ARIZONA HOUSE OF REPRESENTATIVES
Fifty-fifth Legislature - Second Regular Session

HOUSE AD HOC COMMITTEE ON ABUSE AND NEGLECT OF VULNERABLE ADULTS

Report of Interim Meeting
Thursday, July 14, 2022
House Hearing Room 1 -- 2:00 P.M.

Convened 2:01 P.M.
Recessed
Reconvened
Adjourned 4:44 P.M.

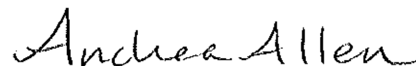
Members Present	**Members Absent**
Representative Longdon, Chairman	Mr. Carey
Representative Dunn, Vice-Chairman	
Ms. Collins	
Thomas Salow, designee of Mr. Herrington	
Ms. Kennedy	
Ms. Knupp	
Mr. Meyers	
Joshua Clark, designee of Ms. Ortiz	
Christopher Rodriguez, designee of Ms. Reed	
Meaghan Kramer, designee of Mr. Rico	
Ms. Snyder	
Mr. Wisehart	

Agenda
Original Agenda – Attachment 1

Committee Attendance
Report – Attachment 2

Presentations

Name	Organization	Attachments (Handouts)
Lindsey Perry	Auditor General	3
Don Herrington	AZ Department of Health Services	4
Paul Vescio	Chaplain	5



Andrea Allen, Committee Secretary
July 15, 2022

(Original attachments on file in the Office of the Chief Clerk; video archives available at http://www.azleg.gov)

CORRECTED

Interim agendas can be obtained via the Internet at http://www.azleg.gov /Interim-Committees

ARIZONA HOUSE OF REPRESENTATIVES

INTERIM MEETING NOTICE
OPEN TO THE PUBLIC

HOUSE AD HOC COMMITTEE ON ABUSE AND NEGLECT OF VULNERABLE ADULTS

Date: **Thursday, July 14, 2022** Convened 2:01p

Time: **2:00 P.M.** adjourned 4:44p

Place: **HHR 1**

Members of the public may access a livestream of the meeting here:
https://www.azleg.gov/videoplayer/?clientID=6361162879&eventID=2022071004

AGENDA

1. Call to Order
2. Introductions
3. Presentation by the Office of the Auditor General
   - Department of Health Services - Performance Audit and Sunset Review 30-month Follow-up Report
4. Response by the Department of Health Services
5. Committee Discussion
6. Update on 2019 Ad Hoc Recommendations
7. Public Testimony
8. Adjournment

Members:

Representative Jennifer Longdon, Chair
Representative Timothy M. Dunn, Vice Chair
David Carey
Sherri Collins
Thomas Salow - designee of Don Herrington
Dana Kennedy
Cheryl Knupp
Jon Meyers
Joshua Clark - designee of Elizabeth Ortiz
Christopher Rodriguez - designee of April Reed
Meaghan Kramer – designee of Jose de Jesus V Rico
Jami Snyder
Michael Wisehart

~~07/08/2022~~
RA

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Attachment 1

ARIZONA STATE LEGISLATURE

Fifty-fifth Legislature - Second Regular Session

INTERIM COMMITTEE ATTENDANCE RECORD

COMMITTEE ON HOUSE AD HOC COMMITTEE ON ABUSE AND NEGLECT OF VULNERABLE ADULTS

CHAIRMAN: Timothy M. Dunn VICE-CHAIRMAN: JENNIFER LONGDON

	DATE	07/14/22	/22	/22	/22	/22
	CONVENED	201 p m	m	m	m	m
	RECESSED					
	RECONVENED					
	ADJOURNED	4:44 pm				
MEMBERS						
Mr. Carey		--				
Ms. Collins		√				
Thomas Salow-designee of Mr. Herrington		√				
Ms. Kennedy		√				
Ms. Knupp		√				
Mr. Meyers		√				
Christopher Rodriguez-designee of Ms. Reed		√				
Meaghan Kramer-designee of Mr. Rico		√				
Ms. Snyder		√				
Mr. Wisehart		√				
Dunn, Vice-Chairman		√				
Longdon, Chairman		√				

√ Present --- Absent exc Excused

Attachment 2

Arizona Department of Health Services

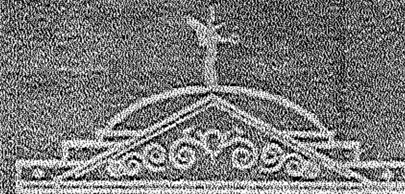
30-Month Followup—Long-term Care Facility Complaints and Self-Reports

Presenter: Melanie M. Chesney

Date: July 14, 2022

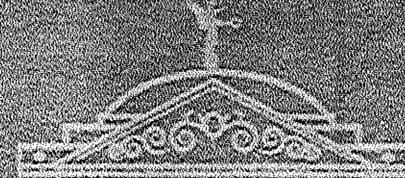
Attachment 3

Department's key long-term care facility responsibilities



- Licensing long-term care facilities (i.e., nursing homes)
- Ensuring long-term care facilities meet both State licensing and federal certification requirements
- Investigating complaints and self-reports involving these facilities in accordance with federal CMS requirements

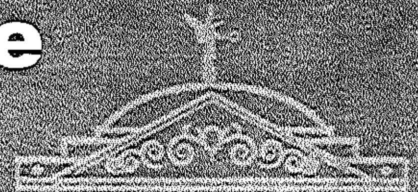
Definitions



- Complaints—An allegation or concern about a long-term care facility regulatory violation, including resident abuse or neglect submitted by an individual or another State or federal agency

- Self-reports—A potential regulatory violation, including resident injuries of an unknown origin, allegations of resident neglect and/or abuse, and misappropriation of resident property, reported by a long-term care facility

CMS' complaint investigation time frame requirements



Complaint and self-report priority levels

- **Immediate Jeopardy**—An immediate and serious threat to health and safety; must start on-site investigation within ***2 working days of receipt***
- **High Priority**—Actual harm that impairs a resident's mental, physical, and/or psychosocial status, or hazards to health and safety that may exist; must start on-site investigation within ***10 working days of prioritization***
- **Medium Priority**—Harm or potential harm of limited consequences; must start on-site investigation ***within 45 working days or by next on-site inspection***

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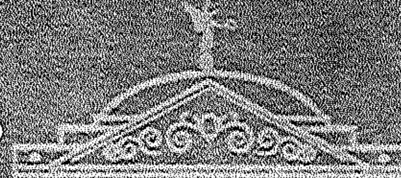
September 2019 audit found complaint investigation problems



Department failed to investigate or timely investigate some long-term care facility complaints and self-reports

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AuditorGeneral
Making a Positive Difference

Followup done to determine whether recommendations implemented

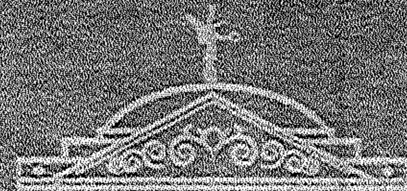
- Reviewed and analyzed Department long-term care facility complaint data for July 1, 2019 through April 21, 2021
- Department had implemented 0 of 5 recommendations
- Identified additional significant complaint-prioritization problems and investigation failures
- State-wide long-term care facility residents' health, safety, and welfare continued to be at risk

Deficiencies with complaint prioritization and investigation processes

Department:

- Closed most High-Priority complaints without required on-site investigation
- Failed to start investigations within required 10 working days for majority of High-Priority complaints it investigated
- Inappropriately changed almost all open High-Priority complaints to lower priorities

Reasons given do not explain deficiencies



Department deficiencies are not explained by:

- Lack of staff
- COVID-19 pandemic

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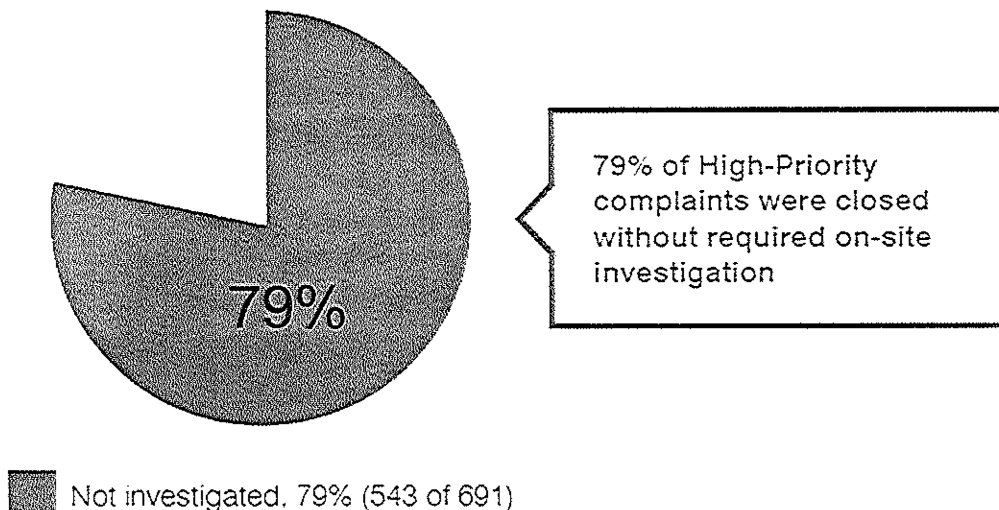
Department closed most High-Priority complaints without required investigation

Department closed 543 of 691 High-Priority complaints without the required on-site investigation



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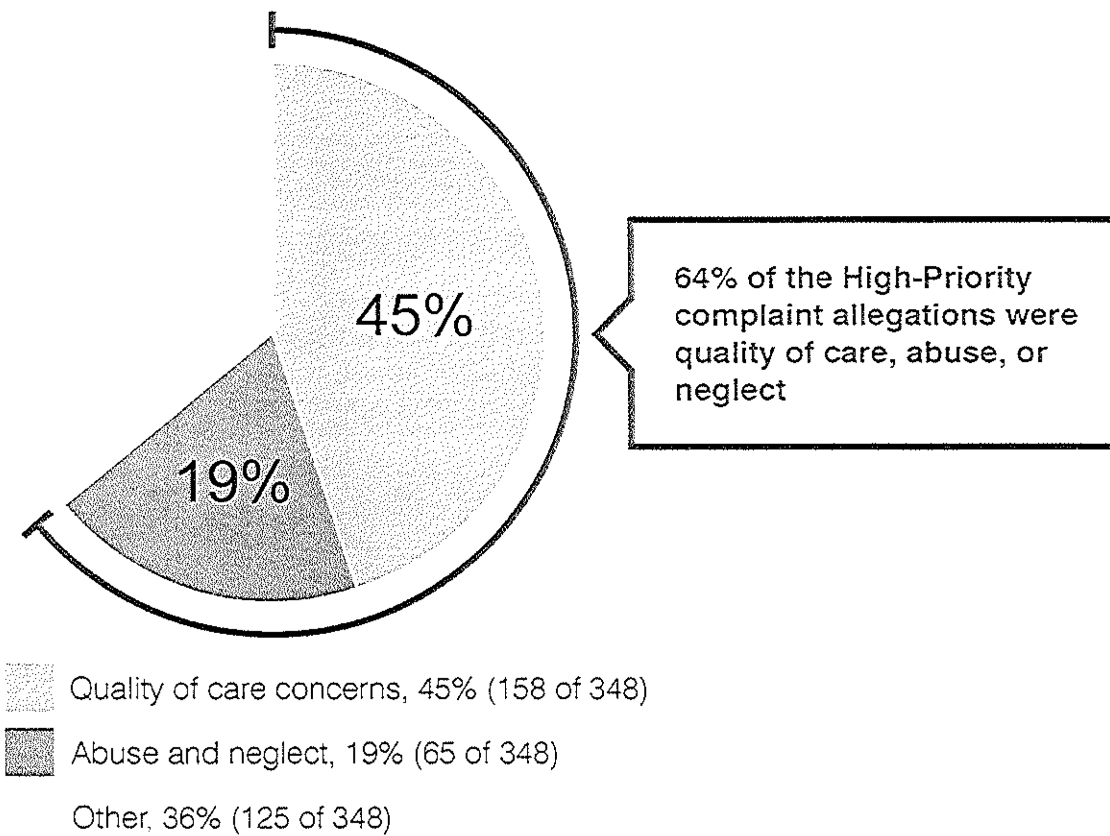
Most High-Priority complaint allegations were quality of care, abuse, or neglect



Department appeared to systematically close complaints without investigations

Department staff: *Department chose to close complaints without conducting investigations to address complaint backlog*

- April 2020, 1 staff member closed 200 complaints in 3 days, taking about 6 minutes to close each one

High-Priority complaint Department inappropriately closed

July 2019, Department received complaint from daughter of long-term care facility resident

She complained that her father, who was nonverbal and resided at the facility since April 2019:

- Was hospitalized in early July 2019 with pressure ulcer
- Pressure ulcer resulted in necrosis of skin and bone infection

Father placed in hospice care due to pressure ulcer

Father died at end of July 2019

High-Priority complaint Department inappropriately closed (cont'd)

Upon receipt, Department:

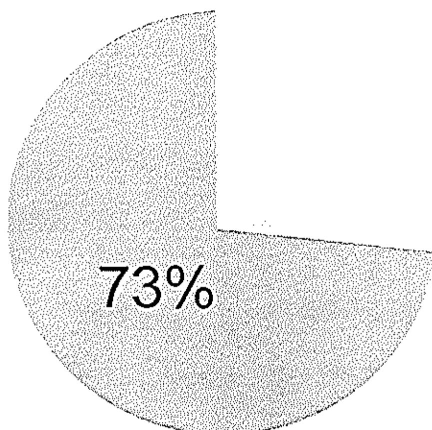
- Classified complaint as alleged neglect
- Assigned complaint High-Priority level, requiring Department to initiate on-site investigation within 10 working days

18 months later, Department instead:

- Closed it without investigation
- Took no action against facility

Department did not start most investigations within 10 working days

Department failed to initiate investigations for 114 of 156 High-Priority complaints within 10 working days



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Auditor General
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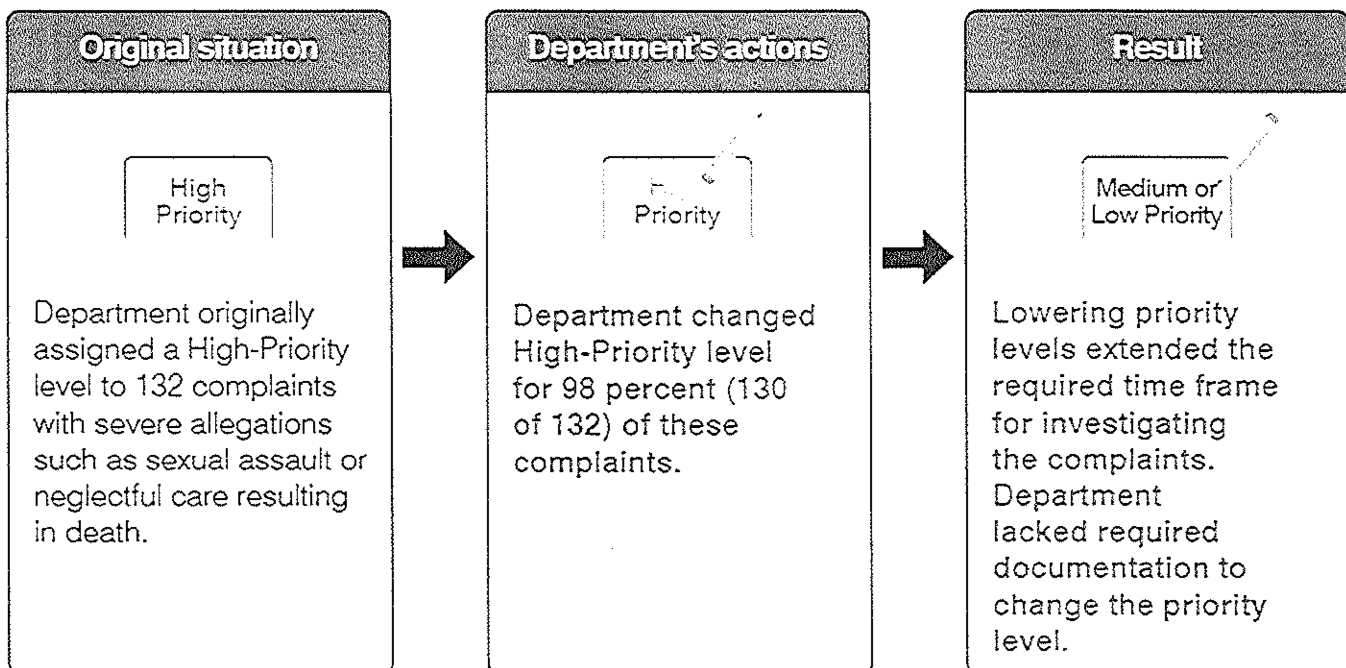
Department improperly changed High-Priority complaints to lower priorities

Department improperly changed 98 percent of its open High-Priority complaints to either Medium- or Low-Priority levels



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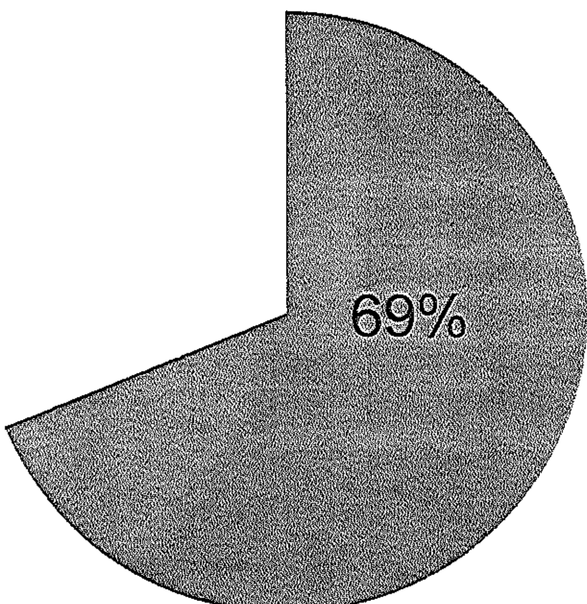
Complaints with lowered priorities had mostly severe allegations



Severe allegations, such as sexual assault or neglectful care resulting in death

Severe allegations, 69% (101 of 146)

Other, 31% (45 of 146)

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Department lacked info to change priority level for all but 1 complaint

Department lacked necessary information to support changing the priority level for 68 of 69 complaints reviewed

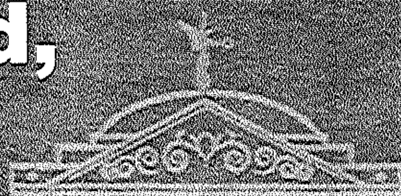
Improperly changing complaint priority level increased time for Department to investigate complaints from 1 day to 1 year

Department staff: *APS and family of deceased complaints not credible*

Staff member who prioritizes complaints explained that complaints from Adult Protective Services and family members of deceased residents are:

- Not credible
- Sensationalized

When complaints not investigated, residents unprotected



Department considered front-line responder

When Department does not investigate complaints, it:

- Fails to provide expected protective oversight
- Fails at prevention

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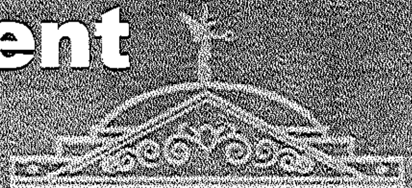
High-Priority self-report Department failed to investigate

October 2020, Department received self-report regarding nonverbal, dependent resident who was found with white, sticky substance on vaginal area

Department classified it as sexual abuse and assigned High-Priority level, requiring Department to initiate its own on-site investigation within 10 days

CMS requirements state that sexual abuse allegations represent a crisis, requiring immediate action

High-Priority self-report Department failed to investigate (cont'd)



Department failed to conduct required on-site investigation and therefore:

- Was unable to substantiate complaint
- Could not take any actions to protect that resident and other residents
- Did not have information from own investigation to take action against facility despite awareness of problems with facility's handling of incident

Eight months after receipt, Department closed self-report without taking action against facility

When complaints not investigated, facilities and staff not held accountable

When Department does not investigate complaints, it:

- Can compromise investigations and requirements placed on facilities to remedy issues

- Can restrict Department's ability to refer facility staff to law enforcement or regulatory boards

When complaints not investigated, public lacks important information

When Department does not investigate complaints, it:

- Cannot provide public with complete information
  - Facility with over 300 complaints, but website has information for only 7 complaints Department investigated
- Undermines public confidence
- Circumvents CMS oversight

Key recommendations

Department should:

- Implement 5 prior report recommendations
- Use risk-based approach to review and reassess improperly handled complaints/self-reports
- Provide staff training on CMS requirements
- Ensure staff follow CMS requirements

Arizona Department of Health Services

30-Month Followup—Long-term Care Facility Complaints and Self-Reports

Presenter: Melanie M. Chesney

Date: July 14, 2022

Department Presentation

Abuse & Neglect of Vulnerable Adults Ad-Hoc Committee

Presented by Interim Director, Don Herrington

July 14, 2022

Attachment 4

Table of contents

P3 Long-Term Care Overview

P4 Why are we here?

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ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

Licensing Overview

The Division of Licensing Services licenses, certifies, and inspects approximately **20,600** facilities and **220,000** individual licensees.

Complaints & Self Reports

- **Average of 8,000** complaints and self-reports received annually

Compliance & Inspections

- In addition to conducting investigations of complaints and self-reports, the Department performs inspections of new facilities before they open as well as compliance inspections for existing facilities.

Long-Term Care Overview

The Division of Licensing Services' Bureau of Long-Term Care (BLTC) Facilities Licensing, licenses, certifies, and inspects approximately 150 long-term care facilities.

Complaints & Self Reports

- **3855** complaints and self-reports received annually

Compliance & Inspections

- In addition to conducting investigations of complaints and self-reports, the Department performs inspections of new facilities before they open as well as compliance inspections for existing facilities.

ARIZONA DEPARTMENT OF HEALTH SERVICES

Health and Wellness for all Arizonans

Why are we here?

Why are we here?

Brief History

- In September 2019, the Arizona Auditor General (Auditor) released a Sunset Performance Review of the Arizona Department of Health Services handling of complaints and self-reports within its Bureau of Long-Term Care Facilities Licensing.
- As part of the Auditor's follow-up, it was determined the Department was not handling complaints and self-reports appropriately.

Auditor Recommendations

Recommendation A

Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

Recommendation B

Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

Recommendation C

Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

Recommendation D

Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

Recommendation E

Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

Recommendation A

Recommendation A. Continue with its efforts to allocate new or reallocate existing staff to prioritize, investigate, and resolve long-term care facility complaints and self-reports on a full-time basis.

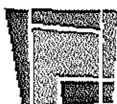
CHALLENGES

Historically, BLTC has had challenges with hiring and retaining staff.

- Nurses are required during investigations to clinically assess clients per the Centers for Medicare & Medicaid Services (CMS) guidelines. Throughout the U.S., nurses are in high demand. The Department is in constant competition with private entities enticing nurses with higher pay, sign-on bonuses, alternative schedules, etc.
- Additionally, once employees have completed CMS training, many leave to join the private sector for higher pay.

SOLUTIONS

- In 2021, the Legislature appropriated approximately $1.6 million in funding to assist the Department with attracting and retaining staff members.
- The Department is reallocating staff to a team that focuses on investigating complaints and self-reports.
- The Department has created a career path for its surveyors to help retain employees and increase pay for surveyors.
- The Department is looking into providing incentives to be paid out incrementally over an employee's first year of employment, as well as referral incentives.
- The Department has hired 2 of what was 16 open surveyor positions at the time of the Auditor's review.
    - 14 surveyor positions remain open and are posted on AZStateJobs.gov
- In addition to surveyors, the Department has posted a Deputy Assistant Director position and has hired a Quality Control Administrator to assist with consistency within BLTC.



Recommendation B

Recommendation B. Develop and implement a time frame for completing investigations and closing long-term care facility complaints and self-reports.

SOLUTIONS

- The Department conducted a comparison of CMS and state policy to identify potential gaps and opportunities for improvements to state policy; as a result, the Department revised its complaint policy for BLTC. The policy sets Immediate Jeopardy complaints to be investigated within 2 calendar days. High Priority complaints are investigated within 10 days.
- The Department implemented the updated policy on July 1st, 2022.

AZ DEPT OF HEALTH SERVICES (ADHS) Division of Licensing Services (DLS) – Long-Term Care (LTC) Facilities	LEVEL	SECTION	NUMBER	DATE
	II	DLS	1.0	07.01.2022
SUBJECT: LTC Complaint Self-Report Triage and Reprioritization Process	SUPERSEDES: DLS Complaint Self-Report Process 2000, 2011, 2019 (for LTC only)			

PURPOSE
To provide a systematic procedure for triaging and reprioritizing complaints and incidents received by the Division of Licensing Services (DLS) for long-term care facility (LTC) licensees [illegible] the licensed individual, administrator or authorized official for the LTC licensee.

POLICY
[illegible]

AUTHORITY
A.R.S. § 36-104.6. Powers & Duties. The Director shall:
Formulate policies, plans and programs to effectuate the missions and purposes of ADHS.

APPLICABILITY
This policy and procedure applies to all State and Federal program personnel in the DLS who [illegible] investigate LTC facilities.

DEFINITIONS
Complaint means a report made to the DLS by anyone that alleges noncompliance with State and/or Federal laws and regulations, excluding required official notifications by the licensee.

Incident means a required official notification to the DLS from a LTC licensee. Also known as a "self-reported incident."

Intake means an allegation of noncompliance that through the intake process is defined as either a "complaint" or "incident."

Licensee means the licensed individual, administrator or licensed facility, or authorized official for the LTC facility.

See Appendix [illegible]

PROVISIONS AND GUIDELINES
1. DLS LTC shall follow State and Federal laws, rules, and requirements for complaints/incidents. The DLS LTC is expected to have written policies and procedures to ensure the appropriate response is taken for each complaint/incident.
2. The Centers of Medicare and Medicaid Services (CMS), the State Medicaid Agency, and the DLS are responsible for ensuring that participating licensees of health care services continually meet Federal requirements. In cases where this is applicable, the State Operations Manual (SOM) requirements are used. NOTE: Should variation exist between this policy and the SOM, the SOM shall take precedence for any case in which the SOM is applicable, unless variation is permitted under the SOM (e.g. State policy applies stricter time frames than SOM for inspection).
3. This policy shall be reviewed and updated as needed, at a minimum, every three (3) years.

ARIZONA DEPARTMENT OF HEALTH SERVICES

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Recommendation C

Recommendation C. Regularly update its policies and procedures to reflect changes in its current long-term care facility complaint and self-report investigation and resolution practices and CMS requirements.

SOLUTIONS

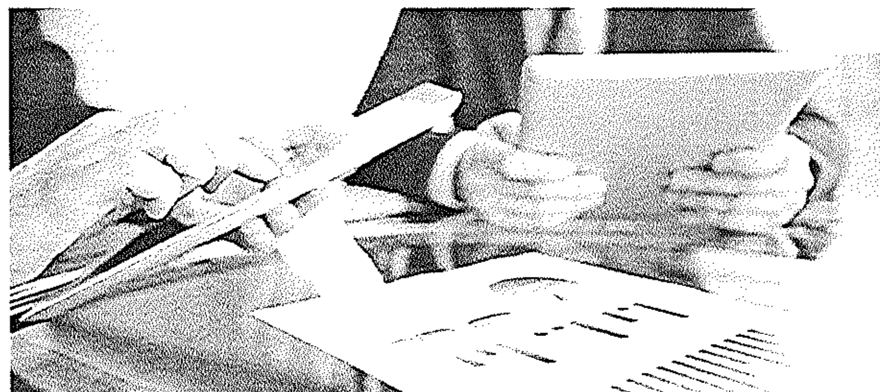
- The Department conducted a comparison of CMS and state policy to identify potential gaps and opportunities for improvements to state policy; as a result, the Department revised its complaint policy for BLTC.
- To further implement the recommendation, the Department updated the BLTC Complaint Review policy and is requiring it to be reviewed and updated every three years. This is consistent with the ADHS policy that all policies are reviewed every three years. It should be pointed out the policy is not limited to every three years and can be reviewed as need arises before the scheduled three year review.

Recommendation D

Recommendation D. Develop and implement additional bimonthly management reports to monitor whether and how quickly its long-term care facility complaints and self-reports are being prioritized, investigated, and resolved.

SOLUTIONS

- The Department will use existing bi-monthly management reports and create additional management reports, as needed, to monitor whether and how quickly complaints and self-reports are prioritized, investigated, and resolved.
- Currently, the Department is holding daily huddles and meeting weekly to review reports. Reports are rolled up to the Agency Scorecard.



Recommendation E

Recommendation E. Ensure that any complaints and self-reports that are investigated during an annual survey or outside of the annual survey are initiated and investigated according to the time frames required by the assigned priority level.

SOLUTIONS

- The Department will continue the complaint and self-report review process using Continuous Quality Improvement methodologies for opportunities to:
  - Bring more complaints to each inspection, and
  - Link each complaint to an inspection in the system.
- The Department will create a team of complaint specialists. The number of intakes (complaints and self-reports) indicate this would be an effective strategy to be timely in investigating and completing data entry.

Department Actions &
Supplemental Information

Summary of Topics

This section is intended to provide data, stats, and additional details related to the Department's actions and other supplemental information; it is broken into three sub-topics.

01
Strides Since 2019 Auditor's Report

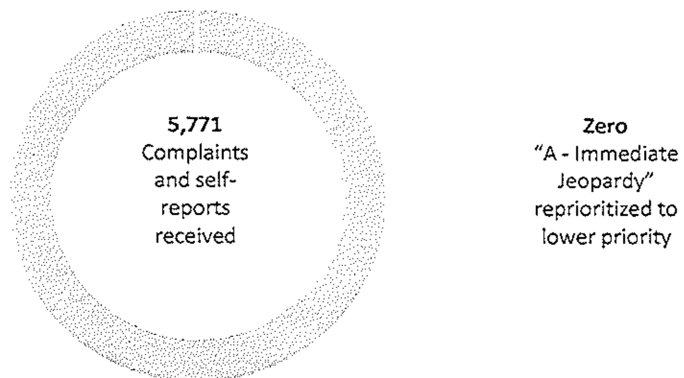
02
Response to Issues

03
Budget

Strides since 2019 Auditor's Report

Reprioritization: Reprioritization of a complaint or self-report can mean the initial priority changes to a higher or lower priority.

Complaints & Self-reports Received Between January 1, 2021 and June 30, 2022



Zero
"A - Immediate Jeopardy" reprioritized to lower priority

Data provided by CMS for Federal Fiscal Year 2022 stated, on average, "Arizona investigates High Priority B complaints within 3 working days as compared to the national average of 9 working days. **On average, Arizona closes these complaints within 19 working days compared to the national average of 39 working days.**" This data from CMS is based on federal complaints linked to a federal investigation.

Strides since 2019 Auditor's Report

Facility Visits

- Since July 1, 2021, BLTC received approximately **2,193 complaints** and **1,739 self-reports**. 99% of those complaints and self-reports were triaged (assigned a prioritization) within 2 business days.
- Since July 1, 2019, BLTC has made **over 1,000 visits** to long-term care facilities and has, on average, visited these facilities at least twice per year. In the last 3-year period, BLTC, on average, visited each facility about **7 times.**

July 1st – June 30th	BLTC Facilities	Facilities Visited (%)	Avg visits per facility	Visits	Onsite Investigated Complaints
FY20	155	100%	2.6	399	522
FY21	155	90%	2.8	438	386
FY22	155	84%	2.1	322	548

Strides since 2019 Auditor's Report

Oversight

Under the State Operations Manual (SOM), *CMS is responsible for monitoring the Department's management of complaints and incidents to assure that the SAs are complying with the provisions set forth in Federal regulations, the SOM, and CMS policy memoranda.*

ARIZONA DEPARTMENT
OF HEALTH SERVICES

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Strides since 2019 Auditor's Report

Interagency Touch Points

- The Department meets with the Department of Economic Security (DES), including Adult Protective Services and the Long-Term Care Ombudsman Program on a monthly basis to discuss interagency issues.
- The Department attends conference calls with CMS at least twice a month to discuss topics that may impact the survey process.

ARIZONA DEPARTMENT
OF HEALTH SERVICES

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02 Response to Issues in the Report

Intake: AZ00157653

Summary: This complaint was submitted with concerns their parent was transferred from the facility to an emergency department for an extensive pressure ulcer, the family was not notified of the skin breakdown prior to the transfer and a bone infection was identified at the hospital. The resident was subsequently enrolled into hospice care.

01

Immediate Action

The Department requested hospital records the same day the complaint was triaged, and the hospital sent records within 30 minutes.

02

Full Review

- Resident was diagnosed with Dementia and Stage 4 Pressure Injury.
- Family notified of a wound approximately two weeks prior to hospital admission, but not notified the wound was worsening.
- 4 days after admission, resident developed a new wound ("Kennedy Ulcer") and a medical practitioner suspected the resident would soon pass away in the hospital.
- Approximately four hours later, the resident was discharged to an unnamed skilled nursing facility.

03

Attempt to Identify Root Cause

The Department requested Medical Examiner records, however, the County Medical Examiner declined to perform the autopsy.

04

Facility Follow Up

The Department has conducted four on-site inspections resulting in deficiencies cited since the date this intake was received and triaged. The Department did not take enforcement action during this time period.

02 Response to Issues in the Report

State Operations Manual – Guidelines for Determining Immediate Jeopardy

Chapter 5 – 5075.1 (Immediate Jeopardy):

- The regulations at 42 CFR 489.3 define immediate jeopardy as, "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident."
- Appendix Q **contains the Guidelines for Determining Immediate Jeopardy.** Intakes are assigned this priority if the alleged noncompliance indicates there was serious injury, harm, impairment or death of a patient or resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment or death of a patient or resident unless immediate corrective action is taken.

Chapter 5 – 5075.2 (Non-Immediate Jeopardy):

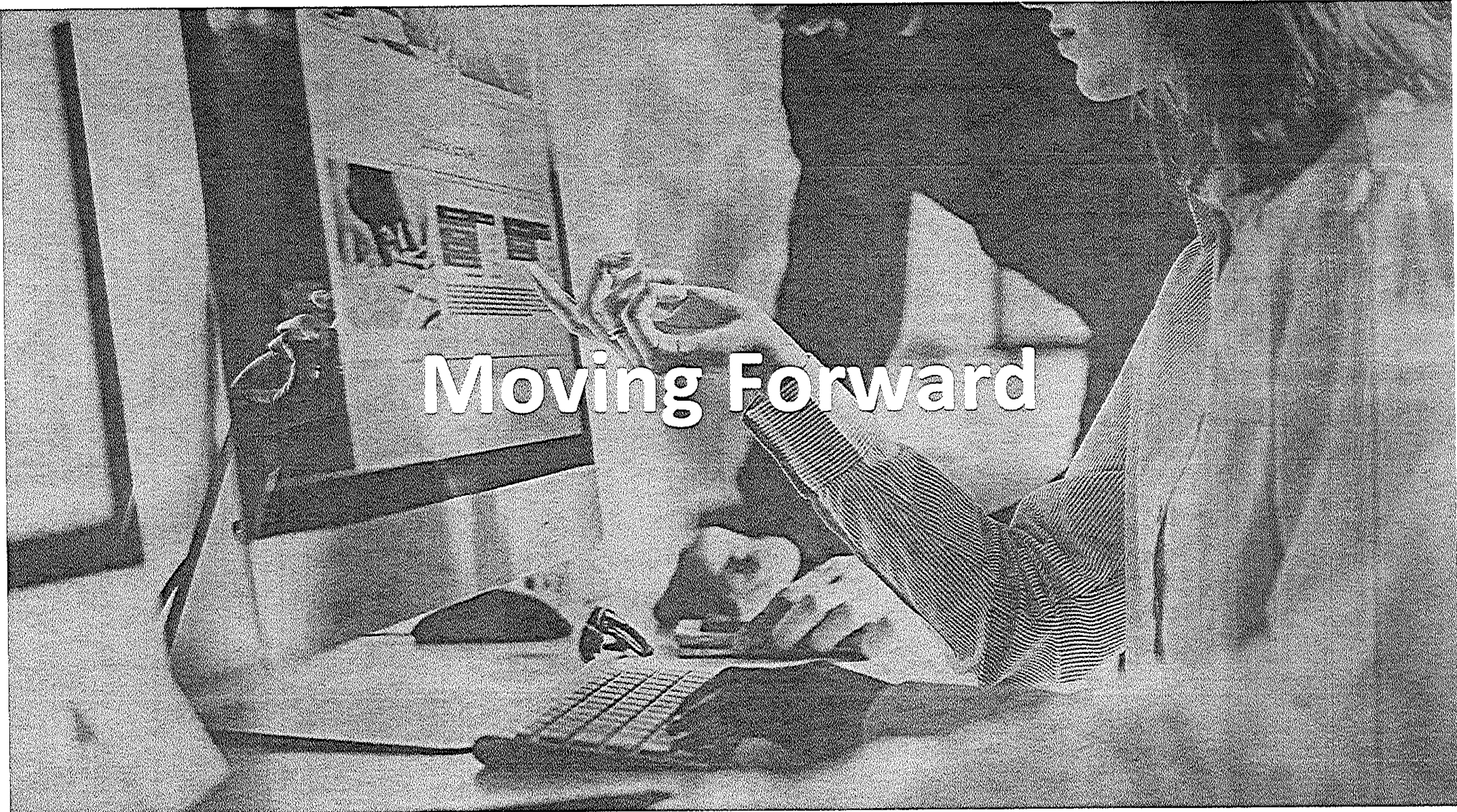
- Intakes are assigned a "high" priority if the alleged noncompliance with one or more requirements may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's well being that a rapid response by the SA is indicated.[2]

[2] CMS, State Operations Manual, Chapter 5, Rev. 50, 07-10-09, pp. 15-16

03 Budget

Funding and Budget

- Funding issue proposed September 2020 for an additional 44 FTEs @ $3,269,280.
- Additional funding, $1,634,700, was appropriated from the general fund for 16 FTE Positions in FY22.
- State Budget: $1.1 Million of the Licensing Fund (HS1995) is allocated toward BLTC.
- As of June 30, 2022, approximately $35,000 of the appropriated money has been spent.


Moving Forward

Moving Forward

- The ADHS Bureau of Long-Term Care Facilities Licensing (BLTC) has been highly engaged with long-term care facilities during the period covered by the Auditor's report. We acknowledge these efforts have not met the Auditor General's 2019 recommendations amid the pandemic.
  - Since July 1, 2019, the Bureau of Long-Term Care has made approximately **1,000 visits** to long-term care facilities, visiting each facility, on average, **seven times.**
- The Department implemented all the recommendations and **responded to the 30-month follow-up report on July 1st**, including:
  - Continue to follow the new complaint assignment process to ensure all investigations are posted on AZCareCheck.com, including those complaints deemed unsubstantiated.
  - Continue to follow the new complaint policy that prohibits complaints and self-reports from being re-prioritized except under specific situations.
- Additional information and updates will be available when the Department follows up with the Joint HHS Committee in **less than 90 days.**

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

In Conclusion…

Amid the COVID-19 outbreak, and on instruction from the Centers for Medicare and Medicaid Services, the Department's main focus shifted to infection control surveys for long-term care facilities with a goal of reducing the chances of outbreaks that could endanger residents. We take pride in ADHS exceeding the CMS requirements for these infection control surveys, which staff conducted for all facilities and handled rapidly when outbreaks were reported. Meanwhile, the ADHS Bureau of Long-Term Care Facilities Licensing continued responding aggressively to complaints and self-reports judged to involve immediate jeopardy to the health and well-being of residents.

At ADHS, we strive to do better today and moving forward.
When we fall short, our priority is to do better.

We sincerely appreciate the Auditor General's detailed review and recommendations for how we can do that. We are responding with specific, actionable, and measurable steps to enhance licensing and oversight of Arizona's long-term care facilities.

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

Thank You

ARIZONA DEPARTMENT
OF HEALTH SERVICES

Health and Wellness for all Arizonans

Healthcare Reform Testimony Submitted Into The Record

By Chaplain Paul D Vescio 7-14-22

In Arizona the staff to patient ratio is 1 RN and 3 to 4 CNAs per 63 patients and at night and on the weekends there are times when there are only 1 RN and 2 CNAs on an entire floor with 60 patients. This lack of staff is causing widespread neglect, abuse, and mistreatment of the patients. I have patients who are having to wait hours to be changed and waiting hours to be cared for. Patients waiting 6 and 7 hours and even longer is inexcusable and places the patient's lives and mental state of wellbeing in grave danger.

When a patient is being forced to wait hours to be changed it not only effects their physical health but it greatly effects their mental health as well. Waiting hours to be changed opens the door wide for infection, bed sores, mersa, rashes, e-coli and the like. When a patient is healing from surgery on their lower back side and is sitting in their soiled diapers for hours on end the urine and their feces can get into the patient's wound and become sepsis. I have had female patients develop e-coli because they were forced to wait for hours to be changed, their feces got into their body where the catheter entered.

The CNAs are responsible for the bathing and the changing of the patients. Most RNs are very reluctant to help the CNAs so if there is only 1 CNA for over 30 patients or more then the wait time is hours to be attended to.

The State of AZ does not have any minimum staffing mandates that are properly enforced. The AZLTC Licensing Dpt informed me that their department does not respond to issues caused because of staffing shortages. When a patient is forced to wait hours to be changed it stings and can be very painful for the patient, not only that but the feces dries and sticks to the skin and when it is being cleaned it is very painful.

No state agency does anything about these healthcare issues except write a report and file it off to NEVER, NEVER LAND and believe me I contacted every single one of them.

The solution is to mandate the staff to patient ratio in our state set at 2 RNs and 4 CNAs per 25 to 30 patients this will greatly improve the safety, comfort, and quality of care for the patients. This min. Staffing mandate needs to be heavily enforced by all state agencies who are responsible to do so with real consequences for noncompliance.

In Arizona if someone defaces or destroys a political sign the fine is $750.00 but if a patient in a AZ nursing home, care center, or medical rehab dies because of neglect the fine is only $500 so the next question becomes, "Does the State of AZ place more value on political signs then they do our lives?

Attachment 5

In order to improve the quality of care the fines for neglect, abuse, and mistreatment in these healthcare facilities that result in death have got to be raised to around $50000, doing this along with mandating the staff to patient ratio will greatly improve the safety, comfort, and quality of care for the patients. No patient in America should ever have to wait for more than 15 min to be cared for it is inhumane and immoral that these poor suffering souls are being treated this horribly and being treated this poorly.

The state of Arizona needs to provide Public Attorneys free of charge to represent families and patients who do not have the resources to hire an attorney when the patients have been abused, neglected, or mistreated. Criminals are afforded Public Defenders provided by the state, I ask you don't we owe it the those who raised us and helped us get to where we are today in life to at least provide these poor suffering people with the resources they need in order to help them stand up and fight back for what's right in American healthcare?

In closing, on Sept 17 2021 CMS issued new visitation guidelines that allowed patients with covid to receive in person visits from members of the Clergy and family. The facility where I serve was out of compliance for over three months before I found out about it and contacted the Reginal Compliance Director of the parent company where I serve as a Volunteer Christian Community Chaplain. Once I brought this issue to the Compliance Director's attention she worked to open up the covid unit for visits by family members and by members of the Clergy. I ask you, how could this have happened? These are CMS Government Regulations that must be followed by law. These regulations are sent out to these healthcare facilities regularly. There are staff meetings that pertain to these regulations so they can be properly implemented. Where was AZLTC Licensing Dept concerning these issues. Why aren't these healthcare facilities contacted by phone when new regulations come out in making sure these healthcare facilities are in compliance? The patients and the family members who were denied their right to have visits for over three months need to be notified by the state of AZ so they can decide what if any action they would like to take so something like this could never happen again? These people have a right to know what happened and the Attorney General needs to do something about it.

The AZ LTC Licensing Dpt conducts only one inspection per year and there are no surprise inspections or any inspections at all at night or on the weekends when there is the least staff and the most violations. The facility where I serve is being tipped off in advance of an inspection and gets everything shined up just right for the inspection. All volunteers including myself were told not to come in during an inspection because they do not what to run the risk of us saying anything negative against the facility and they do not what to run the risk of the Surveyors asking us any questions.

Thank You Respectfully Chaplain Paul D Vescio 602-386-6382 www.miraclesogkingman.com