P U B L I C H E A R I N G

before the

NURSING HOME STUDY COMMISSION

on

"Nursing Homes and Personal Care Facilities
for the Elderly in New Jersey"

Held:
October 17, 1975
Bellmawr Municipal Hall
Bellmawr, New Jersey

COMMISSION MEMBER PRESENT:

Senator John J. Fay, Jr. (Chairman)

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I N D E X

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SENATOR JOHN J. FAY, JR. (Chairman): This public hearing will now come to order. My name is John Fay, and I am the State Senator from Middlesex County and the Chairman of the Nursing Home Study Commission.

For the record, the Nursing Home Study Commission was established pursuant to Senate Concurrent Resolution 15, official copy reprint. The responsibilities of the commission are to inquire into the current condition of health care facilities for the elderly in New Jersey, to investigate the organizations, operations, standards, and policies of such facilities and the adequacy of same, and to determine whether they are meeting the social needs of our State and whether the State's standards for the regulation and supervision of such facilities are sufficient. As a result of these duties and obligations, and in light of the importance of the subject area, the commission is committed to hold as many public hearings as possible, and this is the first public hearing we are conducting in southern New Jersey.

We are looking for all the help and input possible from the citizens, f r o m those who are responsible for administering and supervising the facilities, f r o m those who are in nursing homes and their families, and from those with expertise in the field who can assist us with the final report and recommendations.

Besides legislation, we are looking at the possibility of administrative changes from the Department of Health and the Department of Institutions and Agencies.

One of the major things we are going to look at today is the role of the federal government in direct relationship to the state government and to the nursing home field.

One point I want to stress is that we do have a hearing reporter here, and a transcript of the proceedings will be prepared and will be a matter of public record.

We are hoping to have an interim report ready for the legislators and the public by the end of November.

In January the Senate Concurrent Resolution will be introduced again to keep the commission alive for two more years, again, the major reason being that this subject is much too important and much too complex to rush the study through. What we have been doing - and I think we've been doing it rather well - is to take these things one step at a time and to try to build a proper, objective, constructive study out of which will come our recommendations.

Senator Martindell, a member of the commission, called to notify me that she cannot be present today, and Senator Dumont will join us if he possibly can.

It is now my pleasure to introduce the first speaker of the morning, a former colleague of mine, the present representative from the 1st Congressional District, Congressman James Florio.

C O N G R E S S M A N J A M E S J. F L O R I O: Thank you very much, Senator. I appreciate the opportunity to come here to speak on what I regard as a very vital subject, and I think the commission is to be very much commended for the initiative it has shown.

I think it is fair to say that New Jersey, to this point, has not had the examples of abuse and other horrors that other States have had, New York State, in particular. I think that is all the more reason why we should attempt to make some modifications and reforms before we get to that point. So I commend you and the commission on the initiative that is being taken in attempting to evaluate our own system and make, hopefully, some legislative recommendations as to how to avoid the possibility of some of the bad things we have seen in other States.

My interest in this area comes from a number of

different perspectives. One, of course, was as a result of my involvement in the State Legislature with this very topic. In Congress I serve on two committees that deal in a substantive way with this subject. One is the Subcommittee on Health of the Interstate and Foreign Commerce Committee, and the other is the Select Committee on Aging, which is dealing with this problem among other problems that affect and have an impact upon aging people, and I am very pleased to have an opportunity to address the New Jersey Joint Legislative Commission investigating nursing home practices.

I have joined with Congressman Edward Koch of New York and Claude Pepper of Florida in sponsoring the bill HR 6494, a comprehensive bill to change the nature of federal nursing home regulatory procedures. This legislation would strengthen nursing home controls, making it no longer possible to rob the taxpayers and exploit the elderly. HR 6494 attempts to bring state nursing home institutions into compliance with regulations under Medicare, which affects federally-funded nursing homes. The major provision of my nursing home bill instructs, and in fact mandates, that the States enact regulations which they, in fact, should have adopted a long time ago on their own initiative.

While I am hopeful this bill will pass - and I intend to use my position on the Health and Environment Sub-committee of the House to work for its passage - we in New Jersey cannot wait for the Congress to act before we move to solve our own problems. As I said, I commend this commission for moving in that direction, and I am calling for it. In fact, while several of the legislative proposals I am making in Washington would require state legislative approval for local adoption in New Jersey, many would not. The Commissioner of Institutions and Agencies now has the power to adopt most of these proposals

by her own action or by that of the Governor. It is time they took that action and I urge the State Legislature to move as well.

This issue is too important to leave to generalities, and therefore let me focus on specific actions that we should take in New Jersey as well as in the Congress.

When an operator wishes to open a skilled nursing facility in New Jersey, he has a choice to either enroll in the Medicare program or in the state-administered Medicaid program. Years ago most enrolled in both programs. Since then, the Medicare program has limited its funding for long-term care and strengthened its regulatory role. As a result, many nursing homes throughout the nation have decided to forego enrollment in Medicare. The limited funding under Medicare was not worth the stringent regulations which were imposed upon the nursing home facilities.

While the standards of Medicare and Medicaid are the same for nursing homes, there is a great difference in how they are administered. The Medicare program involves extensive federal review and oversight. These standards force nursing homes to repair dangerous conditions, to remedy defects in their programs, and to hire qualified personnel. Under Medicaid, there is no such federal review. New Jersey, like most other States, simply does not have the staffing to regulate effectively without federal review. Most of the scandals in New Jersey nursing homes have been in facilities not subject to Medicare review. I might add, parenthetically, this is clearly the case with regard to other States, New York State, in particular. Through the loophole of enrolling only in Medicaid, scores of nursing homes get by with only minimal regulation.

The Medicare program has tougher weapons at its

disposal. Under federal statute, when the administrators want to terminate funding to a home, they may do so immediately. In New Jersey, state officials cannot terminate funding until they have completed whatever litigation the nursing home chooses to bring. In fact, we are often caught not merely paying nursing homes we would like to close, but we sometimes pay their legal fees incurred as a result of their contesting the action to terminate reimbursement.

New Jersey could close this loophole in one stroke, by stating that no skilled nursing home be enrolled in Medicaid until it is also enrolled in Medicare. This would force nursing homes to run the gauntlet of federal regulatory procedures as well.

We would also - and I add this emphatically because I think it is a most important point - save money. We now give millions of dollars of state money to reimburse treatment of patients whose bills could be partially paid by the fully federally-funded Medicare program. By requiring nursing homes to enroll in Medicare, we would be able to assure that Medicare paid first dollar and that we in New Jersey were left only to fill in the holes.

My bill would require Medicare enrollment, but the New Jersey State Legislature can do so as easily by state action pending the outcome of Congress's deliberations.

The New York State Legislature is considering enacting just such a statute. We should be moving in that direction in Trenton as well.

A second key reform would be to overhaul New Jersey's obsolete method of funding nursing home care. In New Jersey, nursing facilities are allowed a set amount for all services, whether or not adequate and whether or not excessive. Many homes offer virtually

no care to their elderly, while others strain to offer quality care but cannot do so due to artificially low payment levels.

In 1972, the Congress amended the Social Security Act to require that all States use cost-based reimbursement systems for Medicaid payments for skilled nursing care. This amendment, effective July 1, 1976, will make New Jersey's current method of funding illegal. While we must replace this method, or lose the 50 percent federal funding we now receive, we have made inadequate plans to replace this system. If we make no plans, we will risk lapsing into a pure cost-based system akin to that which has failed so badly in New York State. In such a system, all costs are reimbursed whether or not they are reasonable or prudent.

My bill not only requires that all States adopt a cost-based system by 1976, but also requires that the State check these payments to determine if they are equal to what a prudent buyer would pay for each service rendered in each locality. By setting ceilings, we can see to it that our reimbursement is based on what it costs to render good, quality service, not what some nursing home charges or what some bureaucrat is prepared to budget.

A third key action, which is imperative if we are to restore quality care to our elderly in nursing homes, is to overhaul the process of medical audit. The Medicare and Medicaid programs both require periodic review of nursing home patient populations by teams of medical, psychological, and social personnel. These periodic medical reviews examine all patients in a home at the time of the audit to determine if care quality has been sufficient or if reimbursement has been paid for care not given.

However, that is where the similarity stops. In

most Medicare audits, the federal government can use the audit as a basis for projection over the entire patient population treated by the nursing home over the entire year. Thus, a relatively small audit of a sample can lay the basis for a massive finding against the nursing home. The incentives to proper patient care are major. An unfavorable audit by a periodic medical review team can spell disaster for the propietary nursing facility. This is not so in New Jersey's Medicaid program. Here, only the exact amount of overpayment actually uncovered in the facilities examined may be collected. The result is an audit which, even if the findings indicate substantial poor care, is no more than a minor slap on the wrist.

My bill would permit state agencies to conduct their periodic medical reviews in such a manner as to lay the basis for a statistically valid projection of findings onto the entire home operations for an entire year. New York State's Assembly Democrats have proposed a similar provision for state law there. We could do it here in New Jersey by a simple act of our Legislature, and I suggest to the legislators that they should do this.

We must also act to cope with instances in which nursing home operators are found to owe back payments for overreimbursement. Where a post audit finds such overpayment, it is often impossible to collect such money. Nursing home operators often do not own the land or building in which they operate a facility and can easily close and reopen elsewhere in the nation when confronted by a large bill from the State. I have proposed, in federal legislation, that the state Medicaid agency be required to order nursing home operators to post a bond against excess reimbursement. We should move immediately in New Jersey to impose a similar requirement while legislation is pending in Washington. I might add that

the costs for such bonds are minimal.

Sweetheart relationships between the nursing home operators and the vendors of goods or services which they buy, and we pay for, are a critical problem. Current law prohibits these dealings unless there is an "arm's length" relationship between the two. The definition of "arm's length" is entirely too limited. It precludes family connections and often precludes part ownership of the vendor or operator corporation by prinicpals of the other. It is totally legal, however, to permit dealings between the seller and the buyer in a third business. The recent United States Senate investigations uncovered several examples in which the seller overcharged the nursing home owner, and the State paid the bill. Subsequent investigation showed a separate business relationship between the two in which the overcharge was repaid.

We should bring this kind of dealing to an end. My federal proposals would outlaw such dealings, and we should pass a parallel act in the New Jersey State Legislature immediately. In the interim, the State should require, administratively, disclosure of all such mutual interests between buyers and sellers.

Too often States wait for Washington to act before they act themselves. Overwhelmed by complex and often unbelievable disclosures about the expensive and publically-funded brutality of some nursing homes, we tend to wait for federal solutions. I am working hard, and the Congress is working hard, to generate that kind of federal action. While we are waiting, however, I strongly urge that we solve our problems in New Jersey by ourselves. The suggestions I have made, I believe, are appropriate legislative actions to consider and hopefully will provide for some action at the state legislative level.

I am certain that this commission is doing all that it can and is going in this direction. The commission should be commended for its efforts in conducting these hearings on a statewide basis and allowing those most affected to make recommendations by offering their comments and criticisms.

I thank you for your consideration. My office and the commissions and committees I serve on stand ready to assist you in any way possible. I have a great amount of backup data that I would be happy to make available to the commission.

SENATOR FAY: Thank you very much, Congressman. I want to thank you for a most comprehensive and constructive presentation. We have not always received specific recommendations regarding legislation and administrative changes that should be made through the Commissioners of Health and Institutions and Agencies.

Some of the bills you have recommended are in committee. Senator Martindell has a few bills as does Assemblyman Garrubbo. Up to this time, we have received a great deal of cooperation from the two Commissioners involved.

What I think is most important about your recommendations is that you are the first federal official to come forward to show the very close correlation between the federal government and the state government and to point out that there are so many major responsibilities that the States have to move on whether the federal government moves or not. I think too often the States use this as a convenient cop-out, or for some other reason, they haven't moved, waiting for revenue sharing and waiting for some magic formula to come down from Washington. I think this has been particularly true in the last five years

with respect to nursing home needs.

The first few times it was brought up in the Assembly I was told it was going to be taken care of in Washington. As we all know, it has not been.

We have been in very close contact with the Stein Commission and the Moreland Commission in New York. We have all of the bills that were entered in Albany, a few that have been passed into law, and those that are still in committee. We also have the Moreland Commission's major recommendations, and we are developing a) legislation and b) administrative changes which will definitely be in the interim report.

What I am going to recommend to the other commission members and their staffs is that they go to Washington for a day to meet with you and the staffs of your committees to go further into the details of the work that has been done there.

CONGRESSMAN FLORIO: I would like to raise one point that I think is significant: On the committees that I serve dealing with this problem and a whole range of different problems, particularly those dealing with institutionalization, I think we and Congress have become aware, as the nation has become aware, that many of the social problems that we face, particularly with regard to health and dealing with our senior citizens, have to be addressed in this day of economic crunch on an economic basis as well as on a humanitarian basis. But first and foremost we want to e n s u re that people being treated are getting the appropriate treatment. At the same time, with the economic squeeze that we have in this nation, we realize that we have to make sure that we are getting the most out of our health dollar, the social dollar, that we are spending. I think quite frequently we are not. Therefore, the recommendations

I made here were designed to also save some money, and I think they can save money and perhaps even give better quality care.

I will give one specific example of something that the Select Committee on Aging is looking into: That is the whole question of the advisability of institutionalization for older people. Quite frequently, we have found, institutionalization in long-term care facilities is not the proper mode of assistance, and the thrust of some of our efforts in Congress right now is to come up with alternatives that will not only provide better care, but will also save some money because the enactment of a system of home health services may very well be the more appropriate mode of treatment. That is to say, putting someone away in an institution, be it a good institution or bad institution, quite frequently is not the appropriate mode of treatment, and we may save substantial amounts of money by enacting relatively limited home health care service programs to keep people with their families. Quite frequently, families, well meaning though they be, are unable to shoulder the financial burden of caring for a loved one, a mother, father, grandparent, etc. So the pure economics of the thing are that we very well could be providing better health care at less cost if we explore the alternatives.

The Congress right now is exploring some of these alternatives, one of the major thrusts being enactment of provisions for home health care services.

SENATOR FAY: The only subcommittee we have on this commission is the Subcommittee on Alternate Long-Range Care. Senator Martindell is the chairperson of that subcommittee. One of the bureaucratic brick walls that we have run into is the fact that families who would want to make the effort to keep the mother or father at home, possibly through a visiting nurse type of operation,

find that it would be a financial hardship. The government actually forces families in the middle- or lower-income levels to put their mothers and fathers into nursing home facilities. This contradiction, to me, is obvious and calls for a change, especially on the federal level. One of the first changes I would like to see on the federal level would be this and a deeper look into, and a broader approach to, alternate care.

Something that came out of Senator Menza's Commission on Mental Health was the number of elderly in Greystone or Marlboro who technically do not belong there.

One other thing that we have come upon in our studies so far is the relationship of the VA with the two major veterans' homes in our State. This is something that needs a much closer look, I believe. There are a few contradictions in law between the federal government and the state government with respect to veterans' homes. The one I am most familiar with is the one that adjoins my district in Edison, Menlo Park. We just put up a new wing with one hundred and some beds for the veterans. But we are coming into a period where the World War II veterans are getting closer to the senior citizen category, and I believe the law dealing with the VA and the nursing homes could stand a major review, if not revision.

CONGRESSMAN FLORIO: Let me conclude with a general statement that I think is appropriate: As we look into the expenditure of all of our health dollars, we see that two years ago it cost this country $84 billion, private dollars and public dollars, to foot our health bill. Last year that went to $104 billion. Clearly, health costs have been one of the most inflationary factors in the whole cycle of inflation. I think the point is that we are

reexamining the whole question of allocation of health dollars, be it for senior citizens or the general population.

I think we will have to - and we will- s y s t ematize the health care delivery system we have in this nation. All too frequently we put an emphasis on treatment rather than prevention. We have, as you point out very accurately, in our Medicaid system, or Medicare system, an incentive to put people away, whether they be put away in institutions or temporarily put away in a hospital. That is not wise. We should be attempting to provide incentives to keep people out of hospitals and institutions and to keep them healthy.

I would suggest that the changes that are going to take place are probably going to take place within the framework of a national health insurance system, hopefully one that will be rational, will avoid duplication, and will avoid the hospital kingdom-building syndrome that has taken place in this country all too frequently.

So I think that most enlightened, rational people who are in the field realize that our system leaves something to be desired, that is, the health care delivery system.

As you probably know, I recently had the opportunity to go to the World Health Organization in Geneva, and you can imagine my surprise when I saw that one of the projects of the World Health Organization was to evaluate the respective health care delivery systems of the nations of the world and that the United States ranks right up there with Zaire and a couple of other nations that perhaps are not as sophisticated as they could be.

We have good potential facilities, but a good

health care delivery system requires that all of the population have access to it regardless of income levels. That is clearly not the case in this nation. We have maldistribution with regard to physicians geographically. We have maldistribution with regard to specialties. We have people in the inner-cities who do not have good opportunities to keep a good, healthful condition. We have people in the rural areas who do not have good opportunities to have access to health facilities.

It is astounding to think that the United States, of all the industrialized nations of the world, ranks 13th in its ability to cope with infant mortality.

These things have to be addressed, and I would suggest that your commission is doing a fine job in one particular area, but with regard to the bigger problem, I suppose it is going to fall upon the shoulders of the Congress of the United States. I am very happy to be in a position to perhaps have some input into that.

In conclusion, I thank you for your cooperation.

SENATOR FAY: Thank you very much, Congressman.

Sitting to my left is John Kohler, our staff aide from Legislative Services. If you wish to testify and your name does not appear on the agenda, please notify him. If you have a prepared statement, we would appreciate receiving copies of it.

Our next witness will be Reverend Canon Edward Daley, Executive Director of Evergreens Episcopal Home for the Aged.

R E V E R E N D C A N O N E D W A R D D A L E Y: Senator Fay, I have been Executive of the Evergreens Home for the last 13 years, during which time we have expended over $1 million in new buildings and improving our physical plant.

In 1962 when I came to the Evergreens we had 52 beds; 40 ambulatory and 12 nursing beds. Over the years we have increased this number to 122 beds; 60 nursing and 62 ambulatory. Because of the requirements of the Life Safety Code we gave up 5 beds on the third floor of our main building, thus at the present moment we have 117 beds; 60 nursing and 57 in the Ambulatory Section. Our Nursing Care Unit is approved both for Medicare and Medicaid.

By way of background as to myself, I have been very active in the New Jersey Association of Non-Profit Homes for the Aging, having served the past several years as Chairman of the Standard Committee. As Chairman of this Committee I worked with the Medicaid Department and Department of Health in an effort to develop workable standards for the nursing homes of New Jersey. Both our Committee and the Committee of the Association of Health Facilities have spent untold numbers of hours for long periods of time on this project but, as yet, we do not have a workable or sensible skilled nursing manual. Originally we were asked for input from the Medicaid Department, but after considerable time spent in reviewing the proposed Manual for Skilled Nursing, this project was taken over by the Department of Health. As a result, over a year ago our Committee was sent a proposed Skilled Manual for comment and criticism. We were then invited to a meeting with members of the Department of Health to

offer our comments. This manual, however, was completely unacceptable as well as not workable, and this was so stated to the Committee. Following that meeting in Trenton, our two committees met in New Brunswick to come to a conclusion as to our suggestions to the Department of Health. At that time we agreed that the present Intermediate Care Manual, although it needed some revision, was a workable manual, and that the best approach for implementation of a skilled manual would be to incorporate those requirements for Skilled Nursing into the existing Intermediate Care Manual for Levels A and B; thus, as a result, we would have one manual for all 3 levels of care. When you consider the material that should be encompassed in a good workable manual for all 3 levels, the only real difference for requirements of a Skilled Manual would be found in that section for Nursing Services. You need the same standards for housekeeping, maintenance, dietary, etc., for all 3 levels of care. Nursing services required for skilled nursing are more intense and exacting than those which are required for both Levels A and B of Intermediate Care. That is why, of course, it is required for 1.25 hours of care per patient per day for Level B, 2.5 hours per patient per day for Level A, and 2.75 hours of care for skilled nursing. To date, our suggestions to the Dept. of Health have not been implemented and we have heard nothing more concerning the type manual which we proposed.

Going one step further, I would like to suggest that there should be devised a manual for all levels of care, including hospitals as well as boarding homes for shelter care. In this way, overlapping requirements which are common to all levels of care would not be duplicated, and the requirements for all the various departments within each of the facilities would be consistent. Such a manual should be written so that it can readily be understood by all concerned. One

further small comment before leaving this topic. Insofar as our standards are concerned I would respectfully like to point out that keeping high standards for all levels of care costs money, and that the reimbursement for this care should equal the requirements of a high standard. A tremendous problem today is that we have raised the standards to such a degree, which is correct, because I believe we should have high standards so that we can give excellent care to our patients and residents, but the reimbursement for this care has not met the cost.

Having said this, this leads me to a companion topic - the inspection of our Home by Inspectors and Surveyors. First of all, I would like to state at the present time I am unequivocably opposed to unannounced inspections. By long experience I have found that the coming of the Survey Team for Medicare Inspection was not only for the purpose of seeing that we are in compliance with the regulations, but also to offer our facility suggestions and ideas which help to enhance our operation. Therefore, as I view an inspection, it is not only for the purpose I stated above, but also an educational process as well. At the same time, when I know that the Inspection Team is coming I make arrangements for our medical staff and their consultants to be on hand. If for any reason we are not in compliance in any area this can then be discussed with the consultant and the proper measures taken to correct our deficiency. Another reason is that I, as Executive Director of the Facility, feel that I should be here when the Survey Team puts in an appearance. If for some reason I am out, as I am today, attending this Committee Meeting, should the Survey Team arrive I would not be on the premises for the inspection. Therefore, I think that short notice, say 48 hours, should be given the facility indicating when the Survey Team will arrive. Certainly, if you have grave deficiencies within a facility you

cannot correct them within a space of 48 hours. On the other side of the coin, however, I fully agree that inspection of our Dietary Department for cleanliness and overall health standards should not be announced. The same is true, I believe, of the Building Inspection, but here again as on all inspections, the person who is carrying out this task I do not think should be picayune. When an inspector of the kitchen, for instance, can see that the place is clean and that the food is being well prepared and there are no offensive odors, etc., it seems inconsistent to me that this same inspector should keep looking until he can find some small item he can write down as a deficiency. Let me illustrate briefly. A few years ago, while inspection was in progress for Medicare our butcher brought in our meat order and he inadvertently dropped a few spots of blood on the floor of the walk-in refrigerator. As a result, I received a deficiency which stated, "Although your kitchen appeared to be clean at the time of inspection it was noted that there was dried blood on the walk-in refrigerator floor." In a recent inspection the inspector went through the kitchen, which was clean, and all he could find was a little bit of dust on a pipe over a range and a little residue of food on our steam table which was missed when the girl cleaned it, and downstairs he found a few drops of gravy on the surface of our electric range. The night before we had a kick-off dinner for our building fund drive, at which time we served a rib roast dinner. The gravy was dispensed from a pot on the top of the stove. The inspector made his inspection before one of our girls could clean the stove. To my mind, it seemed ridiculous to cite this kind of thing in an overall operation where the kitchen is spotless.

The final topic which I would like to discuss with you is a problem I have a

strong opinion about - the Certificate of Need Program. As I stated above, we have spent over one million dollars in new buildings and improvements over the past 14 years. During these building programs we have complied with the State Regulations which were in effect at that time.

In 1967 we built a new 56-bed Nursing Unit at a cost of $719,000, and did not ask for one penny from any State or Federal Agencies. At present we are planning to build a 40-bed Ambulatory Section to our Home at an approximate cost of $900,000. Once again, our intent is to raise the money for our new building without asking for any help from any Agency, either Federal or local. Having said this, I wish to relate to you my frustration, and sometimes anger, at the road blocks and delays which have occurred over the past years.

As I stated above, we are now attempting to build a 40-bed Ambulatory Section to our Home, but what we really should be doing is adding to our Nursing Unit because the need is greater in this direction. Almost daily I receive calls from all over the Diocese requesting a bed for someone who needs nursing services. One day last week, Wednesday I believe it was, we received 7 calls in one day and I received one call at home at night. We have an active waiting list of over 40 people waiting to be admitted to our Nursing Care Unit. Because we cannot accommodate these people we do not encourage people now to put their names on the waiting list. The reason we did not attempt to build the Nursing Unit was due to the Moratorium on Nursing Beds which existed for over a year. Because we also needed an Ambulatory building since our waiting list is well over 60, our Board of Trustees decided that, rather than wait we would go ahead and make application to build an Ambulatory Section first and delay construction of the Nursing Care Unit until later.

When our Board decided to go in this direction we made application for a 60-bed Ambulatory Section to our Home. Our Board then authorized our architect to make preliminary drawings and specifications for this 60-bed unit, but when we received the estimate of cost for this building, which was well over one million dollars, our Board decided to change from a two-story building to a one-story building so that we could build 40 beds first, and then if we had sufficient funds build the additional 20 beds without too much difficulty. Therefore, when I made my original application I asked for permission to build a 60-bed Ambulatory Section. I secured the forms from the Department of Health and submitted 5 copies, and then my problems began.

A few weeks after I submitted the copies I was contacted by the Comprehensive Health Planning Board at Westville to come down to review our application with a member of their staff. At that time, being honest, I explained to him what our Board had in mind, as I stated above that we hoped to build a 60-bed unit if we had sufficient funds, but if the funds were not there we would build a 40-bed unit and and the other 20-bed unit at a later date. I was then informed that this was changing the scope of the program and the application would probably not be approved. However, I was not daunted, and I attempted to go ahead and go for the 60-bed unit first by going to the Local Planning Board in Mount Holly, and then I appeared at the meeting of the Task Force of Agency B in Westville. I explained to both the Local Board and Agency B what we were attempting to do. I was then informed I could not go this route, but I would have to make application for a 40-bed unit only and hold in abeyance the 20-bed unit for later on, and that if we found sufficient funds to build the other 20 beds we would have to submit a new application for a Certificate of Need. At this juncture, I would like to state that I submitted this application on November 15, 1974. Already

5 or 6 weeks had elapsed since I submitted the original application. I had been told I would have to reapply at this time and instead of 5 copies I would need 7 copies of the application. In compliance with their request I then re-submitted the application for the Certificate of Need for 40 beds with the Department of Health. Someone in the Dept. of Health then misinterpreted what I was trying to do and sent the 7 copies back to me informing me that the application could not be submitted before May 15, 1975 because, as you know, on any project over $200,000 an application can only be submitted twice a year, May 15 and November 15. I then had to inform the Dept. of Health that this was not a new application and it carried the same serial number as the old application, and that this was the old application being resubmitted. Again, many weeks had gone by in the process of this course of events. Since they returned my resubmitted application of 7 copies I had to once again return them to the Dept. of Health for their consideration. At one juncture I received a call from someone in the Dept. of Health who questioned the cost of the project, which is approximately $30 a square foot. I then, in turn, called our architect who went to the Dept. of Health to meet with this gentleman and explain to him the kind of building we were planning to build.

To make a long story short, I was finally awarded the Certificate of Need on June 15, 1975, which meant that 9 months had elapsed between my original application and the issuance of the Certificate of Need for a building. This means, of course, that I have lost 9 months of construction time, which also means that the cost of this project will be caught up in the inflationary process which is taking place in our country at this time.

Another problem which confronted us and which we are now in the process of solving, is that we could not submit our application for a variance to our

Local Zoning Board until I had the Certificate of Need. Once having secured this Certificate of Need we then made our application to the Local Zoning Board in Moorestown. They passed on the Variance and sent the application to the Township Committee for their approval. While this was going on our architect went to Trenton twice, to Mr. Jones' office, to have our schematic drawings reviewed by the Architectural Section of the Department of Health.

At the present time we are waiting to go before the Site Planning Commission in Moorestown. When we get approval from the Site Planning Commission and our working drawings are completed we will then have to take them to the Dept. of Health for final approval. We are anticipating that we will be able to put our project out for bid on approximately November 3, 1975, and when the bids come in we hope to award the contract at our meeting of the Board of Trustees in December, which will mean that we hope to have the project underway approximately January 1, 1976.

I am sure you will appreciate the frustration, the anger and disappointment that I have experienced in trying to get this project off the ground. I certainly do think we should have controls and reviews of our plans for any building in the State of New Jersey to assure that the Life Safety Code will be met and that all buildings are constructed adequately to care for the Aged people in a satisfactory manner, but I also feel that something should be done to clear away the bureaucracy and the roadblocks which are placed in the way of people who are trying to build facilities to care for our senior citizens. Over and above this I feel, very strongly, that this whole program of Certificate of Need is unconstitutional because it impinges upon the rights of a group or an individual to compete in a society of free enterprise. Moreover,

I think in a religious organization in a Diocese which draws constituents from Bernardsville in the north to Cape May in the south by impeding the progress of our building program we are denying many of our people access to our facilities for care and attention.

The First Amendment of our Constitution states: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof....", and I feel that this Certificate of Need is prohibiting the free exercise of religion on the part of our constituents.

The 14th Amendment, which I cannot at this point quote verbatim, indicates that no State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States.

What we have here then, as far as I can see, is over-control on the part of the state in the free exercise of religion and also free enterprise. If I have a million dollars and I wish to build a motel and can secure the land next to the Cherry Hill Inn there is no law which will impede me from doing so. However, let me say that I do understand the intent of the law concerning the Certificate of Need. It is an attempt to eliminate over-bedding and duplication of equipment, etc., insofar as health delivery services in the State of New Jersey is concerned, but I do not think that this same restriction should be placed upon a church-related organization which is attempting to operate a charitable organization for the well-being of its members.

In conclusion then, it seems to me that some effort should be made on the part of our Legislative Department of the State of New Jersey to take a long, hard look at not only the delays in getting permission to construct our buildings, but also the tremendous cost which goes into these agencies which really bog

down the process of the delivery of health services in this State.

Thank you, gentlemen, for giving me this opportunity to express my views on these very important matters. If there are any questions you would like to ask me on any of the topics covered above or anything else regarding the field of homes for the aged, please feel free to do so. Also, finally, I would like to invite you to come to the Evergreens Home in Moorestown at any time without notice to view our facilities and the work we are doing there. If you arrive before 12:30 p.m., I will cordially invite you to lunch.

SENATOR FAY: That's the best offer we've had in a month.

I think from Reverend Daley's testimony, you can see why we are competing with Zaire in public health and why we are 13th. This is not the first major complaint that we have received about the Certificates of Need. Just in the last month the letters have started to come in. While we did not know this at the beginning of the investigation, we will certainly make this a major issue and find out why there is this maze of red tape. Unfortunately, bureaucrats are too often removed from the political structure, and too often Commissioners, after they are appointed, after being told to start cutting red tape, unfortunately d o n o t. Reverend, from your testimony, which documents this in a way that I think no objective person could question, this is like a "Catch 22" situation. There are too many "Catch 22" situations in public health and in the Departments of Health and I & A. Almost from the beginning, after listening to the Commissioners and their Deputies, it hit us in the face that something is going to have to be done about the red tape, the overlapping between the two departments, and the federal government coming into the

picture, resulting in three inspectors bumping into each other on one day and nobody there later on.

So I think, if nothing else comes out of this, at least it is going to be put before the Governor and the public, and if it is allowed to go on, it will be our shame and humiliation. If you are not in charge of a home, how do you really know? Even the families of people there don't really know what you are putting up with. Your Board of Trustees, I am sure, did not know until you were thrown into this situation of being danced back and forth between the local planning boards, the groups in Moorestown, and Trenton without getting clear answers for such a long period of time.

I don't claim to be able to answer the constitutional question but--

REVEREND CANON DALEY: I think it should be answered.

SENATOR FAY: --it certainly should be posed, particularly with regard to the religious question, as well as the very nature of the law itself. I have never had the question posed to me before, and this will go to our Attorney General, and one of our recommendations will be that we receive an answer to that. We will put the question on the line and hopefully get an answer.

REVEREND CANON DALEY: We draw from the entire Diocese but we are thrown in with a local group in Burlington County and are judged accordingly, and I think this is unfair.

SENATOR FAY: One thing I do disagree with you on is the unannounced inspections. I agree with you with regard to the survey team. When they come down, they need the books, they need the records, and they need you. They need you across the table from them to answer each and every aspect of their questions.

REVEREND CANON DALEY: Perhaps I didn't make myself clear, Senator. I don't oppose a person coming in for

an on-the-spot inspection. What I am saying is this: If they are going to send a survey team in without my knowing they are coming, I cannot get the personnel together.

SENATOR FAY: You are absolutely right. What we have to do here is qualify unannounced inspections. Do the survey teams come down once a year?

REVEREND CANON DALEY: Yes.

SENATOR FAY: For those visits, there is no question that they have to be announced. You have to be there, the auditor may have to be there, the doctor has to be there, the head nurse has to be there, and everybody else involved has to be there. When we recommend - and I have almost from the beginning - unannounced inspections, we are really talking about those where we have had complaints and the department has had complaints, and the inspector should be sent out without an announcement in those cases.

REVEREND CANON DALEY: I serve on the Long-Term Care Committee of Medicaid, and we meet once a month. As I understand it, the survey teams will come in without announcing their arrival. We are due for inspection right now - it's usually around this time of year - but if they should arrive today, I will not be there, and I don't think that is fair to me.

SENATOR FAY: I don't either.

We are mostly concerned:

a) that neither the Department of Health nor I & A had anyone on the night shift. Nobody was on duty after 5:00, which I found ridiculous if not insulting.

b) that there weren't - and I am speaking for the commission - quick enough follow-ups on complaints.

Most of the complaints we have received from every possible area were at night, 8:00, 10:00, 2:00 in the morning. Therefore, it seems to me they have to have

someone on at night. It goes without saying that there should be a 4 to 12 shift with at least nurses and inspectors on at night. In cases like that, obviously visits cannot be announced.

But you are absolutely right with regard to the yearly inspection team; there is that need for 48 hours notice. You should be there, and all of your staff should be there for that kind of meeting.

Reverend, I would also like to get the names of the people you were dealing with with regard to the manual. I want the commission to follow through where they did not answer you quick enough, etc.

REVEREND CANON DALEY: These were people from the Department of Health. The committee from our Association and a committee of the Association of Health Facilities provided input for the manuals. This manual was developed a long time ago, and we gave our recommendations. I think it makes sense to have one manual for all three levels - or even hospitals - which are consistently the same. I have spent a lot of time on this over the years.

SENATOR FAY: This is the first time this has been pointed out to us. We have been aware of the manual, and we were aware of the snags and lack of communications on it. It is most important, and it is a most valid criticism and suggestion, and we intend to follow up on this with the Department of Health.

Thank you very much, Reverend Daley.

Reverend Mr. John Carty, Administrator of Pitman Manor.

R E V E R E N D J O H N C A R T Y: Thank you, Senator Fay. Pitman Manor is one of seven homes operated by United Methodist Homes of New Jersey. Reverend Canon Daley's comments were more direct to some of the problems we are facing. I have prepared a m o r e philosophical statement of the care and needs

of people. Who are we serving and why are we concerned about these persons today before your commission?

What is a modern long-term care facility? I believe certainly we are not thinking of the age or design of the building. The answer lies in the function and the purpose of the facility. "Long-term care" has been used to describe a broad spectrum ranging from facilities offering food, shelter, and clothing to comprehensive care centers offering advanced well-organized and developed health care, therapy programs, and services. These differences are marked, severe and distinguishable, with one falling more within the field of housing and the other falling more correctly in the field of health care.

Our facilities in Methodist Homes in New Jersey are organized along the lines where we will cover the whole range, from the person who is most independent to the person who is most dependent.

Just the other day I received from our Medicaid nurse brief comparisons of the four levels of care: Level 3, which is SNF, and 4A, and 4B, which is ICF A and B, and level 5, which is really in the area of sheltered boarding home care. There are some inconsistencies. This was published by I & A and was given out by my local medical assistance nurse. This is what they have been using in their authorization procedures as they come in and evaluate the need for Medicaid service to a patient within our health care center.

I have one individual who is going from level 4B to level 5, which is our sheltered care unit. When the survey team comes in and sees this person in a wheel-chair or sees another person using a walker, we will be cited for deficiencies because their definition of ambulant is a little different than the definition that

is given in this I & A document, which has not been made a matter of public distribution. In fact, in talking with my two colleagues over here, they had never seen it before. It was published on 4/75, but it was to be used by the medical assistance nurse in her evaluations of the need for care by our patients. This individual I am speaking of will now go from our intermediate care facility - she was spotted as level B - and she will go over into the licensed sheltered boarding home care facility. When the surveyor comes in, she will say, "She has a wheelchair." But as the guide says, the person is "fully ambulant or mobile with self-help, assistant or stablizing devices, as a cane, walker, or wheelchair." There is an inconsistency here as we are being judged. It would be good if all of us could have these guidelines sent to us.

SENATOR FAY: Did you make a direct complaint to Mr. Reilly?

REVEREND CARTY: I just received this yesterday.

SENATOR FAY: Is Mr. Reilly the one who answers you on questions like this?

REVEREND CARTY: Yes, he is the individual. This was published by I & A, and we are talking with the Department of Health. We're trying to bring the two together--

SENATOR FAY: We all are.

REVEREND CARTY: --so we'll all know what we're doing.

SENATOR FAY: That would be a marked improvement. (Laughter)

REVEREND CARTY: Often when facilities for the aged are attacked or criticized, we find ourselves defending a social institution so varied in its form that the criticism is conceivably justified for some and not applicable to others. This does not suggest that

the simple solution is in some new nomenclature. All long-term care facilities need constantly to remember that they are dynamic instruments of an ever-changing society and that they all need the strength to examine themselves, their purpose, their function, and their programs.

We have been examined from many different angles. Our facility was built with FHA 236 funds for a comprehensive care facility, the only one that was built under 236 funds that would provide care from sheltered boarding homes all the way through the skilled nursing care program. We were built with this philosophy to serve the total individual.

Every program or service in the long-term care facility should be the result of a planned process involving study, execution, and evaluation.

Let us accept the premise this morning, for the purpose of discussion, that very few people want to live in an institution. Few people want to be hospitalized either, but they use hospitals. The point is that we should not throw out the baby with the dirty water. Homes, even with their organizational problems, can and do provide vital services and can and do perform important functions. While it may be true that nobody wants to live in an institution, we should be able to develop our programs and our services so they reflect what Mother Bernadette, Administrator of St. Joseph's Manor in Connecticut, said when she entitled one of her speeches, "Nobody Calls This Place an Institution." It's really a home.

There are social science findings that can be applied on group compositions and group dynamics. Long-term facilities should exist not by default but by design so that they are planned to meet particular needs and fill identifiable gaps.

Rather than being a place to go because there is no other place, the modern long-term care home should be and can be the place to go because no place else in society can be its match in the thoughtful planning that it offers as a specialized service.

The total person is whom we have to serve, and understanding the total person is the only way in which we can begin to serve him. The home should program a total plan that takes into consideration all the needs of the aging person and create a design for living that makes life worth living. Our program should in fact be a comprehensive plan to create an atmosphere and an environment in which the older person can live comfortably within the framework of his own expectations, abilities, and frailties with the help and support of the staff where and when needed.

I am a true believer in the social components of care. Social components of care have been defined as "physical or program arrangements which allow and encourage older people fully to realize themselves, both as individuals with personal dignity and as members of the homes' community and of the larger community in which the home is located."

Within Gloucester County, we have been relating our services and our facility and our residents to our educational institutions, Gloucester County College and Glassboro State College. Depending upon the ability of our residents, they have the opportunity to participate in various programs and activities. Whether it be taking the resident out to these programs or bringing the programs into the resident, this has been one of our ways of relating to our community at large and one of the ways of the residents' relating to the community according to their abilities to function.

The above definition has several concepts related

to it. The key concept, of course, is the full realization of the individual - his freedom "to become" and our nurturing his independent spirit. It also implies that the home can be "fully realized" - that it has an ebb and flow, a give and take, that it assumes a posture in the community, that it can spread its services out, and that it can relate and absorb community services within. Lastly, it implies that no man, no home, is an island. To achieve total care, the home must be tuned in on all the community resources, and it must participate in area-wide planning, in health and welfare councils, and in the family of public and private agencies.

As we look at the total person, we are reminded of Abraham Maslow's "Hierachy of Needs" as applied to the needs of older persons. (See page 1 X.) In planning our programs we must consider the lower-order needs as we seek to meet the so-called "spiritual" or higher-order needs. There is a connectedness between the physical and the spiritual needs. We have not met the spirit needs of persons merely by seeing that their physical needs are cared for. Conversely, efforts aimed at the spirit-level needs may misfire if the persons are feeling the dominance of needs on a lower level. The same person may operate on all these levels of need at different times, but the more the lower-level needs dominate one's energies, the less resource one has left to pursue the higher-order or spirit-dimension needs. We must motivate persons.

I have just come back from a training session in Kansas City where I heard Dr. James Peterson of Andrus Gerotological Center, University of Southern California, and he defines senility as a "response of older persons to the lack of a stimulus." Within our facilities, we must always remember that we must provide this stimulus.

I have heard in various testimony or have read in books concerning nursing homes that some people are kept heavily m e d i c a t e d , and this is not the true philosophy of meeting the needs of those individuals. We must meet those needs, and we must provide the stimulus they need to function to the highest level of their being. When I hear of these horror stories, it just shakes me. I believe our surveying of facilities is far ahead of what we have across the river in Pennsylvania where we hear of Woodside Manors and where we hear of the effects that management has had upon the persons they are there to serve.

I feel we are controlling within our New Jersey Departments of Health and I & A--- We do have a concern for persons. I get disturbed at the volume of paper work that must say we are giving tender, loving care. You can create paper work that says you are giving it, but unless you give it from person to person, that paper work doesn't mean very much.

Our homes must pivot on the attitude of love. We must use our imagination whereby a person feels self-esteem and productivity. Because of our respect, they feel better about themselves. Where son and daughter do not come to visit a resident/patient in our home, we must substitute something adequate for it. On the life satisfaction rating scale, one finds health, finances, and love, and love is the most important item on this scale. All staff members must give this. We can require that we will show this kind of love, w e c a n say in legislation that we are going to show this type of love, and we can require it to be reported in the mountain of paper work required for licensure, but the most important fact is that it must be given all the time by staff from the heart. This is the one single characteristic that has the most impact on the life satisfaction scale.

When all is said and done, our reason for existence is service. Philosophically, we do not believe that one should profit from human misery and suffering or from trafficking in human misfortune. Our homes have community accountability and community support, and our obligation is to provide total balanced care for the whole person.

"People base" is at the center of Pitman Manor and our other six homes operated by United Methodist Homes of New Jersey as well as the homes represented by my colleagues here this morning in our New Jersey Association of Non-Profit Homes. Our service begins and ends with people. This is the point I wish to bring before your commission this morning.

SENATOR FAY: Thank you very much for your strong, well-presented philosophy. You wonder how anyone can dispute what you say, but those of us of our age ask the question, "How could any so-called civilized people put 7 million people in a gas chamber?" They went home at night, had dinner, went to church on Sunday, and went back to the crematoriums the next day and started all over again. It's a cliche, but it also happens to be a truism when they say, "What are you doing; this is your own mother; this is your own father; how can you turn your back on people who are helpless, people who are the easiest people in the world to take advantage of?" If they are senile or just old and sick and they don't have a child at all to care or a child who doesn't care, this is where government shows its inadequacy and certainly its limitations. How do you make a person care? How do you say to a person, "Now you're a nurse and you're in charge of a ward, you're well-trained, and you're very proficient, but do you have a heart, and do you have a conscience?" I think that is the great challenge you have, a greater challenge than mine. I go back to Linden High School Monday to go to work, but

you have that direct responsibility of selecting nurses, nurses' aides, therapists, and everyone who works under you and for these people. Some of the most frightening people, and biggest dopes, I've met have doctorate degrees, so it doesn't necessarily mean that education and compassion go hand in hand or that education and a conscience go hand in hand. There are too many horrible examples around us, and history has proven to us that we cannot judge people by degrees. We know there has to be training. I think this may be where your recommendations could come in insofar as the type of training necessary so that people could be weeded out who do not have the very basic human reactions necessary to deal with people who need kindness and understanding as much as they need a talented, qualified nurse.

One of the complaints we have received is this: Because there are no requirements for nurses' aides - this is just one aspect - they run the whole range, from coming in with this love and understanding and a desire to help people to being abusive. I think we have found this in some of our investigations in county and state institutions, and sometimes you do get some real "sickies" in jobs like that who take pleasure in abusing people. They get some kind of sadistic kick out of pushing helpless, defenseless people around.

One of the groups working with this commission is the State Nurses' Association, and these are some of the things we have asked them to do insofar as training in the geriatric field, not only for RNs and LPNs, but also for nurses' aides through t r a i n i n g p r o g r ams, etc.

I think what you are offering is h e l p i n g to break the veneer of the pretty cold, sometimes impersonal, bureaucracy. The people like yourself and the people who

work in your home and the non-profit homes--- I'm not trying to attack the free enterprise system, but I have been so far most impressed with the homes I've been in where they are trying to do more than just provide a health service for a profit. If they are doing it, fine. The ones that have sickened me are those who are making a profit and not supplying the quality and concern. As of this moment, the homes I've been in with a religious affiliation or something else to motivate them other than showing a profit at the end of the year have an awful lot to offer the state government, the county government, and the whole industry. Even the term itself I can repudiate. I have the lobbyists telling me, "I'm here to speak for the industry," when they are talking about nursing homes and the care of people.

Thank you very much. We appreciate your testimony.

REVEREND CARTY: Thank you.

SENATOR FAY: I would like to say at this point that the good citizens of Bellmawr have supplied us with coffee and doughnuts today, and we certainly appreciate that kind gesture.

Janice Stanley.

J A N I C E S T A N L E Y: My mother-in-law, Ruth D. Stanley, is in Greenbriar Nursing Home in Woodbury, New Jersey.

In September of 1974 when I realized my mother-in-law's funds were getting low, I called the Department of Aging in Woodbury and asked them if they could advise me as to what aid was available for the elderly. They referred me to Welfare and suggested that I specifically ask about the SSI program. I did this and explained my mother-in-law's condition and financial situation to the young lady I spoke to there. She in turn referred me to Social Security in Glassboro, New Jersey. I then went

down to Social Security and had an interview with a young lady there. She checked my mother-in-law's records and told me to come back when the funds were down to $1500, and I could apply for SSI at that time. My mother-in-law was under the J-1 benefit at that time.

On November 18, 1974, I went back to Social Security and applied for SSI. Mr. Kestenman, who filed the application for me, said that it looked favorable that Mrs. Stanley would be eligible for SSI and that it would be a good idea to ask Greenbriar to hold the billings as the SSI would be effective as of that date and in light of paying the nursing home some $14,000, that they would probably be willing to do this. I went directly to the nursing home and asked them to do this. I then gave them a check for $224.30 to cover 11-18-74 to 11-24-74. The nursing home then held the billings.

I repeatedly called Mr. Kestenman from that time on reminding him that no money was being paid to the nursing home and that I had not paid Blue Cross and Blue Shield as I understood it would not be necessary if she came under this plan and also checking to make sure that Social Security checks that came after the time of application were rightfully Mrs. Stanley's. I was told, yes, that they were hers until the SSI checks came through.

I called again on Tuesday, January 7, 1975, and Mr. Kestenman told me he would get back to me after he checked things out. On Thursday, January 9, 1975, I received a call and was told everything was set to go to the Gloucester County Welfare and apply for Medicaid only. I did this on January 10, 1975, and was shocked when told by Miss Janet Wagner that Medicaid would be effective as of that date only. Miss Wagner at that time told me that I should never have been permitted to apply for SSI for

Mrs. Stanley and that I should have come to Welfare or Social Security should have sent me back to Welfare. I told her at that time I had called Welfare and was referred to Social Security.

After that I called Social Security speaking to Mr. Nolan, Director, Mr. Harrington, Assistant Director, Mr. Wittrock and others. I also called Medicaid speaking with Mrs. Chatsanoff and Miss Wagner at Welfare. Everyone was most sympathetic, but it just seemed nobody could seem to get this affair straightened out. It just kept going around in circles.

In mid-January I did start to receive SSI checks and held them at Mr. Harrington's direction. Then he said I should return them after I called many more times. By that time I had four checks totaling $542.41. His feeling was if we eventually withdrew the SSI claim that it would straighten things out. I did return the four checks and heard nothing. Finally I did get a call from Mr. Kestenman. He wanted to mail me a withdrawal form to sign. I refused as it was not filled out and I certainly would not sign anything like that, and I also knew through Mrs. Chatsanoff that if I signed that, there was no coverage for expenses before January when I applied for the Medicaid.

In the meantime, I returned four checks, received notices from HEW to the effect that the State had agreed to pay medical premiums under the Medicare program, and received Medicaid eligibility cards. Despite all of this, Greenbriar's bookkeeper told me that through that period they were not receiving any payment toward Mrs. Stanley's bills. I don't believe Mrs. Stanley's personal physician, Dr. R. B. Hutcheson, was being paid either.

Also, since all of the previously mentioned things, Mrs. Stanley had a severe convulsion and her hip broke during the seizure, and she was admitted to Underwood-

Memorial Hospital for surgery. Then I feared there would be even further difficulty with surgical and hospital bills. The whole thing has been a personal and financial nightmare to my family and myself.

Since I contacted Congressman Florio's office, things have straightened out to an extent; through their efforts on our behalf, the nursing home has started to receive payment, although just recently they tell me that over a thousand dollars in payment was taken back. For what reason, neither the nursing home nor I know.

At Mr. Harrington's direction, I went to Social Security and signed releases to get Mrs. Stanley back on Social Security and off SSI. I have received June, July, and August Social Security checks. September check I had to call about, and the January to June SSI has not been resolved as of this date.

All I would like is to see that what is due Mrs. Stanley in terms of medical and nursing care, which she is entitled to, is done without further confusion. I feel that the programs to benefit our elderly loved ones are not well-publicized and very poorly administered. What I personally have gone through has been, to say the least, very frustrating.

I would like to state that Greenbriar Nursing Home has been most considerate as well as patient through this and in no way has this had any effect on the care Mrs. Stanley has received. Her care has been excellent in every way.

SENATOR FAY: Thank you very much. As we have been developing this study, some of the major complaints have been beyond the care in the nursing homes themselves. Some of the things we have learned from the beginning - and this case history - show that we have as much to do with shaking up the governmental agencies as the nursing homes themselves.

Reverend Canon Daley's testimony earlier in the day and your testimony show that there has to be a better, more efficient way of handling the patients' monies. Families being put through this kind of anguish and heartache is unforgivable. What we are going to do is make copies of this testimony. Did you ever contact Commissioner Klein or Commissioner Finley? We will see that copies of your testimony go to them as well as to Mr. Reilly, who is directly responsible for this. Most of these problems, this double-talk and bureaucratic glut, are on that level, I think.

One of the first recommendations we are going to make is going to be aimed at this.

If she was in a bad nursing home and this was going on at the same time, that would be compounding the problem and pouring salt into the wounds.

It is very definite, very specific, and very clear that this is wrong, and it shouldn't be. They have to clarify this chain of command. There has to be a much clearer, direct, and quicker way of handling these kinds of problems so they don't recur.

MRS. STANLEY: I would be told that they were having a meeting, and it would be resolved at that meeting. But it just wasn't being done. It was just going on and on, and I kept making phone calls. I just knew local people to get in touch with; I had no further information.

SENATOR FAY: Another thing I think this commission is trying to do is to inform people like yourself of where to go and how to go. I think this has happened with the number of government agencies escalating; I think we are creating some Frankenstein's monsters. You have the federal government not talking to the state, the state not talking to the county, and

all three of them responsible for the family. They are obviously on one case with one problem and bumping into each other. Either you get it or you don't get it, and it should be spelled out clearly. I am hoping this is the least we can do. You don't need legislation for this. You don't need the President or the Governor coming down from the "ivory towers" to deal with this. This is something that should be handled immediately on the state level. I think if anything turns people off, it's the fact that the moment you need the government you find them giving you this kind of embarrassing runaround.

MRS. STANLEY: Yes, it is very embarrassing to you.

SENATOR FAY: Surely. We are talking about some families being put into bankruptcy, families going through their life savings in a matter of months, because of this unnecessary, unjustified red tape.

Thank you very much for your testimony. We appreciate your being here today.

Dr. Oscar Sussman. Doctor, we appreciate your coming to testify today.

D R. O S C A R S U S S M A N: I have been waiting for this opportunity; I missed it before, and I want to tell you it is a pleasure to be here today. It is certainly an honor to speak before you and to have my remarks put into the record. Aside from your work on the commission, I personally know of your intense interest in the elderly and the sick from our other contacts.

I would like to put into the record that over the past three years, I have been taking an active interest, on the part of the American Public Health Association and the New Jersey Public Health Association, in the lack of care from the standpoint of safety and sanitation, among other things, of activities in health

care facilities including, but not limited to, nursing homes. Now, I'm not putting an indictment, Senator, on all these places, but it is obvious from what happened recently, in the last year or two, that even a thing such as fire safety has really not been taken care of in places where we warehouse some of our elderly people. I think that is very important.

SENATOR FAY: The point is very well taken, Doctor, because this commission's responsibilities are not limited to nursing homes; they extend to all the elderly and their health care no matter where we find them, whether it be a state institution, boarding home, etc. We are not limited to the very narrow topic of nursing homes.

DR. SUSSMAN: I know that you are aware of this, and I would like the record to show that while I may refer to nursing homes in my testimony - and I try to avoid that - we have sort of put the finger on the nursing homes when in fact we may be talking about homes for the elderly, boarding homes, rest homes, etc., all of which may be in worse shape than nursing homes, but which are still taking money and in too many instances, as far as I am concerned, are really warehousing elderly people. They are just sort of waiting for death to come. I think that is a horrible situation.

I would suggest to your commission that it isn't just the walls, the safety, and the food that are important; it is also a question of what we are doing with these people when we get them into these homes. What kind of social care are we giving them? Are we just throwing them in there to get them out of the way?

One of the major objections that I would like to bring to your attention, which has been somewhat cleared up - that the American Public Health Association and the New Jersey Public Health Association had t a k e n the

previous methods of inspection and surveys of nursing homes in their control - was based on an erroneous assumption on the part of the U.S. Department of Health, Education, and Welfare, which in fact prohibited States from making unannounced inspections. They actually did not want to pay Medicaid or Medicare money if you made an unannounced inspection, and that was based on the false presumption--- I know that some of the people who have spoken before you here today object to unannounced inspections, but their objection, as far as I am concerned, is really not as valid when you start to explore it because, in some cases, they say, "If I'm not here; they won't know how to handle the figures; no one knows the fiscal picture; no one knows how the books work." If we follow that line of thinking, then we have to go back to the fact that the bank examiners who found banks that were doing things wrong with money - and you need only look at New York City to see what I am referring to in the nursing home situation - would not have found some of the flagrant abuses that occurred in the banks if they had had to call the bank Presidents and tell them, "We're coming in six weeks from today."

While I feel very strongly that the management has a right to be present, I think that at any time a place is going to be inspected or surveyed, there should be someone who knows enough about the institution on call who can be available within an hour or two to clarify things if someone else doesn't know. But to say that is one of the reasons they have to be notified in advance leaves me to say that I don't agree if we are interested in finding out whether they are following proper fiscal procedures also.

SENATOR FAY: What I tried to make clear to them was this: I do not object to the one inspection per year where they go from A to Z being announced. But on

the other 364 days, to me, there shouldn't be an announcement, particularly when you have gotten a definite written complaint, or the person comes to you and says, "My father is being abused there. He is not being fed." To me, that is the kind of situation I am talking about, where there has to be a complete and immediate check without any warning at all, number one. Number two, I said that I could not understand the Department of Health and I & A not having a night shift of inspectors on. To me, this was -- some of the first complaints we heard were that there was nobody on the 4 to 12 shift or there was no 4 to 12 shift. And now they have come up with spot checks, which I personally still don't find acceptable.

So, the point has been well taken, Doctor. I think this is going to be my recommendation, that there definitely be 7-day a week coverage on the 4 to 12 shift. When I say 7 days a week, I mean Saturdays and Sundays should be included.

DR. SUSSMAN: I want to put in the record that the Consumer Health Services Unit without your recommendation does have inspectors that do work on Saturdays and Sundays, and we do have inspections that were made as late as ten and eleven and twelve o'clock at night, so I can't but agree with you. I don't think our shifts should only be from nine to four-thirty or nine to five. If we are trying to operate a situation, whether it be in nursing homes or in retail food establishments, they shouldn't feel they are never going to be inspected on a Saturday or Sunday, because the state people don't work on Saturday or Sunday. I agree. I think that is a horrible situation. We are trying to correct that in our unit.

Now, I want to point out, Senator Fay, that Dr. Finley was in complete agreement with my contention along with the American Public Health Association, and the New Jersey Public Health Association that inspections should be unannounced. So, I might get in the record that she did say that.

Now, one of the reasons that she agreed -- you know, this American Public Health Association has about 25,000 members, and they really collectively thought about this. One of the reasons they felt that the inspection should be unannounced is that to leave health factors alone --- I mean, everyone assumes that from a health factor standpoint the inspection should be unannounced. But then they - the American Public Health Association - felt that if we are really getting in to see whether those few -- and it's not very many -- institutions are doing something wrong with the money, in order to find out if there were double books, to find out if there were overpayments, to find out how the things were being done fiscally, to find out whether nurses were actually on duty that presumably were being paid, then they felt that an unannounced inspection would be the only way to find that out.

The second problem that Dr. Finley agreed with me on - and we had a complete discussion on that - was that if we were going to have unannounced inspections for retail food establishments and wholesale food places - and this is in my area particularly - then it would be creating a double standard to continue to inform hospitals and health care facilities and nursing homes and others that we were going to do this.

Now, I am sure you are aware - but I think it should be put into the record once again, and I know you have heard this before, and maybe my way of saying it may be just a little different. I say that persons who reside under the care of licensed health care facilities such as nursing homes and homes for the elderly are in fact prisoners. And I think if you don't refer to them in that way--they cannot go outside the place normally and get their food. They do have to depend on the services given to them, and if it is bad service or bad food or an unsafe place, they are in fact locked in there as a prisoner.

If they are locked in by their immobility or their financial resources, illness or infirmity, and they cannot go to another establishment for food, and if it is not equal to the type

of protection they would have on the outside, whether it be a state owned institution or a state licensed institution or a privately operating one should make no difference. I know you are aware, and I know some others are aware of the problem I had whereby we were saying fire safety regulations had to be complied with if licensed health care facilities were money makers. Then we said that it had to be done even if they were eleemosynary institutions, and the same things were being applied to retail food facilities, but don't look at our state owned institutions, you know.

You are aware of that. There seems to be a difference between state owned rats and privately owned rats, and state owned cockroaches and privately owned roaches. I am happy to say that we have overcome that obstacle, and now there doesn't seem to be much biological difference between cockroaches in state owned institutions or private institutions.

So, maybe I should just get to the point. What did we find when we initially surveyed 75 state licensed health care facilities? We found in our initital survey that 13% of the nursing homes, boarding homes, and homes for the elderly were unsatisfactory. Most of them were not in the area of the nursing homes, but there have consistently been two, three and four a year that were in fact licensed nursing homes.

Forty-eight percent were conditionally satisfactory, and people wonder -- some of them say, "Well, I want to be graded on a grading system that says 90, 95 or something like that, but we have resisted this. We felt that when a place is one that we wouldn't want to live in or our parents to live in or us to eat in ourselves, we think it should be classified as unsatisfactory, whether it is owned by the state or has a license by the state.

If it is a place where we would be sort of shy about whether we would eat potato salad or chicken salad or whether we would sleep in from the standpoint of fire safety, then we think it should be given something that says, "Beyond notice,there is something wrong here

and look at the things that are wrong." And that would be conditionally satisfactory.

On the other hand, if there is nothing wrong with the place, and we would feel free and clear and feel happy about living there, then we think that should be a place that would be considered as satisfactory. But to try to get into these fine nuances of whether you go from a 70% to a 72 1/2% and up to 95 1/2% or something like that would make it open to such a disparaging type of situation between inspectors and surveyors, that we don't think it would be very good.

SENATOR FAY: Just one question, Doctor. Were the conditionally satisfactory institutions then given a certain amount of time to correct the situation?

DR. SUSSMAN: We have two situations in the conditionally satisfactory category, particularly with regard to food. If we go into an establishment, and it is conditionally satisfactory, we can discontinue our inspection and tell you as the owner we will be back tomorrow, "Clean this up, or do this." They don't get any report then. It is just in our mind. If we come back the next day and the place is cleaned up and all the discrepancies or the major share of them that are violative are removed, then we are in a position where we give them what we call a white form, which is a satisfactory form, the following day.

So, they have that type of an option, the owner of any place has that type of option. We think that is legitimate. The other thing would be, if they give it a conditionally satisfactory, because it is obviously too difficult to clean up overnight or to straighten up or to do what they have to, then they are given -- they stay with the conditionally satisfactory until we determine we are coming back in, or if they call us in 5 days, 10 days, 15 days, then we will come back. Normally, we would not return to a place within two weeks unless they call us, but if they called us and did not want to have what we call our yellow sticker on - again, this is primarily with regard to food handling - then we would come back

and if the man cleans it up within two days -- some people are very embarrassed, and that is good, because, we do want them to be embarrassed if they are not satisfactory. And they don't want it to be marked on there saying they are unsatisfactory, so we don't have any time limit, except that normally we don't go back in less than two weeks.

SENATOR FAY: And those that are unsatisfactory, does the punishment fit the crime there?

DR. SUSSMAN: Well, you know, you and I have been in discussion, and you have been involved with Senate Bill 859, and we have been eminently unsuccessful in getting it to even come up to a vote in the Assembly.

SENATOR FAY: In the Assembly, yes.

DR. SUSSMAN: One of the things you put in originally, and it has since been taken out, was the fact that the punishment of an unsatisfactory place would be that it would be closed immediately. That is not punishment. That is really protection of the public. Unfortunately, the lobbyists -- and I have to say that out -- were successful in removing that. Their point was that we should go to court and get a court order.

Unfortunately, my position is the opposite. I feel that if someone is running around loose on the street with a gun or if he is drunk driving a car, we wouldn't go to court. We first arrest him. We first stop him. Then we take him in, and then he has a right to have his lawyer say, "They are wrong. I wasn't drunk. Or they are wrong, I am not running around with a gun."

In the case of a food handling establishment now, the State Department of Health does not have the right to immediately close under Title 24, because the Attorney General has ruled - and that applies to health care facilities - that we do not have the right to immediately close them. So while you call that punishment, we don't even have the right to protect. Now, we can ask them to voluntarily close, and if they do, then the public or the people inside that institution are protected. But if they refuse, then --

if it happened to be, like, today and I tried to get an Attorney General, it is very difficult to get one. And if he is complying with our request, and he draws the papers up, and he wants to get a judge, that is much more difficult.

So I really think the public isn't being protected and while S-859 -- and this is not a hearing on this bill -- is not going to be passed, maybe your Committee should consider the necessity for giving the Health Department the right to immediately stop some actions without any further hearing, until such time as the place that is being prevented from being operated -- whether it be using the third floor when they don't have the proper fire apparatus and safety things -- and then have the hearing afterwards. That is, protect the public first, and then have the hearing, because the way it works now, if I were to hand over to Mr. Erdie a request that he have a hearing on a health care facility, it normally would not occur for thirty days. We have worked out an arrangement in our Department, that if anything has to do with food handling and safety and sanitation we will proceed under the normal laws that we have. But they are inadequate, and I have to say that again.

Now, subsequent inspections since the time that we made the 75, have resulted in 45 unsatisfactory ratings in health care facilities. Now that is out of a large number of health care facilities, as many as 700. And I say this, that while that is true, if you think we did 796 inspections from 1973 to 1974 and in 1975 we did 796 -- out of the 796 that we have done, we had 13 out of 796 from the standpoint of our food safety who were unsatisfactory. Now, percentage-wise that is not very much. That is only 2%, when our original inspection showed -- out of the first 75 that we did in September of '73 until October of '73, one month, we had 10 or 13% that were unsatisfactory. So it has gotten better.

SENATOR FAY: That is a marked improvement.

DR. SUSSMAN: But it is not a marked improvement when you stop to think of the people that were eating the junk that they were getting in the 13 that we had to say something about this year. So there still has to be pressure, and there still has to be inspection, because people unfortunately don't see their own dirt.

SENATOR FAY: I do believe that through the publicity in the media the public is suddenly aware of what is going on at this time. The institutions know that they are being watched. That is why I believe so much in public disclosure, and openness. It could be a cliche, but I do feel that when people are going by on the road and see a well-landscaped lawn, and they see a few shrubs and a painted building, they just assume that it is a clean operation. I am maybe being naive, but I do believe that through people like yourself making these issues known and making the public look, whether they want to or not, is the right thing to do. They don't know when somebody like yourself is going to walk in on them. The state is investigating constantly, and the public is being made aware.

DR. SUSSMAN: I really think the point you raise -- and this is really an issue -- if you recall, we recently had a hearing on an Open Public Meetings Act and you were the sponsor of that act.

SENATOR FAY: No, that was Assemblyman Baer.

DR. SUSSMAN: I know, then you supported it in the Senate. I think one of the things that really gets right to the point that you were raising is the fact that Justice Weintraub came there opposing this Open Public Meetings Act. Now, that is the same as opposing the disclosure of inspection reports that our people made. The question then is, well, it didn't get on the open disclosure of, you know, inspection reports. Actually, unfortunately, Supreme Court Justice Weintraub said two things that amazed the hell out of me. He said that if you had the Open Public Meetings Act, and people were going to talk, some of the people that were going

to talk would be afraid that they might seem to be dumb, and therefore they wouldn't talk.

SENATOR FAY: That never stops politicians.

DR. SUSSMAN: I didn't think so, because I thought being at that meeting was dumb. The other thing ---

SENATOR FAY: It never stops judges, either.

DR. SUSSMAN: I know. The other thing that he indicated was that the public doesn't have anything to worry about, because you see -- for example, the State Department of Health or any other group could issue a news release and tell the public everything they should know. Well, we have seen that in Watergate, and we saw it everywhere else. If you let the politicians or the bureaucrats -- and by the way, I heard you speak, and you said bureaucrats, and I want to assure you there are some good bureaucrats and some bad ones. I include politicians in the category of bureaucrats, so in the future when you speak about bureaucrats, remember you are in the same boat with us.

SENATOR FAY: I know.

DR. SUSSMAN: I did want to give you the results of 1974, and I will make available a copy of this. In 1974, out of 684 inspections, there were 12 that were unsatisfactory. These are health care facilities. (SEE APPENDIX - PAGE 2x)

In 1973 there were 375 inspected and 15 were unsatisfactory. I am going backwards, as you can see.

SENATOR FAY: Doctor, why is there almost a doubling of inspections from '73 to '74 and almost 100 more in '75? Are there that many more facilities or do you have more inspectors now or what?

DR. SUSSMAN: I think we become more efficient in inspection, and up until this year with the present fiscal crunch we did get about five more inspectors. And each inspector, in our estimation, can handle about 100 places. So we were able, with the extra inspectors, to do it. I am sorry to say that one of the things that is going to happen is, with the fiscal crunch as it

is, we are going to be deluding or misleading or -- I don't care what word you use -- defrauding the public if they see an inspection legend saying it was inspected . If we only do it once a year, I don't think the average public believes that is often enough. That is 365 days or more between inspections, so I think when they are thinking about the number of things they want to cut and where they want to cut, they ought to find out from the public, does the public expect that inspections in retail food establishments or health care facilities are so unnecessary as to do it once a year, or would the public like to have it done three times a year or every three months or what.

Because if you do it once a year, the obvious fact is we don't have enough inspectors to do it more often. The men that are in the industry are aware of that, so once they have gotten through the one inspection they are not going to worry about it. It almost reminds me of a retail food establishment once where one of our inspectors went in and the place was filthy, and the man agreed to clean it up. He did clean it up, and he was told that we would come back in two weeks. Three weeks passed and then four weeks passed, and five weeks, and we didn't have enough people to send back. He got very irritated and he called his Senator. And he asked his Senator, "How in the hell long do I have to keep this place clean?" The obvious answer would be forever, but he thought he was just going to have to keep it clean until it was inspected again. Well, fortunately this was a friendly Senator, and he explained to the man that he should keep it clean all the time because he ate there.

Well, I have a lot of figures here, and I have taken a lot of your time. I think that I should conclude, perhaps, before you ask any more questions, simply by saying that on the initial state inspections for nursing homes specifically now, not health care facilities in toto, we had in 1973, out of 100 inspections made, only 3 nursing homes that were unsatisfactory.

Now, in 1974 we did 190 homes. These again are nursing homes, and out of that number we only had 3 that were unsatisfactory. So we went from a 3% unsatisfactory rate to a 1.6% rate. You will hear people complaining in the industry, saying that we go in and we make inspections and we find a little bit of dried dirt on the stove, and they were making blueberry pies, and the stove was hot, and we expected them to remove the dirt.

I have to explain something to you, and also for the record. We try to make what we consider a inspection. And by that we mean that in the past inspectors were accused -- rightfully or wrongfully, but some of them obviously were accused rightfully -- that when they made an inspection they did a walk-through inspection, and they might have had a lunch free, or they --- you know, some of them might have even gotten paid off. That is a very small percentage. But there was no way for us to really determine whether that was a good inspector or a bad one, because no one was there at the time he made it.

Now, we have it done, so that when an inspector goes in and he sees the cross-connection, someone put a hose through the bottom of the potato mixer, and stuck it right down into the sewer pipe, and if there is a drain problem, and it backs up and goes right into wherever it is connected to, if it is an illegal connection, we want to know that the inspector has seen it and has commented on it. We don't want him to just take it off and disconnect it, we want it written down. If he sees dirt on the floor, even though it is fresh dirt, and it should have been picked up, we want to know about it. If there are some rat droppings, and they are really doing a good job with controlling it, but they obviously haven't even cleaned up the old, dry rat droppings, then the obvious fact is they haven't done a clean-up job. They may not be rat infested any more, because these are old ones, but all we want our inspectors to do is put everything down. This annoys the heck out of the men who are running the places even though I have tried to explain it time and again, they don't really understand the point. We would

rather say, "Well, we will vacuum it up. Don't write it down." But the reason we are doing this is, I want to be able to send another inspector in. When somebody says that first inspector is on the take, and he is not a good inspector, I want to be able to send another inspector in, without our first inspector knowing it, and see whether he saw the same thing. Now, if our first inspector doesn't have to write everything down, and just gives a satisfactory, then it is going to look bad for the first inspector. On the other hand, if they sort of coincide, then we know we are getting uniformity. So, I know you have heard some comments to the effect that we are picayune, and that we are too tight . It is really not to make the owners feel bad. It is really for our protection, to protect our inspectors from unjust criticism that some of our men may be - and I put that in quotes - "on the take." None of them are to my knowledge.

SENATOR FAY: Doctor, this is why I tried from the very beginning of this investigation to tell the owners and the administrators and their lobbyists in particular whom I believed overreacted, that we are not trying to witch hunt. You are not trying to hurt people. You are trying to help people, and that we can't be worried about everyone's sensitivities. We are talking about health, and welfare, and safety of the public. That is the major premise and the major responsibility of all of us.

If I was dealing with an investigation of the roads in our state, things like 13% or 2%, I would be very willing to accept, but we are not talking about holes in the road or the grass being too high. We are talking about human beings and people who do not have anyone to defend them or protect them, so we have this responsibility. I have had people in here bragging that it is only 13% like -- that is like saying 9 out of 10 are going to live. The guy who is going to die, tell him that it is only 13%, and tell the person in that unsatisfactory home, and tell his mother and father that 75% are good. I couldn't care less, if

I'm not in that home and my mother is not in that home. I never said we were New York City with all of their attending problems, but I am saying that we have bad homes in our state, and I am not about to tolerate one of them.

DR. SUSSMAN: I think one thing you brought to my attention now is something that probably should get into your record also. When we went to the Trenton Psychiatric Hospital -- and again, I have to say that I as a bureaucrate appreciate you help as a politician. I have to tell you that it is true. I hope you do not fail to realize that we have had no request for a hearing from any person at the 13 places we considered unsatisfactory. No one has disagreed with the unsatisfactory rating. They may have been mad, and they may have been unhappy, and they may have been embarrassed, but in no case - nursing home or state institution - did they ever take the position that we were wrong.

The only time they took the position that we were wrong was -- and this I had a fight with the previous Commissioner about --- I want to get back to the Trenton Psychiatric Hospital for a minute. That place had to feed those people and therefore we could not close them down. But, a woman called me and said she had seen cockroaches at that place, and she didn't really worry about it until they allowed her to feed her child, as I understand it. When she was feeding her child, from the pan that she was feeding the child, a cockroach came off and crawled on her and climbed on her hand while she was feeding her. In one case, it went onto the spoon.

Now, I have to tell you, that reminds me of the former Commissioner of Health, Dr. Collins, who said to me once while I was waiting to be uprated before the Attorney General, "Oscar, can't you call those things something else. I mean, do you have to call them cockroaches." And I said, "What would you like me to call them." And he said, Can't you just call them flies, because, you know, people

don't get too upset about flies." So, you know, the mentality that we are dealing with, with people who presumably care about the inmates is astounding sometimes. I wouldn't say this and put it on the record if this wasn't true.

But, I mean the question between whether you call a cockroach a cockroach or you call it a fly, it is ridiculous. The point is, neither cockroaches or flies belong where food is.

And the last thing I have to tell you is -- as a disabled veteran--The disabled veterans home in Menlo Park -- I told you about this, but we didn't get it into the record. Right in the middle of a table like we are sitting at here, which is a steam table, under the table is a hole going down into the dirt, in the midst of a state institution to take care of disabled veterans, there was a hole with dirt, no concrete, and that hole went down into the ground, to the basement, and it was a rat's nest.

That was right in the midst of the kitchen. Now, I defy anyone to tell me how anyone who runs an institution like that -- and I am not talking about the Governor, I am talking about the man who is sitting in the front office -- has the audacity to collect his check and never go into the kitchen and look around. He didn't have to be a genius or an inspector or anything. He just had to see the dirt there and see the rodent droppings. That is what we are up against.

SENATOR FAY: When was this discovered?

DR. SUSSMAN: It was in'73 or '72.

SENATOR FAY: It has been corrected?

DR. SUSSMAN: It has been corrected, but the point I am making is that the reason it existed is that you men and women in the Legislature have to make certain that whatever laws come out, they will prevent that from happening again.

SENATOR FAY: Doctor, your professional advice on the desirability of making all of the nursing homes and other health facilities post the results of inspections -- do you think a copy could be printed for each and every member of the institution, so it can be given to them?

DR. SUSSMAN: When I took over this work, I had a great deal of what I call antipathy thrown at me because one of the things I was concerned with was when an inspector makes a report - up until I got into this - it was always considered -- like, say, if you were running the pizza parlor, or if you were in charge of the state institution, that was a report to you. It was not for that person outside.

And I felt that I was getting paid by the State, and therefore any of the work I did - unless it was classified as secret for some unearthly reason, and I can think of no reports that the State Health Department has under any circumstances, unless it concerns an individual's medical record. I am making this as broad as I can. I don't think any institution or health care facility has any inspection report, whether it be a survey report or not, which should not be open for public inspection. That means that if they make a survey of a place- and this is not done yet, for your information - and in the survey it says something, and then it has to be approved by me or someone else upstairs, I think whatever the inspector saw, or whatever the inspection team found, these are facts. Either they are wrong facts or right facts. Those facts should never be put in a secret file. And I use the term "secret" particularly,

but you can call it anything else. They may sequester it simply because it is a report by an inspector. But, of course, that is not being done today.

Now, when we got into this posting bit, I got a lot of flack, and you are well aware of this. The institutions didn't mind being inspected as long as we didn't tell the newspapers, and as long as we didn't put it up on the wall. One of our primary means - because we have so little inspector staff- of getting other places to comply was by posting it, and by putting it in the papers. The only place we failed, I have to say, is when we inspected the New Jersey Neuropsychiatric Institute and said their kitchens were unsatisfactory. We put it in the papers, and a week later I had arranged to have a meeeting with the Commissioner of Institutions and Agencies then, with all of his top staff. I like to go prepared. But remember, it was in the papers; everyone was all upset. We headed for the New Jersey Neuropsychiatric Institute. You would have thought that all of the other forty institutions or so in the state would have seen, "Look, someone is coming around."

We had a meeting on a Friday, as I remember it, so on a Wednesday or a Thursday, I did something that is horrible among bureaucracies, as I found out later. I sent all my inspectors out to all forty places. I wanted to find out what shape they were in, so that when I came down to talk to these men I could explain what was wrong with their particular places, and I would have the facts. So help me, I really didn't believe that one of them would be unsatisfactory. And as I recall the figures, there were ten of the state-run institutions that were unsatisfactory in their food service.

Well, you know all the hell that broke loose after that. But the point I make is, now they know we are going to be doing it and the same thing applies to the health care facilities. The reason they are all squawking so much is because they don't want the public to know. And I think the public has a right to know.

SENATOR FAY: Doctor, just one final comment. This is something that possibly you can bring back to the state organizations. Is there anything in writing now or any studies being done now to wade through this red tape between the Federal Government and the Department of Health and the Department of I & A? We hear this at almost every hearing. I know the problem, but I just don't know the answers. Is there some way this overlapping and this duplication of efforts between the departments can be handled? Is there some way somebody can come up and say, "Look, I & A shouldn't be doing certain things." Could they centralize it, and maybe put most of the responsibilty and most of the authority with the Department of Health and just leave I & A with what the Federal Government insists upon. I just don't know the answer to this, and I think it is one of our responsibilities, to cut this red tape, and to centralize the authority and to staff them accordingly. I think we have a long way to go to find answers to these constant, constant complaints that we have three inspectors there on one day and none the other; that Health will only go so far, and then they stop, and I & A goes the other way. They will both pass the buck back and forth to each other, and there will be some gray areas.

I wish we could come up with a solution to this very real and very aggravating problem.

DR. SUSSMAN: Well, if you give me a minute or two, I would like to explore that with you, since you asked the question.

First, I think it is too easy for someone to say they had a duplicate inspection. I mean, that is something that nowadays that makes it okay, as soon as they say, we had duplicating inspections, then, forget it, that makes it bad.

There are not really duplicating inspections in most instances. If you have a fire safety inspection, you don't want to send a nurse, so you have to have a fireman -- I use that word to mean expert -- to determine whether there are fire safety hazards. He has to know the size of the building, and

he has to know how deep the wood is, and he has to know the fire retardance of the building. I don't know that, see.

SENATOR FAY: Yes.

DR. SUSSMAN: My men have to know the specifics of all that. Another thing which should be discussed is the inspection in the case of food handling or epidemiology. You can't tell me that the guys that work in my unit -- I mean, in my Department of Health, not in my unit -- who are in health care facilities inspection, that are trying to find out whether the money for Medicaid is properly being used can in any way know a damn thing about whether or not the food is being properly handled, so that is another inspection.

Now, these people who run these institutions, whether they be state or private, immediately say, "See, there is Sussman's group. There is the group from the fire marshal's office, and now the Health Department is looking at the monetary figures."

Now, then, we go to the monetary figures in another situation. We have to find out if there are enough nurses. We have to find out whether the radiologist is doing his job, whether he is getting paid once or twice from the patient. We are looking into Medicare or Medicaid. That is not duplication. They would like us to consider that.

What they would like to have -- and it is ridiculous, because these are things just tossed out to you about duplication -- they would like to have one little team, like the one from the Commission on the Accreditation of Hospitals, and I have to state categorically, they are practically in the past, useless. I mean useless, when you consider that they inspected the state institutions that our men did - and remember, no one has argued with the unsatisfactory - and they passed those ten places which were unholy messes, then you have to say there is a need for duplication. So, maybe in some cases our people won't be as good as others, so you do have to have checks and balances.

Now, then, on the other hand, I have to say I am willing to work with your Committee or anyone who wants to eliminate those unnecessary duplications. But you have to put an adjective in front of it, because I do not believe the term duplication should be used without some sort of an English qualification.

SENATOR FAY: The qualification is valid. And my major point is that it should be centralized. I don't think anyone denies what you have said. You don't expect a food specialist to be a fire safety specialist. But I would like to see both of them going under the same Commissioner.

DR. SUSSMAN: I will put it this way: In our Department, I think, under Dr. Finley at least,in this one area where I am directly concerned with it, we have made arrangements -- and I think it is quite satisfactory from my standpoint, and I should hope that it would be satisfactory from the industry standpoint -- when our men make the inspections on the food handling and perhaps other safety hazards, we, unless there is an immediate unsatisfactory, or if there is anything that has to do with the license or withdrawal or what have you, we send that information to a Mr. Erdie. He is in charge of health care facility licensing, and he uses that as part of his survey mechanism. Even if we did it in January, and he sent his survey team in April, right, our inspection is not once again duplicated. He takes that and he puts it in with his survey team, so they really have that -- we are doing the same thing that they want, but our specialist in food handling or fire safety or general sanitation is doing it in January on a different date from the date they set up.

So, we have already taken some cognizance, and the point you are making is that the licensing of the health care facility does not speak to me. Whether they lose their license or get their license, they speak to the health care facility group. Now, it should be coordinated with the Federal Government. If they are not going to pay Medicare or Medicaid money, it is true that it

shouldn't be that we would give a license to the place. Because if they are not fit to get Medicare or Medicaid money, then they shouldn't be fit to service our people in any event.

The Federal Government is trying to do that, but I think you can be helpful in exploring the situation a little bit further to make it sort of a one-unitary type of approach, and you are on the right track. But don't be misled by the simple term "duplication."

SENATOR FAY: That is well taken.

DR. SUSSMAN: I think that is sort of a blanket statement.

SENATOR FAY: Doctor, thank you very much. As always, you are an excellent witness.

DR. SUSSMAN: Thank you, Senator.

SENATOR FAY: Is a Mr. and Mrs. Holland here? (No response.) Mr. David Joachim? (No response.) We will take a twenty-minute break. Dr. Alexander Price, Chief of Staff of Cherry Hill Medical Center, and Mrs. Bonnie Williams, Director of Social Services at the Cherry Hill Medical Center said they would be here at one-thirty.

(Whereupon there was a short recess taken.)

SENATOR FAY: Dr. Alexander Price, the Chief of Staff of Cardiology and Internal Medicine at the Cherry Hill Medical Center will be our next witness. Dr. Price, please.

D R. A L E X A N D E R P R I C E: Let me make the corrections first. I am Chief of Cardiology, and that is all. We, Dr. Alexander Price, and Mrs. Bonnie Faye Williams, Social Worker and Director of Social Service at the Cherry Hill Medical Center wish our statements to be made part of the record at this public hearing regarding the current conditions of nursing homes and personal care facilities for the elderly in New Jersey.

As providers of comprehensive medical care to New Jersey residents, Mrs. Williams and I are quite concerned about all levels of medical care delivery. At Cherry Hill Medical Center, we are actively attempting to comply with the various regulations and

standards mandated over the last few years. Therefore, we are very aware of the interdependency of the acute care facilities, skilled nursing facilities, intermediate care facilities, boarding homes, home health care agencies, and care given to ill relatives by their families in the home. The latter is an area which seems to need much more attention in this age of rapid transition and medical advancement as they effect the family support systems.

To the question of nursing home conditions and compliance with the State regulations, Mrs. Williams and I have limited our evaluative remarks to two aspects of concern. The first area deals with the condition of patients transferred from the nursing home to the hospital for acute care, and, secondly, the difficulties experienced by hospitals on transferring patients from the hospital to the nursing home, especially Medicaid recipients.

The types of illnesses that we see in nursing home patients who are admitted to an acute care facility consists of the following two categories:

1. Cardiovascular-stroke patients and heart failure patients are the leading causes for hospital admissions. With respect to strokes, prophylactic care is not as good in any institution as we would like it to be. We cannot find fault with the nursing home for this type of patient. Patients in heart failure should have improved prophylactic care. Heart failure can be prevented in many instances, but the patient would have to be seen more frequently and examined more frequently than is now being done.

With respect to this, if I can make some side remarks, one of the problems is the Medicare rule that prohibits a physician from seeing a patient in the nursing home more often than once a month. That frequency of examination is not often enough for a doctor to become aware of impending heart failure.

The manner in which medical care is given must be carefully reviewed and adjusted so that the patient will benefit much more than at present.

2. Diabetic patients, malnourished patients, and those patients who are unable to participate in their own care are the next highest causes of hospital admissions. In the past, we have admitted patients who had been malnutritioned. Some have been chronically incurably ill where malnutrition is an expected development. However, a number of malnutritioned people are seen who have just not eaten enough food because of their inability to feed themselves. This would require more interested and dedicated persons,not necessarily nurses, but just interested people. A diabetic may not get adequate dietary therapy because of the lack of a dietician or other people trained in dietetics. The senile and paralyzed patients need more attention than others and are often those who are malnutritioned and debilitated as a result. These people need help beyond which the average nursing home can afford.

Of those patients who have improved sufficiently to be returned to the nursing home, medicaid patients present the only difficulties. This is purely a financial problem since nursing homes get more money from patients who are financially able to pay for their own care, and from those patients receiving medicare benefits. These patients are the first to be accepted by nursing homes with available beds. However, we have to realize that even people who start off financially able to pay sooner or later, with the high cost of nursing home care,end up without any funds and become medicaid patients, so that even they eventually become part of the same problem.

This has resulted in keeping medicaid recipients in the hospital for as long as three months after they have been well enough to be transferred to a nursing home. This tremendously increases the cost to the state and the hospital which in turn increases the medical costs for every individual.

Many elderly patients, who previously resided in a particular nursing home, experience psychological trauma when transferred to a different nursing home after hospitalization. During the length of stay in the hospital after medical recovery, the patient often experiences a feeling of rejection and confusion in spite of social work intervention.

This would require, in our opinion, a discussion and resolution between the state and the Nursing Home Association to correct the above inequities. This may necessitate the state going into the nursing home business.

In conclusion, we support the need for nursing home facilities in the community. However, we feel that all patients, regardless of socio-economic status, should be given the opportunity to obtain the full spectrum of medical and supportive health care services from within the nursing home facilities.

SENATOR FAY: Thank you, Dr. Price. Mrs. Williams, do you want to also testify at this time, or is that a joint statement?

DR. PRICE: That is a joint statement.

MRS. WILLIAMS: The Doctor and I have combined our statement, however, if there are questions from the Committee, I would be happy to answer them.

SENATOR FAY: Why don't you just move up to our witness table.

B O N N I E W I L L I A M S: Working together as we do with people who are in need of this level of care, we decided that we could best make our statement together.

SENATOR FAY: Is Cherry Hill Medical Center a general hospital for the area?

DR. PRICE: It is an acute care general hospital.

MRS. WILLIAMS: And it is the only one in the Cherry Hill area.

SENATOR FAY: How many patients and how many beds does this medical center have?

MRS. WILLIAMS: Roughly 288, including our nursery beds.

SENATOR FAY: All right, now, the recommendations that you are making, I think some of them would specifically go to both the Federal and the State level.

DR. PRICE: Yes.

SENATOR FAY: Congressman Florio was our first witness this morning, and I would like you to have a copy of his statement, in which he did meet some of the problems. He had some of the same suggestions that you have in your report. The Congressman is aware of the problems and he is working on the Federal level to start correcting some of them, particularly the major recommendation about alternate care, like home care, for example. The Federal laws as they stand now work completely against this. This is something that has an urgency on both the Federal and the State level, as far as the Congressman and myself are concerned.

I think your report is very significant to this Commission study, and will provide input for our Interim Report and Final Report. We have not had a medical doctor come forward or a professional concerned social worker before this. There has been a void in this area. I don't know whether it has been our fault in not looking for the doctors or looking for the social workers, or theirs for not coming forward and volunteering.

The Medicaid rule that you have brought to my attention is self-defeating, because of the very age you are dealing with. Many of the complaints we have received from the families and from nurses concerned the problem of malnutrition. People who have come to me and actually charged criminal negligence, I have immediately referred them to the Attorney General and to the local county prosecutor.

Saint Elizabeth's Hospital in Elizabeth has been the only hospital, besides youself, that has contacted me offering a review of case histories. They are surrounded by a few nursing homes in Elizabeth, and they have built up a file on cases they have received, and also the social worker there has made a personal project of following up problem cases.

Now, as I understand Medicare and Medicaid, social workers are not required in nursing homes. Is that correct? Is there a requirement for social workers per se?

MRS. WILLIAMS: I can't specifically make reference to that. I can say, though, that there are a number of nursing homes who do have designated people working in that area to have contact with families, who have contact with hospitals as well as other levels of care, so that when a person no longer requires skilled nursing care, that person then can work toward getting them transferred to appropriate agencies.

I do know too that the Medicaid social workers do have some involvement in the nursing home, in that there are Medicaid patients there. Now, the depth of that involvement, of course, would be ---

SENATOR FAY: Possibly there could be a recommendation made as to the need of a social worker in any and all nursing homes. I think it is important to have a good medical staff and a good nursing staff, but not to have a social worker there, I think, in too many cases is self-defeating. There is certainly a major void there.

MRS. WILLIAMS: If that becomes an issue, I would also like to say that maybe the qualifications of the person who is designated to the nursing home should be looked at also.

SENATOR FAY: At previous public hearings we have had the State Nurse's Association working with us. One of the projects we have offered them is some kind of formal or informal in-service training of nurse's aides. There is nothing at all in writing to say what a nurse's aide should be.

MRS. WILLIAMS: The same thing would be true in this area.

SENATOR FAY: Is there a state association of social workers in the State of New Jersey?

MRS. WILLIAMS: At the nursing home level ---

SENATOR FAY: No, I mean as professionals.

MRS. WILLIAMS: Yes. There is a national organization of social workers. Also there is a hospital affiliated group of

social workers who meet through the New Jersey Hospital Association. And there are enough social workers who are concerned about this area, so that steps could be taken to further advance this.

SENATOR FAY: I would deeply appreciate it, and so would the State Commission appreciate it if you would do us this big favor and follow this up for us. Would you put us in contact with the state officers in Trenton to go into this aspect of study in more detail?

MRS. WILLIAMS: Yes, I will.

SENATOR FAY: Doctor, are you active in the AMA?

DR. PRICE: Yes. I am active with the American Osteopathic Association.

SENATOR FAY: We have heard nothing at all from the AMA. Like I said, you are the first doctor we have had before us to testify. I have always felt somewhat sad -- it is more than sadness, maybe an anger--that there hasn't been more concern, and there hasn't been more feeling of an obligation to a major medical-social problem as the nursing home is.

DR. PRICE: I'm sure that the reason you haven't heard from any of these organizations is that they are not aware that this is happening.

SENATOR FAY: I even voted for the malpractice bill.

DR. PRICE: Well, individual physicians get involved. Now I am involved because over the years, many of the sick nursing home patients have been referred to me for care, and I have seen examples of what I have cited here many, many times to the point where I have become markedly interested, because I can see areas where we can prevent some of the things that are happening.

And, as you are talking here, I realize one area of prevention would be that each nursing home of sufficient size should have a resident physician, a physician employed full time, who should be knowledgeable, and whose business it would be to make sure that all these people get good care.

Now, we had this. We had Laurel View Manor, a nursing home on the Cooper River, being owned and managed by Dr. James Riviello and his brothers. Dr. James and his brother Ben lived in the nursing home practically. They were there all day. Their patients got very good care. The quality of care these people have received since then has not been as good, for the simple reason that they are not there any more. They became experts in nursing home care, and were suddenly out of that area. This was not only brought about by some Medicare rules, which prevented a physician to own a nursing home or to have an interest in it, from being paid for taking care of patients.

That would be one solution, to have a doctor permanently assigned or employed to take care of the people in the nursing home.

Secondly, with regard to malnutrition, it is purely a matter of having enough people to feed these patients. That means, for one thing, having enough people in that area so that everybody can have a meal at meal time. People who are interested, because what I have seen -- I have seen it in our hospital. The person who delivers trays will deliver the tray, and they come back a half hour to an hour later, and whether the food on that tray has been eaten or not, they just take the tray away. Now, that patient hasn't had the strength or the cerebral ability to feed themselves, and the nurse has not had a chance, or the nurse assigned just has not done it.

SENATOR FAY: Couldn't there be a notation on the patient's chart that food was half eaten? A person could literally starve to death under those circumstances.

DR. PRICE: There should be, and ordinarily a nurse should make a note of how much a person takes in, but we are now in a different era with the hospital costs rising. Naturally, the personnel working in the hospitals want to be paid enough so that their wage is a living wage, and they want to be paid extra for their special skill. You get to the point where these

things have to balance themselves out. And they limit the number of people employed to the minimum, and of course they want patients in to the maximum, so there is a shortage of people.

SENATOR FAY: Are you questioning the ratios that are set up, such as the number of R. N.'s, L. P. N.'s and so forth per ratio of staff?

DR. PRICE: My question is only relevant to the total expense of taking care of patients and yet keeping the hospital costs down to a reasonable limit, and the two don't always balance themselves out.

SENATOR FAY: Do salaries differ greatly in a nursing home and a hospital? Is there much of a gap in salary for an R. N.?

DR. PRICE: They don't let the R. N's get different salaries, but there are different requirements. A nursing home is required only to have one R. N. in the entire home, while a hospital has to have a definite ratio on each floor of R. N.'s and L. P. N.'s to aides, and that ratio has to be adhered to because the hospitals are inspected by respresentatives of the Department of Institutions and Agencies. So the cost of taking care of a patient in a hospital is much greater than that of a nursing home.

This is where the medicaid problem arose. The nursing homes,in order to be paid more money by the state for medicaid patients, actually demonstrated their displeasure by reducing or maintaining their quota of medicaid patients. In other words, the nursing home could have ten empty beds, but if they already have their quota of medicaid patients, they will not admit another medicaid patient.

Also, as Mrs. Williams noted, it is very traumatic to a nursing home patient who has, let's say, been in a nursing home for a number of years - as some of them have - and to be sent to the hospital for an acute illness, and then not be able to get back to the same nursing home where they had friendships

established, and they are acquainted with the personnel. It is a markedly traumatic experience. The nursing homes do nothing to help them in that area, because previously they would keep a nursing home bed open, but now the moment that it is empty they get another patient in there. The waiting list is so long.

MRS. WILLIAMS: May I make a point about the feeding problem. Being aware of the job description and the job classifications set up by the state for the nursing home levels of care, it might very well be that we have to look at new and innovative ways of advancing the care in the nursing home by possibly establishing other positions. We might even look at the feeding problem as the schools look at it in terms of the school crossing guards.

There are specific positions set up for people to come on the job three times a day, in the morning, at noon time, and at school closing. These are people who are usually retired. They are people who can handle the job and who, because they are receiving special assistance - such as Social Security - can only make a limited amount of money anyway. But because of their concern and their ability, they can handle this job. It might very well be that this might be an answer to getting people of various age levels back to work.

SENATOR FAY: These are the kinds of statements that most certainly cannot be treated casually. We are sitting here in a nice comfortable room talking about people dying by inches, and dying through no fault of their own. The very ugliness of that fact should bring us up short. It is something that we should move on immediately.

Like I said, unfortunately, we only have two pieces of testimony so far in this area. But I most certainly would want to be in touch tomorrow with the medicaid directors and with the medical people in charge of this to ask if they could start to document these things, such as the hospitals which do get a great number of people from nursing homes. We would like them

to start taking a closer look, and to start documenting the death reports and the coroner's reports. At the time we went to the nursing homes, we had no real records to look at. There was very, very sloppy record keeping. There were very generalized statements. I think (a) the general hospitals, (b) the coroners, (c) the doctors who are signing these death certificates should be put on notice that this is a very vital document. If not us, the Attorney General and the county prosecutors are going to be told to start taking a closer look at some of these records coming out of the hospitals or the lack of records and the death certificates -- the lack of information on the death certificates.

DR. PRICE: You know, we run into a whole host of problems. Firstly, we have to recognize that everything we are talking about will involve more money.

SENATOR FAY: There is no doubt about that.

DR. PRICE: Secondly, we also have to recognize that the nursing home business is a business for profit. People have invested a great deal of money and they expect a return, and they are entitled to a return. The question is, should the nursing home business be that type of business.

Because you cannot institute these reforms we are talking about as long as we are dealing with somebody else's money.

SENATOR FAY: I know. This is out in the open, and this has been put into the report as well. One of your recommendations here was one of mine, that the state as a government and the county as a government should have this in their long-range plans. I have been told by the nursing home lobbyists, you know, are you so proud of the state and county institutions that exist. My answer is that considering the county institutions that I have been in, the Menlo Park Nursing Home, and the Menlo Park Veterans' Home, yes, I am proud of them. Marlboro and Greystone are two of the disgraces of the western world. But my answer to them would be that it would be all of our responsibilities to do away with and correct the Greystones and Marlboros.

DR. PRICE: As we are talking, these thoughts come to mind. About a year or more ago, I had an offer to be the physician in charge of nursing home inspections. I didn't accept that offer for two very good reasons. First of all, the pay is not enough, and I have an ability which is much greater than that, and I look forward to the future and eventually stopping the work that I do. At that time I might be willing, if that type of offer is still available. I didn't pursue it any further, but it certainly is obvious that proper inspection in a nursing home can only be made by a combination of a knowledgeable and willing physician, a knowledgeable and willing nurse, and a knowledgeable and willing social service worker. That committee or that group, by doing good evaluations and good inspections, should be able to improve nursing care everywhere.

One other problem that would probably make me hesitate to take a job of that sort would be that I would be much too hard. I am not always very practical, and I would be inclined to close up places that could be improved. But this is what it takes, and without improving that we will do a number of things.

First of all, many of these old people can be rehabilitated, and perhaps, if they are not made useful to society, they may be able to enjoy the remaining years of their lives more than they are now. Those who may not be rehabilitated may be made to feel better, and by doing that will not be as much of a problem.

Then you have the remainder for whom nothing can be done, except to be treated as infants. They will have to be cared for and fed, and that's all. But then we brought these old people to this state by improving medical care and medical facilities. We improve their bodies but not their brains. This, in a way, is something we did ourselves. We have to take the responsibility, and when I say "we" I don't mean the Legislature, I mean all of us.

SENATOR FAY: Doctor, another problem you can comment on is the abuse of the use of drugs with the elderly. Do you feel there is over-tranquilization?

DR. PRICE: We find very often when patients are brought to our hospital from the nursing home that they are taking a much larger number of drugs than at first you would seem to feel they need. This is because we are dealing with people who become irritable. They get lost. They may walk down the hall and not know there to find their room again. They can't sleep. It is easier to give them drugs to sedate them and quiet them than it is to look at the problem that is really presented.

We have these old people in our hospital who behave that way there, and I have found myself not able to control them, but I have learned very quickly. We have one psychiatrist in our hospital that I place in service with me, and however he does it, within twenty-four hours, and with a minimum amount of drugs, he will be able to have these people feeling much better emotionally and many a time all he does is stop the drugs they have been getting. So, again, it is a matter of having a knowledgeable individual in the care of this particular area.

By doing that, not only is life made better for the patient, but also for the nursing home and the hospital personnel as well. Because suddenly instead of dealing with a confused and drowsy old person, we find ourselves often dealing with an alert and likeable and pleasant old person with whom it is a pleasure to talk. It is purely a matter of knowing how.

MRS. WILLIAMS: I think in addition to what Dr. Price has said, if we actually look at the ancillary services that are available in nursing homes and how they are used, what we have is people who have people to deal with, not always a nurse. It may possibly be an activity therapist who is involved in meaningful recreation, who can bide some of the time that a resident has in a nursing home, so that he or she does in fact have something to do that makes them feel that they are still pretty much a person, a person who someone cares about, a person who is involved in living. If they don't have that, then what else do they have? How else are they then expected to act? And what messages do we give them by the lack of alternatives they can act on.

DR. PRICE: Are you aware of the Golden Club organizations?

SENATOR FAY: Yes, senior citizen clubs.

DR. PRICE: When my mother was alive, she never missed an activity or meeting of her Golden Club. That was the most enjoyable activity she had in her last few years of her life. And this is what these people need.

MRS. WILLIAMS: I can vouch for that, having been a group worker in a community agency, and having worked with a senior citizen's group. I have picked them up and transported them where they had to go, and I helped them to plan their program. They, of course, treated me like I was their daughter instead of a social worker, but still the idea was that they had something to look forward to each week. They came out even sometimes when they were feeling sick.

SENATOR FAY: The more we broaden the scope of this study, the better our interim report will be. We will issue an interim report in November. The Senate Resolution will go back in in January to keep this Commission alive for two more years. I have already concluded what is needed in the State. We need a permanent commission on aging that would not be limited to just abuses of medical care. The time has arrived to establish priorities and to have a sense of obligation to a growing number of citizens, and to me I would be hoping that this would be a permanent commission on aging. I also hope the next Governor and the next Legislature will have the wisdom to see this.

DR. PRICE: I think we would agree with this.

MRS. WILLIAMS: I think too, in addition to the aging, we do also sometimes find a small number of younger people in nursing homes who - because of accidents or catastrophic illnesses - find themselves being confined to that level of care. I think that if we don't look at this in terms or activities, et cetera, they may become useless too.

DR. PRICE: Have you gone through any nursing homes?

SENATOR FAY: Yes, I have. Just recently some members of the Commission felt that it was time to do this. What we have tried to do is to rebut the charges that we have been trying to sensationalize a problem, and we were just trying to go running in with Channel 4 or 7 and get a few cheap headlines out of this.

What we have established, we have convinced the public that this is not our objective. This is an objective, bipartisan, and non-partisan in many aspects, study and it is only recently that we have now started to go in individually to nursing homes and to hospitals, in which the majority of the people are in geriatrics.

I have been in four different types of nursing homes. The one I mentioned before to you, the soldiers home in Menlo Park---

DR. PRICE: Is a physician a part of your group when you go through?

SENATOR FAY: No; no. I have gone in with one of my legislative aides and just dropped in unannounced and said, "I am here. I want to inspect."

DR. PRICE: It would be beneficial if you had a physician accompany you.

SENATOR FAY: If I could find one, I would be glad to.

DR. PRICE: I would be glad to go with you.

SENATOR FAY: Thank you, Doctor. I will certainly take you up on that.

DR. PRICE: If you give me sufficient notice, I will be very glad to accompany you.

SENATOR FAY: Thank you, I appreciate that offer. It is gracious, and we accept.

MRS. WILLIAMS: One of the things that I in my own way have attempted to do in order to help upgrade some of the area facilities is to act as a consultant to some of the nursing home people who have been designated as the social service representatives.

At the same time, what I have also attempted to do is to, as much as possible, give some information to those people who have been designated as the activities coordinator in terms of understanding people. I don't try to tell them what activities, necessarily, to provide, but how those activities that are being used could be better used, and how they can understand people better and get even more of their residents involved in these activities. But this is also something that I think social workers need to do because we are concerned about people.

SENATOR FAY: That is why I would be glad to hear from the state group. I would like them to work with us, maybe in a subcommittee, or some kind of close relationship. This is going to help us with our report. It is not, as far as I am concerned, going to be a report that is going to be brushed aside too easily or too casually. We are looking for professionals. We are looking for those who care, and their input will be of merit and will be followed through.

DR. PRICE: I am also sure that if you contact the New Jersey Medical Society and the New Jersey Osteopathic Society they will be quite willing to become involved. It is purely a matter of communications.

SENATOR FAY: I am glad to hear that. We will contact them. Thank you very much, Doctor.

DR. PRICE: I think we two are the only ones at our hospital that knew about this meeting, which is why we are here. But the others, I'm sure, would be willing to participate also.

SENATOR FAY: Doctor, I want to thank you very much. Mrs. Williams, your testimony is deeply appreciated.

That ends our public hearing. We are hoping a report will be ready in November. I don't believe we will be holding another public meeting between now and November, but there is the possibility of that. Thank you.

* * * *

(HEARING CONCLUDED)

SUBMITTED BY REVEREND MR. JOHN CARTY

ABRAHAM MASLOW'S - HIERARCHY OF NEEDS

Higher Order

Need for **SELF-ACTUALIZATION** To develop to one's fullest capacity as a human being; to find meaning in life; to find answers to life's questions.
ESTEEM NEEDS Sense of adequacy, of competence, of achievement, of contribution; recognition, prestige.
BELONGINGNESS AND LOVE NEEDS The need for affection, inclusion, place in one's group.
SAFETY NEEDS Security, protection against physical threats; familiarity and stability of the environment.
PHYSIOLOGICAL NEEDS For food, housing, clothing, health care, mobility.

Lower Order

SUBMITTED BY DR. OSCAR SUSSMAN

RETAIL FOOD PROGRAM STATISTICS

SUMMARY REPORT

JANUARY 1, 1973 TO DECEMBER 31, 1973

2 X

STATE INSPECTIONS

	Total Inspections
Retail Food Establishments	3,188
Health Care Facilities	529
Institutions & Agencies	60
Day Care Centers	121
Colleges & Universities	149
	4,047

3 X

RETAIL FOOD ESTABLISHMENTS

STATE INSPECTIONS
Summary
1/1/73 to 12/31/73

	Initial Inspections		Reinspections		Total Inspections	
Satisfactory	850	46.6%	891	65.4%	1,741	54.6%
C. Satisfactory	852	46.7%	469	34.4%	1,321	41.4%
Unsatisfactory	123	6.7%	3	0.2%	126	4.0%
TOTALS	1,825	100.0%	1,363	100.0%	3,188	100.0%

4 X

LOCAL INSPECTIONS *
Summary
1/1/73 to 12/31/73

	Total Inspections	
Satisfactory	17,162	69.4%
C. Satisfactory	7,258	29.4%
Unsatisfactory	305	1.2%
TOTALS	24,725	100.0%

*These figures include only those inspections which were recorded by Data Processing. They do not include the backlog of reports yet to be processed.

RETAIL FOOD ESTABLISHMENTS

STATE INSPECTIONS
SUMMARY
1/1/73 to 12/31/73

CATEGORICAL BREAKDOWN OF STATE INITIAL INSPECTIONS ACCORDING TO ESTABLISHMENT CODES

	Agricultural Markets (1)		Bar & Liquor Stores (2)		Cafeteria (Public) (4)		Catering Kitchen (5)	
Satisfactory	10	71.4%	58	66.7%	4	100.0%	5	50.0%
C. Satisfactory	4	28.6%	27	31.0%	0	0.0%	2	20.0%
Unsatisfactory	0	0.0%	2	2.3%	0	0.0%	3	30.0%
TOTALS	14	100.0%	87	100.0%	4	100.0%	10	100.0%

	Cocktail Lounge, Tavern, Etc. (7)		Commissary (9)		Delicatessen (10)		Grocery Store (12)	
Satisfactory	9	52.9%	5	71.3%	52	55.9%	55	57.3%
C. Satisfactory	7	41.2%	1	14.2%	38	40.9%	33	34.3%
Unsatisfactory	1	5.9%	1	14.2%	3	3.2%	8	8.4%
TOTALS	17	100.0%	7	100.0%	93	100.0%	96	100.0%

5 X

(Breakdown of State Inspections According to Codes)

	Industrial Feeding (13)		Institutions (Schools) (14)		Meat, Fish and/or Markets (16)		Mobile Food Establishments Other Than (Frozen Des. Mfg.)(17)	
Satisfactory	11	57.9%	47	74.6%	11	23.9%	20	83.3%
C. Satisfactory	7	36.8%	15	23.8%	29	63.0%	3	12.5%
Unsatisfactory	1	5.3%	1	1.6%	6	13.1%	1	4.2%
TOTALS	19	100.0%	63	100.0%	46	100.0%	24	100.0%

	Mobile Food Establishments (Frozen Des. Mfg.) (17)		Retail Frozen Dessert Mfg. (19)		Retail Mfg. Other Than Bakery & F.D. (20)		Restaurant (22)	
Satisfactory	3	100.0%	36	87.8%	0	0.0%	327	38.7%
C. Satisfactory	0	0.0%	4	9.8%	2	100.0%	459	54.3%
Unsatisfactory	0	0.0%	1	2.4%	0	0.0%	59	7.0%
TOTALS	3	100.0%	41	100.0%	2	100.0%	845	100.0%

	Retail Bakery (23)		Soda Fountain, Luncheonette, Short-Order Cafe (26)		Supermarket (27)		Temporary Retail Food Establishment (30)	
Satisfactory	29	31.2%	29	39.2%	68	41.2%	14	87.5%
C. Satisfactory	54	58.0%	42	56.8%	84	50.9%	2	12.5%
Unsatisfactory	10	10.8%	3	4.0%	13	7.9%	0	0.0%
TOTALS	93	100.0%	74	100.0%	165	100.0%	16	100.0%

(Breakdown of State Inspections According to Codes)

	Vending Machine (31)		Miscellaneous (39)	
Satisfactory	1	16.7%	58	55.8%
C. Satisfactory	3	50.0%	37	35.6%
Unsatisfactory	2	33.3%	9	8.6%
TOTALS	6	100.0%	104	100.0%

RETAIL FOOD ESTABLISHMENTS

STATE INSPECTIONS
SUMMARY
1/1/73 to 12/31/73

BREAKDOWN OF INITIAL INSPECTIONS CONDUCTED BY STATE INSPECTORS IN THE FOLLOWING COUNTIES:

	Atlantic		Bergen		Burlington		Camden		Cape May		Cumberland	
Satisfactory	17	23.0%	59	44.0%	14	38.9%	40	38.8%	27	43.5%	71	66.4%
C. Satisfactory	50	67.6%	70	52.2%	20	55.5%	49	47.6%	35	56.5%	35	32.7%
Unsatisfactory	7	9.4%	5	3.8%	2	5.6%	14	13.6%	0	0.0%	1	0.9%
TOTALS	74	100.0%	134	100.0%	36	100.0%	103	100.0%	62	100.0%	107	100.0%

	Essex		Gloucester		Hudson		Hunterdon		Mercer		Middlesex	
Satisfactory	89	46.6%	25	43.9%	38	42.2%	4	57.1%	35	47.9%	112	50.5%
C. Satisfactory	94	49.2%	28	49.1%	51	56.7%	3	42.9%	30	41.1%	87	39.2%
Unsatisfactory	8	4.2%	4	7.0%	1	1.1%	0	0.0%	8	11.0%	23	10.3%
TOTALS	191	100.0%	57	100.0%	90	100.0%	7	100.0%	73	100.0%	222	100.0%

	Monmouth		Morris		Ocean		Passaic		Salem		Somerset	
Satisfactory	28	47.5%	48	55.2%	117	57.0%	46	51.1%	0	0.0%	27	49.1%
C. Satisfactory	20	33.9%	37	42.5%	77	37.6%	39	43.3%	10	100.0%	23	41.8%
Unsatisfactory	11	18.6%	2	2.3%	11	5.4%	5	5.6%	0	0.0%	5	9.1%
TOTALS	59	100.0%	87	100.0%	205	100.0%	90	100.0%	10	100.0%	55	100.0%

	Sussex		Union		Warren	
Satisfactory	17	60.7%	14	16.9%	22	42.3%
C. Satisfactory	7	25.0%	61	73.5%	26	50.0%
Unsatisfactory	4	14.3%	8	9.6%	4	7.7%
TOTALS	28	100.0%	83	100.0%	52	100.0%

H E A L T H C A R E F A C I L I T I E S

STATE INSPECTIONS

	Initial Survey 3/16/73 to 9/17/73		3/16/73 to 10/23/73		Summary - 1973 1/1/73 to 12/31/73					
	Initial Inspections		Initial Inspections		Initial Inspections		Reinspections		Total Inspections	
Satisfactory	29	39.0%	129	51.4%	207	54.6%	113	74.3%	320	60.5%
C. Satisfactory	36	48.0%	36	42.6%	153	40.9%	39	25.7%	192	36.2%
Unsatisfactory	10	13.0%	10	6.0%	17	4.5%	0	0.0%	17	3.3%
TOTALS	75	100.0%	251	100.0%	377	100.0%	152	100.0%	529	100.0%

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LOCAL INSPECTIONS (Received as of 12/31/73)*

Satisfactory	287	78.6%
C. Satisfactory	74	21.0%
Unsatisfactory	1	.4%
	362	100.0%

* These figures include only those inspections which were recorded by Data Processing. They do not include the backlog yet to be processed.

HEALTH CARE FACILITIES

CATEGORICAL BREAKDOWN

INITIAL STATE INSPECTIONS

	Hospitals		Nursing Homes		Boarding Homes		Intermediate Care Facilities	
Satisfactory	61	61.6%	62	62.0%	49	44.1%	5	41.7%
C. Satisfactory	35	35.4%	35	35.0%	59	53.2%	6	50.0%
Unsatisfactory	3	3.0%	3	3.0%	3	2.7%	1	8.3%
TOTALS	99	100.0%	100	100.0%	111	100.0%	12	100.0%

	Homes for Aged		Residential School Infirmaries		Government Medical Institutions	
Satisfactory	18	50.0%	8	80.0%	4	44.4%
C. Satisfactory	12	33.3%	2	20.0%	4	44.4%
Unsatisfactory	6	16.4%	0	0.0%	1	11.2%
TOTALS	36	100.0%	10	100.0%	9	100.0%

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STATE INSPECTIONS

INSTITUTIONS AND AGENCIES

Initial Survey 8/30/73 to 9/13/73			Summary 1/1/73 to 12/31/73					
	Initial Inspections		Initial Inspections		Reinspections		Total Inspections	
Satisfactory	10	31%	15	37.5%	16	80.0%	31	51.7%
C. Satisfactory	13	41%	14	35.0%	4	20.0%	18	30.0%
Unsatisfactory	9	28%	11	27.5%	0	0.0%	11	18.3%
	32	100%	40	100.0%	20	100.0%	60	100.0%

DAY CARE CENTERS

Initial Survey 9/12/73 to 12/7/73			Summary 1/1/73 to 12/31/73					
	Initial Inspections		Initial Inspections		Reinspections		Total Inspections	
Satisfactory	38	54%	61	58.7%	15	88.2%	76	62.8%
C. Satisfactory	26	37%	36	34.6%	2	11.8%	38	31.4%
Unsatisfactory	6	9%	7	6.7%	0	0.0%	7	5.8%
	70	100%	104	100.0%	17	100.0%	121	100.0%

STATE INSPECTIONS

COLLEGES AND UNIVERSITIES

Initial Survey 10/29/73 to 11/12/73			Summary 1/1/73 to 12/31/73					
	Initial Inspections		Initial Inspections		Reinspections		Total Inspections	
Satisfactory	22	39%	54	50.4%	30	71.4%	84	56.4%
C. Satisfactory	34	61%	52	48.6%	12	28.6%	64	43.0%
Unsatisfactory	0	0%	1	1.0%	0	0.0%	1	.6%
	56	100%	107	100.0%	42	100.0%	149	100.0%

12 x

JUN 19 1985