Iowa View: Let’s make sure this doesn’t happen again

State officials need to act to prevent cases like John Chedester’s


These are some of the words that readers have used in reaction to Clark Kaufman’s Jan. 28 Des Moines Register article, “Airing Yet ‘Dropped’ by Drake Care Site.” Kaufman told the story of John Chedester, a 65-year-old Navy veteran evicted from an Iowa nursing facility last fall for failing to pay his bill and then dropped off at an unlighted apartment with no food, medication or phone.

So many things were wrong about the story — why Mr. Chedester’s wishes to be placed at the Iowa Veterans Home weren’t met; why the nursing facility lied; why no one intervened to assist; why the nursing facility viewed an unlighted apartment as an acceptable alternative; why the state’s long-term care ombudsman’s office wasn’t notified of the pending eviction; why Mr. Chedester was not notified or his right to be escorted by the ombudsman’s office; and why was Mr. Chedester, after a hospital stay, returned to the same nursing facility that had evicted him earlier?

When the Register asked for my comment, I said, “This is a gut-wrenching and disturbing story. What happened to Mr. Chedester should not have happened, and we need to make sure that it never happens again — to anyone, anywhere.”

How can we help ensure that? While I don’t have all the answers, I offer some recommendations that I hope will be seriously considered by Gov. Terry Branstad, state legislators and other state officials.

- Investigate and hold people accountable. In every case where bad things occur, we need to learn what happened, or did not happen, and why if people in a facility or state agency acted badly and failed to care about and protect residents, they need to be held accountable and face appropriate discipline.

- Make sure that severe violations are met with severe penalties. In this case, the out-of-state group that owns the Oronico facility and over 280 additional nursing homes across the nation was fined $6,762 for its failure to protect Mr. Chedester’s health and safety and failing to provide him with the dignity and respect he deserved. A severe penalty? Hardly.

- Ensure the proper use of mandatory admission screening tools by nursing facilities. Federal law requires the use of a “Pre-Admission Screening and Resident Review” process to assess the potential resident’s mental health needs and the ability of the facility and state to effectively meet them with specialized services. If the facility and state cannot do so, the resident must be served in a different setting.

- Fund a statewide “substitute decision maker” program. This state government office was established in 2007, but the budget was stopped in 2009. The program would provide decision-making assistance to those in care facilities and communities who are unable to manage their personal care or finances.

- Beef up the volunteer ombudsman program. Volunteer ombudsmen are individuals who are to serve as eyes and ears in care facilities. They visit with residents about their quality of care and quality of life, and advocate for their rights. State officials recently said that over 500 volunteers are needed, but only 35 exist.

- Increase the number of long-term care ombudsmen by the state. These paid staff members are charged with protecting the health, safety, welfare and rights of individuals living in long-term care settings. They investigate complaints, seek resolutions to problems and provide advocacy for residents and the quality of care and services they receive. Iowa has eight individuals serving as ombudsmen and should, based on national standards, employ over 20.

- Create a culture of caring in Iowa. Let’s take steps to pursue excellence in every care setting in Iowa. Let’s celebrate those front-line workers who do a great job caring for our families and friends. Let’s identify the outstanding care facilities and apply their best practices elsewhere. Let’s stop paying care center workers the minimum wage and pay them what they deserve for their work.

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