REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

AUTHORIZATION FOR ELECTRONIC MONITORING IN NURSING FACILITIES

(SB 922)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

Joint Commission on Health Care
900 East Main Street, Suite 3072E
P.O. Box 1322
Richmond, Virginia 23218
http://legis.state.va.us/jchc/jchchome.htm

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Preface

Senate Bill 922 (2003) would amend *Code of Virginia* §§ 32.1-127, 32.1-138, and 32.1-138.1 to require the Board of Health to promulgate regulations that "authorize the use of electronic monitoring devices in the room of a resident of a nursing home...for the purpose of detecting abuse or neglect of elderly or disabled persons...." SB 922 was passed by in the Senate Committee on Education and Health which forwarded SB 922 to the Joint Commission on Health Care for study.

There are a number of issues to consider in authorizing the use of electronic monitoring in the rooms of nursing facility residents. Monitoring regulations would need to comply with federal and State wiretap laws and with State laws regarding unlawful filming/videotaping. Monitoring regulations would also need to consider and protect the personal privacy rights of residents and their roommates. Representatives of the Virginia State Police and the Virginia Department of Health (VDH) indicated that with proper consent and notification protections in place, electronic monitoring could be undertaken without any change in Virginia's current laws.

The Joint Commission on Health Care unanimously approved the option to send a letter to the State Health Commissioner to request that VDH monitor the issue of electronic monitoring to determine the necessity for initiating pilot projects and/or for developing advisory guidelines for electronic monitoring in nursing facilities. Options to introduce legislation to require the Board of Health to promulgate regulations authorizing electronic monitoring in nursing facilities were not endorsed.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the numerous individuals who provided information and assistance during the study including representatives of AARP, Alzheimer's Association, Helen Keller National Center for Deaf-Blind Youths and Adults, Office of the Attorney General, Office of the State Long-Term Care Ombudsman, TLC 4 Long Term Care, Virginia Association of Health Care, Virginia Association of Nonprofit Homes for the Aging, Virginia Department of Health, Virginia Hospital & Healthcare Association, and Virginia State Police.

Kim Snead

Kim Snead
Executive Director

December 2003

Executive Summary

Senate Bill 922 (2003) would amend *Code of Virginia* §§ 32.1-127, 32.1-138, and 32.1-138.1 to require the Board of Health to promulgate regulations that "authorize the use of electronic monitoring devices in the room of a resident of a nursing home...for the purpose of detecting abuse or neglect of elderly or disabled persons...." SB 922 was passed by in the Senate Committee on Education and Health which forwarded SB 922 to the Joint Commission on Health Care for study.

Currently there are approximately 1.5 million residents in an estimated 17,000 nursing facilities in the United States. The issue of providing enhanced protection for these residents has gained interest in recent years. Electronic monitoring in residents' rooms is one initiative that has been considered in a number of states.

Federal and State Law

Provisions of federal and state laws must be considered with regard to electronic monitoring. Federal law in U.S.C. Title 18 Chapter 119 prohibits the taping, transfer, or disclosure of private wire, oral, or electronic communications (oral communication) unless at least one participant has consented to the interception. Violation of the federal Wiretap Act may result in considerable civil damage awards. State law in *Code of Virginia* Title 19.2 Chapter 6 contains similar provisions to the federal Wiretap Act. In addition, *Code of Virginia* § 18.2-386.1 prohibits filming, videotaping or photographing "any nonconsenting person if (i) that person is totally nude, clad in undergarments, or in a state of undress so as to expose the genitals, pubic area, buttocks or female breast in a restroom, dressing room, locker room, hotel room, motel room, tanning bed, tanning booth, bedroom or other location and (ii) the circumstances are otherwise such that the person being videotaped or filmed would have a reasonable expectation of privacy."

Representatives of the Virginia State Police and the Virginia Department of Health (VDH) indicated that with proper consent and notification protections in place, electronic monitoring could be undertaken without any change in Virginia's current laws.

Legislation Enacted by Other States

Legislation has been considered in at least seven states, but to date only three states have enacted legislation:

- Texas enacted legislation in 2001 to allow monitoring in residents' rooms.

- Maryland enacted legislation in 2003 to require the Maryland Department of Health and Mental Hygiene to develop guidelines for monitoring undertaken at the nursing facility's discretion with resident consent.
- Louisiana, by concurrent resolution in 2003, directed the Department of Health and Hospitals and the Louisiana Nursing Home Assoc. "to implement a pilot project [in one nursing facility] to study the practicality of installing electronic monitoring devices in nursing home facilities" and to report prior to the 2004 legislative session.

Provisions Contained in SB 922

SB 922 would amend *Code of Virginia* § 32.1-127 to require regulation to include:

- Delineation of electronic monitoring devices allowed
- Consent form denoting sole right of resident if capable of informed decision, and if not, legal representative must make request
- Form to release NF from "civil liability for violation of the privacy rights of the resident who is the subject of the request as well as any other residents in the same room"
- Form to allow roommates to consent to monitoring, and to be "provided privacy protections...or to be moved to another room"
- Procedure to discontinue monitoring if another resident moves in
- Requirements for signs to denote electronic monitoring
- Timeframes for notice regarding initiation of monitoring
- Requirements for reporting abuse/neglect identified through monitoring
- Requirements for placement of electronic monitoring devices
- Protections for residents who do not favor monitoring
- Penalties for facilities that fail to comply with the requirements.

Support for SB 922

Law enforcement personnel generally supported SB 922 provisions. The Director of the Medicaid Fraud Unit (within the Office of the Attorney General) indicated monitoring could assist in ensuring that care paid for by Medicaid is being provided. A Sheriff's department representative was contacted after being identified as working closely with the Department of Social Services on a number of adult protective services investigations. The representative indicated that monitoring would be useful in identifying and substantiating abuse and neglect but that the Sheriff's Department would not have the staff or resources to be responsible for the cameras. A representative of the Virginia State Police indicated that monitoring would be useful as an "objective witness" which would be particularly useful in cases in which the victim would not be able to

testify. The representative indicated it would be important to post notices to address the expectation of privacy, otherwise one consenting individual would need to be present at all times.

A number of patient advocacy groups expressed support for the provisions of SB 922. Those groups include AARP, the Helen Keller Center for Deaf-Blind Youths and Adults, and TLC 4 Long Term Care.

Concerns Expressed about SB 922

VDH, the lead agency for the Administration in reviewing SB 922, did not take a position on SB 922 but expressed concerns. VDH's primary concern is the protection of "the personal privacy rights of the individual being monitored and any possible roommate...." Privacy issues are of great concern considering the very private, personal services that are provided to nursing facility residents that would be subject to monitoring. Current State law is "quite specific about NOT exposing naked, private parts" without consent of the resident. VDH indicated in its explanation of Virginia's policy regarding electronic monitoring: "Family members cannot insist on camera use over the objections of the resident. Facilities cannot use cameras in violation of the law based solely on a family member's request or approval. Documentation should be kept in the resident's medical record."

A second concern for VDH is that the bill may represent "unnecessary governmental interference as there are already laws in place to accommodate the use of cameras where a need might exist...." As noted previously, VDH indicates that electronic monitoring may be undertaken under current law as long as the nursing facility "obtains *documented consent of the resident* to be filmed, including any residents sharing a room with the resident to be filmed."

A number of provider groups expressed similar concerns regarding enacting SB 922. The groups included the American Health Care Association, the Virginia Health Care Association, the Virginia Hospital & Healthcare Association, and the Virginia Association of Nonprofit Homes for the Aging.

Action Taken by the Joint Commission on Health Care

On November 12, 2003, the Joint Commission on Health Care unanimously approved the option to send a letter to the State Health Commissioner to request that VDH monitor the issue of electronic monitoring to determine the necessity for initiating pilot projects and/or for developing advisory guidelines for electronic monitoring in nursing facilities. Options to introduce legislation to require the Board of Health to promulgate regulations authorizing electronic monitoring in nursing facilities were not endorsed.

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I. Authority for the Study/Organization of Report

Senate Bill 922 of the 2003 Session of the Virginia General Assembly would amend *Code of Virginia* §§ 32.1-127, 32.1-138, 32.1-138.1 to require the Board of Health "to include, in its regulations to license nursing homes, provisions to authorize the use of electronic monitoring devices in the room of a resident of a nursing home or certified nursing facility for the purpose of detecting abuse or neglect of elderly or disabled persons...." The summary for SB 922 in describing the content of the regulations reads:

> Such regulations must include, but need not be limited to, (i) a description of appropriate electronic monitoring devices that may be used; (ii) a consent form recognizing the sole right of a resident who is capable of making an informed decision to make such request and, in the case of a resident who is not capable of making an informed decision, the resident's legally authorized representative; (iii) a form releasing the nursing home or nursing facility from civil liability for violation of the privacy rights of the resident who is the subject of the request as well as any other residents in the same room; (iv) a form to provide other residents in the same room the opportunity to consent to such electronic monitoring devices or to be provided privacy protections from the electronic monitoring devices or to be moved to another room, in so far as possible; (v) a procedure to cease any electronic monitoring upon another resident being moved into the room with the subject resident; (vi) the size and location outside the subject resident's room of conspicuous signs to notify the staff, other residents, and the public of the presence of electronic monitoring devices; (vii) timelines for all procedures that include adequate notice of the commencing of electronic monitoring to the subject resident, all residents, the public and the staff; (viii) the responsibility for reporting abuse and neglect detected via electronic monitoring to adult protective services; (ix) instructions to protect the safety of all residents, staff and the public in the placement, size, and stability of the electronic monitoring devices; (x) protections for the privacy of residents who do not wish to be the subjects of or who object to electronic monitoring; and (xi) penalties for nursing home or certified nursing facility failure to comply with the electronic monitoring requirements. Amendments are provided to the law on Rights and Responsibilities of Patients in Nursing Homes to ensure that residents are notified of the right to request electronic monitoring and to prohibit the transfer or discharge of a patient who requests or indicates that he will request electronic monitoring. A second enactment clause requires the Office of the Attorney General to advise and assist the Board of Health in the development and implementation of the regulations relating to the use of electronic monitoring devices in nursing homes and certified nursing facilities for the purpose of detecting abuse and neglect of the elderly or disabled residents.
> (Summary of Senate Bill 922 – 2003.)

SB 922 was passed by in the Senate Committee on Education and Health. A letter referring the matter of electronic monitoring was sent to the Joint Commission on Health Care (JCHC) by the Clerk of the Senate. A copy of the Clerk's letter is included in Appendix A. Senate Bill 922, as introduced, is shown in Appendix B.

ORGANIZATION OF THE REPORT

This report includes four major sections. This section discussed the authority for the study. Section II presents background information on legal issues related to electronic monitoring in nursing facilities as well as a description of legislation that has been considered in some other states. Section III discusses issues to consider in implementing electronic monitoring requirements. Section IV provides policy options that the Joint Commission on Health Care may wish to consider in addressing electronic monitoring in nursing facilities.

II. Background

Currently there are approximately 1.5 million residents in an estimated 17,000 nursing facilities in the United States. The issue of providing enhanced protection for these residents has gained interest in recent years. Electronic monitoring in residents' rooms is one initiative that has been considered in a number of states. There are a number of legal issues to be considered with regard to electronic monitoring.

LEGAL ISSUES

Federal Law

United States Code, ***Title 18, Chapter 119. Wire and Electronic Communications Interception and Interception of Oral Communications.*** Federal law, known as "The Wiretap Act" (*United States Code,* Title 18, Chapter 119) prohibits the "interception" (taping or transfer) or disclosure of private wire, oral, or electronic communications unless at least one of the participants has consented to the interception. Within the Act, a number of exceptions are made including an exception for certain law enforcement reasons and for switchboard operators and radio stations.

The Wiretap Act applies only to the recording of oral communication. Thus, silent videotaping would not violate the Act. No intercepted oral communication "may be received in evidence in any trial, hearing or other proceeding in or before any court, grand jury, department, officer, agency, regulatory body, legislative committee, or other authority of the United States, a State, or a political subdivision thereof if the disclosure of that information would be in violation of" the Wiretap Act (18 U.S.C. § 2515).

The Act allows for the recovery of civil damages against any "person or entity, other than the United States" that violates the Act's provisions. Civil damages may include punitive damages, attorney's fees and other litigation costs. Civil damages may be considerable as the court is allowed to "assess as damages whichever is the greater of – (A) the sum of the actual damages suffered by the plaintiff and any profits made by the violator as a result of the violation;

or (B) statutory damages of whichever is the greater of $100 a day for each day of violation or $10,000." (18 U.S.C. § 2520)

Virginia Law

The *Code of Virginia* in Titles 19.2 and 18.2 addresses issues that could impact electronic monitoring within the rooms of nursing facility residents. *Code of Virginia*, Title 19.2 Chapter 6 prohibits unauthorized interception or disclosure of private wire, oral or electronic communications. *Code* § 18.2-386.1 prohibits the filming, videotaping, or photographing of individuals in a state of undress without their consent.

Code of Virginia, *Title 19.2 Chapter 6. Interception of Wire, Electronic or Oral Communications.* The interception or disclosure of private wire, oral or electronic communications is prohibited in Title 19.2 unless the "person [intercepting the communication] is a party to the communication or one of the parties to the communication has given prior consent to such interception." (*Code of Virginia*, § 19.2-62.B.2.)

Title 19.2 contains a number of provisions which are similar to federal law. These provisions address exceptions for such entities as radio and switchboard operations and for law enforcement officials under prescribed circumstances. In addition, Title 19.2 prohibits the use of communications obtained in violation of statute and allows for the recovery of civil damages. In Virginia, an individual may receive civil damages in the amount of "not less than liquidated damages computed at the rate of $100 a day for each day of violation or $1,000, whichever is higher" as well as punitive damages, and a "reasonable attorney's fee and other litigation costs reasonably incurred." (*Code of Virginia*, § 19.2-69.)

Code of Virginia, *Section 18.2-386.1. Unlawful Filming, Videotaping or Photographing of Another; Penalty.* *Code* § 18.2-386.1 prohibits the filming, videotaping, or photographing of "any nonconsenting person if (i) that person is totally nude, clad in undergarments, or in a state of undress so as to expose the genitals, pubic area, buttocks or female breast in a restroom, dressing room, locker room, hotel room, motel room, tanning bed, tanning booth, bedroom or other location and (ii) the circumstances are otherwise such that the person being videotaped or filmed would have a reasonable expectation of privacy."

Electronic Monitoring within a Resident's Room Could Be Allowed under Current Federal and State Law and Regulation

State agency representatives interviewed for this study, including staff of the Virginia State Police Department and Virginia Department of Health (VDH)

indicated federal and State law would allow for cameras to be placed in nursing facility residents' rooms if proper consent and notification protections were in place. Moreover, VDH staff indicated that there is no prohibition in federal or State certification or licensing regulations preventing nursing facilities from allowing cameras to be placed their residents' rooms. However, precautions are necessary to ensure that federal and/or state law is not inadvertently violated by illegally recording a conversation or by filming a person in a state of undress without his or her consent.

To ensure that the provisions of federal and state law are observed, it would be important to have the following protections are in place:

1. Informed consent for the monitoring by the resident or the authorized representative for any "incapable" resident who is to be the subject of the monitoring.
2. Informed consent for the monitoring by the roommate or the authorized representative for any "incapable" roommate as well as precautions to ensure that a roommate is not inadvertently recorded in a prohibited manner without that roommate's consent.
3. Posted signs outside monitored rooms to ensure that others within the facility understand that filming or videotaping is taking place so there should be no reasonable "expectation of privacy" in those rooms. (As noted previously, federal and State wiretap laws generally prohibit the interception or disclosure of private communication without the consent of at least one of the participants in the communication.)

The VDH website in response to a question about "the policy in Virginia regarding families placing cameras in nursing facilities" states:

> State and federal long-term care regulations do not prohibit the placing of cameras in resident rooms for the purposes of monitoring at risk residents. However, Virginia law prohibits the filming, videotaping or photographing of nonconsenting persons if: "(i) that person is totally nude, clad in undergarments, or in a state of undress so as to expose the genitals, pubic area, buttocks or female breast in a restroom, dressing room, locker room, hotel room, motel room, tanning bed, tanning booth or other location and (ii) the circumstances are otherwise such that the person being videotaped, photographed or filmed would have a reasonable expectation of privacy." Therefore, facilities must have procedures in place to obtain the *documented consent of the resident* to be filmed, *including any* resident sharing a room with the resident to be filmed. Residents have the right to refuse consent to be filmed. Family members cannot insist on camera use over the objections of the resident. Facilities cannot use cameras in violation of the law based solely on a family member's request or approval. Documentation should be kept in the resident's medical record. It is

not necessary to obtain consent of the employees or for using cameras in community areas such as hallways, elevators, or dining rooms. (Virginia Department of Health Internet website.)

VDH staff stated there are statutory safeguards in place to protect nursing facility residents from nursing facility "retaliation" for requesting electronic monitoring in their rooms. *Code of Virginia* § 32.1-138.A.6 requires nursing facilities to have policies and procedures that encourage and assist each resident "to exercise his rights as a patient and as a citizen and to this end...voice grievances and recommend changes in policies and services to facility staff and to outside representatives of his choice, free from restraint, interference, coercion, discrimination or reprisal." In addition, *Code* § 32.1-138.A.8 requires nursing facility policies to ensure that residents are "free from mental and physical abuse." VDH staff indicated that reprisals against residents who request electronic monitoring could be considered to be abuse, neglect, or exploitation of the resident (depending on the actions taken). VDH noted that it would not be inappropriate for the nursing facility to require the resident or the resident's family to pay for the expenses incurred by monitoring that was being initiated by or on behalf of the resident. "The facility has a right to charge appropriately for expenses incurred, and possible disruptions to daily routines, as a result of the establishment and operation of said cameras. Facilities would want that to be clearly understood upfront (merely good business practice) and have a formal agreement with a resident or resident's family regarding the operation of any camera set up, including who pays for use of the equipment."

LEGISLATION TO ALLOW MONITORING IN OTHER STATES

A Number of States Reported that Legislation to Authorize Electronic Monitoring Has Been Introduced but Not Enacted

VDH staff contacted health department representatives in the other 49 states, on behalf of JCHC, regarding legislation addressing electronic monitoring. Representatives of 14 states responded to the VDH query. Representatives in eight states (Georgia, Idaho, Kentucky, Minnesota, Nevada, New York, Ohio, and Rhode Island) indicated no legislation specifically addressing electronic monitoring had been considered in their states. Three states (Arkansas, Florida, and Illinois) reported that monitoring legislation had been considered but not enacted in previous legislative sessions in their states. The Louisiana State Legislature, whose session will adjourn by June 23rd, is considering a bill (House Bill 99) and a resolution (House Concurrent Resolution 206) that address electronic monitoring. Two states (Maryland and Texas) indicated that legislation has been enacted that specifically addresses electronic monitoring in nursing facilities in their states. (According to the National Conference of State

Legislatures, Texas is the only state that has statutorily required nursing facilities to allow electronic monitoring to date.)

The Louisiana State Legislature Is Considering HB 99 and HCR 206, Both of Which Address Electronic Monitoring. HB 99 authorizes a nursing facility resident or the resident's legal representative to initiate electronic monitoring in the resident's room. HB 99 includes such provisions as requiring a posted notice that a room is being monitored, stipulating that the resident bear the cost of the monitoring, and specifying specific penalties for violating the provisions of the bill. HCR 206 directs the Louisiana Department of Health to work with the Louisiana Nursing Home Association to "implement a pilot program to study the practicality of installing electronic monitoring devices in nursing home facilities...." HCR 206 requires a report on the pilot program prior to the 2004 Session of the Louisiana State Legislature.

Texas Is the Only State that Has Enacted Legislation to Require Nursing Facilities to Allow Electronic Monitoring in Resident Rooms

In 2001, Senate Bill 177 was enacted by the Seventy-Seventh Texas Legislature to allow for electronic devices to be placed in the rooms of nursing facility residents. In general, SB 177 allows nursing facility residents or their guardians or legal representatives to conduct "authorized electronic monitoring" (AEM) in the residents' rooms. AEM is defined to include both video and audio monitoring that results in tapes or recordings. The provisions of SB 177 are included in *Texas Statute* Chapter 242 of the Health and Safety Code, Subchapter R.

Provisions Addressing Resident Rights and Responsibilities. Beginning July 1, 2002 each nursing facility resident or his or her legal representatives was required in statute to sign a statement at admission that indicated:

(1) covert placement of a monitoring device or disclosure of any recording may result in civil liability for violating privacy rights,

(2) privacy rights are waived as those rights relate to "images or sounds" that are captured by electronic monitoring if monitoring is undertaken covertly on behalf of the resident,

(3) authorized electronic monitoring is permitted; if the nursing facility refuses to allow monitoring or fails "to make reasonable physical accommodations" the facility should be reported to the Texas Department of Human Services,

(4) specified procedures must be observed in requesting AEM, and

(5) "the manner in which this chapter affects the legal requirement to report abuse and neglect when electronic monitoring is being conducted...."

(*Texas Statute* § 242.844.)

Nursing facilities in Texas were allowed one year to inform residents admitted prior to July 1, 2002 of these provisions. Residents who undertake AEM are required to "post and maintain a conspicuous notice at the entrance to the resident's room" of the monitoring. (*Texas Statute* §§ 242.847. OR 846)

Texas Statute § 242.845 addresses who may request AEM. If the nursing facility resident is capable of making the request and has not been "judicially declared to lack the required capacity, only the resident may request authorized electronic monitoring under this subchapter, notwithstanding the terms of any durable power of attorney or similar instrument." If the resident has been "judicially declared to lack the capacity required for taking an action such as requesting electronic monitoring, only the guardian" may request AEM. If the resident lacks the capacity to request AEM but has not been "judicially declared to lack the required capacity only the legal representative" may request monitoring. *Texas Statute* § 242.845 requires the Texas Department of Human Services to delineate specific guidelines with regard to who would determine whether a resident lacked capacity to request AEM, and who could serve as the resident's legal representative.

The administrative regulations developed by the Texas Department of Human Services require the resident's physician to determine whether the resident lacks the capacity to make the monitoring request. If the physician documents the lack of capacity:

> a person from the following list, in order of priority, may act as the resident's legal representative for the limited purpose of requesting AEM:
>
> 1. a person named in the resident's medical power of attorney or other advance directive;
> 2. the resident's spouse;
> 3. an adult child of the resident who has the waiver and consent of all other qualified adult children of the resident to act as the sole decision-maker;
> 4. a majority of the resident's reasonably available children;
> 5. the resident's parents; or
> 6. the individual clearly identified to act for the resident by the resident before the resident became incapacitated or the resident's nearest living relative.
>
> (Commissioner, Texas Department of Human Services, Provider Letter #02-21 – New Rules Regarding Electronic Monitoring, dated June 14, 2002.)

A representative of the Texas Department of Human Services explained that priority order means that if someone higher on the listing refuses to authorize monitoring, someone lower on the list is not allowed to approve the monitoring. Thus, if a resident's spouse will not authorize monitoring, the resident's children would not be able to authorize monitoring over the spouse's objections.

Texas Statute requires residents who request AEM to release the nursing facility "from any civil liability for a violation of the resident's privacy rights in connection with the use of the electronic monitoring device...." In addition, residents are allowed to determine whether a video "camera will always be unobstructed or whether the camera should be obstructed in specified circumstances to protect the dignity of the resident...." Residents or their representatives are required to pay all of the costs associated with equipment installation, operation, and maintenance except the cost of electricity. (*Texas Statute* §§ 242.846, 242.847.)

Texas statutorily provides protections for roommates of residents who request AEM. The statutory and administrative provisions for consent by a roommate to monitoring mirror the provisions for residents to request AEM. Thus, only the roommate could consent to AEM if the roommate is capable of making the request with no judicial declaration regarding a lacking of capacity, and so on. The same administrative guidelines, developed by the Texas Department of Human Services, are used to determine whether a roommate lacked capacity to consent to AEM (determined by roommate's physician), and in delineating who could serve as the legal representative for the roommate in determining consent for monitoring (See on previous page explanation of Provider Letter #02-21, dated June 14, 2002). Roommates are allowed to require that video cameras point away from them or that audio monitoring devices be limited in their recording. In regulation, Texas specifies that the resident and not the nursing facility must ensure that the monitoring is completed in compliance with any conditions required by a roommate. Thus, the resident would be responsible for turning off audio monitoring when the roommate's minister visited if that were the roommate's stated preference. In addition, AEM must cease whenever a new roommate is moved into the room until the new roommate's consent has been obtained. (*Texas Statute* §§ 242.846, 242.847.)

Provisions Addressing Nursing Facilities. Nursing facilities are statutorily required to make reasonable accommodations and to provide a power source for AEM. Nursing facilities are not allowed to refuse admission or to remove a resident due to monitoring although facilities are allowed to make reasonable demands regarding the monitoring. These demands may include ensuring that the equipment is installed in a safe manner and in a conspicuous place in the room. A nursing facility "may but is not required to place a resident

in a different room to accommodate a request to conduct" AEM. Nursing facilities are required to "post a notice at the [facility] entrance...stating that the rooms of some residents may be monitored electronically by or on behalf of the residents and that the monitoring is not necessarily open and obvious." (*Texas Statute* §§ 242.847, 242.850.)

Provisions Addressing APS and Use of Recordings as Evidence. Texas included in its AEM statutes a provision that addresses responsibility for reporting abuse and neglect and a provision that addresses the treatment of recordings as evidence in court hearings.

In Texas, any person who "has cause to believe that a [long-term care facility] resident's physical or mental health or welfare has been or may be further adversely affected by abuse or neglect and knowingly fails to report" commits a Class A misdemeanor (*Texas Statute* § 242.131.). (In Virginia, only specified individuals such as physicians, nurses, and nursing facility administrators are mandated to report observed abuse and neglect). Texas in its AEM statute states the person who is responsible for conducting the monitoring is assumed to have reviewed each recording "on or before the 14th day after the date the...recording is made." If the recording includes a clear example of abuse or neglect, the reviewer is required to report the abuse or neglect or give the tape to someone else for review. Any person who is given a recording is assumed to have completed the review on or before the 7th day after the recording's receipt. This secondary reviewer is mandated to report any abuse or neglect shown on the recording. (*Texas Statute* § 242.848.)

Texas also includes in its AEM statute that recordings which result from AEM or covert monitoring while subject to "applicable rules of evidence and procedure...may be admitted into evidence in a civil or criminal court action or administrative proceeding." The statute continues in stating that a tape or recording may only be admitted if the time and date are displayed (if a video tape); the tape has not been "edited or artificially enhanced;" and that the tape has not been "transferred from the original format to another technological format [unless] the transfer was done by a qualified professional and the contents of the tape or recording were not altered." (*Texas Statute* § 242.849.)

Provisions Addressing Sanctions for Noncompliance. *Texas Statute* does not specify the sanctions associated with noncompliance with AEM provisions, but requires the Texas Department of Human Services to impose sanctions. Administrative penalties are allowed for administrators and facilities for such violations as refusing to permit monitoring, refusing to admit or for removing a resident due to request for AEM or to covert monitoring. In Texas, there was an instance of covert monitoring that received attention prior to the passage of the monitoring legislation. Residents may not be transferred or discharged due to

covert monitoring. Once covert monitoring is found, it must be converted to overt monitoring and include all of the protections required in statute and regulation. Texas law also specifically notes that individuals who engage in covert monitoring are liable for any violations of privacy laws.

By statute, a person would be guilty of a Class B misdemeanor it that person "intentionally hampers, obstructs, tampers with, or destroys an electronic monitoring device installed in a resident's room...or a tape or recording made by the device...." The statute continues however in stating: "It is a defense to prosecution...that the person took the action with the effective consent of the resident on whose behalf the electronic monitoring device was installed or the resident's guardian or legal representative." (*Texas Statute* § 242.852.)

Legislative Changes Enacted in by the Seventy-Eighth Texas Legislature. The Texas Legislature enacted legislation (SB 1012 – 2003) to extend AEM provisions to assisted living facilities. SB 1012 extends the same statutory provisions for AEM that apply to nursing facilities to assisted living facilities except for enforcement and sanctions for noncompliance. SB 1012 requires the Texas Board of Human Services to adopt regulations by January 1, 2004, that address AEM within assisted living facilities.

Statistics Are Not Available but Texas Officials and Association Representatives Indicate Very Few Residents Have Requested AEM. Two officials with the Texas Department of Human Services indicated that no statistics have been collected on requests for AEM since the legislation does not require such reporting. Both officials indicated that they have heard very little about the issue which leads them to believe very few cameras have been installed. One official, a representative of the Texas licensing division, indicated one situation was brought to his attention because of a family's review of a videotape. The family believed the tape showed their family member was tapped or swatted with a diaper while being changed. The family did not make an allegation and the staff member was transferred within the nursing facility.

JCHC staff contacted a representative with the Texas Health Care Association (THCA) and the Texas Association for Homes and Services for the Aging to ask about the number of member facilities that have residents who requested AEM. Both representatives indicated that they have not heard from their members about the issue which leads them to believe few requests for AEM have been received. The THCA representative indicated that unless a family is very unhappy with the care, she did not think monitoring would be initiated as it would be burdensome for the family to oversee. The TAHSA representative indicated that the issue of monitoring has come up in a number of assisted living facilities.

Maryland Enacted Legislation in 2003 Requiring the Development of Guidelines for Electronic Monitoring

In Maryland, legislation to require nursing facilities to allow electronic monitoring in residents' rooms was introduced from 2000 through 2002 without being enacted.

House Bill 751 Was Introduced in 2000. HB 751, introduced by Delegate Susan Hecht of the Maryland General Assembly, would have required nursing homes and other long-term care facilities to allow residents and their legal representatives to install electronic monitoring in residents' rooms. HB 751 included a number of provisions included in Senator Byrne's introduced bill SB 922 (2003). These provisions included: requiring consent by the resident (or resident's legal representative) and the resident's roommate for the monitoring, making the resident or legal representative responsible for the cost and operation of the monitoring, posting a notice that monitoring is taking place in the room, requiring the nursing facility to make reasonable accommodation for the monitoring, and specifying penalties for individuals and facilities for violating the provisions of the bill. HB 751 was not acted on by the 2000 Maryland legislature.

House Bill 433 Was Introduced in 2001. Delegate Hecht introduced essentially the same legislation as HB 433. In an interview on ABC's *Good Morning America* program, Delegate Hecht indicated that "she began a crusade to pass the so-called 'Grannycam' bill after her mother was mistreated in a nursing home." In the ABC News report, Delegate Hecht related the following:

> "My mom had kept talking about being scared and not getting good care," says Hecht. "She couldn't identify the person, the name, but I happened to walk in during the middle of the day and witnessed an abusive incident of my mother while she was in the bathroom." Hecht says what really scares her is the idea that there is much more similar abuse that simply goes undetected.

HB 433 was referred for study by Maryland's House Environmental Matters Committee. The Committee asked that a pilot project involving electronic monitoring be undertaken under the supervision of the Maryland Department of Health and Mental Hygiene (DHMH). (A DHMH official indicated in June 2003, that the pilot project was never started due to unresolved differences in how resident advocacy groups and nursing facility associations wanted to undertake the project.)

House Bill 880 Was Introduced in 2002. HB 880, which was very similar in its provisions to HB 751 and HB 433 was introduced by Delegate Hecht. No action was taken by the Maryland legislature on HB 880.

In 2003, Two Bills Addressing Electronic Monitoring Were Introduced. HB 1097 and HB 149 took different approaches to electronic monitoring than Delegate Hecht's bills had taken.

HB 1097 required nursing facilities (at the facilities' expense) to install cameras in resident rooms to allow for observation by staff on a 24-hour basis. A camera would be installed only with the written consent of the resident or the resident's legal representative. According to the "Fiscal and Policy Note" prepared by Maryland legislative staff, HB 1097 was expected to have a "meaningful" impact on small providers who would incur additional administrative costs. No action was taken on HB 1097.

HB 149 required Maryland's DHMH to "develop guidelines for nursing homes that elect to use electronic monitoring with specified consent." HB 149 was enacted in May 2003 and DHMH is required to report on the guidelines by December 2003. The Maryland Department of Legislative Services, in its analysis of HB 149 stated:

> Under Maryland's wiretapping and electronic surveillance laws, it is unlawful to willfully intercept any wire, oral, or electronic communication. "Interception" means the aural or other acquisition of the contents of any wire, electronic or oral communication through the use of any electronic, mechanical, or other device. A person who violates these provisions is guilty of a felony and subject to imprisonment for not more than five years or a fine of not more than $10,000, or both. There are specified exceptions for lawful acts performed by such individuals as: (1) a switchboard operator, or wire or electronic communication service employee; (2) an investigative or law enforcement officer acting in a criminal investigation or other specified circumstances; (3) a person who is a party to the intercepted communication, where all of the parties have given prior consent; (4) an employee of a governmental emergency communications center; and (5) a person intercepting an electronic communication that is readily accessible to the general public. There are no provisions in current law authorizing electronic monitoring in nursing homes.

III. Considerations in Implementing Electronic Monitoring Requirements

Senator Byrne, the chief patron of SB 922 discussed the provisions of the legislation with JCHC staff. The next two paragraphs summarize the statements made by Senator Byrne during the discussion.

The purpose of the legislation is to improve the care provided in nursing facilities. National studies have shown involvement by family members results in better care for residents of nursing facilities. Texas, which legislatively provides residents the right to have electronic monitoring in their nursing facility rooms, has allowed residents' families to assure themselves regarding the quality of care being provided. If a resident who has authorized the monitoring is abused or neglected, there will be a visual record of the abuse or neglect. This visual record would be extremely useful, particularly in cases in which the resident might not be able to testify because of disability or limitations. The visual record produced by monitoring could also be a protection for facility staff who might be falsely accused of abuse or neglect without the visual record.

Senator Byrne noted that SB 922 was drafted specifically to address the issues of privacy and consent. SB 922 makes it clear that a consent form must be signed by the resident or the "legally authorized representative" of a resident who is not able to make an informed decision before electronic monitoring may be implemented. In addition, anyone sharing the room with a resident who decides to install a monitor would either need to sign a consent form or would be "provided privacy protections...or be moved to another room...." Moreover, SB 922 requires conspicuous signs to be posted outside of rooms that have electronic monitoring "to notify the staff, other residents, and the public of the presence of electronic monitoring devices...."

SB 922 WOULD AMEND *CODE OF VIRGINIA* §§ 32.1-127, 32.1-138, 32.1-138.1

SB 922 would amend *Code* § 32.1-127 to require the Board of Health to promulgate regulations "to authorize the use of electronic monitoring devices in the room of a resident of a nursing home or certified nursing facility for the purpose of detecting abuse or neglect of elderly or disabled persons that take into consideration Virginia law relating to nonconsensual interception of wire or electronic communications, privacy rights, notice requirements, covert and noncovert placements of such devices, and potential violations of existing civil

and criminal law." The legislation continues by specifically delineating areas that need to be covered in regulation. These areas include:

1. a description of the types of electronic monitoring devices that could be used
2. a consent form "recognizing the sole right of a resident who is capable of making an informed decision to make such request and, in the case of a resident who is not capable of making an informed decisions, the resident's legally authorized representative"
3. a form to release the nursing facility from "civil liability for violation of the privacy rights of the resident who is the subject of the request as well as any other residents in the same room"
4. a form to allow roommates to consent to monitoring, to be "provided privacy protections...or to be moved to another room, in so far as possible"
5. a procedure for discontinuing the monitoring if another resident is moving into the room
6. requirements regarding the "size and location outside the subject resident's room of conspicuous signs to notify the staff, other residents, and the public of the presence of electronic monitoring devices"
7. "timelines for all procedures that include adequate notice of the commencing of electronic monitoring to the subject resident, all residents, the public and the staff"
8. "the responsibility for reporting abuse and neglect detected via electronic monitoring to adult protective services"
9. instructions regarding the "placement, size, and stability of the electronic monitoring devices"
10. "protections for the privacy of residents who do not wish to be the subjects of or who object to the electronic monitoring" and
11. penalties for nursing facilities that fail to comply with the requirements.

In addition, SB 922 would amend *Code* §§ 32.1-138 and 32.1-138.1. In *Code* § 32.1-138, which addresses nursing facility policies and responsibilities, SB 922 would add the requirement that residents receive written notification of their right to authorize electronic monitoring. In *Code* § 32.1-138.1, SB 922 would prohibit nursing facilities from transferring or discharging a resident because that resident "requested or indicated that he will request electronic monitoring...."

SB 922 includes a second enactment clause that requires the Office of the Attorney General to "advise and assist the Board of Health in the development and implementation of the regulations relating to the use of electronic monitoring devices in nursing homes and certified nursing facilities for the purpose of detecting abuse and neglect of the elderly or disabled residents."

Staff within the Division of Legislative Services stated that an amendment that was drafted but not adopted would have made it clear that all of the costs related to the monitoring, except the cost of electricity, would be the responsibility of the resident or his or her family or representative.

COMMENTS OF STATE AND LOCAL REPRESENTATIVES

Virginia Department of Health Has Concerns about Electronic Monitoring

VDH was the lead agency for the Administration in reviewing SB 922. VDH did not take a position on SB 922, but expressed concerns about the bill's provisions.

VDH's primary concern is the protection of "the personal privacy rights of the individual being monitored and any possible roommate...." Privacy issues are of great concern considering the very private, personal services that are provided to nursing facility residents that would be subject to monitoring. Current State law is "quite specific about NOT exposing naked, private parts" without consent of the resident. VDH indicated in its explanation of Virginia's policy regarding electronic monitoring: "Family members cannot insist on camera use over the objections of the resident. Facilities cannot use cameras in violation of the law based solely on a family member's request or approval. Documentation should be kept in the resident's medical record." (VDH Internet website.)

A second concern for VDH is that the bill may represent "unnecessary governmental interference as there are already laws in place to accommodate the use of cameras where a need might exist...." As noted previously, VDH indicates that electronic monitoring may be undertaken under current law as long as the nursing facility "obtains *documented consent of the resident* to be filmed, including any residents sharing a room with the resident to be filmed." If electronic monitoring is going to be undertaken, VDH expects the nursing facility to have policies and procedures in place to ensure that the privacy of residents is protected. Moreover, if problems result from increased demands for electronic monitoring, the Board of Health would not need a legislative mandate to develop regulations.

A VDH representative in discussing SB 922 noted that the idea of electronic monitoring is a relatively new concept for nursing facilities and that relatively little concrete information regarding the implementation of electronic monitoring is currently available. For example, there are a number of unanswered questions. Examples of unanswered implementation questions developed by JCHC staff during the completion of this study include:

> What should a nursing facility do if two roommates want to remain together but one resident requests electronic monitoring and the roommate does not consent?
>
> What should a nursing facility do if a tape is full and taping ceases, or if a tape breaks?
>
> Should the nursing facility be responsible for storing and providing security for tapes that a family has not picked up? If so, should the facility be able to charge for that service and if so, what would be a reasonable charge?
>
> If a tape appears to have been tampered with or stolen, what is the facility's responsibility in investigating?
>
> Should Internet connections that allow a family member to see what is going on in their relative's room at all times be allowed? If so, would the electronic transmission have implications under Health Insurance Portability and Accountability Act of 1996 (HIPAA) patient privacy protections?
>
> Who should be designated to review tapes that are submitted by a family who allege abuse or neglect is shown on the tape?

Alternatives to Statutory Provisions and Administrative Regulations Could Be Considered. Two alternative, pilot projects and advisory guidelines could be used separately or in combination. These alternatives could be useful in identifying and addressing implementation issues as well as the need for additional measures. VDH has written advisory guidelines on a number of subjects ranging from dealing with power outages to using restraints. Guidelines are not subject to exhaustive Administrative Process Act requirements and do not have the authority of regulations. Consequently guidelines are simpler to develop and change but compliance with guidelines cannot be enforced. Figure 1 includes the guidelines developed by VDH for dealing with power outages. While this example is short and straight-forward, guidelines are often much more detailed and lengthy. The guidelines developed for internal investigations of abuse, neglect and misappropriation of resident property for example is nine pages long.

Figure 1

Virginia Department of Health
Center for Quality Health Care Services and Consumer Protection

Extended Power Outages

Principle

Each nursing facility shall strive to maintain temperatures in resident areas at a comfortable and safe level when severe weather disrupts a facility's normal operating procedures.

Introduction

State regulation (12 VAC 5-371-190. Safety and emergency procedures) requires that each nursing facility have an emergency preparedness plan designed to manage natural disasters or other emergencies that disrupt the facility's normal operating procedures. State regulation (12 VAC 5-371-370 E) also requires that facility heating, ventilation and air conditioning systems be capable of maintaining temperatures between 70° F to 80° F throughout resident areas. With the increase in severe weather patterns that result in extended power outages disrupting a facility's ability to operate normally, it is imperative that facilities be proactive in advanced planning to assure that resident health, comfort and safety are not adversely affected. Towards that goal, the Center has developed the following guidelines to assist facilities in enhancing their emergency preparedness plans to include extended power outages.

> An effective emergency preparedness plan requires prompt recognition of a serious situation, availability of an adequate, well-publicized and tested plan, clear assignment of responsibilities, and flexibility in plan implementation.

Definition

"Comfortable and safe" means an ambient temperature that minimizes residents' susceptibility to loss of body heat and risk of hypothermia or susceptibility to respiratory aliments and colds.

General Rules

A. Written policies and procedures shall be developed for responding to ambient temperature fluctuations outside the range defined in regulation (i.e., 70° F to 80° F). The Medical Director shall participate in development of the procedures, which should include identification of:

- Residents at risk or who have the potential to be adversely affected by temperatures outside the acceptable range.
- Circumstances that require notification of the Medical Director or a resident's attending physician, that require medical examination or other medical interventions, or that require notification of the local emergency services personnel, if available.
- Measures to be taken to assure the health, safety, and comfort of residents remaining in the facility.
- Available sites for relocation of residents, including identification of suitable healthcare facilities available to receive transfers if the temperature adversely effects or has the potential for adversely affecting the health and safety of residents.
- Sources of back-up auxiliary generators to insure an uninterrupted emergency electrical system.[1]
- Appropriate time frames for these actions based on the needs of the individual residents.

Figure 1 continued

B. The facility's administration shall maintain a current listing of residents at risk or who have the potential to be adversely affected by temperatures outside the acceptable range. The measures necessary to assure a resident's health, safety, and comfort in the event of power outages should be recorded in the resident's medical record or Plan of Care.

C. There shall be a written plan and procedures for the transfer of residents to another medical care facility if complications arise. Such plans and arrangements shall include arrangements for an ambulance and the escort of the resident, when appropriate.

D. When temperatures are outside the acceptable range, the facility shall immediately evaluate the situation, monitor residents at risk, and take appropriate action to ensure the health and maximize comfort of residents.

E. The facility shall maintain arrangements with qualified contractors to provide emergency mechanical services in the event of an electrical, heating, ventilation or air conditioning failure or malfunction.

F. Repairs shall be completed or emergency power equipment shall be operational as soon as possible after the power outage.

G. The nursing facility shall notify the Virginia Department of Health when emergency situations that disrupt the normal course of business occur. Written documentation of each episode shall be retained in the facility for 3 years plus the current year.

Upon culmination of the emergency, the facility should evaluate the actions taken during the episode and update its emergency preparedness plan as necessary.

It is expected that facility management will exceed these measures when reviewing and updating their facility's emergency preparedness plan.

[1] For federally certified facilities, the applicable Life Safety Code requires a back up power source for heating all rooms utilizing life support devices. The electrical systems are to be designed and installed according to NFPA 70 and NFPA 99. The allowable exception is any life support equipment used on an emergency basis as defined in section 12-5.1.3 of the Life Safety Code.

Law Enforcement Personnel Generally Supported the Provisions of SB 922

Personnel who are involved in or are familiar with the issues entailed in prosecuting adult abuse and neglect were interviewed by JCHC staff with regard to the provisions of SB 922.

Office of the Attorney General (OAG) Representative Discussed Provisions of SB 922. The Director of the Medicaid Fraud Unit within OAG discussed the provisions of SB 922 with JCHC staff. The Fraud Unit Director considers electronic monitoring to be a good idea in terms of ensuring that the care being paid for by Medicaid is being provided. At this time, quality care is not always provided because the patient-to-staff ratios in nursing facilities are not always good. The Fraud Unit Director believes facilities would increase

staffing if monitoring showed that proper care was not being provided. The Director of the Medicaid Fraud Unit cautioned that the privacy requirements included in the Health Insurance Portability and Accountability Act of 1996 should be considered in implementing electronic monitoring.

The Fraud Unit Director reported that a special unit was created within OAG in 1999, to investigate patient abuse and neglect. (Sexual assaults and more serious felonies are investigated by local law enforcement authorities.) During the three-year time period, approximately 150 complaints have been considered by the unit (specific statistics have not been compiled). While a number of the complaints are still under investigation, only 10 to 12 convictions have been obtained to date. In many of the unsuccessful cases, the victim has been unable to identify the perpetrator. Most of the convictions have been secured on the basis of having an eye witness, such as a facility employee who witnessed the offense. The Fraud Unit Director stated videos would be admissible and should assist in increasing the number of cases in which the perpetrators could be identified and convicted.

Officer within a Sheriff's Department Discussed Provisions of SB 922. JCHC staff contacted a sheriff's department that was identified as working closely with the Department of Social Services (DSS) on adult protective services investigations. The officer, who was interviewed, indicated that the sheriff's department would be in favor of electronic monitoring as presented in SB 922. The officer wanted to make it clear that his department would not have the personnel or the resources to operate the cameras themselves, however. The officer stated that he believed most law enforcement personnel would support the idea of having electronic monitoring to assist in identifying and substantiating adult abuse and neglect.

Virginia State Police (VSP) Representative Discussed Legal Issues Surrounding the Provisions of SB 922. A VSP representative who is a specialist with regard to wiretapping law discussed the provisions of SB 922. The representative indicated that the concept behind the recordings could be useful. Individuals who have severely decreased mental capacity typically are not capable of testifying accurately as to abuse or neglect they may have experienced. The camera, on the other hand, is "the silent witness without bias."

The VSP representative indicated that while videotape is the most objective "witness" in showing what took place if abuse or neglect is alleged, there are important legal issues involved in electronic monitoring. Legislation will need to be crafted so as to not violate the federal and state wiretapping provisions. It will be important to clearly post notices that electronic monitoring is being conducted in the resident's room so there should be no expectation of privacy. As noted previously, at least one participant must consent to the

recording of any private conversation in order to keep from violating federal and state wiretapping laws. Otherwise, wiretapping laws could be violated if a "private" conversation were recorded while the resident who consented to the recording was out of the room. It will also be important to ensure that informed consent is obtained from any individual who may be captured on videotape in a state of undress. An important exception to this provision would be if an individual was captured on tape exposing himself or herself to another person (thereby giving up any expectation of privacy).

The VSP representative indicated that any recorded evidence should be admissible in court as long as no violation of law occurred in making the recording and the tape has not been altered.

COMMENTS OF CITIZENS AND ADVOCACY GROUPS

Comment Received from Citizen in Response to Notice on Elder Rights Listserve Supported SB 922

Kay Chidlaw, whose husband was a nursing facility resident wrote in support of SB 922. Ms. Chidlaw's letter read:

> I would urge the positive support of SB 922, Electronic Monitoring for Residents of Nursing Homes etc...my husband (expired) was a resident of a nursing home in Northern Virginia. Examples of the need for electronic monitoring of residents' rooms....1) his doctor ordered my husband's feeding tube turned off prior to lowering the head of the bed(mattress-to not less than 45 degrees) to prevent back up of food stuff into his lungs, when his soiled underclothing was being changed, bed made etc. He was on antibiotics for pneumonia (and hospitalization) several times I suspected the CNAs were not following orders in that it was easier for them to do their work if the head section was fully lowered and the feeding tube remained on. Electronic monitoring would have guarded against these actions in my absence and given support to my suspicions. 2) Medications were not given timely nor was hydration as prescribed which led to dehydration and further suffering 3) he was not bathed or bed linens changed if at all until mid or late afternoon many times, 4) on occasion he was left sitting up in his chair all day without change of soiled clothing etc. Electronic monitoring would have alleviated these conditions. When approached nursing home personnel claimed they were following orders and regulations.
>
> Electronic monitoring as proposed, for those who choose it for their loved ones, will bring more peace of mind to the families of the residents of Virginia's nursing homes and Nursing Home Administrators and supervisory staff will benefit by being able to maintain closer supervision of their CNAs and other personnel interacting with the residents.
>
> Kay Chidlaw
> Citizen of the Commonwealth

TLC 4 Long Term Care Supports Legislation that Ensures that Nursing Facility Residents May Have Electronic Monitoring in their Rooms

TLC 4 Long Term Care's position statement on video technology in nursing facilities is shown in Figure 2 (on the next two pages). TLC 4 Long Term Care indicates electronic monitoring can assist in improving quality of care by allowing family members to be more proactive in their loved ones' care, by facilitating more frequent visitation including "video visitation," by documenting both exemplary and poor care, and by discouraging abuse, neglect, and theft.

TLC 4 Long Term Care's position statement also addresses requirements for nursing facilities that should be included in legislative provisions. These provisions include requiring nursing facilities "to make reasonable accommodations for the installation of [monitoring] equipment;...to notify residents of their right to use video technology;...and [to p]rotect the privacy of roommates." In addition, the position statement indicates legislation should "prohibit a facility from refusing to admit or from removing a resident who uses such technology" and provide "for sanctions against facilities that refuse to permit electronic monitoring or against employees that tamper with equipment or [commit] similar violations...."

TLC 4 Long Term Care's position statement also discusses two arguments made against monitoring. These arguments concern privacy issues and the cost of monitoring both of which the position statement asserts are the authority of the nursing facility resident to address.

AARP Supports Legislation that Ensures that Nursing Facility Residents May Have Electronic Monitoring in their Rooms

AARP supports legislation that would allow for electronic monitoring. An AARP representative indicated that monitoring is expected to have a significant role in the future. With the current technology, it is user friendly and can be undertaken at no cost to the State. Monitoring would provide comfort for families and protection for both the resident and the facility. If a resident alleged abuse or neglect, monitoring would allow the family and the facility to see what actually occurred. In some instances, the facility would benefit by being able to show that abuse or neglect did not occur.

The AARP representative stated that the real issue is staffing within nursing facilities in Virginia. There are residents who are lacking in care because there are not enough staff to provide appropriate care.

Figure 2

Position on the Use of Video Technology by Nursing Home Residents
TLC 4 LONG TERM CARE

TLC4LTC, a state-wide, all-volunteer advocacy organization working for quality care for Virginia's nursing home residents, strongly supports legislation that would protect the right of nursing home residents or their legal representatives to utilize video technology for the purposes of surveillance, documentation of care or virtual visitation. While there is currently no state or federal law that prohibits such use, legislation is needed to ensure that residents or prospective residents who wish to utilize such technology are not subject to reprisals, denied admission or penalized in any way. Legislation is also needed to clarify the duties and responsibilities of the parties with respect to a variety of issues such as installation costs, maintenance of the technology, notice of use, utilization in court proceedings, and enforcement.

TLC4LTC supports legislation specifically authorizing the use of video technology by nursing home residents or their legal representatives for many reasons. We believe that this exciting new technology can help improve quality of care by:

1. Helping family members to be proactive in the care of their loved ones. For example, a camera may help explain unusual bruises about which a family is concerned. A camera may indicate that the resident is frequently rubbing his arm against a portion of a wheelchair. The family member may point this out to the facility, which, in turn, can use cushions to prevent future bruises;

2. Facilitating additional visits and more frequent communication between nursing home residents and their family members. While nothing can replace in-person visits, video visitation can be the "next best thing";

3. Documenting exemplary care, allowing family members to acknowledge and communicate instances of exceptional service on the part of one or more caregivers;

4. Documenting poor care, neglect or abuse. As numerous studies have detailed, including a recent General Accounting Office study on abuse, the physical and sexual abuse of residents is a fact of life in nursing homes. More than 30 percent of nursing homes have been cited for violations that harmed residents or placed them in immediate jeopardy. Cases of physical and sexual abuse are frequently not reported in a timely manner and few allegations of abuse are ultimately prosecuted. Currently, these victims suffer in silence. Video cameras offer a voice to these victims;

5. Deterring abuse, neglect and theft. Video surveillance is extremely widespread today. It is an accepted and proven deterrent to theft, robbery and other crimes. The presence of cameras has been shown to reduce theft among employees and produce significant improvements in school children's behavior.

Figure 2 continued

Position on the Use of Video Technology by Nursing Home Residents
TLC 4 LONG TERM CARE

It is important that any legislation enacted:

1. Specifically prohibit a facility from refusing to admit or from removing a resident who uses such technology;

2. Require facilities to make reasonable accommodations for the installation of the equipment;

3. Require facilities to notify residents of their right to use video technology;

4. Provide for sanctions against facilities that refuse to permit electronic monitoring or against employees that tamper with equipment or similar violations; and

5. Protect the privacy of roommates.

Many of the arguments made by opponents of the use of video technology by nursing home residents involve issues of privacy. It is important to note that privacy is a right exercised by the resident or her legal representative, not by the facility. Employees have little expectation of privacy while performing their duties, and current technology is able to monitor only the resident who has requested monitoring, thereby protecting the privacy rights of any roommates. As a recent report by the Florida Legislature on Cameras in Nursing Homes stated, "The privacy rights of a roommate must be considered, but this is more a technical/logistical problem than a fundamental legal issue."

Another argument against the use of video technology is the potential cost to either the nursing home or the state. Any legislation should require the resident or the resident's legal representative to cover the costs associated with the monitoring, except for electricity. With respect to any costs to the state, the fiscal note that accompanied a video camera bill in Maryland (Maryland House Bill 433 from the 2001 Session) concluded that the provisions of the bill are "not expected to significantly affect state government finances or operations".

In conclusion, we would urge Virginia to adopt legislation that would specifically permit residents and their legal representatives to utilize video technology. As stated in the aforementioned report by the Florida Legislature:

> "In conclusion, the likely deterrent effect on resident abuse and neglect, together with the benefits to management, residents and their families and friends, suggest that the voluntary use of cameras in nursing homes and resident rooms – similar to what is allowed under Texas law—would work well in Florida. Legislation should allow Floridians to make this choice."

TLC4LTC and its members strongly believe that Virginians deserve to make this choice as well.

Representative of the Helen Keller National Center for Deaf-Blind Youths and Adults Commented in Support of SB 922

Paige Berry commented in support of SB 922, in writing:

> Thank you for the opportunity to comment on Senate Bill 922. I am the national older adult specialist for the Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC) in Sands Point, NY. The Department of Rehabilitation Counseling at VCU gives me a professional home.
>
> HKNC supports Senate Bill 922 that would require the Board of Health "to include, in its regulations to license nursing homes, provisions to authorize the use of electronic monitoring devices in the room of a resident of a nursing home or certified nursing facility for the purpose of detecting abuse or neglect of elderly or disabled person?."
>
> Older adults who are deaf-blind, blind, deaf, hard of hearing and severely visually impaired are potentially at great risk for abuse. For those residents whose primary language is sign language, it often becomes a communication issue because care providers are unable to communicate with residents. The reporting of abuse, with this population, may also be difficult due to the language barrier.
>
> Paige Berry
> Older Adult Specialist
> Helen Keller National Center
> Assistant Clinical Professor
> Department of Rehabilitation Counseling
> Virginia Commonwealth University

The State Long-Term Care Ombudsman Indicated that Residents Should Have the Right to Use or Refuse Video Technology

The Office of the State Long-term Care Ombudsman submitted the position statement shown in Figure 3 on the next page. As noted, the Ombudsman indicated that nursing facility residents should be allowed to employ video technology if they so choose. The Ombudsman indicated it should be the resident's choice and if conducted, the monitoring should do so in a way "as to avoid compromising the rights and privacy of other residents." While supporting the resident's right to use or refuse video technology, the Ombudsman points out the limitations of the technology in terms of "capturing the extent to which either good care or poor care, neglect or abuse occurs" and "cautions that any use of video technology must never be considered an alterative to serious efforts to increase the numbers of qualified direct care staff, to improve staff training and supervision, and to strengthen survey and enforcement activities." The Ombudsman continues by saying: "The real tragedy is that the increased interest in the use of video technologies reflects the fact that many residents and families feel that the current system of monitoring

Figure 3

Position of the Office of the State Long-term Care Ombudsman with regard to the use of video technology in nursing facilities:

The State LTC Ombudsman believes that, while it should never be expected or allowed to substitute for effective governmental oversight and enforcement, residents have the right to choose to employ video technology. The use of such technologies should always flow from the choice of the resident as the resident expresses it, or would express it, if able. Its use must be undertaken in such a way as to avoid compromising the rights and privacy of other residents.

In our program's experience, the reasons that residents and family members want to employ these technologies fall primarily into two categories:

1. "Virtual visitation" – allowing families and residents to have electronic 'virtual visits' with a family member in a nursing home at times when the family is unable to be physically present with the resident. Residents should certainly have access to any such option that expands the opportunity for desired contact with family members and others.
2. Monitoring care and staff interactions with resident: Many family members support the use of video technologies in nursing homes as a means of monitoring their loved ones' care, and as a means of protecting the resident from potential abuse or neglect.

While **firmly supporting the right of residents to use or refuse the use of video technology**, the Office of the State Long-Term Care Ombudsman:

- Recognizes and cautions that such technology is limited in its ability to capture the extent to which either good care or poor care, neglect, or abuse occurs in nursing homes.
- Urges that residents and families contemplating the use of such technology take steps to ensure that the rights and privacy of any roommate are not compromised.
- Urges families contemplating the use of video technology on behalf of a loved one who is unable to give clear consent to carefully weigh the resident's right to privacy and autonomy against the family's right to visit and monitor care of their loved one.
- Strongly opposes the use of video surveillance technologies in resident rooms by nursing facilities, unless the resident(s) specifically request it.
- Strongly cautions that any use of video technology must never be considered an alternative to serious efforts to increase the numbers of qualified direct care staff, to improve staff training and supervision, and to strengthen survey and enforcement activities.

The real tragedy is that the increased interest in the use of video technologies reflects the fact that many residents and families feel that the current system of monitoring and enforcement is not effective in preventing poor care and abuse. This is all too true.

While the use of such technologies may be a necessary response in the short run, we must not let any false security it produces derail us from a full frontal sustained attack on the endemic problems in our whole 'system' of long-term care. Ideally we want to build a care environment in which well-trained and caring employees are carefully selected, hired, and retained in a setting that supports and rewards their efforts to give skillful and humane care. While we all recognize that the challenges are significant in getting from 'here' to 'there,' we must not lose sight of the fact that that is our true mission, else we shall have to have video cameras in every nook and cranny of every facility. And we will have to settle for a system that must focus tremendous energies on ensuring that perpetrators are caught and stopped, rather than one in which harm is averted altogether, and our elders receive the kind of care we would all want.

and enforcement is not effective in preventing poor care and abuse. This is all too true."

The Public Policy Coalition of Virginia's Alzheimer's Association Does Not Have a Position on Electronic Monitoring at this Time

A representative of the Alzheimer's Association indicated that Association members have been polled regarding their opinions of SB 922. The responses have lead to the conclusion that there are too many unanswered questions about the provisions of SB 922 for the Association to take a position at this time. The following examples of unanswered questions were submitted by the Virginia Alzheimer's Association:

1. Who has the responsibility to maintain the monitoring equipment?
2. When will the tapes be viewed and by whom?
3. Would this be a violation of HIPAA?

COMMENTS OF INDUSTRY ASSOCIATIONS

American Health Care Association and Virginia Health Care Association Have Concerns about Electronic Monitoring in Residents' Rooms

Virginia Health Care Association (VHCA) representatives provided JCHC staff with a written statement of the President and Chief Executive Officer of the American Health Care Association (AHCA) regarding surveillance cameras in residents' rooms. The statement which is shown in Figure 4 indicates the AHCA position that there are better ways of protecting nursing facility residents than surveillance cameras. Furthermore, the statement delineates a number of potential, negative consequences of surveillance such as infringing on the resident's dignity and diminishing privacy and confidentiality.

Consistent with the AHCA statement, VHCA representatives spoke of a number of concerns regarding the electronic monitoring. The primary concern was reported to be that of the dignity of the residents. There would be no way to electronically "pull the curtain" when very personal assistance was being provided for the resident. A concern was voiced that some procedures when viewed on tape could be misinterpreted to be inappropriate and abusive in nature. VHCA representatives indicated that monitoring could hamper a nursing facility in its endeavor to hire staff, if applicants felt that their every move would be recorded. The point was raised that if the issue is the prevention of elder abuse, whether the incidence of abuse in nursing facilities warrants this response. And if so, perhaps monitoring of care in the home should be promoted

since the majority of abuse allegations result from care provided in the home. Moreover, perhaps monitoring of care should be extended to additional venues in which vulnerable adults and children are cared. VHCA representatives indicated an additional concern that some older nursing facilities would not have the wiring necessary to allow for cameras to be operated. The representatives wanted to be certain that there would be no requirement to rewire an entire facility to allow for cameras.

With regard to the wording of the bill itself, VHCA noted that there is a conflict in the bill related to what action to take if a resident objects to the monitoring that his or her roommate desires. While the facility would not want to "punish" roommates by requiring either of them to move, that would seem to be the only option the facility would have.

In closing, the need for legislation was questioned by VHCA representatives who pointed out nursing facility residents are already allowed to undertake monitoring if they desire. According to VHCA, monitoring is not a request that residents and families bring up with nursing facilities.

Virginia Hospital & Healthcare Association Has Concerns about Electronic Monitoring in Residents' Rooms

A VHHA representative indicated that the Association has serious concerns about electronic monitoring for the same reasons noted in the VHCA response. In addition, VHHA would like to "emphasize that given critical budgetary and workforce problems in long-term care facilities, the widespread use of cameras would exacerbate those problems without any evidence of clear benefit [with regard to] resident protection. A better approach is continued work to improve reporting of adult abuse and neglect, especially in in-home settings where most problems are found, emphasizing education of mandated and voluntary reporters. The Virginia DSS is currently working on this with a large group of interested entities, including VHHA and VHCA."

Virginia Association of Nonprofit Homes for the Aging (VANHA) Does Not Favor Legislation to Require Monitoring

VANHA representatives indicated that although most of their members allow for a camera to be installed at the resident's request, their members generally do not favor legislation to require cameras. The following written statement regarding the provisions of SB 922 was provided by VANHA:

During the legislative session the Virginia Association of Nonprofit Homes for the Aging did not support the need for this legislation. There are many factors that must be considered when installing an electronic monitoring device in a resident's room including privacy, dignity, and the facility's ability to accommodate the family's request. In

Figure 4

American Health Care Association
Statement by Charles H. Roadman, II, M.D.
President and CEO, The American Health Care Association

Surveillance Cameras in Resident Rooms

The most important consideration should be the security and safety of the resident. The American Health Care Association (AHCA) believes that instances of abuse, while very rare, cannot and should not be tolerated. However, surveillance cameras observe, they do not protect. In the rare situations where abuse is suspected, families should alert facility management or local authorities and immediately move the patient to a safe location. That action has the best interests of the resident in mind. Placing a camera in a room is often the action of someone looking to sue; moving a patient to a safe location or taking other immediate steps in the reactions of someone who cares.

If patients or families would feel more secure with a camera in a patient's room, they should ask the facility for help in installing one. If a camera is to be used, then informed consent of all parties is the key. The resident needs to understand that placing a video camera in his/her room can encroach on dignity and may erode privacy and confidentiality protections. Cameras can also have the effect of unduly disrupting a positive, trusting relationship between a patient and caregivers and can interfere with their therapeutic relationship as well. It is important to understand that in a nursing home a great deal of intimate care takes place at the patient's bedside. Patients are often bathed, dressed, even toileted while they're in bed. Physician exams may also occur there along with other medical procedures.

The most effective ways to assure quality are through family involvement in patient care, ongoing staff education, careful screening of potential employees and responsible abuse prevention programs. AHCA supports five key initiatives, which have been part of AHCA's policy agenda for several years, which the Association believes, will enhance the quality of care provided in long term care facilities nationwide:

- Create a national, interstate background check system to allow providers to thoroughly screen prospective employees.
- Create career ladders for nursing staff in long term care to help recruit the best and keep them in the long term care setting.
- Revise the current government inspection system to focus on fixing problems rather than punishing caregivers for honest mistakes that do not cause real and lasting harm to residents.
- Create a quality measurement system that is focused on outcomes and that encourages continuous quality improvement.
- Since 80 percent of the care provided to resident in a nursing facility is paid for by the government, the government must provide additional resources to allow nursing facilities to pay competitive wages in order to retain qualified caregivers.

addition, the bill has no provisions to protect a resident in a semi-private room that does not wish to be monitored. Electronic monitoring should only be done as an intervention

not as a matter of practice. The installation of electronic monitoring devices in the room of a nursing home resident is a practice that should not be statutorily mandated. (VANHA letter dated May 19, 2003.)

IV. Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue with regard to authorizing electronic monitoring within nursing facilities.

Option I: **Take no action.**

Option II: **Introduce legislation to amend the *Code of Virginia,* Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) requiring the Board of Health to promulgate regulations authorizing electronic monitoring in nursing facilities. (See language in Appendix B.)**

Option III: **Introduce legislation to amend the *Code of Virginia,* Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) as well as to require the Board of Health to include one or more of the following provisions in the regulations the Board promulgates:**

A. Notify residents of their liability for violating privacy laws due to noncompliance with regulation or covert monitoring.

B. Require that covert monitoring (except for covert monitoring undertaken by law enforcement authorities) when discovered must be discontinued with the stipulation that authorized monitoring may be initiated after all requirements for monitoring have been met.

C. **Specify that all installation, operating, maintenance, and repair costs related to the monitoring, except the cost of electricity, will be the responsibility of the resident or the resident's family or legal representative.**

D. **Specify that the resident, not the nursing facility is responsible for retrieving and replacing any tapes used in monitoring.**

E. **Specify that the resident, not the nursing facility is responsible for ensuring that the roommate's conditions for consenting to monitoring are observed.**

F. **Specify that the resident, not the nursing facility is responsible for ensuring that electronic monitoring is discontinued if a new roommate moves into the room and that the monitoring will not resume until all requirements for consenting to the monitoring have been completed with the new roommate.**

G. **Provide guidance regarding steps the nursing facility should take to ensure compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.**

Option IV: **Send a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner to request that the Department of Health monitor the issue of electronic monitoring to determine the necessity for initiating pilot projects and/or for developing advisory guidelines for electronic monitoring in nursing facilities.**

In response to a JCHC request after the study was completed, the State Health Commissioner responded regarding VDH's ability to implement Option IV. The Commissioner indicated that VDH is in the process of amending its current guideline on electronic monitoring to be more detailed. In addition, VDH "would also consider initiating a pilot project, based on the guideline, should the need become evident. However, based on the experience in Maryland in developing its pilot project, we are uncertain as to the viability or benefit of such a project. However, if it becomes apparent that a pilot project

would be helpful, the Center [for Quality Health Care Services and Consumer Protection within VDH] would first attempt to solicit volunteers to carry the cost of the project, which would result in no additional impact to the Center. Should a volunteer effort fail, however, the Center could not mandate participation and a pilot project would not be possible. As we stated in an earlier letter, though electronic monitoring technology is fairly new, we expect its use to become commonplace in the future. We also believe that the guideline will appropriately address the concerns of nursing facilities while providing a foundation for family members. Therefore we support Option IV as an appropriate alternative to address the concerns of individuals responding to the study."

APPENDICES

APPENDIX A

Letter from Clerk of the Senate

COMMONWEALTH OF VIRGINIA

SUSAN CLARKE SCHAAR
CLERK OF THE SENATE
POST OFFICE BOX 396
RICHMOND, VIRGINIA 23218

SENATE

March 17, 2003

The Hon. Harvey B. Morgan
Chairman
Health Care Commission
P.O. Box 949
Gloucester, VA 23061

Dear Delegate Morgan:

The following subject matter from legislation introduced during the 2003 Virginia General Assembly has been referred to your commission or subcommittee. If the Senate Clerk's office can assist you in any way with these referrals, please let me know.

SB 922

With kind regards, I am

Sincerely yours,

Susan Clarke Schaar

SCS/tcg

cc: E. Kim Snead, Director
Health Care Commission

APPENDIX B

Senate Bill 922 (2003)

035805406

SENATE BILL NO. 922

Offered January 8, 2003

Prefiled January 7, 2003

A BILL to amend and reenact §§ 32.1-127, 32.1-138, and 32.1-138.1 of the Code of Virginia, relating to the use of electronic monitoring devices in nursing homes and certified nursing facilities to detect abuse of the elderly or disabled residents.

Patron—Byrne

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-127, 32.1-138, and 32.1-138.1 of the Code of Virginia are amended and reenacted as follows:

§ 32.1-127. Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.) of this chapter.

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to assure the environmental protection and the life safety of its patients and employees and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; and (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Health Care Financing Administration (HCFA), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in HCFA regulations for routine contact, whereby the provider's designated organ procurement organization certified by HCFA (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (i) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (ii) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible

for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the father of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be based on Joint Commission on Accreditation of Healthcare Organizations' standards;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report; ~~and~~

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed seventy-two hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order; *and*

12. Shall include provisions to authorize the use of electronic monitoring devices in the room of a resident of a nursing home or certified nursing facility for the purpose of detecting abuse or neglect of elderly or disabled persons that take into consideration Virginia law relating to nonconsensual interception of wire or electronic communications, privacy rights, notice requirements, covert and noncovert placements of such devices, and potential violations of existing civil and criminal law. Such regulations shall include, but need not be limited to, (i) a description of appropriate electronic monitoring devices that may be used; (ii) a consent form recognizing the sole right of a resident who is capable of making an informed decision to make such request and, in the case of a resident who is not capable of making an informed decision, the resident's legally authorized representative; (iii) a

form releasing the nursing home or nursing facility from civil liability for violation of the privacy rights of the resident who is the subject of the request as well as any other residents in the same room; (iv) a form to provide other residents in the same room the opportunity to consent to such electronic monitoring devices or to be provided privacy protections from the electronic monitoring devices or to be moved to another room, in so far as possible; (v) a procedure to cease any electronic monitoring upon another resident being moved into the room with the subject resident; (vi) the size and location outside the subject resident's room of conspicuous signs to notify the staff, other residents, and the public of the presence of electronic monitoring devices; (vii) timelines for all procedures that include adequate notice of the commencing of electronic monitoring to the subject resident, all residents, the public and the staff; (viii) the responsibility for reporting abuse and neglect detected via electronic monitoring to adult protective services; (ix) instructions to protect the safety of all residents, staff and the public in the placement, size, and stability of the electronic monitoring devices; (x) protections for the privacy of residents who do not wish to be the subjects of or who object to electronic monitoring; and (xi) penalties for nursing home or certified nursing facility failure to comply with the electronic monitoring requirements.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot which is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

§ 32.1-138. Enumeration; posting of policies; staff training; responsibilities devolving on guardians, etc.; exceptions; certification of compliance.

A. The governing body of a nursing home facility required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter, through the administrator of such facility, shall cause to be promulgated policies and procedures to ensure that, at the minimum, each patient admitted to such facility:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities, *including, but not limited to, the right to request electronic monitoring*;

2. Is fully informed, prior to or at the time of admission and during his stay, of services available in the facility and of related charges, including any charges for services not covered under Titles XVIII or XIX of the United States Social Security Act or not covered by the facility's basic per diem rate;

3. Is fully informed in summary form of the findings concerning the facility in federal ~~Health Care Financing Administration~~ *Centers for Medicare and Medicaid Services'* surveys and investigations, if any;

4. Is fully informed by a physician of his medical condition unless medically contraindicated as documented by a physician in his medical record and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

5. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and is given reasonable advance notice as provided in § 32.1-138.1 to ensure orderly transfer or discharge, and such actions are documented in his medical record;

6. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

7. May manage his personal financial affairs, or may have access to records of financial

transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with state law;

8. Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;

9. Is assured confidential treatment of his personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution or as required by law or third-party payment contract;

10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. May associate and communicate privately with persons of his choice and send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical record;

13. May meet with and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician in his medical record;

14. May retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other patients and unless medically contraindicated as documented by his physician in his medical record; and

15. If married, is assured privacy for visits by his or her spouse and if both are inpatients in the facility, is permitted to share a room with such spouse unless medically contraindicated as documented by the attending physician in the medical record.

B. All established policies and procedures regarding the rights and responsibilities of patients shall be printed in at least twelve-point type and posted conspicuously in a public place in all nursing home facilities required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter.

These policies and procedures shall include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to patients upon admittance to the facility and made available to patients currently in residence, to any guardians, next of kin, or sponsoring agency or agencies, and to the public.

C. The provisions of this section shall not be construed to restrict any right which any patient in residence has under law.

D. Each facility shall provide appropriate staff training to implement each patient's rights included in subsection A hereof.

E. All rights and responsibilities specified in subsection A hereof and § 32.1-138.1 as they pertain to (i) a patient adjudicated incapacitated in accordance with state law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who is unable to communicate with others shall devolve to such patient's guardian, next of kin, ~~sponsoring agency or agencies,~~ or *the patient's authorized* representative ~~payee~~, ~~except when~~ *but shall not devolve to* the facility itself ~~is representative payee, selected pursuant to section 205(j) of Title II of the United States Social Security Act~~.

F. Nothing in this section shall be construed to prescribe, regulate, or control the remedial care and treatment or nursing service provided to any patient in a nursing institution to which the provisions of § 32.1-128 are applicable.

G. It shall be the responsibility of the Commissioner to ~~insure~~ *ensure* that the provisions of this section and the provisions of § 32.1-138.1 are observed and implemented by nursing home facilities. Each nursing home *or certified nursing* facility to which this section and § 32.1-138.1 are applicable shall certify to the Commissioner that it is in compliance with the provisions of this section and the provisions of § 32.1-138.1 as a condition to the issuance or renewal of the license required by Article 1 (§ 32.1-123 et seq.) of this chapter.

§ 32.1-138.1. Implementation of transfer and discharge policies in nursing homes and certified nursing facilities.

A. To implement and conform with the provisions of subdivision A 4 of § 32.1-138, a facility may discharge the patient, or transfer the patient, including transfer within the facility, only:

1. If appropriate to meet that patient's documented medical needs;

2. If appropriate to safeguard that patient or one or more other patients from physical or emotional injury;

3. On account of nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act and the Virginia State Plan for Medical Assistance Services; or

4. With the informed voluntary consent of the patient, or if incapable of providing consent, with the informed voluntary consent of the patient's authorized decision maker pursuant to § 54.1-2986 acting in the best interest of the patient, following reasonable advance written notice.

B. Except in an emergency involving the patient's health or well being, no patient shall be transferred or discharged without prior consultation with the patient, the patient's family or responsible party and the patient's attending physician. If the patient's attending physician is unavailable, the facility's medical director in conjunction with the nursing director, social worker or another health professional, shall be consulted. In the case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the facility shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge.

C. Except in an emergency involving the patient's health or well being, reasonable advance written notice shall be given in the following manner. In the case of a voluntary transfer or discharge, notice shall be reasonable under the circumstances. In the case of an involuntary transfer or discharge, reasonable advance written notice shall be given to the patient at least five days prior to the discharge or transfer.

D. Nothing in this section or in subdivision A 4 of § 32.1-138 shall be construed to authorize or require conditions upon a transfer within a facility that are more restrictive than Titles XVIII or XIX of the United States Social Security Act or by regulations promulgated pursuant to either title.

E. No patient shall be transferred or discharged because such patient has requested or indicated that he will request electronic monitoring pursuant to subdivision B 12 of § 32.1-127 and the Board of Health's implementing regulations.

2. That the Office of the Attorney General shall advise and assist the Board of Health in the development and implementation of the regulations relating to the use of electronic monitoring devices in nursing homes and certified nursing facilities for the purpose of detecting abuse and neglect of the elderly or disabled residents.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
_____		_____	
Clerk of the Senate		Clerk of the House of Delegates	

APPENDIX C

Summary of Public Comments

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS
Authorization for Electronic Monitoring in Nursing Facilities

COMMENTS RECEIVED ON OPTIONS ADDRESSING ELECTRONIC MONITORING IN NURSING FACILITIES

Twenty-seven comments were received in response to the JCHC report addressing electronic monitoring in nursing facilities. Comments were submitted by the following:

- Barbara Chewning
- Kay Chidlaw
- Janet L. Clement
- Mary M. Davis
- Friends and Relatives of Nursing Home Residents
- Rosemary Furcher
- Mary Highsmith
- Sandra Martin
- Bernadette McConnell
- Anne M. McGraw
- Mary A. Mulherin
- Northern Virginia Long Term Care Ombudsman Program
- Carol Nottingham
- Carol O'Connor
- Susan and Lewis Pauley
- Perrie Powers
- Evelyn D. Proctor
- Jake and Victoria Saker
- Sheila and Bernard Smith
- State Long-Term Care Ombudsman
- Daniel H., Danielle, and Sandra J. Taylor
- Virginia Coalition on Aging
- Virginia Department of Health
- Virginia Health Care Association
- Virginia Hospital & Healthcare Association
- Dottie Lee Wingo
- Nurse Practitioner *(No Name Provided)*

POLICY OPTIONS PRESENTED FOR CONSIDERATION

Option I: Take no action.

Option II: Introduce legislation to amend the *Code of Virginia*, Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) requiring the Board of Health to promulgate regulations authorizing electronic monitoring in nursing facilities. (See language in Appendix B.)

Option III: Introduce legislation to amend the *Code of Virginia*, Title 32.1 to incorporate the provisions of Senate Bill 922 (2003) as well as to require the Board of Health to include one or more of the following provisions in the regulations the Board promulgates:

A. Notify residents of their liability for violating privacy laws due to noncompliance with regulation or covert monitoring.

B. Require that covert monitoring (except for covert monitoring undertaken by law enforcement authorities) when discovered must be discontinued with the stipulation that authorized monitoring may be initiated after all requirements for monitoring have been met.

C. Specify that all installation, operating, maintenance, and repair costs related to the monitoring, except the cost of electricity, will be the responsibility of the resident or the resident's family or legal representative.

D. Specify that the resident, not the nursing facility is responsible for retrieving and replacing any tapes used in monitoring.

E. Specify that the resident, not the nursing facility is responsible for ensuring that the roommate's conditions for consenting to monitoring are observed.

F. Specify that the resident, not the nursing facility is responsible for ensuring that electronic monitoring is discontinued if a new roommate moves into the room and that the monitoring will not resume until all requirements for consenting to the monitoring have been completed with the new roommate.

G. Provide guidance regarding steps the nursing facility should take to ensure compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996.

Option IV: Send a letter from the Chairman of the Joint Commission on Health Care to the State Health Commissioner to request that the Department of Health monitor the issue of electronic monitoring to determine the necessity for initiating pilot projects and/or for developing advisory guidelines for electronic monitoring in nursing facilities.

SUMMARY OF COMMENTS

As shown in the summary Table below, 24 of the 26 comments supported **Option II**. Comments submitted on behalf of the Virginia Department of Health, Virginia Health Care Association, and the Virginia Hospital & Healthcare Association supported **Option I**. The Virginia Health Care Association also indicated having no objection to **Option IV.**

SUMMARY OF COMMENTS RECEIVED ON OPTIONS

Policy Option	Comments in Support
I – Take no action.	3
II – Introduce legislation to incorporate provisions of SB 922 as introduced.	24
III – Introduce legislation to incorporate provisions of SB 922 with one or more modifications to the legislation.	0
IV – Send a letter from JCHC to the VDH Commissioner to monitor the issue of electronic monitoring in nursing facilities.	1*

* One comment in support of Option I indicated no objection to Option IV.

The following are excerpts from some of the comments submitted in support of **Option I**.

Robert B. Stroube, M.D., M.P.H.
Virginia Department of Health

Dr. Stroube, the State Health Commissioner commented in support of Option I. Dr. Stroube stated, in part:

"Regarding the four policy options in the JCHC issue brief, VDH supports Option I (Take No Action). As stated in testimony before the 2003 Senate Education and Health Committee, and reiterated during interviews with Commission staff, the Department believes SB922, as introduced in the 2003 General Assembly Session, is unnecessary. The State Board of Health already has the authority to promulgate regulations 'as may be necessary.' This could include provisions for the use of monitoring cameras in nursing facilities should it become necessary to do so. However, the use of cameras in nursing facilities as an abuse and neglect prevention tool is still relatively new, may compromise a resident's right to privacy, can be cumbersome to install and operate efficiently, and may disrupt the daily functioning of a facility.

As part of its ongoing tracking of trends in nursing facilities and long term care, the Center plans to follow-up with Texas state officials on the "success" of their legislative and regulatory initiative regarding cameras. The Center will also contact Maryland state officials for a copy of their legislatively mandated guideline for possible distribution to facilities in Virginia. I believe this to be a more reasoned approach to the issue, until such time as camera usage increases or the Center receives substantiated reports that facilities are uncooperative with families requesting the installation of cameras. We would be happy to report back to the Commission on those efforts.

In closing, I would like to take this opportunity to reinforce to citizens and advocacy groups that the VDH Center for Quality Health Care Services and Consumer Protection stands ready to assist families that have concerns that their family member is not receiving appropriate care in, or who are experiencing difficulties with, nursing facilities. The Center takes its mission to protect vulnerable adults very seriously, as do I. However, outreach to families on protective measures and activities may need to be increased. Therefore, I have instructed the Center to review its outreach mechanisms for possible improvement."

Mary Lynne Bailey
Virginia Health Care Association

Ms. Bailey, Vice President for Legal & Government Affairs commented in support of Option I. Ms. Bailey noted, in part:

"Virginia nursing homes strive to provide a safe and secure home and quality care for their frail elderly and disabled residents. With VHCA's support, more than ten years ago, Virginia became the second state in the nation to require a criminal record check before a person could be employed in a nursing home or assisted living facility. Abuse and neglect in Virginia nursing homes is not tolerated, and any staff member suspected of neglect or abuse of a resident is reported to the appropriate authorities. They are not allowed to continue to work with frail residents.

VHCA has serious concerns about electronic monitoring of residents, such as patient dignity, privacy, and confidentiality, plus the potential for increased staffing difficulties. VHCA believes there is no need for action (Option I), but has no objection to Option IV,

which would ask the Department of Health to monitor the necessity for a pilot project or guidelines for electronic monitoring."

Susan C. Ward
Virginia Hospital & Healthcare Association

Ms. Ward, Vice President & General Counsel commented in support of Option I. Ms. Ward noted, in part:

"The VHHA supports Option 1, which suggests that no action be taken on this issue. Such monitoring raises complex issues, including protection of residents' privacy and impact on current serious workforce shortages. Given critical budgetary and workforce problems in long-term care facilities, the widespread use of cameras would exacerbate those problems without any evidence of clear benefit with respect to resident protection. A better approach is continued work to improve reporting of adult abuse and neglect, especially in in-home settings where most problems are found, emphasizing education of mandated and voluntary reporters. The Virginia Department of Social Services is currently working on this with a large group of interested entities, including the VHHA."

The following are excerpts from some of the comments submitted in support of **Option II.**

Kay Chidlaw

Ms. Chidlaw summarized her support of Option II by saying:

"Electronic monitoring as proposed, for those who choose it for their loved ones, will bring more peace of mind to the families of the residents of Virginia's nursing homes and Nursing Home Administrators and supervisory staff will benefit by being able to maintain closer supervision of their CNAs and other personnel interacting with the residents."

Janet L. Clement

Ms. Clement wrote, in part:

"I am writing in support of Option II of Senate Bill 922, 2003. As the daughter of a nursing home resident whose 'care' left much to be desired, I can attest to the need for electronic monitoring of nursing home residents.

Had I been able to check on her through video monitoring, I would have been able to see that she had been left naked on her bed covered in her own feces for hours. I would have been able to see the bed sores and infections on her buttocks and in her genital

area and how and if those were being treated. I would have been able to see her shaking uncontrollably from pneumonia. I would have been able to see how roughly (or gently) she was moved from her wheelchair to her bed. I would have been able to see that she was being gotten up at 4:30 a.m. for her breakfast long before I found that out.

I believe her life in long term care facilities would have been dramatically improved had electronic monitoring been available and... I would have been more than happy to pay for it."

Anne See
Friends and Relatives of Nursing Home Residents

Anne See commented on behalf of Friends and Relatives of Nursing Home Residents, a citizens' advocacy group in the Shenandoah Valley. Ms. See commented, in part:

"Our group strongly favors Electronic Monitoring in Nursing Homes. Over the years, our members have encountered numerous situations where such monitoring would have been beneficial not only to residents, but also to facilities. For example, a routine problem in nursing facilities is a resident who falls frequently and suffers serious bruising. Such a situation would be a perfect use of electronic monitoring. Often facility staff do not see residents fall and have no idea how it happens. Naturally, the family becomes concerned about the possibility of abuse and neglect. Electronic monitoring would show exactly how the fall is occurring so that the facility can take measures to correct the problem whether it be a simple matter of better positioning in the resident's wheelchair or staff intervention."

Rita Schumacher, Director
Northern Virginia Long Term Care Ombudsman Program

Rita Schumacher commented in support of Option II, noting in part:

"I have mixed feelings about the bill in that I do not believe that electronic monitoring devices are the answer to the multi-faceted issues of quality care in nursing facilities....

Quality of care issues are getting more complicated and video cameras would certainly help, but not solve all of the problems in the bigger picture....I have been with the Ombudsman Program since October of 1990. In 1990 and for a few years thereafter, the Ombudsman Program was hearing more about cold food and lost laundry. The present complaints of pressure sores, call bells not answered, poor hygiene, dehydration and malnutrition are ever present and increasing in severity. Nursing staff are not provided the resources to give the level of care necessary to our elderly who are living longer with more complications due to their chronic and acute illnesses. When are we going to make the 'Enron's' of the long term care industry responsible for the care of the people residing in their facilities? How is it we can stand by and read about the millions of CEO's make

in stock options on the backs of our frail, sick elderly? The message is that our elders are not important enough to our society to do something about our long term care industry.

In closing, when will our legislators look at the foundation, or lack of it, in long term care? Good care starts at the top or the bottom, wherever we choose to see the most strength in positioning. Certified nursing assistants provide the most hands-on care and therefore spend the most time with the residents. Whether we see them at the top or at the bottom of the pyramid, they are fundamental to nursing facilities. Doesn't it make more sense to provide nursing assistants with the knowledge, and support – monetary and educational – to provide the best care that they can to our elderly? The industry is setting nursing assistants up for failure by not seeing them as an asset and adding to their value with the aforementioned."

David Sadowski
Virginia Coalition on Aging

Mr. Sadowski commented in support of Option II, stating in part:

"In the interest of safety and protection, the use of video monitoring in Virginia is already being used in schools, school buses, retail stores, private homes, public buildings, and yes even in health care facilities. In fact, video monitoring is currently being used in direct patient care areas, nurseries, critical care units, surgical and operating rooms, and patient rooms (high risk patients) in the interest of safety, protection and quality of care.

I am confident that the Board of Health can and will be able to develop and implement the appropriate guidelines to ensure the protection of resident's rights and privacy."

Dottie Wingo
Roanoke, VA

Ms Wingo commented in support of Option II, in saying:

"I would like to encourage the Joint Commission on Health Care to support Option II of the recommended choices in the study of electronic monitoring in nursing homes. In this age of advanced technology in which we live today, I feel it is not unreasonable for nursing homes to use these technologies for benefit of the residents.

My mother was in a nursing home for two years before her death, and I can assure you that our family would have liked to have used electronic monitoring for the following reasons: 1) Mom fell and was injured several times when she was left alone in her geri chair in the room, a violation of her care plan which stipulated she was not to be left alone in room except when staff were present and when she was in bed with both side rails up (allowed at that time). With electronic monitoring, we could have easily documented these occurrences for administration and staff and hopefully corrected the situation. 2) On many occasions Mom was not fed, but staff indicated they had attempted to feed her and she refused to eat. With electronic monitoring, we could have

been assured that efforts were being made to feed her. 3) On many occasions, linens were not changed twice a week on bath days as they were supposed to be. With electronic monitoring, we could easily have shared this with staff and administration for correction of the problem. 4) On a number of occasions, personal belongings would disappear from Mom's room, and it would have been easy to pinpoint the individual(s) involved with electronic monitoring. 5) Mom frequently had bruises, scrapes, 'skin tears', etc. and electronic monitoring could have helped us identify the source. 6) Mom was on a bowel/bladder program that was frequently not followed and/or well documented. Electronic monitoring might have helped prove this. 7) Mom had multiple [urinary tract infections] UTIs and eye infections. Electronic monitoring could possibly have helped by showing failure to change & toilet as often as necessary and failure to wash her hands after toileting. We experienced <u>many</u> problems with Mom's care in the nursing home setting, other than the few listed above. For these and a number of other reasons, my family and I feel that video technology would have helped resolve many of these issues more easily as they occurred. We also feel that this offers a very positive benefit to the nursing homes staff and administration for it can demonstrate to families of residents that their loved ones are indeed being care for appropriately."

JOINT COMMISSION ON HEALTH CARE

Executive Director

Kim Snead

Senior Health Policy Analyst

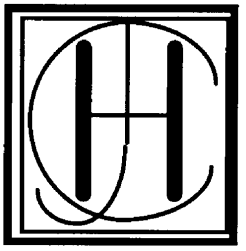
April R. Kees

Intern

Ashley E. Hopkins

Office Manager

Mamie V. White



Joint Commission on Health Care
900 East Main Street, Suite 3072E
P.O. Box 1322
Richmond, Virginia 23218
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm