene. The Cognitive Care Area Assessment (CAA), dated 04/22/20, indicated she admitted with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . She would nod her head to yes or no questions and was alert and oriented to her name only. The Communication CAA, dated 04/22/20, indicated that R4 spoke very little and did follow cues and instructions. The Quarterly MDS, dated [DATE], matched the prior MDS with these changes: wandering occurred daily, she required limited assist of one for bed mobility, and required extensive assistance of two or more staff for toilet use. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0608 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan, dated 10/08/20, revealed that R4 had impaired cognitive function and impaired thought process and directed the staff to ask yes or no questions in order to determine needs. The staff were to identify themselves at each interaction, face her when speaking and make eye contact. Staff should reduce distractions such as turning off the television, radio, closing the door, etc., and know she understood consistent, simple, directive sentences. The staff were to provide her with necessary cues and stop and return if agitated. R4 should have one thought, idea, question, or command presented to her at a time. The care plan also included that R4 needed assistance with her care needs, she could ambulate through the memory care unit and staff were to supervise for safety. Two staff were needed to assist with dressing, one staff for personal hygiene and transfers, and one to two staff were required to assist with toilet use. Review of the facility investigation summary, undated, for R4, indicated that on 12/24/20 at approximately 03:30 PM Administrative Nurse D received a call from agency staff OO reporting that Certified Nurse Aide (CNA) M observed Temporary Nurse Aide (TNA) LL smack a resident five or six times. The investigation summary revealed that Administrative Nurse D dismissed CNA M's allegations. On 12/30/20 CNA M reported to Administrative Nurse D that she had observed TNA LL pop R4 on the face multiple times on 12/23/20. Also, during an interview on 12/30/20, CNA P reported to Administrative Nurse D that she had witnessed TNA LL pop R4 in the mouth on 12/24/20. The facility failed to report the allegation to the State Agency and one or more law enforcement entities. On 01/05/21 at 04:10 PM, Administrative Nurse D reported there was an investigation for R4, but she felt like nothing had happened, and that administrative staff did not call the allegation into the state. On 01/06/21 at 01:11 PM, Administrative Staff A revealed an internal investigation was done and we deemed it did not occur, so we did not report it to the state. The facility policy Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, dated 2017, that included Addendum A, undated directed that in response to allegations of abuse, neglect, exploitation or mistreatment, staff shall: Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The facility failed to report the allegation of abuse to the State Agency and one or more law enforcement entities.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 39 residents. Based on interview and record review, the facility failed to protect the residents of the facility from an alleged perpetrator (AP) when staff allowed the AP to work after they received notification of alleged abuse on 12/24/20. The facility received notification from a nursing staffing agency on 12/24/20 at 03:30 PM that a Certified Nurse Aide (CNA) M witnessed the alleged perpetrator, Temporary Nurse Aide (TNA- staff member that has completed a shortened training course to be able to do the duties of a CNA during the COVID-19 pandemic) LL hit Resident (R)4 in the mouth multiple times. TNA LL was on duty at the time of the allegation and remained on duty until 12/25/20 at 06:50 AM, 15 hours and 20 minutes after the facility received the notification of the alleged abuse. Failure to remove the alleged perpetrator from the facility pending an investigation placed all of the residents in the facility at risk for staff to resident abuse. Findings included: - The Physician Orders, located in the electronic medical record (EMR), dated 11/02/20, included diagnoses [MEDICAL RECORD OR PHYSICIAN ORDER] . The Admission Minimum Data Set (MDS), dated [DATE], assessed R4 as having clear speech, she could sometimes make herself understood, and she could sometimes understand others. Her Brief Interview for Mental Status score (BIMS) had an answer of not applicable on the MDS due to her being rarely/never able to make herself understood. The staff assessment for mental status indicated R4 had short and long-term memory problems, no memory/recall ability, and severely impaired decision-making skills. She had no behaviors, but did wander four to six of the seven days in the assessment period. She required supervision and set-up for bed mobility, walking in room and corridor, locomotion on and off the unit, and eating. She required limited assistance of one staff member for transfers and extensive assistance of one staff for dressing, toilet use, and personal hygiene. The Cognitive Care Area Assessment (CAA), dated 04/22/20, indicated she admitted with a diagnosis [MEDICAL RECORD OR PHYSICIAN ORDER] . She would nod her head to yes or no questions and was alert and oriented to her name only. The Communication CAA, dated 04/22/20, indicated that R4 spoke very little and did follow cues and instructions. The Quarterly MDS, dated [DATE], matched the prior MDS with these changes: wandering occurred daily, she required limited assist of one for bed mobility, and required extensive assistance of two or more staff for toilet use. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Care Plan, dated 10/08/20, revealed that R4 had impaired cognitive function, impaired thought process, and directed the staff to ask yes or no questions in order to determine needs. The staff were to identify themselves at each interaction, face her when speaking, and make eye contact. Staff should reduce distractions such as turning off the television, radio, closing the door, etc., and know she understood consistent, simple, directive sentences. The staff were to provide her with necessary cues and stop and return if agitated. R4 should have one thought, idea, question, or command presented to her at a time. The care plan also included that R4 needed assistance with her care needs, she could ambulate through the memory care unit, and staff were to supervise for safety. Two staff were needed to assist with dressing, one staff for personal hygiene and transfers, and one to two staff were required to assist with toilet use. Review of the facility's Investigation Summary, undated, indicated on 12/24/20 at approximately 03:30 PM Administrative Nurse D received a call from Agency Staff OO reporting that CNA M observed TNA LL smack a resident five or six times on 12/23/20. The investigation summary revealed Administrative Nurse D dismissed CNA M's allegations. On 12/30/20 CNA M reported to Administrative Nurse D that she observed TNA LL pop R4 on the face multiple times on 12/23/20. Also, during an interview on 12/30/20, CNA P reported to Administrative Nurse D that she witnessed TNA LL pop R4 in the mouth on 12/24/20. The facility failed on 12/24/20 to complete a thorough investigation of the alleged violation and dismissed the allegation until 12/30/20, when interviews were being conducted and the allegations were brought to the attention of Administrative Nurse D again. Review of the Timecard Detail Report, dated 12/20/20 through 01/02/21, indicated TNA LL clocked in on 12/23/20 at 02:00 PM and clocked out at 10:35 PM. On 12/24/20 at 10:00 AM she clocked in, then clocked out at 07:30 PM, clocked back in at 08:00 PM, and remained clocked in until 12/25/20 at 06:50 AM. The facility failed to remove TNA LL from access to residents when notified of the allegation of abuse. Review of the Complaint Investigation Witness Statement, revealed statements were collected on 12/30/20, including from CNA M, CNA P, and TNA LL, six days after receiving notification of the allegation on 12/24/20. On 01/04/21 at 07:28 PM, CNA M reported she worked the night shift at the facility from 06:00 PM to 06:00 AM and was in the room with TNA LL while providing cares to R4 and saw TNA LL pop the resident in the mouth six times or more. CNA M reported to the charge nurse what she had seen, and the charge nurse shrugged her shoulders. The next morning, she contacted the agency she worked for and informed them of what she had seen. On 01/05/21 at 04:10 PM, Administrative Nurse D reported there was an investigation for R4, but she felt like nothing happened, and that administrative staff did not call the allegation into the state. Furthermore, she revealed that administrative staff did not suspend TNA LL because she was PRN (as needed) and not on the schedule. On 01/06/21 at 11:55 AM, Administrative Nurse F revealed that CNA M reported to her on 12/25/20 at the beginning of her 06:00 PM to 06:00 AM shift that TNA LL had moved her hand back and forth lightly over R4's mouth, and that it had also happened a few days prior. Administrative Nurse F revealed that she texted Administrative Nurse D after CMA M told her what CNA M reported. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/06/21 at 01:11 PM Administrative Staff A revealed an internal investigation was done and determined the abuse did not happen, so they did not suspend TNA LL. On 01/07/21 at 09:37 AM, Agency Staff OO confirmed CNA M reported to her on 12/24/20 that she had seen another staff slap a resident four to five times. Agency Staff OO revealed she notified the facility the same day and reported the allegation to Administrative Nurse D. The facility policy Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, dated 2017, that included Addendum A, undated directed that in response to allegations of abuse, neglect, exploitation or mistreatment, staff shall: 1. Have evidence that all alleged violations are thoroughly investigated. 2. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in process. a. Means of prevention shall include but are not limited to: suspension of employment, removal from the building and/or premises, removal from work assignment, prohibition from entering the building or premises, restraining order separation of residents, 1:1 observation or other means as necessary to the situation. 3. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The facility failed to ensure the residents of the facility remained free from contact from the TNA LL from the time the facility received the allegation of abuse on 12/24/20 at 3:30 PM, when they allowed TNA LL to work on 12/24/20 from 10:00 AM to 7:30 PM, and then from 8:00 PM until 6:50 AM on 12/25/20. This placed all of the residents in the facility at risk for staff to resident abuse. On 01/07/21 at 04:08 PM, Administrative staff A was informed the residents were in immediate jeopardy and was provided the Immediate Jeopardy Template for failure to protect the residents of the facility when staff allowed the alleged perpetrator to remain on duty at the time of the allegation, placing all of the residents of the facility at risk for staff to resident abuse. The facility abated the immediate jeopardy on 01/08/21 at 09:30 AM when they completed the following: 1. The last day TNA LL worked was 12/25/20 at 06:50 AM. 2. Provided education to the facility staff regarding Abuse, Neglect, and Exploitation including the need to provide protection to the residents of the facility until competition of the investigation and the outcome was determined. Completed 01/07/21 at 10:00 PM. 3. Developed a system where the administrator will monitor compliance weekly for four weeks and then monthly for six months. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. Held a QAPI meeting with all required disciplines on 01/08/21 at 9:30 AM to discuss and develop a plan for compliance of the identified deficient practice. Following validation of the removal of the immediate jeopardy, on 01/08/21 at 9:30 AM, the deficienct practice remained at a scope and severity of an F.