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FINAL REPORT

Detecting, Addressing and Preventing Elder Abuse In Residential Care Facilities

Grant Number: 2005-IJ-CX-0054

**Report to
The National Institute of Justice
U.S. Department of Justice
Bethany L. Backes, M.P.H., M.S.W., C.H.E.S.
Social Science Analyst and Project Officer**

**Report from
The Program on Aging & Long-Term Care Policy
The School of Rural Public Health
Texas A&M Health Science Center
College Station, Texas**



TEXAS A&M

HEALTH SCIENCE CENTER
SCHOOL OF RURAL PUBLIC HEALTH

November 2009

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Catherine Hawes, Ph.D.
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We are also very grateful to all the State and local or regional agency staff and administrators, as well as consumer advocates, who took the time to help us understand the workings of the agencies that regulate residential care and assisted living facilities, as well as the agencies responsible for intake, investigation, and resolution of allegations of elder abuse in residential care. They generously spoke with us about how to enhance efforts to prevent abuse and neglect of residents in these facilities.

In addition, we appreciate the assistance of the NCCNHR (formerly the National Citizens Coalition for Nursing Home Reform) and the Long-Term Care Ombudsman Resource Center. They helped us arrange focus groups with ombudsmen from around the country at the 2006 annual meeting. We are also grateful to the ombudsmen who participated in these focus groups.

Further, we want to recognize the valuable contributions of Marie Therese Connolly, who helped start the elder abuse initiative at the Department of Justice, and of our project officers, Catherine McNamee, Carrie Mulford, and Bethany Backes. They made important substantive contributions to the project. Moreover, we want to recognize the incredibly important role played by the Department of Justice and its research arm, the National Institute of Justice, in its singular effort to advance knowledge and policies and practices that will protect the nation's elders from abuse and neglect.

At Texas A&M, we benefited from the opportunity to present key study findings and our conclusions to the faculty in the Department of Health Policy and Management and receive their thoughtful reactions and suggestions. In addition, we appreciate the assistance of two doctoral candidates, SangNam Ahn and Darcy Moudouni of the School of Rural Public Health at the Texas A&M Health Science Center. They helped with the final report, reviewing newspaper and journal articles and reports on elder abuse and on residential care and assisted living. Ms. Moudouni also worked on editing the manuscript, as did Dr. Charles D. Phillips. We are also grateful for the support of Linnae Hutchison, from the SRPH Office of Research, and Sara Lauter, from the Texas A&M Research Foundation.

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Disclaimer

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¹ Dr. Kimbell was a Research Associate at SRPH, Texas A&M HSC during the period of data collection and site visits. She is now a Clinical Psychologist at the South Texas Veterans Health Care System, San Antonio, TX.

Detecting, Addressing and Preventing Elder Abuse in Residential Care

ABSTRACT

Background. This study focused on detection, investigation, and resolution of elder abuse and neglect complaints in what are known as residential care facilities (RCFs). These facilities are the most rapidly growing form of senior housing. This growth is a result both of the preferences of the elderly and their families and of public policy aimed at reducing nursing home use. RCFs are referred to by a variety of names across the states, including assisted living facilities, personal care homes, domiciliary care homes, adult congregate living facilities, adult care homes, and shelter care homes. The best estimate is that some 50,000 facilities nationwide house a mainly older population in between 900,000 and one million beds. In addition, an unknown number of unlicensed homes house a mixed population of poor older persons and individuals with mental illness. By contrast, there are about 17,000 nursing homes with 1.6 million residents.

Purpose of the Study. The federal government does not regulate RCFs, so this study focused on examining state processes for detecting, investigating, resolving and preventing elder abuse in RCFs. In addition, we sought to identify smart practices that might be replicated in other settings.

Study Methods. To achieve our goals, we conducted a national survey of all state mandatory reporting laws, a telephone survey of all agencies identified as the “first responder” agency to which complaints about elder abuse should be made, and reviewed all state RCF licensing laws. We also conducted focus group interviews with 22 long-term care ombudsmen from around the country. Based on these data and working with NIJ and our Technical Expert Panel, we identified six states for more intensive case studies because of special features of their processes for dealing with elder abuse or their regulation of RCFs. In each of the study states we interviewed administrators of the agencies that had some responsibility for detecting, investigating and resolving elder abuse in residential care. These included state agencies that license RCFs, Adult Protective Services (APS) agencies, and long-term care ombudsman programs. In addition, we conducted focus group interviews with complaint investigators from the licensing agencies, caseworkers from APS, and local ombudsmen. We also interviewed consumer advocates in some of the study states and staff from what was usually known as the Medicaid Fraud Control Unit (MFCUs) in the state Office of the Attorney General, which handled elder abuse cases in long-term care facilities. Finally, we interviewed law enforcement officials.

Results. We found significant challenges to effective detection, investigation and resolution of elder abuse in RCFs, even in states thought to have effective processes. The major barrier in all states and all agencies was the lack of adequate resources to carry out their responsibilities. We found underreporting of elder abuse, and many instances in which intake workers screened-out many cases that may have warranted further investigation or referral to other agencies. In addition, processes for investigating cases were deeply flawed. Staff lacked forensic training, and investigations were seldom completed in a timely fashion. Significant barriers to resolution were also discovered, including policies that required “intent” for an act to be “abuse” – something difficult to achieve when perpetrators were other residents with dementia or were over-worked and under-trained staff. Also, while involvement of police was reportedly increasing, it was still uneven across jurisdictions. In addition, prosecutors and judges were often unprepared or unwilling to deal with elder abuse cases. Finally, unlicensed homes remained a serious, largely unaddressed problem in some states.

Conclusions. The universal lack of resources, the enormous variation across jurisdictions, and the low priority given to elder abuse and neglect make it difficult to see how significant progress can be made without some federal standards and financial support for investigating, detecting, resolving and preventing elder abuse in residential care. Substantial additional research is also needed to further investigate the underlying causes of elder abuse in RCFs, to more comprehensively examine related policies and processes, and to identify and disseminate effective practices and policies aimed at protecting the vulnerable citizens residing in RCFs.

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“There is no recognition that elder abuse even existsWe are where domestic violence was 20 years ago.” APS caseworker

Executive Summary

1. Background

This study focused on detection, investigation, and resolution of elder abuse and neglect complaints in what are known as residential care facilities (RCFs). In theory, the nearly one million elder and disabled people living in RCFs should be well-protected when it comes to detection, investigation and resolution of elder abuse cases. Three agencies have some type of responsibility in such cases: the agency that licenses facilities; the long-term care ombudsman program; and Adult Protective Services (APS). Moreover in some states, the Attorney General’s office, usually the Medicaid or Healthcare Fraud Control Unit (MFCU), has some responsibility for investigating and prosecuting elder abuse cases in long-term care (LTC) facilities. Law enforcement – police and sheriff departments, prosecutors, and judges – also have responsibilities in this area since almost all states have laws that prohibit elder abuse and mandate reporting. Multiple agencies have responsibility for some part of detecting, reporting, investigating, resolving and preventing elder abuse.

While it appears that sufficient safeguards against elder mistreatment are in place in RCFs, in fact, little is known about how these agencies perform. This study describes the role of agencies with some responsibility for addressing elder abuse and the processes they use to detect, investigate, and resolve cases of elder abuse in RCFs. In addition, the study sought to identify “smart practices” that might feasibly be implemented in other agencies or states.

Focus on Residential Care Facilities. RCFs are referred to by a various names across the states, including assisted living facilities (ALFs), personal care homes, domiciliary care homes, adult congregate living facilities, adult care homes, and shelter care homes. RCFs, including assisted living, are an important component of long-term care services, one that has expanded rapidly over the past two decades. RCFs have been the most rapidly growing form of senior housing since the mid-1990s. This growth is a result of the preferences of the elderly and their families and public policies aimed at reducing nursing home use. Moreover, policies promulgated at the federal and state level are encouraging greater use of this “community-based” alternative.

Residential Care Facilities (RCFs) are known by several names, such as:

- Assisted living facilities
- Adult congregate care facilities
- Homes for the aged
- Adult care homes
- Domiciliary care homes
- Shelter care homes
- Personal care homes
- Residential care facilities for elderly

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The best estimate is that some 50,000 facilities nationwide house a mainly older population in between 900,000 and one million beds. In addition, an unknown number of unlicensed homes house a mixed population of poor older persons and individuals with mental illness. (*By contrast, there are about 17,000 nursing homes with 1.6 million residents.*) There is considerable variation within the industry, from expensive, largely private-pay purpose-built apartment-style facilities to converted motels and private homes. However, they share some key characteristics. First, regulation of these facilities is by state agencies; there is no federal regulation. Second, the regulations in most states allow low staffing levels and require relatively few hours of staff training, factors that increase the likelihood of situations that foster abuse. Finally, a combination of consumer preferences, industry over-expansion in some markets, financial pressure on providers to maintain high occupancy rates, and state and federal policies are leading to greater acuity and heavier care needs among residents. These factors have led to a situation in which nearly one million frail elders and others with disabilities live in RCFs, many of whom have significant risk factors for abuse.

Vulnerability of Residents. An extremely vulnerable population resides in RCFs, with a mix of advanced age, chronic disease and disability, and social isolation. An estimated 87 percent of residents are not married, while 27 percent have no living family members, and many residents are poor. Many are cognitively impaired, while others have intellectual disabilities or persistent and severe mental illness, and some exhibit challenging behaviors. These characteristics make it difficult for residents to safeguard their own interests. Numerous studies suggest that cognitive impairment, behavioral symptoms, and limitations in activities of daily living (ADLs) increase an elder’s risk for physical, sexual or psychological abuse. In addition, several studies have found that RCF residents suffer from chronic diseases, and such diseases or conditions are often misdiagnosed or “under-treated.” Such residents may be at risk for abuse because of their level of impairment, but as importantly, they face significant risk of neglect that may lead to premature mortality or increased morbidity.

2. Study Methods

To achieve our study goals, we conducted a national survey of all state mandatory reporting laws, a telephone survey of all agencies identified as the “first responder” agency to which complaints about elder abuse should be first

The main agencies that the study focused on were:

- State RCF licensing agency
- Adult Protective Services
- Long-Term Care Ombudsman

made, and reviewed all state RCF licensing laws. We also conducted focus group interviews with 22 long-term care ombudsmen from around the country. Based on these data and working with NIJ and our Technical Expert Panel, we identified six states for more intensive case studies because of special features of their processes for dealing with elder abuse or of their regulatory system for RCFs. The states were Alabama, California, Maine, New Mexico, North Carolina, and Texas. In each of the study states, we asked about the processes in place to address complaints or allegations of elder abuse and, to a lesser degree, neglect in RCFs. Thus, we asked key informants about the role and performance of these agencies in terms of detection, including intake, investigation, resolution, and prevention. We interviewed administrators of agencies with some responsibility for detecting, investigating and resolving elder abuse in residential care. These included state agencies that license RCFs, Adult Protective Services (APS) agencies, and

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long-term care ombudsman programs. In addition, we conducted focus group interviews with

Exhibit E.1 Study Participants	
<i>Type of Participant</i>	<i>Number</i>
State LTC Ombudsman	6
Local/regional ombudsmen from study states	49
LTC ombudsmen from 15 states – national focus groups	22
Licensing agency administrative staff	19
Licensing agency surveyors/complaint investigators	37
Adult Protective Service agency administrators	9
APS caseworkers	24
Other (State AG staff in Medicaid Fraud Control Units, other law enforcement, consumer advocates)	18
Total	184

complaint investigators from the licensing agencies, caseworkers from APS, and local ombudsmen. We also interviewed consumer advocates in some of the study states and staff from what was usually known as the Medicaid Fraud Control Unit (MFCUs) in the Offices of the Attorneys General, which handle elder abuse cases in long-term care facilities, as well as other law

enforcement personnel and staff from elder death review teams.

3. The Nature of Elder Mistreatment in RCFs

No current studies provide reliable estimates of the prevalence of elder abuse and neglect in RCFs. In fact, relatively few empirical studies have examined the quality of care in RCFs. Unfortunately, one finds evidence of elder abuse in RCFs from research studies, reports to APS, ombudsmen, and state licensing agencies, and cases handled by the Medicaid Fraud Control Units (MFCUs) or similar health care fraud units in the Office of State Attorneys General. In our investigations, we reviewed considerable secondary data. We used various search engines, including Google and Lexis-Nexus, to search for any reference to abuse and various names for RCFs. We searched PubMed and reviewed all peer-

“Research into elder abuse...has become locked into the family violence model, whereas in reality much more research attention needs to be paid to abuse in residential settings...”

Glendenning, 1999, p. 1.

reviewed journal articles on studies of assisted living and residential care over the last 15 years. We reviewed materials from a newsfeed summary, provided as a service to members of the Elder Abuse listserv by the National Center on Elder Abuse (NCEA). We also conducted a search of newspaper articles through an online news service, reviewed government reports, the National Ombudsman Reporting System data, Congressional testimony, and bimonthly Medicaid Fraud Reports/Newsletters, issued by the Office of the National Association of Medicaid Fraud Units (NAMFCU) from November/December 2005 through July/August 2008. We also heard about cases from individuals interviewed during this study who were responsible for detection/intake, investigation, or resolution of elder abuse.

Considerable evidence from these sources indicates that elder mistreatment is persistent, serious and widespread in residential LTC settings, including RCFs – licensed and unlicensed. In focus groups with coroners and medical examiners (MEs) for a previous NIJ-funded project, several MEs argued that they saw more cases of elder mistreatment deaths from

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“board and care” homes or RCFs than from nursing homes. The sources we reviewed showed evidence of sexual abuse, physical abuse, psychological abuse, and gross neglect leading to serious harm or death. Further, we found that the perpetrators, when identified, included owners of facilities, staff, other residents, and family members. Examples of the types of abuse we found included:

Sexual abuse cases involved a range of behaviors from inappropriate touching to rape. Perpetrators included staff, residents, and family members. The following two cases provide examples of the types of incidents we discovered during the study:

- A state health department investigation found that during a four-month period, an 84-year-old male resident who suffered from dementia sexually and physically assaulted five elderly women at an assisted living center. Investigators interviewed RCF staff who reported that they had found him multiple times in the rooms and beds of female residents, sometimes dressed, sometimes not. One aide saw him rubbing an elderly woman through her adult diaper; another caught him on top of a resident, her pajamas pushed up around her neck. He was found in one woman's room as she covered behind a chair, naked. The women were fearful. One begged an aide to lock her door. But none of the employees called the police, APS, the state licensing agency or the LTC ombudsman.
- Two ombudsmen in one of our focus groups reported that they and the police uncovered a group of RCF employees who worked in several different facilities who were sexually assaulting elderly female residents. These men were using an online password-protected “chat-room” and website, to share stories of these assaults, photographs of the victims, and chilling discussions of their attraction to elderly, frail and vulnerable women.

“Well, I think part of the problem, which is probably a national problem, is that there is not even a recognition that, you know, elder abuse...exists ...People can't understand and get their minds around...[or] even acknowledge that there's a problem with it.”

North Carolina APS Staff

Many of the reported cases of **physical abuse** involved staff as perpetrators and often involved residents with significant cognitive impairment. For example:

- An 83-year-old World War II veteran, died in a residential care facility. The RCF specialized in care for people with Alzheimer's disease or other forms of memory impairment. A nurse listed the cause of death as "failure to thrive." However, the owner of the funeral home saw a 1-foot-by-1-foot, blue-and-black bruise along the dead resident's left side and phoned the coroner. The resulting criminal case resulted in a 30-year prison sentence for a facility caregiver who was convicted of murder for kicking the demented resident after he soiled his bed.
- A staff person in an RCF was incarcerated for abuse of a vulnerable adult, a resident with cerebral palsy and cognitive impairment. A coworker in another room heard muffled crying

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and screaming coming from the victim's bedroom. She went into the room and found that another staff person had stuffed a wadded segment of the resident's nightgown into the resident's mouth. The perpetrator admitted stuffing the nightgown in the resident's mouth because the resident was making noises she disliked hearing. She also admitted that she had previously stuffed a wash cloth in the resident's mouth to silence her.

When residents were perpetrators of physical abuse against another resident, the perpetrator typically suffered from either dementia or persistent and severe mental illness.

- Police were called by the coroner to investigate the death of a 72-year-old with Alzheimer's disease at a Sacramento residential care facility. The resident died after being punched in the face by another 73-year old resident with Alzheimer's. The facility did not notify the police or anyone of the assault. When the facility was being investigated because of its history of having more health deficiencies than any other facility in California, the attack came to light. However, the resident was not charged due to a "lack of self awareness" (Lillis, 2006).
- At an RCF in eastern Virginia, a young mentally ill woman attacked her 83-year-old roommate, jabbing her behind the ear with a pair of blunt scissors and sending her to the hospital (Fallis, 2004b).

We also learned of the problem of **drug diversion** by staff. The cases all involved residents who were receiving prescribed medications for conditions causing significant pain, such as cancer. Staff diverted drugs in a variety of ways, from using a syringe to remove the drug from a Fentanyl patch, to substituting water for morphine in capsules, to taking a resident's pain medications and falsifying the medication records. All of these strategies caused residents to experience significant unnecessary pain.

- An LPN at an RCF used cranberry juice to dilute liquid Oxycodone prescribed for an 87-year-old resident, significantly reducing the strength of the drug and causing the resident increased pain. She also diverted Vicodin tablets prescribed for to a 97-year-old resident for her own use.

Neglect is part of elder mistreatment. Though often not thought of as being as serious as abuse, neglect can and does cause significant injury and, sometimes, mortality. In extreme cases, neglect is prosecuted by local law enforcement or by the MFCUs in the Attorney General's office. Neglect cases we found included inadequate treatment of pressure ulcers, scalding of residents during bathing, malnutrition, medication errors, and incidents in which residents wandered away from the facility and perished or were injured.

- The Oregon MFCU prosecuted an adult foster home owner and two caregivers on Criminally Negligent Homicide charges for the death of a resident. When paramedics responded to the home, they found the resident malnourished, dehydrated, hypothermic, and suffering from Dilantin toxicity. The victim, who died at the hospital, was 6'1" tall but at the time of death weighed 110 lbs and was suffering from approximately 60 pressure ulcers.

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We found fewer reported and prosecuted cases of **psychological abuse**. If prosecuted, these cases usually involved threats as well as some type of physical abuse. However, in a study of a random sample of more than 1,100 staff in 512 RCFs in 10 states, 15% of the staff reported witnessing other staff engage in verbal abuse (e.g., threats, cursing, yelling) or forms of punishment, such as withholding food, excessive use of physical restraints, or isolating difficult residents. The prevalences reported were similar to that found in interviews with a national probability sample of staff in high service or high privacy ALFs.

Inadequate resources to carry out their responsibilities are crippling the attempts of licensing agencies, ombudsmen programs, and APS to detect, investigate, and resolve elder abuse in residential care.

Another problem related to elder mistreatment emerged with the finding that a significant number of **unlicensed RCFs** operated in at least three of the study states. However, these study states were not alone. As of 2006, as many as 20 states allowed some facilities with more than two beds to operate legally without a license or they did not offer state supplemental payments for residents who rely on Supplemental Security Income (SSI). This lack of supplemental payment gives facilities no financial incentive to become licensed. In one state, the regulatory agency felt that problems of unlicensed facilities were mainly limited to the inability of those facilities to meet the fire safety code, which required sprinklers to prevent fire deaths. However, in other states, we found evidence of serious quality problems, neglect, and abuse in unlicensed facilities. One example illustrates the kinds of problems that existed in many unlicensed homes:

- In one unlicensed facility, a city inspector found “*sinks without pipes, open electrical outlets, bathrooms with no running water, and toilets with no running water filled with feces.*” The inspector also found “*moldy walls, broken windows, and no hot water in half of the building,*” as well as finding hungry residents, little food, and staff complaining of bounced paychecks. State regulators repeatedly documented similar problems at this unlicensed facility and at the owner’s licensed homes in a nearby city.

* * * * *

Thus, we found substantial evidence that elder mistreatment occurred in RCFs and that such mistreatment was serious in nature, involving sexual, physical and psychological abuse, as well as severe neglect.

4. Challenges to Effective Detection, Resolution & Prevention and Smart Practices to Address Those Challenges

Inadequate Resources. The most significant challenge faced by all the state agencies was a lack of adequate resources. More than 90 percent of the staff in the agencies we interviewed identified resource constraints as the most significant challenge they faced and one of the three main barriers to improving the complaint investigation process. This lack of

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adequate resources was evident in several aspects of the process for detecting, investigating, resolving and preventing elder abuse.

Several factors have contributed to this widespread lack of adequate resources. First, unlike nursing homes, states do not receive federal support for regulating residential care/assisted living facilities (other than some funds for Medicaid waiver programs). Second, the industry's growth has outstripped the capacity of the state agencies. Third, state policymakers have not allocated the resources needed to meet the double challenge of an expanding industry and a resident population that is increasingly impaired and at risk for abuse and neglect. Fourth, state agency officials indicated in interviews that much (though not all) of the assisted living/residential care industry has resisted efforts to enhance regulations and the capacity of the state agencies to assure quality. Finally, state budgets are increasingly being challenged by the faltering economy, and cuts to the ombudsmen and APS programs have been severe in many states.

"I went to NAPSA [National Adult Protective Services Association] conference in Atlanta, and every state said they wished they [APS] had the money that was put into child welfare."

APS caseworker

Inadequate resources can be seen as a major culprit in several of the problems we observed in state performance. These include (but are not limited to) such issues as:

"I have 8 counties and about 1600 residents that I visit in nursing homes, family care homes, and personal care homes."

Ombudsman

- Inadequate numbers of surveyors in the licensure agencies so that "annual surveys" may be months or even years in arrears (one state surveys RCFs only once every 5 years).
- So few complaint investigators or caseworkers that complaint calls are screened out for on-site investigation in order to control investigator caseload.
- Too few complaint investigators in the licensure agency to conduct timely complaint investigations; many are responsible for surveys and complaint investigations – leading to delays of weeks or months in investigations – resulting in low substantiation rates and leaving residents unprotected;
- Too few abuse complaint intake staff so that many callers must leave messages in voicemail; lines often not manned or monitored on nights, weekends, or holidays.

"This program has so many systemic problems that have gone unnoticed, unchecked and unregulated for a decade, I don't have enough staff to fix it. By the time we get out to them, many homes are in so much trouble that they can't fix the problems - or somebody's already been harmed."

Licensing Agency Administrator

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- Ombudsmen with unsustainable workloads who are unable to visit RCFs regularly or conduct training or other abuse prevention activities; none of the states met the IOM's recommended ratio of ombudsmen to LTC beds;
- APS staff with unmanageable workloads and marginal responsibility for RCF residents;
- Inadequate numbers of support staff in agency headquarters, particularly in the licensing agencies, where even the availability of legal support is inadequate;
- Too few funds for training staff in licensure agencies and ombudsmen programs;
- Too few inspectors to detect and investigate unlicensed homes and too few attorneys to handle prosecutions of unlicensed facilities;
- Funding difficulties in terms of moving residents – out of a facility that is inappropriate for the resident, out of unlicensed facilities, or out of facilities that should be closed because of licensure violations.

"90% of the regulations are not care-based. They are strictly paperwork."
Licensure surveyor

Licensing regulations: During the last several years, many of the licensure agency directors at the annual meetings of the Association of Health Facility Survey Agencies (AHFSA) have expressed concern that their regulations were not adequate to meet the needs of the types of residents now living in RCFs.

Most states did not specify minimum staffing ratios and had minimal requirements for staff training. A survey of a national probability sample of staff found that the average staff member received only 16 hours of training. In 2004, another survey of state regulations found that 12 states did not set special training requirements for dementia-care units, and 27 states did not have special staffing requirements for dementia-care units in RCFs. This study also found that 27 states did not have a specified grievance process for residents.

Study participants were also critical of the licensing standards. In three of our study states, surveyors who conducted annual inspections and conducted complaint investigations and ombudsmen argued that the regulations for RCFs were too weak and lacked a focus on quality issues, including abuse and neglect. As one respondent noted, **"Pretty much the gardener or janitor can give insulin, change a Foley catheter or colostomy bag."** In one state, surveyors reported that their state had been extremely progressive in RCF regulation in previous years, but that in the last two years the regulations and their enforcement had become much weaker. Further, in several of the study states, the regulations did not include a mandatory ban preventing RCFs from employing staff who had previously abused or neglected an older person or a child.

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Detection: The detection of elder abuse was affected by several aspects of state agency activities and policies affecting their ability to detect elder abuse and neglect. These included outreach – education about the nature of elder abuse in RCFs and how to report it; intake of complaints or allegations about abuse and neglect; and under-reporting by residents and

mandatory reporters. **Outreach.** The most common form of outreach was the licensure requirement that demanded that RCFs post a notice providing the state’s phone number if someone wished to report abuse or neglect. In some states, there was also outreach by ombudsmen and APS agencies that engaged in community education about elder abuse and mandatory

reporting. **Complaint Intake** is another important aspect of detection. Across the U.S., we found that 14 states did not have toll-free elder abuse reporting lines, and half the states did not have a hot-line that was attended by a person on nights, weekends, and holidays. In addition, the criteria states used and the way they used them were a potential disaster. First, many respondents told us that because of shortages of investigators, the supervisors “were in triage mode” and that

“With intake, supervisors are in the triage mode - screening out complaints to manage workload.”

APS Caseworker

“Intake frequently has answering machines instead of people. Not being able to get someone to take the report is a problem. It delays response to even serious abuse cases.”

APS Administrator

they set the screening criteria to assure a manageable workload for investigators. This meant that many allegations or complaints were not investigated or were scheduled to occur during the annual licensure survey. Second, intake staff made decisions about whether a complaint or allegation warranted investigation. They also decided whether abuse reports made by RCFs had been adequately handled by

the facility and could be screened-out,” that is, not referred for investigation by the agency. Rates for complaints that were “screened-in” ranged from 30% to 85%, raising troubling questions about the causes of such variation. While some agencies reviewed decisions, based on the information provided by the intake worker, we did not find any intake agency that conducted an independent field assessment of calls that were screened out in order to determine whether the decision was a correct one and whether the screening criteria used by the state were reliable and valid. **Under-reporting** of abuse and neglect was regarded as a

serious and widespread problem by all respondents. Residents, families, facility staff, and other mandatory reporters, such as healthcare workers, under-report for reasons documented in prior research. In addition, ombudsmen noted that complaints by residents were often discounted by agencies.

Policies in the licensing agencies, APS and the LTC ombudsman program led to significant under-reporting and failure to refer allegations of abuse for investigation or for victim support.

In part this was because agencies often took the position that an “unwitnessed” event reported by a resident could not be “substantiated.” In addition, as one ombudsman noted, resident complaint were often not accepted because the reports were “perceived as being from someone whose reality is compromised because of dementia or mental illness.”

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In addition, as noted above, we found that agencies under-reported. Intake decisions may result in under-reporting and inadequate responses. This is particularly true for licensing agencies, which sometimes focus more on whether the facility is in compliance with licensure regulations (e.g., paperwork compliance with policies about elder abuse) than with whether abuse actually occurred. Also, intake often screened-out substantiated abuse and neglect reports if the report came from an RCF and the facility's incident report indicated that the facility had taken appropriate steps to resolve the problem. Thus, licensing agencies often do not report or refer the case of the individual resident to APS or the ombudsman program for follow-up.

Similarly, APS focuses on individual cases and on evaluating the need of that resident for protective services. Thus, in many instances, APS did not even report or refer substantiated cases to the licensing agency, so that it might determine whether an RCF was in compliance with regulations or whether other residents were at risk for the same type of abuse or neglect. Further, ombudsmen are typically mandatory reporters under state law, but the federal Older Americans Act prohibits ombudsmen from

**"We can't investigate what licensing doesn't tell us about."
APS Caseworker**

reporting abuse or neglect if the resident refuses to give permission for such a report to be made. This often results in ombudsmen not reporting instances of suspected abuse or neglect or being able to report only in a way that does not identify the resident – which often limits the ability of the licensing agency or police to investigate. Finally, respondents from several of the states and from different agencies noted that the consolidation of responsibility for intake and for investigations in their states. The respondents recognized the intent was to "make better use of resources." However, they noted that these policies resulted in significant declines in referrals and worried about the fate of the types of residents whose cases they previously received and investigated.

Investigation: Processes for investigating cases were deeply flawed. The problems included:

- Lack of training on how to conduct abuse investigations;
- Workload - too few staff;
- Over-reliance on facility investigations;
- Lack of timeliness; and
- Inadequate coordination among agencies.

**"They give us about an hour [on elder abuse] and then throw us out into it."
Complaint investigator**

Most of the respondents argued that they needed more training on the nature of elder abuse and how to conduct investigations in RCFs. However, respondents felt that the most serious of the problems was the workload. Except for the administrator of one licensing agency, all of the respondents from all of the agencies reported a lack of adequate resources, particularly staff, to carry out their responsibilities. (This included staff from the licensing agency in which the administrator denied that resources were a problem.) Respondents also noted that staff shortages seemed to contribute to over-reliance on facility investigation and reports of "abuse" incidents and the facility's assurances that the case had been resolved. All but one

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respondent also said that inadequate resources was a major barrier to effective quality assurance and to detecting and resolving the problem of elder abuse and neglect in residential care facilities.

Resolution: We discovered significant barriers to resolution, both in terms of dealing with perpetrators and also with victims of elder abuse. First, the role of facilities was seldom a focus of investigations or resolution, even when the facility created working conditions that virtually ensured abuse or neglect (e.g., inadequate staff training, under-staffing leading to burnout, inadequate supervision, lack of monitoring and strategies to address challenging resident behaviors). Second, many abuse investigators and surveyors felt that the agencies were reluctant to pursue cases aggressively. Facility surveyors and complaint investigators argues that their supervisors and the enforcement staff held them to unreasonable expectations. As one said, **"A CNA admitted [to me that] she hit a resident. There was a written statement and witnesses...[B]ut enforcement didn't want to do the case because I didn't see her hit the resident."** The felt similarly hampered by the interpretation supervisors and enforcement staff gave to the definitions of abuse and neglect,

"We do an investigation...and the department says [to the RCF], 'Well, don't do it again!'"
Licensure agency surveyor

particularly in terms of whether an act was "willful" or "intended to harm." **"The assisted living resident had a feeding tube, and facility records showed the staff had not been feeding him adequately. He has lost 60 pounds - nearly a third of his weight - in less than six months and was severely malnourished. I wrote it up as neglect, but**

my supervisor [over-ruled me and] said there was no intent to harm." In addition, staff felt that there was often no meaningful sanction or penalty when abuse or neglect occurred in a facility.

While involvement of police was reportedly increasing, it was still uneven across jurisdictions. In addition, prosecutors and judges were often unprepared or unwilling to deal with elder abuse cases. However, several of the MFCUs were involved in efforts aimed at prevention and prosecution, and in at least two of the study states, there were Elder Death Review Teams making significant contributions to raising awareness of the issue, coordinating activities among the agencies with some responsibility for elder abuse, and improving detection and prosecution of elder abuse.

One of the more glaring problems we discovered was the paucity of services for victims of elder abuse who lived in RCFs. Resident who suffered serious trauma were too often left to their own devices. None of the support or services so often found in crime victim assistance programs was in evidence for victims of abuse or neglect in RCFs.

Prevention: Prevention activities largely consisted of three activities in the study states. Healthcare personnel registries that listed individuals who were excluded from working in RCFs because of prior acts of abuse or neglect were used in some but not all of the states. However, even where used, there were differences in the requirements. Second, some states required criminal background checks for healthcare staff, although they differed on who

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conducted these checks and what the standards were for crimes that excluded an individual from working in an RCF. Our research suggests that these mechanisms – health care personnel registries and criminal background checks – fail to address abuse and neglect associated with low staffing levels and inadequate staff training. Thus, a third group of prevention activities focused on these and other potential causes of abuse and neglect. Several groups, including ombudsmen and MFCUs, undertook a variety of activities aimed at prevention, including providing training to RCF staff on residents rights, abuse, neglect, and the causes and appropriate approach to residents with cognitive impairment and challenging behaviors.

"Abuse prevention - ha! We are slapping on band-aids and putting out fires."
Licensure agency surveyor

Unlicensed RCFs: Three study states acknowledged a significant problem with unlicensed facilities, and in one other study state consumer advocates and ombudsmen reported the existence of unlicensed facilities. Licensure agency officials had inadequate resources or laws to deal with these facilities or no resources do to so. Residents in these facilities are largely unprotected by the licensing agencies, and in most of our study states, APS had very limited responsibility and involvement in RCFs. The ombudsmen program did not extend to unlicensed facilities.

Smart Practices: Despite the widespread problems we found in the study states, we also found what refer to as "smart practices." All respondents were asked to identify any practices or programs they viewed as particularly innovative and effective, practices we referred to as "smart practices," that they felt might be useful in other states. These smart practices are summarized in Exhibit E.2. The final column of Exhibit E.2 indicates the page number within the text of the full report where these practices are described in greater detail. However, it is important to note that the effectiveness of these practices has not been rigorously evaluated.

5. Conclusions

In our study, we found considerable variation in how states approached detecting, investigating, resolving and preventing elder abuse in RCFs. However, one constant across all the study states was a tremendous shortage of resources among the licensing agencies, LTC ombudsmen programs, and APS. The licensing agencies and their complaint investigators, APS caseworkers, and state and local ombudsmen all provided evidence of workload and resource constraints that prevented them from appropriately carrying out their responsibilities. The effects of these resource constraints were seen in all areas of the process, and they seriously weakened the ability of states to detect and investigate allegations of elder abuse and provide care and services to elderly victims.

While the obvious cause of many of the problems was resource constraints among the agencies, this lack of resources could be considered an indicator of the low priority given to the issues of elder abuse and residential care by policymakers at all levels – local, state and national. The only public or legislative outcries come on the heels of well-publicized

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Exhibit E.2 Summary of Smart Practices		
Area	Practice	Page
Resources	Agency makes a public report on consequences of inadequate resources (e.g., delays in annual survey visits)	45
	More extensive requirements for RCF staff training, including training on managing behaviors and residents rights	51
Licensing standards	Mandated uniform resident assessment to guide care planning and generate additional RCF payments for heavy care residents	55
	Ombudsmen provide training on residents' rights, recognizing and reporting elder abuse to paramedics, EMTs, ED & hospital staff	58
Outreach	Ombudsman programs around the country provide training on elder abuse to police and sheriffs departments	74
	Ombudsmen uses large posters in RCFs to advertise what the local ombudsmen can do to help residents with complaints; poster gives name, photo and contact information for local ombudsman	58
	Elder abuse awareness activities, including Elder Abuse Month, to raise community awareness	58
	AG's office conducted public campaign to encourage reporting of elder abuse, developed website with information and links on identifying and reporting elder abuse	96
	Job training for intake staff involves "job shadowing" with abuse complaint investigators	57
Intake	Aging & Disability Resource Center: unified call center for reports of elder abuse that is also a "one-stop" resource on aging network services, benefit counseling, legal services, APS and ombudsman	60
	On nights/weekends/holidays, calls to the state-wide abuse hotline are automatically transferred to cell phones of on-call staff who have authority to call regional APS supervisors if an immediate jeopardy situation	59
	Intake staff do "real-time" data entry to an intake & referral database; allows another worker to add information from a second call; facilitates monitoring of nature of complaints, workload, etc.	62
	Intake agency sends reporters a 1-page summary that describes the process; conducts satisfaction survey of reporters (except residents)	65
	State APS has Clearinghouse for state-of-the-art tools on intake process and evaluations of elder abuse allegations for facility setting	78
	State LTC ombudsman gives all ombudsmen cell phones that can time-date photographs of physical evidence; ombudsmen in other states also use camera-phones to document injuries, neglect	72, 78
	Local ombudsman are trained with licensure agency surveyors – to increase the ombudsmen investigative and reporting skills and to enhance credibility of their reports of abuse or neglect to the licensing agency or complaint investigators	72

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Exhibit E.2 continued		
Area	Practice	Page
Ombudsman reporting	Local program hired retired policeman as ombudsman – he trains ombudsman on how to interview and write up reports; trains police on elder abuse reporting laws, how to interview in RCFs	72, 74, 98
	Ombudsmen disagreed about whether to report criminal abuse if the resident refused to report, but several discussed what they would do to encourage residents to report or to find another reporter	73
Investigations	Because of rising resident acuity, licensing agency uses RNs to inspect/survey facilities and investigate complaints	82
	The agency developed materials for facilities on how to conduct investigations of abuse & neglect allegations involving staff	84
	Staff who investigate complaints of sexual or physical abuse in RCFs are trained as peace officers – enhanced training on how to write investigative reports, present evidence to law enforcement/prosecutors	97
Collaboration	In several states, the ombudsmen or APS held quarterly meetings with law enforcement, RCF administrators, home health agencies, mandatory reporters; ombudsman meets quarterly with regulatory agency to discuss concerns about specific RCFs	88
Prevention	Health care fraud unit in AG’s office has MOU with agencies involved in intake & investigation that gives the AG/MFCU data on intake and referrals so they can look for patterns that suggest abuse (even if case was unsubstantiated by agency) and target facilities and staff for further investigation by the AG’s office	95 and see text
	Area Agency on Aging funds a detective in sheriff’s department – who trains ombudsmen on investigations, does community outreach	96
	State Department of Justice mails training curriculum and video on elder abuse to all RCFs for use in training staff within 60 days of hire; Ombudsmen provide training to facility staff	77 and 102
Program/ Agency Oversight	The Maine ombudsman program is a not-for-profit, private agency which allows it greater independence in evaluating and reporting on the performance of government LTC regulatory agencies	89
Resolution	The Maine Elder Death Analysis Review Team is beginning to fulfill a requirement that all members of law enforcement get at least 2 hours of training on elder abuse	80
	A state-level initiative called SAFE in Long-Term care developed a 3-day curriculum to law enforcement on how to interview older persons and persons with dementia; also identifies resources in the aging network & reviews criminal statutes that can be used for elder abuse	81
	MFCUs and similar units on healthcare fraud in AG’s office support investigation, prosecution, prevention	95– 97
	Elder Death Review Teams	99
	Archstone Foundation provides support for victims of elder abuse. Local ombudsman program secured a grant to train ombudsmen and provide supportive services and counseling to abused residents	100

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scandals, and most legislative reform attempts have died on the altar of fiscal notes addressing the cost of reform. As many of our study participants noted, this stands in stark contrast to the issues of child abuse and domestic violence, in which federal and state policymakers have responded with funds and legislation, and mandatory reporters are well-schooled in their obligations.

*"A lot of the solutions are money, money, money and then accountability."
Licensure agency administrator*

While the child abuse and domestic violence sectors are far from perfect, they are certainly more advanced than what is found in the area of elder abuse. Changing the priority the public and policymakers give to elder abuse and to residential long-term care settings is not a technical issue. Instead, it requires recognizing the problem and generating the political will to do something about it.

Policymakers can take a series of concrete intermediate steps to improve detection, investigation and resolution of elder abuse and neglect in residential care. First, they should address the training needs identified by study participants (and summarized in Exhibit E.3). Complaint investigators, ombudsmen and APS caseworkers need more training on their authority, how and when to involve law enforcement, investigative techniques, including forensics, and how to write reports so that they support their findings and conclusions can be used effectively in enforcement or prosecution actions. Law enforcement – from police to prosecutors to judges – also need

*"In cutting state budgets...now they are discovering they cut into the bone, not fat. Changes are based on money, not what is best for the client."
Abuse investigator*

additional education and training on the nature and consequences of elder abuse, on residential care settings, on the special issues involved with elderly persons as victims and, potentially, witnesses, and on how they can be more effective in resolving abuse cases and preventing future abuse. Finally, policymakers need to require and provide training for RCF owners, operators and staff that is aimed at preventing elder abuse and neglect.

Second, policymakers also need to commission research on the nature, prevalence, and prevention of elder abuse, as well as research focused specifically on elder abuse in residential LTC settings. Some of the recommended topics for research are summarized in Exhibit E.4. Research is needed to describe the characteristics of residents in RCFs. While a national study is being designed by RTI International and funded by the U.S. Department of Health and Human Services, this is just a start. Such research is also needed to produce state-level estimates, so that states can tailor their policies and the licensure requirements for facilities to meet the needs and preferences of that resident population and to protect the wellbeing of vulnerable residents. Currently, in most states, the licensure standards, survey process, complaint investigation process, and compliance mechanisms are not tied to the nature of the resident population or their vulnerability to abuse and neglect.

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In addition, research and policy are needed to address the issue of under-reporting. Resident fears and unwillingness to report abuse must be understood and addressed, perhaps with

lessons from the domestic violence arena. Residents live in the environment in which the abuse occurred and may have no realistic way to exit. Similarly, research and more effective policies are needed to address under-reporting by such mandated reporters as staff in RCFs, EMTs, hospital personnel, health care providers, and so on. Policymakers, the AoA and state and local ombudsmen also need to confront directly the conflict faced by ombudsmen caught between the mandates of conscience, the requirements of state law, and the provisions of the Older Americans Act.

Exhibit E.3 Summary of Training Recommendations	
Population	General Content
Facility owners, operators & staff	<p>Residents rights and mandatory reporting requirements</p> <p>The causes or precipitators of abuse by staff and how to prevent abuse and neglect arising from these factors</p> <p>How to manage challenging resident behaviors – both those that may precipitate aggression or rough treatment by staff AND those behaviors that endanger and injure other residents</p>
Surveyors, complaint investigators, APS, ombudsmen	<p>The nature of their authority to investigate, interview suspected perpetrators</p> <p>Investigative techniques, forensics</p> <p>How to write reports that substantiate their conclusions</p> <p>How to structure their reports to support administrative sanctions or prosecution; how to testify</p>
Police and prosecutors	<p>The relevant law on elder abuse and how other laws on rape and assault apply to residential care setting</p> <p>The nature and consequences of elder abuse for both cognitively intact and cognitively impaired residents</p> <p>Information about the aging network and how to work with it</p> <p>Information about residential LTC settings, their residents, legal responsibilities re: abuse, neglect</p> <p>How to interview frail elders and people with cognitive impairment</p>

The universal lack of resources, the enormous variation across jurisdictions, and the low priority given to elder abuse and neglect make it difficult to see how significant progress can be made without some federal standards and financial support for investigating, detecting, resolving and preventing elder abuse in residential care. Federal policymakers – from the Congress to the Administration – need to recognize that states do not have sufficient resources and, in some cases, sufficient political will to address these issues. Thus, the federal government should become more involved in sponsoring relevant research, in funding the development and provision of needed training, and in providing some uniformity in standards. Further, the federal government should provide financial support, training, and oversight/monitoring for state surveyors, complaint investigators, caseworkers, and ombudsmen on how to conduct abuse and neglect investigations in RCFs.

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Exhibit E.4 Summary of Research Recommendations

To determine the prevalence of elder mistreatment in RCFs, whether it varies across types of facilities (e.g., ownership, staffing, resident case mix) or states, and factors associated with such variation

To identify the underlying causes of abuse, neglect and rough treatment by staff and effective interventions to prevent such elder mistreatment

To identify the causes and predictors of resident-on-resident abuse and effective interventions; To determine how to effectively manage the care of residents who exhibit physically aggressive, intimidating or sexually inappropriate behaviors

To examine the impact of housing frail elders with paroled prisoners and with younger persons with mental illness and how to handle this situation

To understand the sources of RCF resident and family reluctance to report elder mistreatment and how to address these concerns

To identify facility practices that minimize elder mistreatment and facilitate reporting

To determine how to educate and persuade mandatory reporters to recognize and report abuse

To examine the impact of all types of elder mistreatment on cognitively impaired and cognitively intact residents and identify appropriate victim supportive services

To determine which aspects of state systems (e.g., licensure standards, inspection processes, sanctions, complaint investigations, ombudsmen program support, APS program support) minimize elder mistreatment

To determine how facility “incident reports” are handled by state agencies, what type of agency follow-up occurs, and whether there is any referral to appropriate agencies for victim support

To examine the criteria used to screen calls - complaints of elder mistreatment -- and what happens to calls & facility incident reports that are “screened out” of investigation (*sensitivity & specificity*)

To examine in depth the processes used to investigate abuse and neglect complaints and incident reports from facilities – whether there is an on-site investigation, the timeliness of the investigation, the training and qualifications of investigators, the criteria used to determine “substantiation,” and the accuracy of their reports/findings

To determine rates of substantiation for complaints of elder abuse and neglect and whether and how they may vary across states or agencies

To determine the degree to which substantiated cases of abuse reported by facilities are referred to APS or ombudsmen for follow-up services for the victim

To examine how cases of resident-on-resident abuse are handled by the regulatory process

To determine the amount of time between a complaint or incident report and resolution, including the time elapsed in substantiated cases involving staff and the barring or other outcome for staff

To examine the outcomes/resolution of abuse cases – in terms of the facility, perpetrator, and victim

To examine the use of the healthcare personnel registries and their effect on preventing abuse

To examine the role of the MFCU

To identify barriers to effective involvement with law enforcement in cases of abuse

To identify barriers to effective action by prosecutors and how to overcome those challenges

Research on the “smart practices” we identified to assess their effectiveness and utility in other states and settings – and to identify additional smart or “best practices”

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Limitations: The findings of this study are necessarily limited by the fact that we conducted in-depth site visits in only six states and collected only limited additional data on several other states. Thus, what we found may not be generalizable. In this regard, we would note two facts. First, we selected states based on expected variation among them. However, even in what we expected to be “good” states with effective mechanisms in place to detect, investigate and resolve elder abuse in RCFs, we found significant problems – including a lack of resources that hampered their performance. Second, some of our findings were consistent across all of the study states. In any event, even if the problems we found were localized in these particular study states, they should be addressed. Additional research of this type in other states may clarify the nature and scope of the problems involved in detecting, investigating, resolving, and preventing cases of elder abuse in residential care facilities.

“I’ve been an ombudsman almost 20 years now. We’ve made no progress in elder abuse prevention in my opinion. I think elders are being assaulted, raped, attacked, beat, whatever on a daily basis in our residential long term care facilities. And I don’t know how to stop it....I don’t see that we’ve made any inroads.”

Ombudsman

Section 1. Introduction and Background

Residential care facilities (RCF) are the most common long-term care setting outside of nursing homes and the most rapidly expanding form of senior housing. Such settings house as many as one million frail elders and persons with disabilities. In addition, there are a large but unknown number of unlicensed facilities housing the poorest elders and people with mental illness. RCF residents are vulnerable to mistreatment, including abuse and neglect for several reasons. These include the prevalence of physical frailty, cognitive impairment, and mental illness among residents; concerns about whether RCFs are capable of meeting the needs of the heavier care residents as a result of their low staffing levels and inadequate staff training; and growing recognition of the limited capacity of the regulatory systems responsible for assuring quality and protecting elders from abuse and neglect.

1.1 Purpose of the Study

The main goal of the project was to assess the public programs designed to detect, investigate, and prosecute or otherwise redress abuse of frail elders who live in residential care facilities (RCFs) and make recommendations for strengthening these processes.

Glendenning (1999, p. 1) argued forcefully for this, noting that “research into elder abuse and neglect has become locked in the family violence model, whereas in reality much more research attention needs to be paid to abuse in residential settings as well.” He is correct for many reasons, not the least of which is that residential care and assisted living facilities are the most rapidly expanding form of long-term care services. RCFs house an estimated one million people, including an estimated four percent of the elderly in the United States (Hawes et al., 2003; Mollica & Johnson-Lamarche, 2005).

Despite their growing role in caring for older persons, there is no federal regulation of these facilities. While a variety of surveys and reports describe the states’ varied regulations, there has not been any examination of the effect of these regulations since a study sponsored by the U.S. Department of Health and Human Services, Office of the Assistant

“Research into elder abuse...has become locked into the family violence model, whereas in reality much more research attention needs to be paid to abuse in residential settings...”

Glendenning, 1999, p. 1.

Secretary for Planning and Evaluation (ASPE) that was completed 1990s (Hawes et al., 1995; Wildfire et al., 1997). Moreover, this study examined the effects of regulation in only 10 states and did not examine processes for detecting, investigating and resolving allegations of elder mistreatment. However, there is ample evidence that abuse in RCFs is occurring, including the fact that 21 percent of the reports “screened-in” for evaluation by Adult

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Protective Services (APS) in 2005 involved adults 60 years of age and older in residential care settings (NCEA, 2005-2006). Similarly, the long-term care ombudsman program (LTCOP) has consistently reported that complaints about abuse in RCFs have been among the five most common types of reported complaints (AoA, 2004; AoA, 2006).

Only a few studies have focused on the processes for detecting, investigating and resolving allegations of elder abuse and neglect in nursing homes (Hawes, Blevins and Shanley, 2001; U.S. DHHS, Office of Inspector General (OIG), 1990a, 1990b, and 1997; U.S. GAO, 1999). In general, the findings have been extremely disappointing, demonstrating enormous variability in systems across states

and seriously flawed processes, despite federal mandates and funding support for state activities. However, the Centers for Medicare & Medicaid Services (CMS) and the Administration on Aging (AoA) and its long-term care ombudsman programs

Studies of processes to detect, investigate, and resolve elder abuse in nursing homes have found seriously flawed policies and practices, despite federal standards and financial support. There have been no comparable studies in assisted living and other residential care settings.

(LTCOP) have initiated programs aimed at improving both reporting of complaints, including allegations about elder mistreatment, and also processes for investigating and resolving cases of elder mistreatment. There are also joint efforts by the U.S. Department of Justice, the State Offices of Attorney General, the licensing and certification agencies, the LTCOPs, and Adult Protective Services (APS) to create state working groups to improve the process of detecting, investigating and addressing elder mistreatment in nursing homes.

There have been no comparable national initiatives to improve the processes for addressing and preventing elder abuse in assisted living and residential care. This is unfortunate since this sector houses nearly one million elderly and disabled persons, and elder abuse in such settings is a growing concern in the U.S. and around the world (Connolly, 2008; Glendenning, 1999; Wierucka & Goodridge, 1996). This study for the National Institute of Justice (NIJ) is designed to contribute to remedying the gap in information about the processes states use to detect, investigate, resolve and prevent elder abuse in residential long-term care settings.

In order to achieve this overall goal, the study focused on several specific aims that included:

1. To describe and assess the responsibilities and processes in agencies that license RCFs for identifying, addressing and preventing abuse and neglect of residents (e.g., outreach, intake, investigation), including links to and coordination with Adult Protective Services (APS), long-term care ombudsmen programs, and law enforcement in six study states.
2. To describe mandatory abuse reporting laws in all 50 states, with greater detail for the selected case study states.
3. To examine the issue of underreporting of abuse of RCF residents, the reasons for any underreporting, and potential solutions, particularly for mandatory reporters.

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4. To describe and assess the role and performance of licensing agencies, APS and ombudsmen in investigating and resolving abuse allegations, including the processes they use and resources available for activities related to RCFs.
5. To describe the role of law enforcement in investigating and prosecuting cases.
6. To identify and describe what appear to be innovative/“smart” practices or model systems
7. To identify options for changes in policies and programs and assess the feasibility of their implementation in other states.

1.2 What Is Abuse²

According to the National Research Council’s (NRC) report from the Panel to Review Risk and Prevalence of Elder Abuse and Neglect, *elder mistreatment* is “(a) intentional actions that cause harm or create a serious risk of harm, whether or not intended, to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder’s basic needs or to protect the elder from harm” (Bonnie & Wallace, 2003, p. 39).

The NRC defined *abuse* as “Conduct by responsible caregivers or other individuals that constitutes ‘abuse’ under applicable state or federal law” (Bonnie & Wallace, 2003, p. 39). The NRC report noted that under state laws, abuse generally included: “(1) physical acts causing pain or injury; (2) conduct inflicting emotional distress or psychological harm; (3) sexual assault; (4) financial exploitation; and (5) neglect” (Bonnie & Wallace, 2003, p. 35).

In fact, all 50 states and the District of Columbia have laws that define elder abuse and authorize APS agencies to respond to reports of such abuse. In addition, states have licensing laws for assisted living and residential care facilities. In these, as well as in their mandatory reporting laws, several states also include additional concepts of what constitutes abuse. Examples include isolation, unreasonable confinement, withholding food for punishment, and use of physical restraints for punishment (Steigel & Kelm, 2007a, 2007c).

The reality is that while laws in all states address the issue of abuse, there is considerable variability across states and within states, between agencies, in how abuse is defined operationally. Some of the variations include:

- The definition of victim – variation on the specified age for someone to be a victim of elder abuse and whether a person must meet a definition of “vulnerability” to be considered a victim of elder abuse;

² In addition to the excellent discussion in Bonnie & Wallace (2003), Olshaker, Jackson & Smock (2007, pp. 175ff) in their book, *Forensic Emergency Medicine*, compare definitions of abuse and neglect from that specified by the U.S. Congress in the 1985 *Elder Abuse Prevention, Identification and Treatment Act*, by the American Medical Association (Aravanis et al., 1992), and by the National Elder Abuse Incidence Study (NEAIS) (U.S. Department of Health and Human Services, 1998).

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- The definition of perpetrator – variation on whether it is abuse only if committed by “a person in a position of trust” and, in assisted living and residential care facilities, whether it is considered abuse if the perpetrator is another resident;
- The definition of acts – variation in whether verbal or emotional/psychological mistreatment is considered abuse and whether an act must be intended to harm the victim in order to be considered abuse.

Obviously, the states and agencies in our study had such variations. However, we focused on sexual abuse and physical abuse – the types of mistreatment about which there is the greatest agreement (Hawes, 2003). We also asked about verbal, psychological, or emotional abuse, although there was less agreement among agencies about whether that should be included as a category of elder abuse. We had an inclusive view in terms of victims (any resident), of perpetrators (anyone), and of acts (whether “intended” to harm or not). This inclusiveness placed us somewhat at odds with usual concepts of abuse and elder mistreatment. First, we did not require the perpetrator to be a “person in a position of trust.” Second, we did not require the intent to harm. If these elements were considered essential, abuse by a resident with dementia or other mental illness could be excluded. Yet such incidents are common in residential LTC settings and a significant source of physical and emotional injury to vulnerable elders (Lachs et al., 2007; Teaster et al., 2007).

We recognized that our definition was a departure from the 2003 Panel to Review Risk and Prevalence of Elder Abuse and Neglect (Bonnie & Wallace, 2003). Moreover, it may go further than some federal statutes and policies. For example, the Administration on Aging, in its instructions to long-term care ombudsmen, defines abuse as “the *willful* infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, or mental anguish or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness” (AoA, 1998, p.13; *emphasis added*). It is also more expansive than the definition used by the Centers for Medicare & Medicaid Services (CMS) – although in practice, CMS is concerned with resident-on-resident abuse.

The nursing home reforms contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987, Pub L. No. 100-203) specified that nursing home residents had the “right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion” (42 CFR Ch. IV (10-1-98 Edition) §483.13 (b)). The Health Care Financing Administration (HCFA), which is now the Centers for Medicare & Medicaid Services (CMS) issued regulations and guidelines implementing these provisions of the OBRA 1987 legislation. These regulations specified the following definition of abuse:

“Abuse means the willful infliction of injury, unreasonable confinements, intimidation, or punishment with resulting physical harm, pain, or mental anguish.”

Under this federal regulation, *physical abuse* includes hitting, slapping, pinching, kicking, pushing, or striking with objects. In nursing homes, other types of actions have been included,

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such as improper use of physical or chemical restraints. Residents and certified nursing assistants (CNAs) also view rough handling as abuse (Broyles, 2000; Hawes, Blevins & Shanley, 2001). Physical abuse also typically includes *sexual abuse* or nonconsensual sexual involvement of any kind, from rape to unwanted touching or indecent exposure,

As noted above, there is somewhat less agreement among researchers and in state statutes about whether *verbal* or *psychological abuse* should be included in the general category of abuse when applied to older persons. However, the federal guidelines promulgated by CMS are clear that psychological or verbal abuse is included. Psychological abuse is generally thought of as “intentional infliction of anguish, pain, or distress through verbal or nonverbal acts” and includes threats, harassment, and attempts to humiliate or intimidate the older person (Clarke and Pierson, 1999, p. 632). In focus group interviews conducted in 2000 (Hawes, Blevins & Shanley, 2001), certified nursing assistants (CNAs) in nursing homes included threats, yelling in anger, speaking in a harsh tone, cursing at a resident, or saying harsh or mean things to a resident.

These were the concepts we used in our study – a broad definition of abuse (sexual, physical and psychological), regardless of intent or type of perpetrator. We should note, however, that the respondents focused on each state agency’s own statutes or regulations, definitions and views of what constituted abuse.

1.3 What Is Residential Care

The term “residential care facility” (RCF) describes a variety of settings; however, in general it refers to non-medical community-based residential settings that house two or more unrelated adults and provide some services such as meals, medication assistance, and some type of assistance with activities of daily living (ADLs). RCFs are known by different names across the country, including adult congregate care, personal care homes, homes for the aged, domiciliary care homes, adult care homes, shelter care facilities, and assisted living facilities (ALFs). They serve a mainly elderly population, although some RCFs house a mixed population of frail elderly and residents who have some type of psychiatric condition, including persons with intellectual disabilities who have aged-in-place. Indeed, RCFs are believed to be the most common residential settings that house persons with mental illness outside of state institutions. In the early 1990s, there were an estimated 34,000 licensed and unlicensed RCFs with more than 600,000 beds (Clark et al., 1994; Hawes et al., 1993; Hawes et al., 1995). The rapid growth since then of assisted living facilities (ALFs) has increased the total number to more than 50,000 RCFs with more than one million beds serving mainly the elderly or a “mixed” elderly and non-elderly adult population with a primary psychiatric diagnosis (Hawes et al., 2003;

Residential Care Facilities (RCFs) are known by several names, such as:

- Assisted living facilities
- Adult congregate care facilities
- Homes for the aged
- Adult care homes
- Domiciliary care homes
- Shelter care homes
- Personal care homes
- Residential care facilities for elderly

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Mollica, 2002; Mollica & Johnson-Lamarche, 2005; Spillman, Liu & McGalliard, 2002).³ As a point of comparison, there are an estimated 17,000 licensed nursing homes with approximately 1.6 million beds serving more than 1.5 million residents (Spillman, Liu & McGalliard, 2002). Thus, RCFs are a significant care setting for frail elders and persons with chronic disabilities. As many as four percent of the nation's elderly reside in RCFs on any given day – and they are older persons with significant risk factors for being abused.

1.3.1 Variability among RCFs.

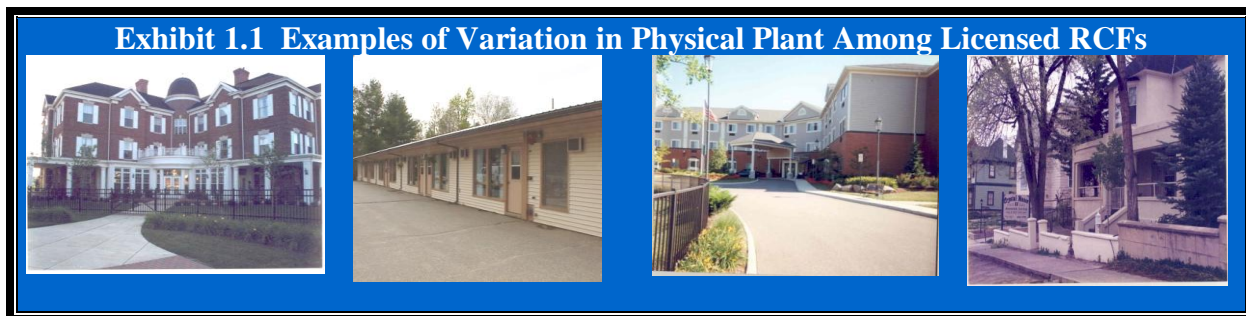
While RCFs are a critical component of the long-term care system, the population of facilities exhibits tremendous variation – which represents a challenge to consumers seeking to select the appropriate facility and to the agencies with regulatory or oversight authority. As Mollica and Johnson-Lamarche (2005, p. 8) noted: “*States historically have licensed two general types of residential care: (1) adult foster care or family care, which typically serves five or fewer residents in a provider's home; and (2) group residential care that typically serves six or more residents in a range of settings.*” However, more than that, states have envisioned different roles for assisted living and residential care in their long-term care “system” (Carlson, 2005; Mollica & Johnson-Lamarche, 2005). The variability in public policy has been matched by diversity among ALF providers. Studies of assisted living have consistently demonstrated that ALFs differ in size, ownership, auspices, target population, physical environment, price, and services. Thus, both public and private policies have contributed to the emergence of different types of assisted living facilities across the country. The result can be seen in a variety of national, state, and multi-state studies (Burdick et al., 2005; Hawes, Rose, & Phillips, 2000; Hawes, Phillips, Rose, Holan & Sherman, 2003; Hedrick et al., 2003; Phillips et al., 2003; Newcomer, Lee & Wilson, 1997; Zimmerman et al., 2003). This variation has implications for the risk for elder mistreatment and for the ability of various state agencies to protect vulnerable residents.

Variation in Population Served. First, there is variation among RCFs in the population they serve, from facilities that serve only older persons to those that serve a mixed population of residents, that is, a mix of persons who are elderly with those who have persistent and severe mental illness and intellectual disabilities (Burdick et al., 2005; Gruber-Baldini, Boustani, Sloane, Zimmerman, 2004; Hawes et al., 1995; Hawes, Phillips and Rose, 2000; Hedrick et al., 2003; Rosenblatt et al., 2004). Even within those facilities serving only older persons, some RCFs have a mix of physically frail elders with residents who have some type of cognitive impairment, while other RCFs are dementia-specific. This variability is a challenge for specific providers – in terms of meeting the diverse needs of a mixed population. It is also a challenge for regulatory and oversight agencies which may have difficulty devising regulations that are appropriate for the wide variety of facilities and for the sundry needs of the resident population. Finally, some residents may be at risk for physical or verbal aggression from other residents, particularly from residents with psychiatric illnesses ranging from psychosis to dementia.

³ This number excludes RCFs and group homes licensed by state departments of mental health for specialized populations.

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Variation in Physical Plant and Accommodations. As illustrated in Exhibit 1.1, one also finds tremendous variation among facilities in terms of their age, the building code standards they meet, and the accommodations they offer, as well as whether they are located on a “campus” that includes other types of health care facilities. First, facilities vary in size from 2 beds to more than 1400. The average size in a national study of assisted living facilities was 56 beds; however, the study excluded facilities with fewer than 11 beds (Hawes, Phillips & Rose, 2000; Hawes, et al., 2003). Second, there is considerable variation among facilities in the types of accommodations they offer. The widespread perception is that assisted living facilities offer private accommodations, most commonly in apartment-style units. However, the only national study of assisted living facilities (ALFs) found that among ALFs offering a relatively high level of privacy in accommodations or a relatively high level of services,⁴ only about half of the units were apartments. The remaining accommodations were single rooms, most with at least a private half-bath. However, 59 percent of the facilities known as assisted living offered mainly semi-private accommodations (Hawes et al., 2003). In addition, there were some RCFs, licensed and unlicensed, that offered what are considered “ward” accommodations, that is, rooms housing three or more residents. Third, RCFs differed in age, from such places as old, converted motels to purpose-built ALFs. Finally, facilities differ in the building and fire code standards they follow, sometimes as a matter of state law and sometimes as a matter of facility choice. The result was that many facilities did not have fire sprinklers, escaping this requirement by arguing that all their residents were capable of “self-evacuating” in the event of an emergency. These variations affect the risk that residents face from death or injury from fire. The effect of shared accommodations on the potential for elder mistreatment is more difficult to estimate, although there is evidence that these arrangements do not meet the preferences of most older persons who are cognitively intact (e.g., Jenkins, 1997; Kane et al., 1998).



Variability in Price and Payer-Source. RCFs also varied in the price they charged for basic monthly services, from about \$630 per month to more than \$5,000 per month. Some facilities housed a resident population that is mainly low income, often supported only by Supplemental Security Income (SSI), while other RCFs – the “high-end assisted living” were mainly private pay facilities where residents were charged more than \$60,000 per year. While one might expect that the likelihood of abuse or neglect differs across these facilities, state

⁴ High service ALFs offered a range of supportive/personal care services, had a full-time registered nurse (RN) on staff, and were willing to offer nursing monitoring or care with staff. High privacy ALFs offered private accommodations in at least 80% of their units. These high service or high privacy ALFs comprised only 41% of places known as or calling themselves “assisted living” (Hawes, et al., 2003).

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agency staff members who were interviewed in this project noted that elder mistreatment occurred in all types of facilities.

Variability in Staffing and Staff Training. RCFs also demonstrated considerable variability in staffing -- in terms of the ratio of staff to residents, in whether they had a licensed nurse on staff, and in terms of the amount and type of staff training (Hawes et al., 2003; Hedrick et al., 2003; Phillips et al., 2003; Zimmerman et al., 2003). This lack of supervision by professional nursing staff, the paucity of staff training, and low staffing levels have implications for the likelihood of abuse and neglect. Prior studies and interventions aimed at preventing abuse in nursing homes indicated that “short” staffing and inadequate staff training increased the risk for resident abuse (Broyles, 2000; Hawes, Blevins & Shanley, 2001; McDonald, 2000; Pillemer & Moore, 1989; Pillemer & Hudson, 1993).

1.4 Vulnerability of Residents to Abuse

As a result of facility decisions about the population they wish to serve and state licensing regulations, RCFs are housing an increasingly impaired population in most states, although there is variability in this across facilities and across states. Some states and some RCFs house what one APS administrator interviewed for this study referred to as “*the canasta set*.” Initially, many policymakers and advocates of assisted living believed that people who moved into ALFs would have only slight physical or cognitive limitations and moderate care needs. Further, the assisted living sector was largely private-pay. Thus, many observers concluded that the risk for abuse or neglect was low, since they presumed that residents were immune from abuse or neglect, could move if a facility did not meet their needs, or could turn to family if they had any problems.

The reality is that many residents are frail and have significant functional limitations. Over the last 15 to 20 years, as assisted living has emerged, many states have allowed such residential care facilities to house residents with greater levels of impairment. By the mid-1990s, the majority of state licensing agencies allowed RCFs and ALFs to house residents who were chair-fast because of health problems or who used wheelchairs to get around inside the facility. One-third of the licensing agencies allowed such facilities to retain residents who were bedfast (Hawes, Wildfire & Lux, 1992). As a result of a variety of factors, including the *Olmstead* decision and federal policies designed to increase the use of “community-based services,” many states embarked on more aggressive strategies for expanding the potential role of RCFs (Kane & Wilson, 1993; Mollica, 1998 and 2002; Mollica & Johnson-Lamarque, 2005; Newcomer, Lee & Wilson, 1997; Reinhard, Young, Kane & Quinn, 2006; U.S. GAO, 2001). This process has been augmented by the focus at the federal and state level on “rebalancing” the long-term care system by decreasing the role of nursing homes and increasing the role of

“The weak standards, inadequate inspections, low payment, combined with the push for higher use of RCFs, this is a recipe for aging in place in a way that doesn’t promote any dignity. It’s a recipe for disaster.”

Consumer Advocate

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“community-based” care, which included residential care and assisted living. Indeed, to facilitate “aging-in-place,” many states have allowed increased acuity and services in RCFs, permitting the provision of daily or intermittent nursing care (including skilled care) and hospice care in these facilities and modifying state nurse practice acts to allow non-licensed personnel to provide certain services independently or under supervision, loosely defined. Most observers, including the heads of state licensing agencies, argued that these policies, combined with consumer and family preference for settings other than nursing homes, have led to increasing levels of acuity among residents of RCFs.

Exhibit 1.2: RCF RESIDENT CHARACTERISTICS – Summary from Several Studies							
Resident Characteristic	Hawes et al 1995¹	NC 1995²	Maine 1999³	Hawes et al., 2003	Hedrick et al 2003⁴	Zimmerman et al.⁵ traditional new	
Female	66%	66%	67%	79%	68%	77%	75%
White	91%	71%	98%	99%	92%	92%	95%
Black/African American	7%	29%	--	1%	--	--	--
Aged 85+	34%	24%	33%	54.3%	Mean age 78	57%	52%
Currently married	13%	8%	8%	12%	15%	10%	14%
Mental retardation/DD	11%	23%	11%	--	--	--	--
Self-reported mental, emotional or nervous condition	33%	51%	42% with diagnosis	--	--	--	--
Fell during last 12 months	32%	34%	34%	37%	--	--	--
Moderate/severe cognitive impairment	40%	64%	44%	27%	47%*	23%	35%
Received help with medications	75%	--	98%	77%	--	--	--
Received help with 1-2 ADLs	21%	21%	32%	13%	79%	15%	25%
Received help with 3+ ADLs	10%	20%	19%	8%	65%	--	--
Urinary incontinence	23%	39%	37%	32%	--	--	--
Any behavioral symptom (e.g., wandering, physical aggression)	--	29%	31%	--	--	37%	39%
Received any psychotropic	41%	--	40%	--	--	--	--
Average No. of medications	6	--	7	6	--	--	--
Use of ER in 12-month period	28%	28%	24%	24%	--	--	--
Hospital use in last 12-months	32%	30%	34%	32%	--	--	--
Medicaid or SSI eligible	34%	71%	18%	--	--	--	--

(1) Hawes et al., 1995a; (2) Hawes et al., 1995b; (3) Fralich & McGuire, 1999; (4) Hedrick et al., 2003 used the Short Blessed and the estimate represents “some degree of cognitive impairment” (Hedrick et al., 2003, p. 478); (5) The two columns from Zimmerman et al., 2003 represent estimates for the traditional “board and care” (shown in the first column) and the “new” or “purpose-built” assisted living facilities (shown in the second column).

RCF residents are an extremely vulnerable population, with a mix of advanced age, chronic disease and disability, mental illness and cognitive impairment, poverty, and social isolation, as the data in Exhibit 1.2 illustrate (Fralich et al., 1997; Hawes et al., 1995a, b;

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Hawes et al., 2000). These characteristics make it difficult for residents to safeguard their own interests. Moreover, studies indicate that cognitive impairment, behavioral symptoms, and in some studies - limitations in ADLs -- increase the risk for being physically, sexually and psychologically abused (Burgess, Dowdell & Prentky, 2000; Coyne, Reichman & Berbig, 1993; Dyer et al., 2000; Pillemer & Finkelhor, 1988; Pillemer & Sutor, 1992; Wolf & Pillemer, 1989). These risk factors are common among older persons living in RCFs, including a high prevalence of cognitive impairment and challenging behaviors (Aud & Rantz, 2005; Beattie, Song & LaGore, 2005; Gruber-Baldini et al, 2004; Hawes, Rose, & Phillips, 2000; Hedrick et al., 2003; Rosenblatt et al., 2004; Tornatore et al., 2003).

Their risks are augmented by social isolation. For example, an estimated 87 percent of residents are not married, while 27 percent have no living family members, and many residents are poor (Fralich & McGuire, 2006; Hawes, Phillips & Rose, 2000; Hawes et al., 1995a, b).

In addition, several studies have found that residents have significant chronic disease and that such disease and conditions are often misdiagnosed or “under-treated.” Studies have also found significant levels of medication errors (Gray et al., 2006; Gruber-Baldini et al., 2004; Maust et al, 2006; McNabney et al. 2008; Sloane et al., 2003; Sloane et al., 2004; Spore et al., 1995; Spore et al., 1996; Spore et al., 1997). Thus, RCF are at risk for neglect that may lead to premature mortality or increased morbidity.

* * * * *

In summary, residential care facilities, including assisted living, are an important component of long-term care services, one that has expanded rapidly over the past two decades. Moreover, policies promulgated at the federal and state level are encouraging greater use of this “community-based” alternative. Further, there is considerable variation within the industry, with some factors, including low staffing levels and very low staff training, that increase the likelihood of situations that foster abuse. Finally, a combination of consumer preferences, industry over-expansion in some markets, financial pressure on providers to maintain high occupancy rates, and state policies are leading to greater acuity and heavier care needs among residents. These factors have led to a situation in which nearly one million frail elders and others with disabilities live in RCFs and many have significant risk factors for abuse and neglect.

1.5 ORGANIZATION OF THIS REPORT

- Section 2 describes the study methods.
- Section 3 describes the general nature of the elder abuse in residential care facilities.
- Section 4 describes state agency roles, responsibilities and performance in terms of detecting, investigating and resolving allegations of elder abuse in RCFs, including barriers and challenges and what respondents identified as “smart practices.”
- Section 5 discusses the implications of the study findings and recommendations for policy, research and training.

Section 2. Study Methods

This section of the report describes the study methods. As noted, our focus was on those agencies involved in responding to complaints or allegations of elder mistreatment for those living in residential care facilities. This included the state agencies that licenses residential care facilities (RCFs), Adult Protective Services (APS), and the long-term care ombudsman program (LTCOP). In some states, it also involved the state Attorney General’s office. In a few states, other agencies and organizations were involved, from special initiatives, such as a state-wide Elder Death Review Team, to consumer advocacy groups. To achieve the study objectives, we employed a mix of collection and analysis of quantitative and qualitative data. This involved a collection and review of secondary data, including state mandatory reporting laws, identification of the “first responder” agencies under these laws, a national telephone survey of “first responder” agencies, focus groups with a national sample of ombudsmen, and a series of state case studies with in-person and focus group interviews with key agency personnel and other stakeholders.

The main agencies the study focused on were:

- State RCF licensing agencies
- Adult Protective Services
- Long-Term Care Ombudsman

2.1 Review of National Data and Survey of All States

We collected and reviewed data from a variety of sources that related to our study goals. We used this information to get a better understanding of state laws and practices that affected the ability and performance of state agencies to detect, investigate and resolve cases of elder abuse in residential care settings. We also used information from these activities to select the seven study states for site visits.

2.1.1 Collection and review of state elder abuse reporting laws

We reviewed the mandatory abuse reporting laws for each state, focusing on such issues as the type of mandatory reporters, the agency or agencies identified as “first responders” to which reports must be made, and the criteria used to define the types of incidents, reports or observations that were covered under the state law. We were greatly aided in this endeavor by the work of Lori Steigel and her colleagues at the American Bar Association’s Commission on Law and the Elderly. They reviewed and summarized each state’s mandatory elder abuse reporting laws and updated this review in 2007 (Steigel & Kelm, 2007a; Steigel & Kelm, 2007b; Steigel & Kelm, 2007c).

2.1.2 Telephone survey of “first responder agencies”

We turned to the U.S. Department of Health and Human Services, Administration on Aging’s National Center on Elder Abuse (NCEA). Under “State Resources” on the NCEA website,

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“Help Lines and Hotlines” are listed (see http://www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx). We used the telephone numbers listed there to call each identified entity for intake of elder abuse complaints or allegations, selecting the one identified for complaints about residents in LTC facilities where such specialization was noted. Our goal was to determine how easy or difficult it might be for reporters to get information and lodge a complaint or allegation. We asked about the process for lodging a complaint about elder abuse for someone living in a residential care facility, when the complaint line had a “live” person answering calls, how calls were handled when the hotline was not “manned” by a person, and whether the intake agency had formal criteria for evaluating a complaint and assigning a priority for investigation.

2.1.3 Review of state licensing laws for residential care and assisted living facilities.

We reviewed several reports that summarized state licensing laws, those that focused on particular aspects of licensure regulations, such as staff training requirements, and those that provided comparative information about nursing home and RCF supply. These included:

- Carlson, E (2005). *Critical issues in assisted living: Who’s in, who’s out, and who’s providing care*. Los Angeles, CA: National Senior Citizens Law Center.
- Harrington, C, Carrillo, H & Mercado-Scott (2005). *Nursing facilities, staffing, residents, and facility deficiencies, 1998 through 2004*. San Francisco, CA: University of California, Department of Social and Behavioral Sciences.
- Mollica, R & Jenkins, R (2002). *State assisted living practices and options: A guide for state policy makers*. Princeton, NJ: Robert Wood Johnson Foundation (<http://rwjf.org>).
- Mollica, R (2005). *Residential care and assisted living: State oversight practices and state information available to consumers*. Portland, ME: National Academy for State Health Policy.
- Mollica, R., & Johnson-Lamarche, H. (2005). *Residential care and assisted living compendium 2004*. Washington, DC: Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation. Also shown as Mollica, R., Johnson-Lamarche, H. & O’Keeffe, J. (2005). *Residential care and assisted living compendium 2004*. Research Triangle Park, NC: Research Triangle Institute.
- Pozer, K (2006). *Assisted living state regulatory review 2006*. Washington, DC: National Center for Assisted Living (www.ncal.org).
- Pozer, K (2007). *Assisted living state regulatory review 2007*. Washington, DC: National Center for Assisted Living (www.ncal.org).

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- Spillman, BC, Liu, K, McGalliard, C (2002). *Trends in residential long-term care: Use of nursing homes and assisted living and characteristics of facilities and residents*. Report to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Washington, DC: Urban Institute.

We also reviewed reports on the role of regulations or laws governing APS in the States, state mandatory reporting laws, state requirements on criminal background checks for staff of RCFs, and APS abuse registries. These reports included:

- American Prosecutors Research Institute. (2003). *Fifty-one experiments in combating elder abuse: A survey of state criminal laws relating to elder abuse and mandatory reporting*. Produced under Grant No. 98-LS-VX-0002 from the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice.
- Steigel, L & Kelm, E (2007a). *Reporting requirements: Provisions and citations in adult protective services laws by state* (as of 12.31.06). Washington, DC: American Bar Association Commission on Law and Aging.
- Steigel, L & Kelm, E (2007b). *Explanation of the reporting and referrals to law enforcement chart series* (as of 12.31.06). Washington, DC: American Bar Association Commission on Law and Aging.
- Steigel, L & Kelm, E (2007c). *Abuse registries: Comparison chart of provisions in adult protective services laws, with citations by state* (as of 12.31.06). Washington, DC: American Bar Association Commission on Law and Aging.
- Steigel, L & Kelm, E (2007d). *Explanation of the “abuse registries: Comparison chart of provisions in adult protective services laws, with citations by state” chart* (as of 12.31.06). Washington, DC: American Bar Association Commission on Law and Aging.
- Steigel, L & Kelm, E (2007e). *Information about laws Related to Elder Abuse (Laws current as of 12.31.06)*. Washington, DC: American Bar Association Commission on Law and Aging.
- Teaster, P., Dugar, T. A., Mendiondo, M., Abner, E., Cecil, K., & Otto, J. M. (2006). *The 2004 survey of state adult protective services: Abuse of adults 60 years of age and older*. National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association.

In addition, we reviewed available information on the LTCOP in the states, including:

- Aravanis, S., & Stack, S. (2007). *2005 survey of state units on aging: Utilization of elder abuse prevention funding under Title VII, Chapter 3 of the Older Americans Act*. Washington, DC: National Association of State Units on Aging.

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- National Association of State Units on Aging (2004). *2003 Survey of state unit on aging elder rights system development activities: Progress in elder rights*. Washington DC: National Center on Elder Abuse.
- National Ombudsman Reporting System, Administration on Aging, data from 2004. Downloaded from http://www.aoa.gov/prof/aoaprogram/elder_rights/LTCombudsman/National_and_State_Data/2004nors/2004nors.asp

Finally, we reviewed data from all states that reported cases or complaints of elder abuse and neglect in RCFs in order to understand the nature of the problems experienced by frail elders. These activities and the data search and collection activities we pursued are described at greater length in Section 3.

Ombudsman focus groups:

- 22 ombudsmen - from
- 15 states & District of Columbia

2.2 National Focus Groups

As part of this study, we also conducted two focus group interviews with state and local ombudsmen who were active in residential care facilities.

Qualitative social research attempts to gather data from the perspective of those being studied. Focus groups provide information generated in a natural environment and are particularly useful in exploring domains of meaning and social norms within a specified community or group of people with shared experiences (Krueger & Casey, 1994). Focus groups produce qualitative data that provide insights into the attitudes, perceptions and opinions of participants. These results are solicited through open-ended questions and a procedure in which respondents are able to choose the manner in which they respond and also from observations of those respondents in a group discussion. The focus group presents a more natural environment than that of an individual interview because participants are influencing and influenced by others -- just as they are in real life (Krueger & Casey, 1994; Miles & Huberman, 1994; Morgan, 1993).

Because of the nature of the information we were attempting to collect and because we wanted ombudsmen's opinions to be placed within the context of their experience, we concluded that a formative, qualitative approach was called for. Thus, the focus group method, one well-known qualitative approach to collecting data, seemed best suited to our analytic needs.

Our goal was to learn about ombudsmen's roles, responsibilities, experiences and opinions about investigating and preventing abuse in RCFs and their views about what worked well and what worked poorly in their states, including interactions with the licensing agency, APS, and law enforcement. They were also asked to identify any practices or programs they viewed as particularly innovative and effective, essentially "smart practices" that they felt might be useful in other states.

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The focus groups were organized at a national conference attended by ombudsmen from around the country. The NCCNHR⁵ conference was held on October 21 and 22 of 2006. A total of 22 participants were drawn from 15 states and the District of Columbia, including Arizona, California, Colorado, Delaware, District of Columbia, Georgia, Hawaii, Illinois, Kentucky, Nevada, New Mexico, North Carolina, Ohio, Texas, Washington, and Wisconsin.

Ombudsmen were provided a nominal gift of \$25 for participating, and a meal was served before the start of each of the two focus group sessions, which lasted two hours.

2.3 Selection of Study States

As noted, in addition to collecting and reviewing existing national data, we selected seven states for more intensive, on-site data collection through individual and focus group interviews. A key project task was to select the study states. Our project officer at the National Institute of Justice (NIJ) and the project's Technical Expert Panel (TEP) recommended that we consider states thought to be doing a good job of detecting, investigating, resolving and preventing abuse in RCFs and some states thought to be experiencing problems. (Members of the TEP are shown in Exhibit 2.1.) Further, they recommended giving preference to states in the former category, since one of our primary study objectives was to identify "smart practices."

The rationale for selecting states with a reputation for good performance and those with features thought to be problematic was that both types of states had something to teach us about how states are performing and how performance might be improved.

2.3.1 Potential Agency Performance Indicators

Selecting indicators that would likely distinguish between states with "good performance" and those with poor performance or problematic features was a complex undertaking for several reasons. They include:

- First, there are multiple agencies involved in detecting, investigating, resolving and preventing elder abuse. At a minimum, they include the state agency that license RCFs, the long-term care ombudsman program, and Adult Protective Services (APS). Moreover, we were interested in how these agencies interacted with law enforcement. Thus, we hoped to identify meaningful indicators of overall state performance for a wide variety of agencies in selecting study states.
- Second, there have been few evaluations that empirically assessed the effectiveness of individual features of state regulatory systems, particularly with respect to residential care facilities. The same is true with respect to the performance of APS and the

⁵ Formerly the National Citizens Coalition for Nursing Home Reform, NCCNHR has broadened its focus to include residential care/assisted living and is starting to include home and community-based care services, such as home health. NCCNHR also includes the AoA-funded National Long-Term Care Ombudsman Resource Center, which is jointly operated with the National Association of State Units on Aging (NASUA).

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LTCOPs in residential care. As a result, we had to rely on expert opinion to identify what were thought to be effective and ineffective features of the systems.

- Third, we were hampered by a lack of available secondary data on many of the aspects of state agency performance thought to be indicative of good or poor performance.

Exhibit 2.1. Project Technical Expert Panel (TEP)	
Member	Position/Experience in 2006
William Benson	Vice President for Public Policy, National Adult Protective Services Association (NAPSA); member of the board of the National Citizens Coalition for Nursing Home Reform (NCCNHR); former head of the Administration on Aging (AoA)
Eric Carlson	An attorney specializing in LTC issues for the National Senior Citizens Law Center, he authored a recent review of state assisted living regulations
Meredith Cote	Oregon State Long-Term Care Ombudsman
Rick Harris	Director, Bureau of Health Provider Services, Alabama Department of Public Health; member of the Assisted Living Workgroup representing the Association of Health Facility Survey Agencies (AHFSA)
Naomi Karp	Senior Policy Advisor focusing on elder abuse, guardianship, and other legal rights of vulnerable older persons at the AARP Public Policy Institute
William Lamb	Chair of the Board, Friends of Residents in Long-Term Care; University of North Carolina at Chapel Hill, Center on Aging
Karen Love	Founder and Chair, Consumer Consortium on Assisted Living
Paula Mixon	A consultant in private practice, she was in APS for > 25 years, including as Division Administrator for APS Strategic Planning and Program Support in the Texas Department of Protective and Regulatory Services.
Robert Mollica	Senior Program Director, National Academy for State Health Policy; he and colleagues have published summaries of state assisted living regulations every 2 years
Carolynne Stevens	Former Director of Licensing Programs, Virginia Department of Social Services; board member of the National Association of Regulatory Agencies (NARA)
Jane Tilly	Director, Quality care Advocacy and co-director of the Campaign for Quality Residential Care., Alzheimer's Association
Randolph W. Thomas	Consultant to law enforcement agencies on investigating and prosecuting elder abuse cases; President-Elect, National Committee for the Prevention of Elder Abuse

- Fourth, even when secondary data were available, data from different sources often presented a conflicting response to the same question, such as licensure requirements for staffing levels and staff training requirements (Carlson, 2005; Mollica & Johnson-Lamarche, 2005). Such discrepancies can be caused by many factors: (a) regulations may change over the period of a few months; (b) respondents may differ from survey to survey and have different knowledge or interpretation of the regulations, and (c) many states have different requirements for various types of RCFs (e.g., for small RCFs, for larger RCFs, for RCFs specializing in dementia care, and for RCFs operating under a Medicaid waiver). Similarly Stiegel and Kelm (2007b) noted that their analysis of state mandatory reporting for APS was based on state APS regulations. Different answers might emerge if one focused on APS policies and memoranda of understanding (MOU) with other agencies, rather than state laws.

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Moreover, some states had multiple reporting laws for elder protective services and APS, while other states had more than one APS law.

Our expectation was that characteristics of licensing agencies might affect the ability of those agencies to detect and investigate allegations/complaints of elder abuse. Further, focused on the overall nature of the regulatory system – the standards (e.g., whether licensure was required, the nature of staffing and staff training requirements), the complaint intake process, the inspection or survey process, and the enforcement remedies. We expected that all of these features might affect the “quality” in facilities and the likelihood of abuse.

Unfortunately, there have been few studies that assessed the effectiveness of regulatory processes in terms of state agencies that license residential care facilities. One prior study found that more extensive regulatory systems were associated with better facility performance on a variety of quality indicators (Hawes et al., 1995; Wildfire et al., 1997). However, this study examined the performance of overall systems, including licensing standards, inspection or monitoring processes, and enforcement remedies. Thus, there was no way to determine which elements of the more extensive systems had the greatest impact the quality indicators. Despite this, we recognized that all of the most extensive regulatory systems had the following common features: they required licensure for all facilities, had unannounced, annual inspections, and had and used a range of sanctions if facilities violated standards. Thus, while these were not definitive characteristics of effective regulatory systems, the findings did suggest that these might be important features. Other studies we relied on addressed comparable processes in nursing home regulation, including a study of the Nurse Aide Registries, that assessed how states detected, investigated, and resolved allegations of elder abuse, neglect and exploitation in nursing homes (Hawes, Blevins & Shanley, 2001). Finally, we relied on the expert opinion of the TEP members.

We also recognized that the characteristics of APS and the LTCOP were likely to have a significant impact on detection, investigation, and resolution of elder abuse and neglect cases in residential care. Thus, we also collected available data about these programs.

The criteria we considered included having a mix of states, with one or more of the following characteristics that we thought might affect the effectiveness of their elder mistreatment reporting and prevention activities:

- States that made aggressive use of residential care, that is, high use relative to nursing homes for frail elderly persons. *Rationale:* states with higher use are likely to have an RCF resident population that is more physically and cognitively impaired and thus at greater risk for abuse and neglect.
- States that had a significant number of unlicensed homes. *Rationale:* there are often variations in and even questions about who handles complaints about abuse in unlicensed homes, compared to licensed facilities; states with a large number of unlicensed homes may need different policies and practices to protect residents. *Indicator:* self-report and states without any state supplement for residents who have only Supplemental Security Income (SSI).

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- States with processes thought to be effective (based on prior studies in nursing homes of abuse reporting and complaint investigations systems and on TEP opinion)
 - Standards – state has mandatory elder abuse reporting law and, ideally, specifically includes RCFs; law specifies multiple reporters and has penalties for non-reporting; licensure agency has relevant regulations addressing such issues as:
 - Residents’ rights
 - Requirement that facilities post in a prominent place the toll-free abuse reporting hot-line
 - Grievance procedures specified in regulations
 - Appropriate staffing levels required by regulations – in terms of workload for direct care staff and in terms of supervision
 - Adequate staff training required by regulations – in terms of topics and hours
 - Special staffing and training requirements for dementia care
 - Detection of abuse, neglect
 - Outreach – state agency makes an effort to inform residents and families of their rights and of procedures for making allegations or complaints; state has clearly identified point of entry for complaints about abuse;
 - Intake – state agency accepts telephone complaints/allegations; accept anonymous complaints; have toll-free hot-lines for reporting; have 24 hour-a-day and 7-days a week manned hotlines; use professional, trained staff to perform key intake functions;
 - Appropriate triage criteria – agencies have and use appropriate formal criteria for identifying complaints or allegations that should be investigated immediately and those that can be placed on a slightly slower “time-track;”
 - Efficient complaint tracking system – state agency can track progress of the complaint from intake to resolution AND can compile data in ways that facilitate monitoring and improvement of their processes;
 - Frequent on-site, unannounced inspections/surveys by the licensing agency
 - Surveys/inspections include observation and interaction with residents rather than paper compliance
 - Abuse & Neglect Complaint Investigations
 - Timely responses to complaint allegations – agencies respond in a timely way in intake, investigations, resolution, and communication with families; this is particularly critical in terms of the start and conclusion of the investigation after intake;
 - Dedicated, qualified complaint staff for intake and investigations- agency has staff dedicated only to abuse complaint investigations; staff are trained for intake (questions to ask; triage criteria; referrals needed) or investigations (investigative techniques; interviewing frail elders; methods for addressing complaints involving residents with cognitive loss or communication deficits);
 - Quality control and monitoring mechanisms for the complaint process – agencies have systematic ways to monitor their complaint processes and identify elements working well and those that work poorly;

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- Adequate resources, both fiscal and staff – agencies have sufficient staff (investigators, support staff to file reports, attorneys) to perform key functions; this includes adequate resources for staff training;
 - Resolution
 - Effective coordination - between the licensing agency and other agencies involved in complaint investigation activities (i.e., APS, LTCOP) and with law enforcement and prosecutors;
 - Victim assistance programs
 - Other
 - High level of involvement of the ombudsman program in RCFs;
 - Proactive approaches for analyzing the causes or contributing factors to elder abuse – agencies are actively involved in identifying causes and developing and implementing targeted prevention activities;
 - Proactive approaches for educating mandatory reporters about their responsibility and for addressing any barriers to reporting.
- We also identified processes thought to be ineffective, such as:
- *No outreach/consumer education and ineffective intake processes* – for example, no toll-free hotline; no “manned” hotline 24 hours/7 days a week; inadequate numbers of intake staff;
 - *No mandatory reporting*;
 - *Poor coordination, overlapping responsibility, or gaps in responsibilities* – between licensing, APS and the ombudsman program;
 - *Poor coordination with law enforcement*;

In addition, we were interested in states in which there was high use of residential care facilities for mixed populations of elders and persons with persistent and severe mental illness and intellectual disabilities. *Rationale*: caring for mixed populations is a very complex challenge for providers and staff, and the presence of residents with potentially challenging or aggressive behaviors is likely to increase the risk of abuse of other residents and of abuse by staff of these residents.

As one might expect, we were not be able to secure information on all of these features of state systems prior to state selection; however, we collected all data possible from secondary sources and from our telephone interviews. However, between our review of secondary data and our primary data collection, we did amass a substantial amount of relevant information. One finding was that some of the sources covered the same topics but were not always in agreement. In part this was because of the variety of laws, agencies, and types of RCFs involved. In addition, as we discovered, state policy and practice is often fluid from year to year (and state budget to state budget). Thus, data that were accurate in 2004 may have changed by 2006 and changed again by the time we conducted our site visits.

2.3.2 Rating Study States

Our second step in this process of study state selection involved examining methods of ranking states in order to select states that have implemented what appear to be good practices

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and those with processes or systems thought to be less effective. The goal is both to identify innovative practices and, in states with less effective systems, potential barriers to more widespread implementation of what appear to be best or “better” practices. There are various formal models that use “attribute sets” to rank states or organizations’ performance against policy goals (e.g., Beynon & Kitchener, 2005). In this case, the policy goals involve identifying what are thought to be effective detection, investigation, resolution, and prevention policies related to elder abuse in residential care facilities (RCFs). However, we concluded that there were several reasons for abandoning these formal methods for ranking all 50 states and the District of Columbia and then selecting a small number of study states. First, we were limited to use of existing data on state systems. Our preliminary investigation demonstrated that there was too much missing data available from secondary sources to allow effective use of these formal ranking techniques. Second, our goal in the case studies was to explore the actual functioning of the state systems, not merely the appearance on paper of the features of state systems. Thus, we wanted to select some states that appear to have good elements or good systems and some with what appear to be less desirable systems. This does not require a formal ranking of all 50 states and the District of Columbia. Thus, we opted for a less formal process, using the advice of experts in the field – our TEP members. The TEP provided thoughtful feedback and argued that we should visit a mix of states – those with what we believed were good practices and some with potential problems.

2.4 State Case Studies

Many states were candidates, using the criteria discussed above. Many, even those with what we regarded as potential deficits, also were thought to have both interesting features and often one or more of what appeared to be “smart practices.” (*Indeed, this turned out to be true. We discovered “smart practices” in each of our study states that are worthy of consideration by other states.*)

2.4.1 Study States

We considered fifteen states as potential study states, as shown in Exhibit 2.2. Thirteen of the states were nominated by project staff and our NIJ project officer. An additional two states were suggested by members of the TEP. From those, we selected seven study states for site visits with in-person interviews. Those states were:

- Alabama
- California
- Maine
- North Carolina
- New Mexico
- Pennsylvania (*later excluded*)
- Texas

In Exhibit 2.2, we provide a brief overview of the features we considered in selecting the study states. We should note that at the time of the site visits, Pennsylvania was in the middle of significant legislative and administrative activity around the issue of licensure and regulation of residential care facilities. As a result, we conducted abbreviated interviews with only a few respondents in Pennsylvania. Thus, we effectively have only six study states.

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Exhibit 2.2. Study State Selection				
SUMMARY OF TEP VOTES for STATES, RATIONALE, & FINAL SELECTION (shaded)				
TEP votes	State*	NF beds	RCF beds**	Rationale
7	Texas	110,049	42,245	Some reported good practices but no SSI supplement and reports of many unlicensed homes; has > 1100 licensed RCFs; limited requirements for staffing, staff training and for dementia care in RCFs
6	California	120,460	154,830	Licensed by community care not health dept.; high use of RCFs; inspections conducted every 5 years; ombudsmen first responders
6	Pennsylvania	85,203	76,385	Relatively high use of RCFs; coroner/ME expresses concern over mistreatment deaths in RCFs in PA; recent newspaper stories and reports suggest significant quality problems; new regulations being considered
5	North Carolina	40,839	39,942	Apparently good practices, including monthly visits by county DSS B&C specialist; high ombudsman involvement; very impaired resident population; high use for MI/ID; recent spate of deaths in RCFs
5	Alabama	22,923	9,876	New licensure standards and inspections, with very interesting model for quality assurance and consumer information; no state SSI supplement which may contribute to large #s of unlicensed homes; hot-line not manned 23/7.
5	New Mexico	5,910	Not reported 346 RCFs	Some apparently good practices, including high ombudsman involvement; hot-line manned 24/7 by forwarding to cell phone of on-duty staff; State ME involved in investigating facility deaths/elder abuse
5	Virginia	28,349	34,598	Difficulties associated with placement of former prisoners and forensic MH clients in RCFs and concerns about aggression and violence against residents; high use of RCF
4	Washington	21,785	24,498	Lic. agency considering new standards; resident assessment; high ombudsmen involvement; model systems in NFs for outreach, detection, investigations, resolution and prevention; may carry over to RCFs
4	Colorado	18,955	13,799	No mandatory reporting; no toll-free hotline and no 24/7; poor intake/confusing questions; no special standards for staffing of dementia-specific RCFs; no state supplement
4	Maine	47,581	9,022	Apparently good practices in licensure standards; proactive agency on quality improvement; very impaired population; small number of RCFs but mixed population; high use of Medicaid to pay for personal-care services; toll-free hotline manned with 24/7; Elder Death Review Team.
4	Wisconsin	38,718	27,375	High use of RCFs; many poor practices from a state that usually has good practices, including hot-line not manned 24/7; no special requirements for staffing in dementia units/facilities; limited ombudsman involvement.
3	Oregon	12,227	21,092	Leader in use of Medicaid for RCFs; aggressive use; varying views of reg. system but explicit regulations for all RCFs, including additional standards for training and staffing for dementia care RCFs/units
2	Indiana	93,060	11,767	Relatively low use relative to NFs; several seemingly good practices, including APS abuse registry; high ombudsman involvement
<p>OTHER STATES -- suggested by TEP members: 1 for Illinois; 1 for Florida: because of different levels of care offered and allowing high levels of impairment among residents</p> <p>* Grayscale shading indicates a study state</p> <p>**Data on number of facility beds are from 2004/2005 – from Mollica & Johnson-Lamarche, 2005 and Harrington et al., 2005.</p>				

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2.4.2 The Interviews – Focus of the Site Visits

In the study states, we conducted interviews with the following:

- 1.5 hour interview with Licensure agency administrator (the administrator of the agency that licensed residential care/assisted living facilities and, often, other administrative staff, such as the head of the intake unit or the supervisor of the complaint investigators) *(except in one state in which the administrator did not show up for the appointment and did not return subsequent telephone calls)*
- | Exhibit 2.3 Study Participants | |
|---|---------------|
| <i>Type of Participant</i> | <i>Number</i> |
| State LTC Ombudsman | 6 |
| Local/regional ombudsmen from study states | 49 |
| <i>Ombudsmen from 15 states & DC– national focus groups</i> | 22 |
| Licensing agency administrative staff | 19 |
| Licensing agency surveyors/complaint investigators | 37 |
| Adult Protective Service agency administrators | 9 |
| APS caseworkers | 24 |
| Other (State AG staff in Medicaid Fraud Control Units, other law enforcement, consumer advocates) | 18 |
| Total | 184 |
- 2-hour focus group with the field staff who conduct the complaint investigations
 - 1.5 hour interview with the APS agency administrator (the administrator of the agency that investigated allegations of abuse, neglect, and exploitation in RCFs, and, often, other administrative staff, such as the head of the intake unit or the direct supervisor of the complaint investigators) *(except in California-where we were told most APS activities were funded and administered at the county level)*
 - 2-hour focus group with the field staff who conduct the complaint investigations
 - 1.5 hour interview with the State LTC Ombudsman
 - 2-hour focus group with the local or regional ombudsmen
 - In some states, interviews with staff of the State Attorney General (e.g., the section chief for Healthcare Fraud/Medicaid Fraud Control unit (MFCU) and usually the chief investigator) in those states in which the MFCU also took responsibility for prosecuting elder abuse in residential care settings
 - In some states, interviews with consumer advocacy groups, law enforcement personnel, and staff of special state initiatives, such as a state-wide Elder Death Review Team that addressed elder abuse in RCFs.

Overall, we interviewed 184 stakeholders, as shown in Exhibit 2.3.

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Participation Rates. In general, we had excellent participation. People agreed to be interviewed or to participate in a focus group. In some states, there was initial reluctance, probably associated more with an overwhelming workload than with any aversion to the study. Only one agency administrator scheduled an interview and did not appear for the interview or respond to subsequent telephone calls. However, in one state, we did have difficulty securing participation because the state was in the middle of a series of hearings and proposals for new standards and processes as a proximate result of a tragic resident death and a grand jury report on the death that sharply criticized the state’s regulatory processes. Further, there had been newspaper stories and other reports of serious instances of abuse and neglect and criticism of the regulatory failures that allowed the conditions to exist (e.g., Dilanian, 2007). As a result, many of the individuals we hoped to interview individually or in focus groups were involved in activities related to hearings and regulatory overall. Thus, we were concluded that it was not a good time to try to schedule interviews because of the on-going activity which was likely to alter the existing system.

Focus of the Interviews. Our intent for the case studies was to focus on the state agencies that license RCFs, APS, and the LTC ombudsman program. For each of these, we sought to accomplish the following:

- To describe and assess the processes for detecting and investigating abuse of RCF residents;
- To describe how such cases of elder abuse are resolved/addressed;
- To identify any practices aimed at preventing abuse of residents.

In our examination, we included processes for outreach, intake of complaints or allegations, investigation of complaints, resolution of substantiated cases, as well as formal and informal links and coordination among the agencies and with the law enforcement community.

In addition, we sought to achieve the following:

- To describe the role of law enforcement in investigating and prosecuting cases.
- To determine whether there was underreporting and, if so, the reasons and potential solutions, particularly from the point of view of mandatory reporters.
- To identify and describe what appear to be “smart practices” and the feasibility of their implementation in other states.

Copies of the recruitment materials, informed consent documents, interview guides for administrators, and moderator guides for the focus groups appear in Appendices A, B, and C.

Thematic Analysis. Our focus in the analysis of the individual and focus group interviews was on identifying major themes raised by the respondents – and on any “outlier” opinions. In addition, we asked all respondents to identify “smart practices” their agency or state employed in regulating RCFs and for detecting, investigating and resolving cases of elder abuse and neglect.

Section 3. The Nature of Abuse in Residential Care

The widespread perception is that there is little abuse or neglect in residential care and assisted living facilities. However, this view is typically limited to the newer facilities that were specifically constructed with assisted living in mind, often referred to as “purpose built.” Such facilities tend to offer private accommodations, either in an apartment or a room with an attached bath and to be operated on a largely private-pay basis. The assumption is that such facilities attract residents who have sufficient funds to select a facility that meets their needs and preferences and that such residents would be able to move if a facility offered poor care, much less neglected them, or allowed abusive conditions to exist. In addition, as one state regulator noted, people often (mistakenly) assume that assisted living residents are the “canasta set,”⁶ that is, people who need social interaction, meals and medication reminders but are otherwise physically and cognitively intact and able to assert their rights and resist or report abuse.

“There is no recognition that elder abuse even exists.... We are where domestic violence was 20 years ago.”

APS caseworker

Unfortunately, this is not a realistic picture of either the assisted living/residential care industry or of the residents. Several research studies have shown that there is considerable variability in the industry in ownership, size, accommodations, services, staffing, and price. Facilities range from “high-end” assisted living that offers private accommodations and a wide array of supportive services, including nursing care and supervision, to facilities with rooms shared by several residents, few if any services, with supervision by a high school graduate, and a dilapidated physical plant (Carlson, 2005; Curtis et al., 2005; Hawes, Phillips & Rose, 2000; Hawes et al., 2003; Hedrick et al., 2003; Mollica and Johnson-Lamarche, 2005; Zimmerman et al., 2003). In addition, the mix of residents is complex, ranging from residents who are fairly intact and need few services to residents with Alzheimer’s disease or other dementias, to residents with significant physical limitations to residents with intellectual disabilities or persistent and severe mental illness (Aud & Rantz, 2005; Ball et al., 2004; Beattie, Song & LaGore, 2005; Curtis et al., 2005; Gruber-Baldini et al., 2004; Hawes et al., 1995; Hawes, Phillips & Rose, 2000; Hedrick et al., 2003; Wood & Stephens, 2003; Zimmerman et al., 2003). Indeed, research shows conclusively that many residents of assisted living and other residential care facilities have significant risk factors for being abused.

3.1 Risk Factors for Elder Abuse

Prior research among community-dwelling elderly and, to a lesser extent, among residents of nursing facilities has demonstrated that there are known risk factors for abuse. Several studies have examined the characteristics of individuals living in community settings (e.g., their own

⁶ The authors often note that some people believe that assisted living residents are like the title character in the movie “Driving Miss Daisy,” someone who needs help with housekeeping, meal preparation, and transportation but is otherwise physically and cognitively intact.

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home or that of others) in an attempt to identify factors that place an older person at greater risk for being abused or neglected. Such studies found that persons suffering abuse or neglect were more likely to be older, nonwhite, and to have greater limitations in physical and cognitive functioning, although there has been some disagreement about whether functional impairment in the activities of daily living (ADLs) is a risk factor for abuse (Bristowe and Collins, 1989; Wolinsky & Johnson, 1991; Lachs et al., 1994; Lachs et al., 1996, 1997; Pillemer & Finkelhor, 1988; Podnieks, 1992). However, there is strong evidence that the presence of cognitive impairment is associated with higher risk for being abused (Coyne et al., 1993; Dyer et al., 2000; Homer & Gilleard, 1990; O'Malley et al., 1983; Pavesa et al., 1992; Pillemer & Finkelhor, 1988; Pillemer & Suito, 1992; Wolf & Pillemer, 1989).

Studies of individual risk factors for elderly people living in residential long-term care facilities are more limited but generally suggest the existence of similar risk factors for individual residents. For example, Burgess and her colleagues (2000) argued, “The risk for abuse increases simply as a function of their dependence on staff for safety,

There is widespread agreement, based on research, that residents with cognitive impairment and challenging behaviors are at higher risk for being abused.

protection, and care” (Burgess, Dowdell & Prentky, 2000, p. 12). They found that a diagnosis of Alzheimer’s or other dementia or some type of memory loss or confusion was present at a higher rate among nursing home residents who had been sexually abused than among cognitively intact nursing home residents, although those data were from a small case study (Burgess, Dowdell & Prentky, 2000). The findings from other studies suggest that residents with behavioral symptoms, such as wandering, verbal or physical aggression, or resisting care, appear to be at higher risk for physical abuse by facility staff (Pillemer & Bachman-Prehn, 1991; Shinoda-Tagawa et al., 2004), a finding supported in another study that included focus group interviews with CNAs (Hawes et al., 2001) and studies of precipitating factors among community-dwelling elders who have been abused (Pillemer & Suito, 1992).

These findings on risk factors, combined with data on the characteristics of residents suggest that many residents of residential care and assisted living facilities are at significant risk for abuse.

- A study of national probability sample of residents in assisted living facilities (ALFs) that offered high services or high privacy – or both⁷ - found that an estimated 27% of residents had moderate to severe cognitive impairment and 21% received help with ADLs (Hawes et al., 2003).

Other studies, including those conducted in a few states or in one state have found much higher rates of functional limitations, particularly when the full array of residential care and assisted living facilities are included (not simply the “high end” facilities). For example:

⁷ High privacy ALFs offered private rooms or apartments in > 80% of their units. High service ALFs offered a range of supportive services, from medication administration to assistance with such ADLs as bathing and dressing and nursing services by an RN on staff full-time (Hawes et al., 2003).

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- A 1999 study of Maine’s residential care/assisted living residents found that 42% had a psychiatric diagnosis; 44% had moderate to severe cognitive impairment; and 52% received help with ADLs. By 2005, the level of resident acuity had increased dramatically; 84% of the residents had some type of cognitive impairment, such as short-term memory loss, a third (33.1%) exhibited some type of challenging behavior, from wandering to resisting ADL assistance (personal communication from Julie Fralich and Cathy McGuire, University of Southern Maine on 6/19/2006).
- In a cross-sectional study of a random sample of AL facilities in central Maryland (The Maryland Assisted Living Study), geriatric psychiatrists evaluated 198 participants and assigned dementia diagnoses to 134 residents (67.7%) (Maust et al., 2006).
- In a four-state study (Florida, Maryland, New Jersey, North Carolina), researchers examined a probability sample of 2,078 RC/AL residents aged 65 and older. Approximately one-third (34%) of RC/AL residents exhibited one or more behavioral symptoms at least once a week (Gruber-Baldini et al., 2004).
- Three studies examined residents discharged/transferred from assisted living/residential care facilities to nursing homes and found high prevalence of dementia and depression among the residents, although the studies disagreed about whether neuropsychiatric symptoms were predictive of such transfers (Aud and Rantz, 2005; Dobbs et al., 2006; Rosenberg et al., 2006).
- All of the multi-state studies have found that moderate to severe cognitive impairment, usually associated with Alzheimer’s disease, is the most common serious chronic condition and affects between 25% and 40% of the resident population (Hawes et al., 1995; Wildfire et al., 1997; Hawes et al., 2000; Hawes et al., 2004; Spillman et al., 2002; Sloane, 2003). Some state studies have found significantly higher percentages of residents with cognitive impairment (Fralich & McGuire, 2006; Hawes et al., 1995b; Maust et al., 2006). Moreover, research suggests the proportion of residents with Alzheimer’s disease or other dementias may be higher, since these studies found that a significant percentage of assisted living residents with cognitive impairment were under-diagnosed (Magsi and Malloy, 2005; Rosenblatt et al. 2004).
- An additional factor that places RCF residents at risk for abuse and neglect is that they experience considerable social isolation. Several studies found that 83 to 85% were unmarried, and one-quarter of the residents had no living children (Fralich et al., 1997; Hawes et al., 1995a, b, c; Hawes et al., 2000). In one study conducted in the mid-1990s, the research found that one-third of 3,200 residents in 10 states reported they had not left the facility in the preceding 14 days; 19% reported no visits with family or friends in the preceding 30 days; and 24% had visited with friends or family only one or two times in the preceding 30 days (Hawes et al., 1995b). Similarly, in a 1998 survey of a national

Many residents of RCFs and ALFs have characteristics that place them at risk for being abused, including cognitive impairment, physical frailty, and social isolation.

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probability sample of residents in assisted living facilities that offered high services or high privacy, 9% reported no visit with family or friends in last 30 days, and 27% had visited with friends or family only once or twice in the last 30 days (Hawes et al., 2000). Thus, many residents lacked close family or friends who could be their advocates.

- Finally, as noted previously, several studies have found that RCF residents have significant chronic disease and that they are often misdiagnosed or “under-treated,” and experience significant levels of medication errors (U.S. GAO, 1999; Gray et al., 2006; Gruber-Baldini et al., 2004; Maust et al., 2006; McNabney et al., 2008; Sloane et al., 2003; Sloane et al., 2004). These residents may be at risk for abuse because of their level of impairment, but as importantly, they are at significant risk for neglect that may lead to premature mortality or increased morbidity.

3.2 Prior Evidence of Abuse in Residential Care

There are no resident-level estimates of elder abuse in RCFs; however, there are reasons for concern (Bonnie & Wallace, 2003; Hawes, 2003; Lachs & Pillemer, 2004).⁸ First, there is considerable evidence from research studies that the problem is persistent, serious and widespread in residential LTC settings, such as nursing homes and, in fewer studies, in RCFs (Broyles, 2000; Hawes, 2002; Kayser-Jones, 1990; Liao & Mosqueda, 2006; Monk et al., 1984; Ramsey-Klawnsnik, 2008; Special Investigations Division, 2001; Stannard, 1973; Teaster et al., 2007; U.S. GAO, 2002; US House, 1990; U.S. Senate, 1975). Similarly, Teaster and Roberto (2004) found that over a five year period, 72 percent of APS substantiated sexual abuse cases in Virginia occurred in LTC facilities (nursing homes and RCFs), compared to 28 percent in the community. Second, Long Term Care Ombudsmen Programs (LTCOP) respond to complaints of abuse, gross neglect, and exploitation from residents of nursing facilities and, to a more limited degree, from resident of assisted living and other types of residential care facilities. Reports from local and state ombudsmen indicate that complaints about abuse in RCFs have been common types of reported complaints in the area of complaints about residents rights, and among different types of abuse, physical abuse was the most common type reported (AoA, 2004; AoA, 2006; National Ombudsman Reporting System Data Tables 2003). This is significant since there is widespread recognition that residents and families are reluctant to report abuse, are unaware of how to make such complaints, or are unfamiliar with the ombudsman program (AoA, 2000; Bowers, Hawes & Burger, 2003; Broyles, 2000; Hawes et al. 1995a; Wood & Stephens, 2003).

Second, there is some evidence of elder abuse in RCFs and growing concerns about neglect and overall quality problems. As noted above, reports from LTC ombudsmen indicate that complaints about physical abuse of residents in RCFs were common (AoA, 2000; National Ombudsman Reporting System, 2003). In a study of a 10-state probability sample of RCF staff in one 10-state study and in one national study about whether they had engaged in a list of behaviors toward residents or seen other staff do so; these behaviors involved physical or

⁸ Unfortunately, the federal government has not collected data that includes persons living in residential LTC settings. Neither the National Center on Elder Abuse’s national incidence study nor the National Crime Victimization Surveys have collected data on residents in nursing facilities (NFs) or RCFs.

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verbal/psychological abuse (Hawes et al., 2000; Hawes et al., 1995a). In the study of a random sample of > 1,100 staff in 512 RCFs in 10 states, 15% of the staff reported witnessing other staff engage in verbal abuse (e.g., threats, cursing, yelling) or forms of punishment, such as withholding food, excessive use of physical restraints, or isolating difficult residents (Hawes et al., 1995a). The numbers were similar for the national probability sample of staff in high service or high privacy ALFs (Hawes et al., 2000). In addition, in focus groups with coroners and medical examiners (MEs) for a previous NIJ-funded project, several MEs argued that they saw more cases of elder mistreatment deaths from “board and care” homes or RCFs than from nursing homes.⁹

Third, findings on abuse are coupled with several studies of RCFs throughout the 1980s that found neglect and inadequate care, including unsafe and unsanitary conditions, widespread use of psychotropic drugs, lack of staff knowledge about medication administration, and other problems, including abuse (Avorn et al., 1989; Budden et al., 1985; U.S. GAO, 1989; U.S. House, 1989). These concerns were heightened in the 1990s because of the increasingly heavy care needs of residents and continued media reports and studies showing serious quality problems, including neglect (Bates, 1997; Spore et al., 1995; Spore et al., 1996; Spore et al., 1997; Stark et al., 1995; U.S. GAO, 1992; U.S. GAO, 1999; Wildfire et al., 1997-98).

3.3 The Types of Abuse in Found in Residential Care Facilities

For this NIJ-funded study, we collected and reviewed secondary data on the types of elder abuse cases in residential care from a number of sources. In addition, we were told about cases (without identifying details) in each of the states in which we conducted site visit/case studies. Thus, we collected fairly significant data on the nature (though again, not the prevalence) of abuse in residential care. The sources included:

- National Association of Medicaid Fraud Control Units, Written Statement before the U.S. Senate Special Committee on Aging Hearing – *Abuse of Our Elders: How Can We Stop It*. Washington, DC: July 18, 2007.
- The bimonthly Medicaid Fraud Reports/Newsletters, issued by the Office of the National Association of Medicaid Fraud Units (NAMFCU) from November/December 2005 through July/August 2008. Available at: www.namfcu.net/publications/medicaid-fraud-reports/
- A newsfeed summary, provided as a service to members of their Elder Abuse listserv, by the National Center on Elder Abuse (NCEA)
- A search of newspaper articles accessible through an online news service
- Google and Lexis-Nexus searches using the terms *personal care homes; assisted living; residential care facilities; board and care homes*; and all of these names linked with “abuse.”¹⁰

⁹ These focus groups were led by Dr. Hawes.

¹⁰ One limitation with using internet search engines to find reports is that many of the listings were produced by law firms that are reporting on cases and their ability to represent clients. We did not use these in our review.

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What these sources portrayed has been a largely ignored phenomenon, certainly not one routinely discussed or addressed in most policy-making bodies at the state or federal level – at least when it comes to residential care and assisted living. Yet as the sample of cases we present illustrate, the problem of abuse and neglect leading to injury or death in these settings is quite severe. In the cases presented below, we have mainly relied on reports from the Medicaid Fraud Control Units (the actual name varies by state) for the bulk of our reports, since they have been fully investigated, substantiated and resulted in prosecution.

The cases reported below are not intended to be representative of all cases, although they illustrate the types of abuse and neglect and of perpetrators. Moreover, they generally fit into the categories used by many researchers and the federal government to define and categorize abuse and neglect.

What is abuse?

The definitions of abuse and neglect were discussed earlier in Section 1.2.

Sexual abuse is defined as “non-consenting sexual contact of any kind” (National Center on Elder Abuse, 1995, p.1), and includes unwanted touching; sexual assault or battery, such as rape, sodomy, and coerced nudity; sexually explicit photography; and sexual contact with any person incapable of giving consent. Sexual abuse also includes “hands-off offenses” such as sexual harassment, threatening rape or molestation, forcing a victim to view pornographic materials, and exhibitionism (Ramsey-Klawnsnik, 1991, 1996).

As noted earlier, the definition of **physical abuse** involves injury or harm to a person and often includes the idea that it was carried out with the *intention* of causing suffering, pain, or impairment (Clarke and Pierson, 1999; Lachs, Berkman, Fulmer & Horowitz, 1994; Lachs and Pillemer, 1995; Tatara and Kuzmeskus, 1996-1997). The Administration on Aging, in its instructions to long-term care ombudsmen, defines abuse as “the willful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain, or mental anguish or deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness” (2009, p. 2). As noted in Section 1.2, this is generally consistent with the definition used by the Centers for Medicare & Medicaid Services (CMS) in its guidelines to the states on reporting of abuse and neglect in nursing homes, as reported below.

Physical abuse is generally thought to include hitting, slapping, pushing, or striking with objects. In nursing homes, other types of actions have been included, such as improper use of physical or chemical restraints. Physical abuse also typically includes *sexual abuse* or nonconsensual sexual involvement of any kind, from rape to unwanted touching or indecent exposure (Olshaker, Jackson & Smock, 2007).¹¹

¹¹ Clarke and Pierson (1999, p. 635) argue that examples (or possibly indicators of potential abuse and neglect) of abuse are “falls and fracture, physical or chemical restraints, malnutrition, dehydration, bed sores, defective equipment, lack of supervision, weight gain or loss, theft of money and personal property, unexpected or

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As we discussed earlier, one problem is that most definitions of abuse are inadequate for residential long-term care settings, in which physically and sexually abusive acts occur in which the resident is a perpetrator and another resident is the victim. First, many of the definitions of abuse incorporate a concept of the perpetrator as having a relationship of trust with the victim. However, much of the abuse in residential care settings involved “resident-on-resident” acts (Lachs et al., 2007). Second, cases in which a resident is the perpetrator are often not recorded as abuse or treated as such by law enforcement because the resident perpetrator may lack the mental capacity to have “*intent*,” as defined by most laws, or to have “*willfully*” harmed another. However, these incidents in which a resident is a perpetrator are a significant source of injury, psychological trauma, and sometimes death for victims, as shown in prior research on nursing homes and residential care/assisted living facilities (Bledsoe, 2006; Fallis, 2004b, d; Lachs et al., 2007; Rosen et al., 2008; Teaster et al., 2004; 2007; Townsend, 2006; Wood & Stephens, 2003). Moreover, as RCFs are increasingly housing mixed populations of frail elders with others, including paroled prisoners and persons with persistent and severe mental illness, many of the study participants expressed concern that resident-to-resident abuse in residential care facilities would increase in volume and severity.



Ruth Cecil died after wandering outside into 100-degree heat. She was found unconscious, with a body temperature of 108 degrees and burned skin peeling from one arm. (McCoy & Appleby, 2004); photo from *USA Today*.

There is somewhat less agreement about whether *verbal* or *psychosocial abuse* should be included in the general category of abuse when applied to older persons, although it is included in federal regulations governing nursing homes as a prohibited type of abuse. This is generally thought of as “intentional infliction of anguish, pain, or distress through verbal or nonverbal acts” and includes threats, harassment, and attempts to humiliate or intimidate the older person (Clarke and Pierson, 1999, p. 632).

Neglect of older persons is another area that has received increased attention in recent years. As Clarke and Pierson noted, “Definitions of neglect are probably the most disputed of any category” of maltreatment of elderly persons (Clarke and Pierson, 1999, p. 632). However, neglect can cause great physical and psychological harm, including death. In general neglect is thought of as including “the refusal or failure of a caregiver to fulfill his or her obligations or duties to an older person, including . . . providing any food, clothing, medicine, shelter, supervision, and medical care and services that a prudent person would deem essential for the well-being of another” (Clarke and Pierson, 1999). Neglect is typically thought of as the failure by the responsible caregiver to provide the goods and services needed to maintain the elder’s physical and mental health (Aravanis et al., 1992; Bonnie & Wallace, 2003; Olshaker, Jackson & Smock, 2007). The CMS definition, as applied to the nurse aide registry, is

wrongful death, unsanitary conditions, untrained or insufficient staff, over-sedation, substandard medical care, and poor personal hygiene.”

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“failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.”

In the case studies we conducted and our review of substantiated complaints and Medicaid Fraud Reports, we found sexual abuse, physical abuse, psychological abuse, and neglect leading to severe injury or death. We also have a category of financial exploitation. Finally, we report on the special case of the mistreatment of elders and vulnerable adults in unlicensed residential care facilities.

3.3.1 SEXUAL ABUSE

The cases varied in terms of the types of sexual abuse and in terms of the relationship of the perpetrator to the victim. In some cases, we know the outcome in terms of what happened to the perpetrator, but there was seldom any information about the effect on the victim.

- In Washington State, a caregiver at a residential facility was found guilty of Indecent Liberties and Kidnapping in the Second Degree. The defendant took the victim to a vacant room in the facility and had sexual relations with the victim. The case was ultimately solved based upon DNA evidence recovered from the victim that matched the defendant’s DNA. He was sentenced to 48 months in prison and ordered to make restitution in the amount of \$6,375. This sentence was “exceptional” because of the victim’s vulnerability and the status of the defendant as a caregiver. (*National Association of Medicaid Fraud Control Units [NAMFCU] Written Statement, 2007*)
- A staff person in a Virginia residential care facility was convicted of sexually abusing a disabled resident after management had ignored previous complaints about the employee (Fallis, 2004c).
- According to law enforcement authorities, a 74-year old resident died complications as a result of being raped in 2004 by a live-in handyman in an assisted living home outside Pittsburgh (Dilanian, 2007).
- A male nurse at a group home made inappropriate sexual comments to a resident, kissed, and used offensive language in front of the resident and other staff members. (NAMFCU, 2004).
- In New York., a grand jury in September indicted an assisted living employee for attempted sexual abuse of a resident while he worked at an assisted living facilities specializing in dementia care. He was convicted on four criminal charges and sentenced to 15 years in prison. The facility agreed to pay a \$75,000 fine for failing to report the incident (Appleby, 2004).
- Over a few days, neighbor of a residential care home noticed some of the elderly women residents crying on the front porch or in the yard. One appeared to be trying to hide in the bushes. The neighbor called the ombudsman, who came to the facility and discovered that one of the male residents had raped four of the female residents. Staff had witnessed the assaults but not reported them. The ombudsmen arranged for the women to be taken to the hospital for exams and, if needed, treatment. The police were called and took the perpetrator into

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custody. The police then escorted the male resident to a homeless shelter, arguing that he was demented and did not have “criminal intent.” (*Ombudsman focus group 10/21/2006*)

- Staff of a residential care facility suspected that an 83-year old resident who was cognitively impaired was being sexually abused based on some skin tears and what appeared to be semen on her underclothing and bedding. The staff became more watchful and discovered the resident’s son in bed with his mother starting to disrobe her. (*Interview with a complaint investigator for the licensing agency*)
- During a four-month, an 84-year-old male resident, who suffered from dementia, sexually and physically assaulted five elderly women at an assisted living center, a state health department investigation concluded. Workers caught him time and time again in the rooms and beds of female residents, sometimes dressed, sometimes not. One aide saw him rubbing an elderly woman through her adult diaper, another caught him on top of a resident, her pajamas pushed up around her neck. He was found in one woman's room as she cowered behind a chair, naked. The women were fearful. One begged an aide to lock her door. But not one of the employees called the police. The man was not moved out of the 40-bed facility. No one told the women's families or informed their physicians. State investigators first heard the allegations after a staff member privately called the resident’s daughter, who then reported it to the police. The prosecutor who investigated the case wrote that the health department “had sufficient evidence that Alterra failed to provide adequate staff and failed to notify families.” He added that there was “credible evidence” that RCF supervisors “threatened employees with the loss of their jobs if they disclosed the sexual abuse.” At the time, the RCF was owned by one of the nation's largest assisted living chains, which paid a \$10,000 fine to the state in connection with the allegations (Appleby, 2004).
- Two ombudsmen in one of our focus groups reported that they and the police uncovered a group of RCF employees who worked in several different facilities who were sexually assaulting elderly female residents and using an online password-protected “chat-room” and website, were sharing stories of these assaults, photographs of the victims, and chilling discussions of their attraction to elderly, frail and vulnerable women. The police referred to this group as “gerophiles” and asserted that this was a more common phenomenon (state case study – local ombudsman focus group).

3.3.2 PHYSICAL ABUSE

We found a wide variety of types of physical abuse in assisted living and residential care facilities. We have included such mistreatment as hitting, slapping, shoving, and so on, in one category and drug diversion in a second category.

3.3.2.1 Hitting, kicking, slapping, shoving

Abuse by Staff Caregivers:

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- Four former employees of an assisted-living facility in an upscale California community were arrested on suspicion of elder abuse stemming from the suspicious death of an 80-year-old resident a year earlier. The four were suspected of abusing the elderly man, based on an anonymous call from the RCF told the resident's family and authorities that the man had been the victim of "foul play." Sheriff's Department homicide detectives said they had evidence that one of the aides assaulted the elderly resident in the minutes before his death and had been tormenting him for months beforehand. Apparently, a group of former employees routinely abused and verbally harassed the resident who died and several other residents of the RCF, which specialized in Alzheimer's/dementia care. The coroner's office ultimately determined that the resident had suffered blunt force trauma (Glover, 2008).
- An 83-year-old World War II veteran, died in a Pennsylvania RCF. The RCF specialized in Alzheimer's/dementia care. A nurse from the facility listed the cause of death as "failure to thrive." However, the owner of the funeral home saw a 1-foot-by-1-foot, black and blue bruise along the dead resident's left side and phoned the county coroner. The resulting criminal case ended with murder conviction and 30-year prison sentence for an RCF staff member who kicked the demented resident after he soiled his bed. In addition, the grand jury that indicted the facility caregiver issued a report addressing the factors causing or contributing to the resident's abuse and death. The report "constituted a virtual indictment of Pennsylvania's regulatory system for its alleged failure to oversee the facility" (McCoy & Hansen, 2004). That grand jury report, combined with other cases of abuse and scandalous care, led policymakers to attempt reform of the Pennsylvania RCF regulatory system.

In Pennsylvania, a grand jury indicted an RCF employee for murder of a resident and issued a report criticizing the state's "failed" regulatory system.
- A caregiver at a residential care facility was seen "grabbing" the victim by the front lapels and shoving her to the ground. The victim was heard crying out, "Please don't hit me again... [and] Please help me! Someone help me!" (National Association of Medicaid Fraud Control Units [NAMFCU] May/June 2008).
- Minnesota Attorney General Mike Hatch announced that an unlicensed staff caregiver at an RCF pled guilty to "disorderly conduct". The staff person slapped a resident across the face, verbally abused her, and ripped a necklace off her neck and was sentenced to 185 days in the county jail suspended, 24 months probation, and ordered to pay a \$1,000 fine (NAMFCU, 2004).
- A staff person in an RCF was sentenced for abuse of a vulnerable adult, a resident with cerebral palsy and cognitive impairment. A facility caregiver heard muffled crying and screaming coming from the resident's bedroom and entered. She found the resident with part of her nightgown stuffed into her mouth. The staff person in the room admitted that she had stuffed part of the nightgown into the resident's mouth because the resident was making noises that she did not want to hear. She also admitted to having previously put a wash cloth in the resident's mouth to silence her. The staff member pled guilty to one misdemeanor count of abuse of a vulnerable adult and received a suspended sentence and was ordered to serve 18

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months probation. As a condition of probation, she had to complete 100 hours of community service, complete any counseling ordered by her probation agent, and serve 30 days in jail (NAMFCU, 2004).

- A staff person physically assaulted a resident by hitting him with a hairbrush and a shoe. Another staff member who witnessed the event made an audio tape recording of the incident. (NAMFCU, January/February 2007).
- A personal care attendant in an RCF was charged with repeatedly striking a resident in her head while taking the resident back to her room (NAMFCU, November/December 2007).
- A cook/laundry worker in an RCF pleaded guilty in a County Circuit Court to hitting residents with a belt (NAMFCU Reports, 2004).

Abuse of Persons with Mental Illness. Although they were not specifically within the scope of our grant, which focused on elder abuse, reports of abuse in residential care facilities housing people with intellectual disabilities and persistent and severe mental illness were common. While a small number of such facilities are licensed by state departments of mental health, most fall under the same licensure agencies and regulations governing RCFs and ALFs that housed older people or a mix of elderly and non-elderly adults. Thus, in both the Medicaid Fraud Control Unit reports and in cases discussed in general terms during our interviews with licensing agencies and APS, participants discussed abuse in these settings and with this population of vulnerable adults. Many of the cases were strikingly awful, since these individuals were often particularly vulnerable, given their mental illness, poverty, and social isolation.

- In testimony before the U.S. Senate, a representative of the NAMFCU reported: “In Kansas, the owners and operators of a group home were found guilty on multiple counts of conspiracy, forced labor, involuntary servitude, health care fraud, money laundering, mail fraud, and obstructing a federal audit. They owned and operated a residential facility for mentally ill adults where more than 20 residents lived. The owners and operators controlled virtually every aspect of the resident’s lives. . . . They used physical force and threats to intimidate the residents, to isolate them from their families, and to sexually humiliate them. At times, residents were forced to strip naked and were confined to a seclusion room, forced to urinate and defecate into a wastebasket, shocked on the genitals with a stun gun, and forced to perform sexual acts while being videotaped. Repeatedly, the residents were warned that if they did not obey their abusers they would wind up in jail or in state mental institutions. Some of the residents of the home had previously attempted to report the abuse. However, because the abusive conduct was so horrific, the owners had been successful in concealing it for years by convincing local authorities, family members, and others that the reports of abuse were the unbelievable delusions of mentally ill residents. Verification of the abuse and the validation of the residents’ reports were contained in over 100 hours of videotapes that were made by the owners and discovered by search warrant in their private residence.” (National Association of Medicaid Fraud Control Units, *Written Statement*, 2007).

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- A licensed practical nurse (LPN) was indicted in Kentucky for punching and torturing a mentally retarded man for over 20 minutes as punishment for the victim's act of overturning his lunch tray. The entire abusive encounter was captured on videotape. (National Association of Medicaid Fraud Control Units, *Written Statement*, 2007).

Physical Abuse by Residents. As noted, we also found many cases of resident-to-resident abuse, a phenomenon that is well-established in the literature and in practice in the aging network. For example, between 1997 – 2002, ombudsmen reports to the Administration on Aging (AoA) indicated that physical abuse by anyone and resident-to-resident abuse were the highest rates of abuse reported (Jogerst, Daly & Hartz, 2005). Two other studies examined resident-to-resident abuse in nursing homes (Lachs et al., 2007; Rosen et al., 2008). One of those studies conducted focus groups with staff and residents. The researchers identified 35 incidents of physical, verbal, and sexual resident-on-resident abuse, with screaming or yelling being the most common type of incident (Rosen et al., 2008). Another study examined the records of more than 100,000 nursing home residents and violent incidents of resident-to-resident abuse that resulted in some type of injury. The study found that 294 residents sustained fractures (n = 39), dislocations (n = 6), bruises or hematomas (n = 105), lacerations (n = 113), and reddened areas (n = 31) (Shinoda-Tagawa et al., 2004). We also found cases of elder abuse in which staff and, more frequently, residents were victims and residents were perpetrators. In all the cases we reviewed, the perpetrators had a psychiatric condition, from Alzheimer's disease or other dementia to schizophrenia or psychosis. These cases were rarely reported by the MFCUs, since prosecution was never brought against a resident – although in a few cases facilities were penalized for knowing of the risk factors or prior incidents and failing to protect residents.

Resident-on-resident abuse is a common source of physical injury, and facilities differ on the degree to which they attempt to prevent such abuse with such interventions as staff training, behavior management programs, and more staff supervision.

- Police were called by the coroner to investigate the death of a 72-year-old Alzheimer's patient who died after being punched in the face by another 73-year old resident with Alzheimer's at a Sacramento residential care facility. The facility did not notify the police or anyone of the abuse. The attacker was not charged due to a "lack of self awareness." The facility, however, was being investigated, since it had a history of having more health deficiencies than any other facility in California (Lillis, 2006).
- At an RCF in eastern Virginia, a young mentally ill woman attacked her 83-year-old roommate, jabbing her behind the ear with a pair of blunt scissors and sending her to the hospital (Fallis, 2004b).
- At another Virginia facility, a 30-year-old resident -- who had previously been discharged from another RCF because of "anger problems" -- pushed an elderly resident down a flight of stairs, seriously injuring him (Fallis, 2004b).

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- At a rest home, a converted motel, staff caught one resident molesting another resident, a paralyzed stroke victim (Fallis, 2004b).

3.3.2.2 Drug Diversion

We first heard of “drug diversion” as a type of abuse in occurring in RCFs during an interview with a state MFCU. The bi-monthly reports of the MFCUs supported this Assistant Attorney General’s analysis that this was common problem. Cases of drug diversion in hospitals, nursing homes, assisted living facilities, and physician’s offices. The actions of staff were remarkable, from using a syringe to remove the drug from a fentanyl patch, used for patients with severe pain, such as patients with cancer or multiple sclerosis, to substituting water for morphine in capsules, to taking a resident’s pain medications and falsifying the medication records.

- An LVN falsified facility records in order to divert narcotic pain relief medication for her own personal use (NAMFCU, March/April, 2005)
- A certified nursing assistant removed Duragesic patches, a pain relieving medication, from residents for her own personal use (NAMFCU, 2004).
- An LPN at an RCF diluted liquid Oxycodone that had been prescribed to an 87-year-old resident with cranberry juice, significantly reducing the strength of the drug and causing the resident increased pain. She also diverted Vicodin tablets, prescribed to a 97-year-old resident, for her own use (NAMFCU, January/February 2008).



Dorothy Lundh: Regulators found that she died shortly after staffers mixed up a medication order, triggering severe withdrawal symptoms. (McCoy & Appleby, 2004; photo from USA Today)

3.3.3 Neglect Leading To Death or Severe Injury

Neglect, though often not thought of as serious as abuse, can and does cause significant injury and, sometimes, mortality. In extreme cases, neglect is prosecuted by local law enforcement or by the MFCUs in the Attorney General’s office. Many of the cases involved inadequate treatment of pressure ulcers, scalding of residents during bathing, and medication errors, as well as incidents in which residents wandered away from the facility and died or were injured.

- Police and emergency medical personnel were summoned to an RCF in response to a call about a resident being injured while being bathed. They arrived to find the resident so severely burned that strips of skin were in the process of sloughing off his legs and feet. A staff member admitted that the resident showed signs of distress, indicating that the water was too hot by kicking and splashing at the water. A witness in the facility reported seeing the staff person push the resident into the bathroom and then heard "banging" and other sounds of a "struggle" coming from the background. Health and safety regulations specify maximum temperatures in RCF and nursing home bathrooms, since second and third

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degree burns can occur in six seconds in water that is 140 degrees F. An officer at the scene tested the hot water tap in the bathtub where the victim was bathed and found the water reached 145 degrees F. in 30 seconds. (NAMFCU, May/June 2008).

- In an Ohio RCF, the staff observed a small area of red skin on the resident's coccyx area. After a few days, the red area opened and became a pressure ulcer. The administrator instructed the staff caregivers not to write in the regular daily logs about the care of the pressure ulcer but to record it in a special notebook that she provided for that purpose. Even as the pressure ulcer was getting worse, the administrator assured the staff that the consultant Registered Nurse (RN) was aware of the resident's pressure ulcer and that it was being handled properly. She threatened staff who wanted to speak to the RN directly. In fact, the consultant RN had not been informed of the pressure ulcer. Several months later, the RN became aware of the ulcer on the resident's coccyx which, by this time, was several inches long, several inches wide and several inches deep, exposing the bone. Despite the RN's initiation of appropriate treatment at that point, it was too late to save the resident. Sepsis from the pressure ulcer killed the resident a few weeks later (NAMFCU, January/February 2005).
- The manager of a group home in Missouri pled guilty to involuntary manslaughter and admitted to recklessly causing the death of a resident by failing to make adequate provisions for the treatment of pressure ulcers developed by the wheel-chair bound resident. The resident died in a hospital from sepsis caused by the severe pressure ulcers (NAMFCU, 2007).
- Two residents died in a fire at a Nevada RCF. The MFCU prosecuted the owner of the home for one count of Elder Neglect Resulting in Death and one count of Involuntary Manslaughter for failing to have sufficient staff on duty to protect the residents. The owner agreed to plead to one count of Involuntary Manslaughter and was sentenced to prison for 12 to 30 months (NAMFCU, *Written Statement*, 2007).
- The Oregon MFCU prosecuted an RCF owner and two caregivers on Criminally Negligent Homicide charges, for the death of a resident of the home. When paramedics responded to the home, they found the resident malnourished, dehydrated, hypothermic, and suffering from Dilantin toxicity. The victim, who died at the hospital, was 6'1" but at the time of death weighed 110 lbs and was suffering from approximately 60 decubitus ulcers" (NAMFCU, *Written Statement*, 2007).
- A 91-year-old woman died within 30 days of entering an RCF after personal care attendants gave her wrong medication (McCoy & Hansen, 2004).
- An 85-year-old man, living in a Florida assisted living facility was autistic and had dementia. As a result, he was unable to communicate verbally with staff or physicians about the cancer and infection that ate away nearly half his face. Staff and facility administration did nothing. His plight was discovered when an official from the state's Public Guardianship Office came by the facility to see another resident and smelled the odor from Larson's room as she passed by. The resident has since died, but his case

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inspired a State Senator to introduce legislation aimed at providing greater protections to vulnerable residents, require the licensing agency to notify law enforcement when investigating abuse, increase the number of inspections, and require criminal background checks of ALF employees (Andrews, 2008).

- A resident in an RCF died of serious neglect and was not sent to the hospital until it was too late to save his life. By the time the 85-year old resident was rushed from an RCF to a hospital, “his heart was racing, his kidneys were failing, infection raged in his body, and his right leg was cold and dead” from gangrene. Doctors didn't believe that the 85-year-old man would survive the double amputation he needed in an attempt to save his life, and in fact, he did not survive. An intake nurse labeled his case "suspected neglect/abuse" (Fallis, 2004c).
- An unlicensed staff member at an RCF pled guilty to “disorderly conduct.” She did not check the water temperature while helping a resident bathe, and the resident received first and second degree burns.
- An ombudsman arrived at an RCF in response to a complaint about elder abuse and immediately called the police. She and the police found doors nailed shut, locks and chains barring doors, and windows screwed shut. A city fire inspector, said, “One of the doors had a two-by-four nailed on the outside of the door with multiple nails.” The facility owner apparently did this because she “didn't want the residents leaving because some of the caregivers were asleep at night” (Smith, 2007).
- A 91-year-old Alabama retiree with Alzheimer's disease was discharged from one ALF because he needed more care than the facility could provide. He and his wife moved into another ALF that, as a reporter noted, was “a hotel-style brick facility...where visitors... were greeted by the homey view of a chandelier, a grandfather clock and a china cabinet.” The facility accepted him even though it wasn't licensed to care for residents with dementia. A few weeks later, his wife was hospitalized. State inspection records show that staff noted that he began “roam[ing] the facility, muttering about finding his wife.” However, the facility staff did not alert his doctor, family or the facility administrators so that an intervention could be put in place to keep him safe. The next day, he climbed “out the window of his room on a night when the temperature dipped to 26 degrees. He was found dead of exposure” (McCoy & Appleby, 2004).
- In Vermont, an RCF owner was charged with criminal neglect of residents. As a representative of the National Association of Medicaid Fraud Control Units noted in testimony before the Congress, “The Vermont Medicaid Fraud and Residential Abuse Unit convicted the registered nurse and residential homeowner who admitted to recklessly



Grover McCurdy suffocated after choking on a 2-by-3-inch chunk of meat. State inspectors said the only caregiver on duty didn't know how to dislodge the meat (McCoy & Appleby, 2004; photo from *USA Today*)

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failing to provide care for the residents of the home. The investigation revealed that the owner was responsible for allowing conditions at the facility to deteriorate significantly, exposing the residents there to a reckless environment of filth, inattention and substandard care. Specific instances of neglect included the careless dispensing of inappropriate medications, failing to properly treat diabetic residents, which necessitated emergency care on several occasions, and the serving of meals lacking required nutritional value that was inconsistent with the care plans of numerous residents. Further, the facility was often found in an unsanitary condition, perpetuating a climate of depression and disregard ” (NAMFCU, *Written Statement*, 2007).

3.3.4. Psychological Abuse

In studies of nursing homes, staff reported high levels of verbal abuse, cursing, and threats. Similarly, in the two surveys of RCF/ALF staff, they also reported that this was the most common form of behavior they observed or committed themselves, based on their review of a list of actions that would meet the definition of physical or psychological/verbal abuse. However, in most states, nursing home residents, families and others seldom made complaints about psychological abuse (Hawes, Blevins & Shanley, 2001). In addition, newspapers, reports by the DHHS Office of Inspector General, reports by the U.S. Government Accountability Office (GAO), and the MFCUs seldom reported cases of psychological abuse. Thus, there is scant evidence about the nature of such actions. The few cases we uncovered were usually associated with some other action, such as physical abuse, neglect or exploitation.

- The State Attorney General announced that the owner and operator of an RCF had been arrested and charged with exploiting an elderly resident of the facility. The victim, a 74-year old resident, reported that he was forced to sleep on a couch for the better part of three weeks and that the owner would constantly harass him for money and threaten him in order to make him designate her as the beneficiary of his life insurance policy. (NAMFCU, January/ February, 2008).
- An employee for an RCF in Arizona was accused of abusing three vulnerable adults, allegedly slapping the first victim, pulling on a second victim’s stomach hair to move him from one room to another, and engaging in a pattern of verbal emotional abuse with the third victim (NAMFCU, *Written Statement*, 2007).

3.3.5 Financial Abuse

We did not concentrate on the issue of financial abuse in this study, although we heard quite a bit about it from APS caseworkers and others during our interviews. Apparently, it was common for RCFs to ask the help of state agencies, including ombudsmen and APS, to assist them in collecting bills for residents’ care from families that managed the residents’ funds. As more than one caseworker observed, “They want us to be bill collectors.” However, thefts from residents and from facility-maintained resident trust funds, check forgery, and identify and credit card theft were also reported in the MFCU bi-monthly reports (NAMFCU, 2004; NAMFCU January/February, 2005; March/April, 2005; NAMFCU, *Written Statement*, 2007).

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3.4 Unlicensed Homes

Respondents in three of our study states acknowledged having a significant problem with illegally unlicensed residential care facilities, that is, places that met the conditions requiring licensure but that have avoided becoming licensed or that were dropping licensure. In other study states ombudsmen and consumer advocates felt there were also some unlicensed facilities. One of the study states has been plagued with scandals about the abysmal conditions in unlicensed facilities in several of its largest cities. In another study state, APS conducted a study and estimated that there were half as many unlicensed facilities as there

were licensed ones, An official of the state licensing agency argued that they resisted licensure largely because they could not meet the fire safety code imposed on licensed homes. In the third state, regulators reported that some facilities were withdrawing from licensure in order to avoid inspections and sanctions for not meeting state regulations.

Our three study states were not alone. As many as 20 states allowed some facilities with more than two beds to operate without a license or did not offer a state supplemental payment for residents who relied on Supplemental Security Income (SSI) to pay for their care. Many regulators argue that without a state supplement or Medicaid waiver funds, which can be restricted to licensed facilities – RCFs have little incentive to become licensed, particularly if there were an additional cost for staffing or fire safety to become licensed.

These unlicensed facilities, as discussed later, represent a significant challenge in terms of regulatory solutions. Many also represent a challenge in terms of elder abuse and neglect, as well as abuse and neglect of persons with persistent and severe mental illness (Crowder, 2006; Hancock, 2007a).

- The Texas Attorney General executed an emergency court order to protect residents at an unlicensed assisted-living facility in Arlington while officials investigated allegations that at least one mentally-impaired resident was sexually assaulted by one or more of three registered sex offenders who were living at the facility (Jones, 2008).
- At an unlicensed facility in Texas, a schizophrenic resident started setting fires in the facility and kept doing it for years until he set a fire that killed two other residents and injured four others. He was committed to Terrell State Hospital after the fatal fire but when released, he returned to another of the unlicensed home operated by the woman who has housed him for years (Hancock, 2007b).
- A married couple operated unlicensed homes despite a 2000 permanent injunction banning them from running unlicensed facilities. In one unlicensed facility, a city

“Nobody else wants them.”

Unlicensed home owner explaining why, after she was forced to close two licensed homes for widespread, serious, and persistent health and safety violations, she took three residents to live in an unlicensed facility.

(Fallis, 2004b).

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inspector found “sinks without pipes, open electrical outlets, bathrooms with no running water, and toilets with no running water filled with feces.” The inspector also found “moldy walls, broken windows, and no hot water in half of the building.” State regulators had repeatedly documented similar problems at this unlicensed facility and at the couple's licensed RCFs in a nearby city. Inspectors also found hungry residents, little food, and staff complaining of bounced paychecks. Despite this and a law suit by one city to close the unlicensed facility, it remained in business (Hancock, 2007a).

- A mother-daughter team in Virginia owned RCFs that had years of quality problems and deficiency citations, such as medication errors, unexplained hospitalizations and tenant trust funds in disarray. In one facility, staff waited three days to get help for a resident whose condition had so deteriorated that she could no longer walk, talk or feed herself. In another incident, a resident struck a disabled stroke victim with a chair. A staff person was convicted of sexually abusing a disabled resident after the owners discounted complaints about the employee perpetrator. Eventually, these two operators were forced to close their licensed RCFs because of deficiencies. Some residents were moved to other licensed RCFs. But the owners took advantage of state licensing regulations that allowed “caretakers” to house up to three residents without a license, and each owner took three tenants to care for separately at a “compound” of unlicensed facilities/houses at a “remote, wooded site.” One of the owners asserted that her residents were happy and anyway, as she said **"nobody else wants them"** (Fallis, 2004b).

Section 4.

Challenges to Effective Detection, Investigation, Resolution and Prevention and Smart Practices for Addressing Those Challenges

There is no federal regulation of residential care, with the exception of the 1976 “Keys Amendments,” which required that states certify to the federal government that Supplemental Security Income (SSI) recipients residing in RCFs are not living in substandard conditions. The certifications are provided and received in a pro forma manner each year, with both federal and state agencies acknowledging the meaningless of the exercise and “toothlessness” of the penalty if a SSI recipient is in a substandard RCF (Clark & Turek-Brezenia, 1993; Hawes et al., 1993; US GAO, 1989; US House, 1989).¹²

States regulate RCFs, and the regulatory systems are highly variable in the standards they set for residential care and assisted living (Carlson, 2005; Mollica, 2002; Mollica & Johnson-LeMarche, 2005). Earlier studies also found that states varied in their surveillance systems, including the frequency of inspections and types and numbers of staff who monitored facilities, and in the availability and use of enforcement remedies (Hawes et al., 1993; Hawes et al., 1995a; U.S. GAO, 1989; OIG, 1990a). None of these earlier studies, however, addressed the specific issue of how they handled complaints, much less allegations of elder abuse or neglect, and how the interface with APS, ombudsmen, and the legal system. Yet all of these agencies may play a critical role in detecting, investigating, and resolving and preventing cases of elder abuse in residential care.

“Well, I think part of the problem, which is probably a national problem, is that there is not even a recognition that, you know, elder abuse...exists ...People can't understand and get their minds around...[or] even acknowledge that there's a problem with it.”

North Carolina APS Staff

The multiplicity of agencies that may be involved in this process can also mean that allegations are treated differently depending on which agency investigates and whether and how local law enforcement is involved. In addition, there are significant variations across and within states in the working definitions they use to identify cases of abuse, their investigative techniques, the resources they have for addressing issues of elder abuse, the allocation of those resources across program responsibilities (e.g., community-dwelling elders, nursing home residents, RCFs), and the standard of proof they require for substantiating allegations

¹² As Clark and Turek-Brezini (1993) noted, “The Federal role in board and care regulation is primarily defined by the 1976 Keys Amendment. Substandard homes are subject to having the Federal Supplemental Security Income (SSI) payments reduced “by the amount of the State supplement paid to SSI recipients for ‘medical or remedial care’” (U.S. General Accounting Office, 1989:34). Such a sanction is widely seen as virtually unworkable in practice and has never been enforced.”

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(Administration on Aging, 2000; Baron and Welty, 1996; Hawes et al., 2001; Hirst, 2002; Huber et al., 2001; OIG, 1990b and 1999). It was also important to determine the level of funding available to APS and LTCOP in each state. Finally, allegations of elder abuse may be investigated and resolved very differently depending on whether they are handed by the licensing agency or referred to APS, the LTCOP, law enforcement or jointly handled.

Recently the U.S. General Accountability Office (GAO), the National District Attorneys Association (NDAA) and American Prosecutors Research Institute (APRI) have focused attention on the role of law enforcement, including prosecutors, in addressing elder abuse in residential LTC settings (DeFrancis, 2002; Miller, 2002; Morgan & Scott, 2003; Brandl, Dyer, & Heisler, 2006; U.S. GAO, 2002). None, however, have addressed elder abuse in RCFs. Thus, generating information about this during our study was an important goal.

As noted, the goal of the study was to learn more about the ways in which states detect, investigate and resolve cases of elder abuse and to identify “smart” practices that might be feasible in other states or agencies. This section of the report addresses the conditions that represent significant barriers or challenges to effectively addressing and preventing elder abuse in residential long-term care facilities. It also presents “smart practices” in key areas of system performance. We have presented the barriers and smart practices in the same section, since a focus only on the barriers or challenges might convey a sense of intractability in terms of finding solutions. It is important to note that the “smart practices” are ones identified by the agency staff or by us rather than policies and procedures that have been rigorously evaluated and identified as meeting “best practice” standards. Thus, they are practices that, in their face, seem sensible and effective to the administrators or field staff involved in detecting, investigating or resolving cases of elder abuse.

Inadequate resources to carry out their responsibilities are crippling the attempts of RCF/ALF licensing agencies, ombudsmen programs, and APS to detect, investigate, and resolve elder abuse in residential care.

4.1 Lack of Resources

Clearly, the most significant challenge faced by all of the state agencies was a lack of sufficient resources. More than 99.5 percent of the staff in the agencies we interviewed identified the resource constraints as the most significant challenge they faced and one of the three main barriers to improving the complaint investigation process. This lack of adequate resources was evident in several aspects of the process for detecting, investigating, resolving and preventing elder abuse and neglect.

There are several reasons for the lack of adequate resources. First, unlike regulation of nursing homes, states do not receive federal support for regulating residential care/assisted living facilities (other than some funds for Medicaid waiver programs). Second, the industry’s growth has outstripped the capacity of the state agencies. Third, state policymakers have not allocated the resources needed to meet the double challenge of an expanding

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industry and a resident population that is increasingly impaired and at risk for abuse. Finally, much (though not all) of the assisted living/residential care industry has resisted efforts to enhance regulations and the capacity of the state agencies to assure quality. As a result, the challenges are quite severe.

4.1.1 State Licensing Agencies

The licensing agencies depended solely on state support for regulation of residential care facilities and investigation of complaints about abuse or neglect. However, these resources have not kept pace with the growth in the supply and use of assisted living or with the rising level of disability and care needs among residents. During the last 20 years, a new industry – assisted living – has arisen and together with more traditional residential care homes has become an important part of the long-term care sector. There are now more than 50,000 RCFs of various types and size, with capacity for more than one million residents. This stands in stark contrast to regulation of nursing homes – where states must assure quality in only about a third as many facilities (17,000 with approximately 1.6 million residents). However, nursing home regulation is largely governed by federal regulations and receives substantial federal support for state activities, such as surveys and complaint investigations.

This rapid growth in the industry has been accompanied by serious and widespread budget troubles in nearly all states. FY 2001 – FY 2003 were years of intense fiscal stress for the states. In FY 2004, state revenues started to improve, and budget shortfalls started to shrink. States were also helped in FY 2004 by \$20 billion in temporary federal fiscal relief, including \$10 billion directly for

Medicaid. Despite this, 23 states still reported spending overruns for some portion of their budgets (NCSL, 2004). During FY 2005, revenues grew somewhat, but FY 2005 also marked the end of the temporary federal fiscal relief. Many states still faced budget shortfalls. While smaller than

in previous years, these shortfalls continued to place great stress on state budgets (Smith et al., 2004). While there was some improvement in state revenues, many states continued to have spending overruns; fewer than half the states avoided budget overruns in FY 2007 (NCSL, 2007). Policy-makers anticipated FY 2008 balances would fall. But the decline in state finances was worse than expected. As the fiscal year ensued, a growing number of states were faced with widening budget gaps. More recently, the collapse in the housing market, a slowing economy, and growing unemployment promise a decrease in revenues and increase in demand for state services, such as Medicaid and SCHIP. In addition, throughout this period, states experienced growing demands from Medicaid and other health care programs, elementary-secondary (K-12) education, transportation, infrastructure and employee

"A lot of the solutions are money, money, money and then accountability."

Licensing Agency Administrator

"Well, it all comes back to resources. Not having enough time to meet time frames because staff [investigators/surveyors] are backlogged on the work they are doing. I think resources [are] the biggest, for us."

Licensing Agency Administrator

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compensation (NCSL, 2005). Spending more on program administration was a distant – very distant – priority in most states.

Inadequate resources will be seen as a significant culprit in several of the problems we observed in state performance. These include (but are not limited to) such activities as:

- Inadequate numbers of staff in the licensure agency so that “annual surveys” of RCFs were months, and in some cases, years in arrears;
- Too few complaint investigators in the licensure agency to conduct timely complaint investigations;
- Too few complaint intake staff so that many callers had to leave messages in voicemail about abuse and neglect;
- Ombudsmen with unsustainable workloads;
- APS staff with unmanageable workloads;
- Inadequate numbers of support staff in the agency headquarters, particularly in the licensing agencies, where even the availability of legal support was inadequate;
- Too few funds for training in licensure agencies and ombudsmen programs;
- Too few inspectors to detect and investigate unlicensed homes and too few attorneys to handle prosecutions of unlicensed facilities;
- Funding difficulties in terms of moving residents – out of a facility that is inappropriate for the resident, out of unlicensed facilities, and out of facilities that should be closed because of licensure violations.

This was an exchange between four different RCF complaint investigators:

Male 1: We've got the residential care but it's just the complexity of the complaints. They were just not like that a few years ago.

Male 2: The acuity of the residents has changed.

Female 1: I think that's a big change is the acuity of the residents. And not enough staff and not enough staff training.

Female 2: And that's universal."

Licensing Agency Complaint Investigators/Surveyors

Three examples of inadequate complaint investigator or surveyor caseload are telling about resource constraints in the state licensure agencies. This is particularly critical since in the study states (and apparently in most states) the facility licensure agencies have primary responsibility for investigating complaints about abuse and neglect in RCFs/ALFs.

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- In one study state, the new chief of the key state regulatory agency for residential care/assisted living acknowledged to a newspaper reporter that her survey staff was “overwhelmed” (Dilanian, 2007). At the time, she had 31 inspectors for some 1,600 residential care facilities with nearly 51,000 beds. This is a ratio of one surveyor for every 52 facilities – and one for every 1645 resident beds. As we heard in several of the other study states, while trying to respond to serious complaints about abuse and neglect, the survey staff had fallen behind on the annual licensure inspections. As the agency administrator noted, “This program has so many systemic problems that have gone unnoticed, unchecked and unregulated for a decade, I don't have enough staff to fix it. By the time we get out to them, many homes are in so much trouble that they can't fix the problems - or somebody's already been harmed” (Dilanian, 2007). The state plans to add up to 10 new surveyors/complaint investigators. However, the state is also adding licensure regulations for a new type of facility defined in the regulations as “assisted living” that can provide a higher level of care than the current residential care facilities. Thus, it is unclear that the situation will actually improve in terms of the workload for regulatory staff and agencies.
- In another study state, there were six surveyors to conduct annual surveys, new licensure inspections, and complaint investigations. There were approximately 420 licensed facilities – for a ratio of one surveyor for every 70 facilities. One surveyor reported that they were as much as 2.5 years behind on annual licensure surveys for RCFs. Further, several participants suggested that it might take several weeks, even months sometimes, for an abuse or neglect complaint about abuse or neglect to be investigated. Finally, a study by the APS agency estimated that there were more than 200 unlicensed facilities in the state. Thus, the performance of the assisted living licensure agency – which had developed and implemented many innovative quality improvement initiatives – was hobbled by the state budget.
- These problems did not exist only in our study states. For example, during the last decade, the number of ALFs in Arizona has doubled, and the industry trade association estimated that the number of seniors in assisted living had tripled. Unfortunately, the structure for inspecting these homes and responding to complaints has fallen behind. As of 2007, an estimated 26,000 Arizona seniors lived in 1,900 ALFs. For these, there were has between 23 and 27 inspectors responsible for overseeing the 1,900 ALFs, up from 19 surveyors in 2006. However, as of 2007, only 23 of the 31 authorized positions had been filled, given an effective ratio of 83 facilities per surveyor (Crawford, 2007). These surveyors also had to inspect facilities applying for a new licensure inspection and those that closed – an estimated 340 per year. In addition, they were responsible for annual surveys of the 1900

The impact of no federal funding for residential care oversight is striking. Arizona reported having 31 surveyors for 135 nursing homes, where there is federal financial support, and the same number of inspectors (31) authorized to inspect and investigate complaints for 1,900 ALFs.

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RCFs/ALFs and for responding to complaints. A local newspaper investigation examined the complaints, approximately 1000 complaints a year about ALFs, “hundreds involving neglect, abuse and even suspicious deaths” (As assisted living grows, worries mount, 2007). The result of this short-staffing among the survey/complaint investigation staff was predictable. An estimated 460 ALFs, 24 percent of the total number of facilities, were operating with expired licenses because state health department surveyors were unable to conduct the required annual reviews in a timely fashion. Some estimated that ALFs were going as long as two years without an inspection. Similarly, complaints often languished for months before being investigated (Crawford, 2007).

The contrast to the nursing home regulatory structure, which operates with substantial federal funding, is striking. Arizona has 31 inspectors for the 135 nursing homes – or one surveyor for every 4 facilities (although nursing home inspections often involve a multidisciplinary team) (Crawford, 2007). Still the contrast between 31 surveyors for 135 nursing homes and 31 “authorized” and 23 actual inspectors in 2007 for 1,900 ALFs was a stark one.

The examples cited above of limited resources for the licensing agencies have focused on the impact on the number of surveyors and complaint investigators and their workload, the lack of adequate resources was evident in many other aspects of agency performance, from intake to prosecution. For example, in two study states, there was only one staff person assigned to the complaint intake line handling all complaints – from abuse and neglect to residents’ rights and quality of care. As a result, residents, family members and others who called in to the state abuse and complaint “hotline” often got only a voicemail option. Ombudsmen and APS staff said that it could take several days for the complainant to get a call-back from the intake staff person in states in which complaints were routinely taken on agency voicemail. This alone causes a significant delay in the timeliness of investigations.

One group of RCF licensure agency staff surveyors who also conducted complaint investigations argued that they did not have enough surveyors. They reported that their

Potentially Smart Practice: As noted, in most states, agencies reported having too few resources to carry out their responsibilities in the area of residential care. One state agency decided to become proactive about the situation. In Maryland, in 2006, the licensure agency had too few staff to complete annual surveys; 73 percent of the RCFs did not get an annual survey. The agency also fell behind on new facility licensure inspections and complaint investigations. In an attempt to highlight its plight, the agency provided a report to legislators detailing poor treatment in some residential care/assisted-living centers. For example, in one instance cited by the agency’s report, an ALF resident was left outside for hours on an exceptionally hot day, and the resident’s recorded temperature at the Emergency Department was 107 degrees. Residents in another ALF were locked in a boiler room for “misbehaving” (Editorial Board, 2007). The hope among advocates for better care was that making poor conditions “visible” to the public and legislature would produce some positive action in terms of the agency’s budget. Unfortunately, facing a budget crunch, the state did not respond with more staff (Editorial Board, 2007). However, this is an approach that in other states has produced reform in the area of nursing home care.

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workload was such that they were not given any days in the office to write up reports and that they had no secretarial support. The result was delays in completing abuse and neglect investigations and resolving the cases. Moreover, they noted that their workload was continuing to increase. Their regional supervisor said they could expect to have 40 new RCFs open in their region each month, increasing the demand for new licensure visits, as well as annual surveys and complaint investigations.

Participants also mentioned the negative effect of resource limitations on their ability to prevent abuse and neglect. For example, in two of the study states, respondents reported that before resources became so limited, the RCF licensure agencies had provided consultation on quality improvement to RCFs. One state provided feedback and analysis of quality indicators to RCFs, focusing on how to improve their performance. Both states offered training and consultation to RCFs that requested help and to all RCFs that were cited for serious violations, including abuse or neglect. As one complaint investigator noted, "We had technical support training people to help facilities who needed consultation or training, but they are no longer offered...[W]e are expected to do this now. But we have no time - so it does not happen." In short, limited resources not only make it difficult to detect and investigate cases of abuse, it also harms the ability of licensure agencies to engage in activities that might prevent abuse.

4.1.2 Long Term Care Ombudsman Program

The ombudsman program receives most of its funding (on average across the states, about 60%) from federal sources, largely Titles III and VII of the Older Americans Act.¹³ Despite this, it has inadequate funding for the scope of the responsibilities assigned to the ombudsman program. An evaluation conducted by the Institute of Medicine (IOM) as far back as 1995 concluded that the ombudsman program was understaffed and underfunded in terms of its broad and complex responsibilities (Harris-Wehling, Feasley & Estes, 1995).

Economic conditions for the ombudsman program have not improved, with federal budget allocations that remained relatively flat in recent years. Yet ombudsman responsibilities have increased. Between FY 2002 and FY 2007, ombudsman program funding from all sources (federal, state and local) increased at an average annual rate of 3.95%, just above the annual rate of inflation in the general economy (3.05%) and not commensurate with the expanding responsibilities. As a result, the ombudsman program has been unable to fulfill the mission

"I have eight counties and about 1600 residents that I visit in nursing homes, family care homes, and personal care homes."

Ombudsmen from rural area who tries to visit every resident monthly and respond to complaints

¹³ A report for the US Senate (Colello, 2008) reported that ombudsman programs receive about 60% of their support from the federal government, although it is higher in states that provide little or no support. For example, in his proposed budget for FY 2009 in California, Governor Schwarzenegger proposed eliminating all state funding for the ombudsman program.

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envisioned for it by Congress (AoA, 2009). Only in states in which the federal allocation has been supplemented by the state have ombudsmen programs been able to expand to meet demand. However, as shown in Exhibit 4.1, there was substantial variation among our study states in the degree to which states were supporting their ombudsman programs. As noted above, even with state supplementation to federal funds allocated to the ombudsman program, funding has barely kept pace with inflation.

In FY2006, ombudsmen reported serving just over 16,750 nursing facilities (NFs) and more than 47,000 other residential LTC facilities operating nationwide. Since FY2000 the total combined number of licensed LTC facilities (NFs and RCFs/ALFs) has increased by 5 percent from about 60,900 to more than 63,000 in FY2006. This growth occurred on the top of significant expansion in the number of RCFs during the 1990s – when federal funding for the

Exhibit 4.1				
Source of Funding for LTC Ombudsman Program FY 2007				
	Spending	Percent of Program Funds by Source		
	Total-All Sources	Federal Funds	State Funds	Local Funds
National/US	\$81,755,282	58.8%	32.7%	8.5%
Alabama	\$675,768	80.7%	7.7%	11.6%
California	\$12,216,002	31.5%	52.4%	16.1%
Maine	\$610,649	62%	37.9%	-
New Mexico	\$851,843	56.3%	43.7%	-
North Carolina	\$2,594,392	85%	6.5%	8.5%
Pennsylvania	\$3,687,125	44.2%	54.1%	1.7%
Texas	\$4,027,922	87.3%	6.7%	6.0%

Source: Administration on Aging (2009), Long-Term Care Ombudsman Program, Annual Report, A-9: Long-Term Care Ombudsman amount of program expenditures by source FY 2007.

ombudsman program remained relatively flat. In addition, many ombudsman programs also significantly expanded the range of services they provided in RCFs during the last decade. Thus, ombudsmen were attempting to cope with more LTC settings but also offering a greater range of services to RCFs and residents without concomitant growth in their budgets.

Ombudsmen investigate and resolve complaints from all residents in residential long-term care facilities, although for many years, this was largely restricted to nursing homes. However, ombudsmen responsibilities expanded to include responding to complaints from other types of facilities, such as board and care homes. Over time, many ombudsman programs expanded their outreach to include visiting residents in RCFs and ALFs, offering training to facilities and their staff, helping set up resident and family councils, and advocacy for policies that will more effectively protect the residents and meet their needs and preferences. As a result, the workload of staff and volunteers has been substantial and growing, as shown by the reported ratio of staff to facilities and beds (AoA, 2009; Colello, 2008).

Many of the ombudsmen commented on their heavy workloads and the difficulty of fulfilling their responsibilities in nursing homes and RCFs. This was critical since they played a key

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role in outreach and detection of elder abuse in RCFs and, in one study state a central role in investigating these cases. All of the programs noted the difficulty in meeting these responsibilities with existing resources.

- A State LTC Ombudsman identified funding problems as a barrier, saying the programs don't have the resources they need. **"The state's been very generous to us, but in a state this size, it is not enough... even with hundreds of volunteers...The IOM recommendation was 1 full-time paid ombudsman to every 2,000 LTC beds. We're at about 1 to every 2,700 beds."**
- A regional ombudsman noted that her program was receiving "more intense cases" of abuse and neglect in RCFs now than in the past. However, her program covers an eight- county area with eight paid staff for 16,500 RCF beds and 3,500 NF beds, for a ratio of one FTE paid ombudsman for every 2500 LTC beds.
- A local ombudsmen said, **"We don't have enough resources for anything...There's not enough of us [in the program]...This is serious, since I see us...in the preventive role - educating the public, staff, etc."**
- Several of the ombudsmen noted that because of shortages of paid staff, one ombudsman may cover several counties, which makes timely responses to complaints difficult.
- Another State LTC Ombudsman said the program needed 19 positions to be consistent with IOM recommendations. She wrote a report for a state commission examining the state's capacity to meet the needs of an aging population. This commission made a recommendation to the legislature for 11 new ombudsmen positions. Eight were approved by the legislature. That still left the program shy of meeting the IOM recommended workload.

In other study states, ombudsmen noted that budget cuts had limited their travel to such training opportunities as the annual meetings at NCCNHR and the National Long-Term Care Ombudsman Resource Center and other training opportunities, both out-of-state and in-state. One program said it had to cancel its annual training, since there were no travel funds to pay for gasoline or hotels. Ombudsmen noted that under conditions of severe budget constraint, it was difficult to serve RCF residents as effectively as they served nursing home residents.

Unfortunately, as noted above, state revenues have not been available to all ombudsmen programs. Moreover, state funding is a guaranteed source of revenue in only a few states – such as those in which a set amount (e.g., \$100 per bed) is allocated from facility licensure fees. In other states, the amount has depended on the overall health of the state budget. Thus, facing a significant budget deficit, Governor Arnold Schwarzenegger proposed slashing 100 percent of state funding for the California Long Term Care Ombudsman Program in his budget (Rutherford, 2008). That represented a 40 – 50 percent reduction in their total budget

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at the same time that the number of facilities (more than 7,000 RCFEs for the elderly) continued to expand – and when the ombudsman program was designated as a “first responder” for receiving reports of elder abuse and neglect.

4.1.3 Adult Protective Services

According to APS administrators surveyed in 2001, the two greatest barriers to providing adequate adult protective services were insufficient funding and inadequate staffing and staff training, issues that have become more critical with cutbacks in federal support for the Social Services Block Grants and the Older Americans Act (Otto & Bell, 2003), the two major sources of federal funding for APS.

Unfortunately, like ombudsman programs and state licensing agencies, APS had not fared well in several of our study states in terms of state funding. In two of the study states, there was virtually no state-level funding for APS. Instead, counties were expected to fund APS activities. In another study state, APS was seriously understaffed until a scandal about a death of a vulnerable adult who was homeless led legislators to provide the needed funding to expand APS staff. Nevertheless, these were funds to be used for outreach and services to older persons living in the community rather than in a “protected setting,” such as a licensed RCF.

“I went to the NAPSA [National Adult Protective Services Association] conference in Atlanta, and every state [APS] said they wished they had the money that was put into child welfare.”

In our study states, APS caseworkers and administrators identified scarce resources as a problem. For example, one administrator reported that the only way they could control their caseload was to develop a tighter screening criteria in an attempt to limit the number of abuse and neglect complaint allegations targeted for in-person investigations. APS caseworkers often mentioned intake screening as a strategy set by APS supervisors to manage workload. These APS staff recognized the need to control caseworker workload; however, none were confident that the stricter screening criteria were ensuring acceptance of every case that warranted an investigation.

“With intake, supervisors are in triage mode.”

APS caseworker

In another study state, APS caseworkers identified their caseload levels as a barrier to effective detection, investigation and resolution of cases. As one participant said, **“We are slapping on band-aids and putting out fires.”** She said they often close a case and then get another referral from the same RCF and sometimes even on the same resident because **“we haven’t had time to do what we should have done to resolve the issue.”**

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In summary, all of the primary agencies with some responsibility for detecting, investigating, and resolving cases of elder abuse and neglect in residential care facilities faced financial barriers to doing their job.

4.2. State Licensing Regulations

One of the realities of residential care is that the state licensing agencies play a key role in detection, investigation, resolution and prevention of elder abuse. The Association of Health Facility Survey Agencies (AHFSA) is a national organization whose members are responsible for regulation of residential care/assisted living facilities in most states. In states in which licensing is conducted by community care/social service agencies, administrators typically belong to the National Association for Regulatory Administration (NARA).¹⁴ In 2005, these two groups held their annual meeting jointly in Albuquerque, and it was clear from the sessions on residential care that most administrators recognized and were troubled by several things, including: the growing acuity of residents, concerns about whether existing licensing standards were commensurate with the level and type of care needed by residents,

In a highly unusual move, after being presented a case about a fatal incident of elder abuse in an RCF, a Pennsylvania grand jury issued a report that was highly critical of the state's "failed" regulatory system.

"...[There is] just so much gray in those regulations, and I'm constantly told by surveyors there are not enough teeth in the regulations. The regulations focus too much on the environment, not about quality of care. They say 'We can't make them [quality of care deficiencies] stick, and therefore we can't do anything.'"

Local Ombudsman

and the need for stronger regulatory systems. At the same time, most administrators spoke of the lack of resources to enhance their regulatory standards and oversight. The NARA administrators spoke in particular of the differences in the resources and expertise available for administration and regulation of facilities and services for children compared to that available for elder abuse.

Our review of reports and surveys of states identified several factors that might affect their ability to regulate

adequately or that suggest potential problem areas, as shown in Exhibit 4.2.

- **High use of RCFs:** 18 states had fairly high use of residential care, meaning that there were nearly equal numbers of RCF/AL beds compared to nursing home beds;
- **Intake:** In 2006, 14 states did not have a toll-free hotline that was listed for reporting complaints of elder abuse; in addition, 25 states did not have a hotline that was "manned" by a person 24-hours a day, 7 days a week;

¹⁴ AHFSA's website is www.ahfsa.org, and NARA's is www.naralicensing.org.

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- **Unlicensed facilities:** between 20 and 24 states had features that typically led to higher numbers of unlicensed RCFs, including allowing some types of facilities to be legally unlicensed (e.g., 24 not requiring licensure for small facilities or apartment-style facilities) or not providing a state supplemental payment for care of SSI recipients who lived in licensed RCFs – thus providing no financial incentive for facilities to be licensed;

Exhibit 4.2 State AL/RCF Regulatory Features	
Feature	States
High use of RCFs for long-term care	18
Features that seem to encourage the existence of unlicensed facilities	20 - 24
No toll-free hotline for reporting	14
Hot-line <u>not</u> manned 24 hours a day/7 days a week	25
No special training or staffing requirements for dementia-care units	27
No specific grievance process for residents	27

Based on review of Carlson (2005), Mollica & Johnson-Lemarche (2005), Hawes et al. (1995a), and our 2006 telephone survey of state agencies designated for intake of elder abuse reports

- **Licensing standards:** Most states did not specify minimum staffing ratios and had minimal requirements for staff training; the average staff member received only 16 hours of training (Hawes et al., 2000); in 2004, 12 states did not set special training requirements for dementia-care units, and 27 states did not have special staffing requirements for dementia-care units in RCFs; finally, 27 states did not have a specified grievance process for residents.

4.2.1 Criticism of Existing Licensure Standards in Study States

In our study states, participants’ comments often mirrored the concerns expressed at these national meetings about such issues and, in particular, the inadequacy of existing standards of care and the resulting difficulties this causes in detecting, investigating, resolving and preventing elder abuse and neglect in residential care.

Smart Practice

In North Carolina, the licensing agency reported that it had much more significant requirements for facility staff training than most states. The basic requirement was successful completion of an 80-hour personal care training course, established by the state licensing administration. This included at least 34 hours of classroom training and 34 hours of supervised practical experience, including cognitive behavior and social care for all residents including interventions to reduce the behavioral problems for residents with mental disabilities; residents’ rights; and issues related to abuse and neglect. The staff person was required to demonstrate competency in observation, documentation, and basic nursing skills including special health related tasks.

In several study states, participants – from ombudsmen to state surveyors who also did complaint investigations to program administrators -- expressed concern about the adequacy of the regulations governing residential care facilities in terms of protecting residents from abuse and neglect. The problems they noted included:

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- Lack of regulations or weak regulations in independent living or community care RCFs.
- Staffing ratios that were either inadequate (e.g., a minimum of two staff per 100 residents on night shift) or too general (e.g., “sufficient staff to meet the needs of residents”) to be effectively enforced.
- Weak requirements for being an administrator. In some cases, only a high school diploma was required to be an administrator of an RCF.

“Because it’s federally funded, all the focus is on nursing homes. Assisted living is put on the back burner.”

Licensure agency staff

- In some states, there was no residents’ bill of rights or the requirements have “no teeth” in terms of the ability of the licensing agency to cite related deficiencies and to enforce the law.
- In several of the study states, there was no mandatory employment ban for unlicensed staff who worked in RCFs, even if they had previously abused or neglected an older

“90% of the RCF regulations are not care-based. They are strictly paperwork.”

Licensure surveyor

person or a child. In at least one study state, the regulations did not require the same background checks for contract staff or for agency staff as they did for staff who were employed by the RCF. Further, in two of the study states, participants argued that the rules were not sufficient to keep someone from being rehired even if they had previously been

found guilty in a case of abuse or neglect. In addition, in some states, facilities were allowed to hire someone who was listed on the Nurse Aide Registry for CNAs who had been barred from working in nursing homes. Finally, APS caseworkers in two study states noted that they had identified RCF staff who were on the Child Protective Services registry for abuse of children. In fact, one ombudsman noted that RCFs/ALFs were one of the state-approved training and work sites for people who have had children removed from their homes and are participating in welfare-to-work programs.

- Participants in several study states decried the state licensure agencies’ failure to set appropriate standards on medications. As one of those participants noted, **“Pretty much the gardener or janitor can give insulin, change a Foley catheter or colostomy bag.”** (State surveyor/complaint investigator)

“We have these wonderful regulations for SNFs...But for residential care, there are no similar provisions to prevent people from being tied up, [for] no bed rails. The regulatory system for residential care is piss-poor and the enforcement system is even more piss-poor.”

Ombudsman

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- Several participants noted that the resident case mix in residential care is in many ways more complex than that found in nursing homes, because many RCFs house not only frail elders and those with some type of dementia but also large numbers of non-elderly adults with intellectual disabilities or persistent and severe mental illness. Despite this, they noted that the standards in residential care, as well as the inspection process, compared unfavorably with regulatory processes in nursing homes. . Surveyors in several of the study states argued that the standards and inspections focused too much on “paper compliance” with environmental standards and policies. This, they argued, made it difficult to cite facilities for poor quality of care or neglect. As one surveyor argued – with the verbal agreement of other complaint investigators in the room: **“We don't have enough regulations to hold them to anything. And they [owners] will fight them [deficiency citations for neglect] tooth and nail.”**

- Complaint investigators from two study states gave examples of ways in which the regulations governing RCFs/ALFs hindered their ability to cite facilities for neglect or abuse. In one study state, a family member complained that they had to bring in towels to the personal care home because the staff said there were not enough towels, and they were using paper towels to dry off her mother. The complaint investigator reported:

“I investigated this, and while I was there a staff person asked me if it was OK to finish drying a resident with a pillow case because there were no more towels. The aide said they are only issued 15 towels for 32 residents on the floor. I found that there really were plenty of towels, just the laundry staff being controlling. But I was told [by the licensure agency supervisor] that I could not write this or the complaint up as neglect. I had to write it up as a housekeeping issue instead.”

“I think a barrier...is that we don't have the... regulations... I'm talking about unlicensed personnel...I think if we had the mechanism, like the CNA Registry..we would have a better handle on the unlicensed personnel. I think that is a big barrier for us because we really can't do anything about... We can ding the facility [for abuse], but we cannot ding the person. And I feel...[an unlicensed aide in an RCF] who does some abuse -- I would like to see that person annotated and taken off the market.”

Licensing agency administrator

- In another state, a surveyor investigated a complaint from an ombudsman about a resident in an ALF. The ombudsman was concerned about the resident's weight. The surveyor found that the man had entered the ALF weighing 195 pounds and then, five months later, weighed only 135 pounds. The surveyor wrote the case up as severe neglect, since the

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resident did not have any medical condition that explained his weight loss. However, he had Alzheimer's disease and needed help with eating. The agency rejected the citation for neglect, arguing that there was no proof in the records that would prove neglect, particularly since the definition of neglect required "intentional" withholding of needed care and services." The agency supervisor felt that there was no proof of *deliberate intent*. Further, the licensure standards did not focus on resident outcomes or process quality and did not specify that a facility had to have a registered dietician or have a care plan in place to address nutritional problems. The complaint investigator's frustration and disbelief were evident from her statement:

"How can that not be abuse or neglect? How can an agency supervisor not think that a 60-pound weight loss was proof by itself? What kind of attorney couldn't take that case to court, if the facility appealed, and win? Where did she go to law school?"

- Field staff from many agencies across the study states and some administrators expressed concern that the standards did not match the current acuity level of residents in terms of assessment and care planning, staffing levels and staff training. In three of the study states, participants argued that there had not been any significant revision to the licensing standards in as much as a decade, despite changes in resident acuity. Similarly, in the District of Columbia, assisted living centers had not been licensed or inspected for eight years after the DC Council mandated government oversight of the facilities and set standards for such matters as dispensing medication, training staff and providing adequate bathrooms (Spinner, 2008). Some agency staff, ombudsmen, and consumer advocates felt that abuse and neglect were more likely under these conditions. Only one licensure administrator expressed complete confidence in the regulations governing RCFs in his state. He said, "We are comfortable with the current level of acuity we're seeing now with the caveat that we expect care to be provided by appropriately skilled professionals." However, surveyors, complaint investigators,

Smart Regulatory Practices

- Some states, including Maine, Illinois, and Washington mandated a uniform resident assessment in RCFs/ALFs.
- In Maine, the licensure agency required RCFs to enter the resident-level data in an electronic file and submit the annual resident assessment data to the agency. The agency used this data to set a case-mix adjusted payment to facilities. However, it also used the data to identify the types of residents living in RCFs and their care needs – and to identify and develop quality improvement initiatives and training for facilities, based on resident characteristics.
- North Carolina used a small set of assessment items for Medicaid beneficiaries in RCFs to identify residents with "heavy care" needs. The said paid a supplemental Medicaid payment to the facilities for the care of the heavy care residents, and a case manager was assigned in each county to ensure that heavy care residents had an adequate care plan and were receiving needed care.

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and ombudsmen from this state had noted that this agency does not collect any information about the characteristics of the RCF residents. They further noted that the state schedules inspections of only 20 percent of the facilities each year. This means that an RCF would be inspected only once every five years. They argued that these factors made it difficult for anyone to be confident that current levels of resident acuity were acceptable and that adequate care was being provided.

- Several participants were critical of the focus of the standards, which in their view, focused on structural standards of quality. As one surveyor argued:

"Ninety percent of the regulations are not care-based. They are strictly paperwork. In fact, like when two of us [surveyors]...go in [to an RCF] at the same time, one of us can do the care issues while one of us does the paperwork -- and it takes the same amount of time. Whereas on a federal [nursing home] survey, you can have the paperwork done in a day, but it takes you four days to look at care issues. To make sure that they're cared for. The paperwork is important, but is that the reason why we're there?"

These investigators argued that this focus on compliance with structural standards – paperwork compliance with policies and procedures, has made it more difficult to cite an RCF for abuse, neglect or poor quality of care.

- Several participants, including ombudsmen and staff of Medicaid Fraud Control Units were critical of the licensing agency's failure in many of the study states to require some type of uniform resident assessment and collection of that data by the state. As one participant from a consumer advocacy group observed, **"How can they know if their regulations are adequate...if they don't know what the population looks like?"**
- Advocates in some states were also concerned about the lack of data for monitoring the performance of facilities and of the state agencies. For example, one argued, **"No one knows how many violations have been cited or of what type, how many abuse complaints, who is living... [in RCFs] and what residents are like, for example, how many with dementia, and so on because the Department... doesn't keep data on this in their database."**
- Participants across study states discussed the view of residential care/assisted living as a "social model." They also noted that because much of the industry is "private pay" and has adopted "negotiated risk contracts," the burden for securing adequate care is on the resident. This can shift the burden for any failure by the facility to provide needed services onto the resident or resident's family, rather than the facility. Some felt this focus

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oversimplified the situation and made it difficult in some cases for complaint investigators to substantiate abuse and neglect cases. One ombudsman spoke about this:

"...Our clients are caught in this debate between medical model of care and the social model of care. What a bunch of hooey! You know, who's going to be able to determine neglect in those over-dichotomized... situations? It's like a marketplace now.... And so the onus is to the residents to pay more for care. How is anyone going to prove neglect if they put the onus back on the consumer, on the resident, to pay that money if they need more care? Then neglect can look like their fault or their choice."

4.2.2 Difficulty of getting new legislation passed

We were told about providers actively campaigning for improved standards in RCFs/ALFs in only one of our study states. However, citizen advocacy group staff, ombudsmen, and licensure agency staff in four of our study states explicitly commented on the power of the RCF/ALF industry in terms of development and implementation of policy, including limiting the regulations that govern the facilities. There was no question about the industry in our interview guides. Thus, these comments about the industry were spontaneous and mentioned in terms of major challenges or barriers to assuring quality and preventing abuse and neglect.

In one study state, the State ombudsmen, APS caseworkers, and volunteers from a state-wide citizen advocacy group all commented on the strength of the organizations representing RCFs, the effectiveness of their lobbying efforts, and the amount of campaign contributions they made to the governor and members of the legislature. They argued that the political power of the industry affected the standards, the enforcement remedies, particularly financial sanctions, and weakening the consumer oversight of the LTC system.

In another of the study states, ombudsmen argued that providers did not support quality improvement. As the State LTC Ombudsman said:

"I think that, for example, the...[RCF association] ought to do a lot more about educating its members, and, you know, raising the quality of care. But they're not going to do that. Their interest is, to be quite frank with you, is to go in and get money from the legislature. That's their thing."

In a third study state, the ombudsmen and consumer advocates reported that the RCF/ALF industry in the state had successfully prevented any revision of the standards for more than a decade. In the latest attempt to re-examine the standards, the industry opposed increasing the 16-hour training requirement for staff. It also opposed the state agency's proposal to study the relationship between staffing and quality in residential care. Finally, it opposed changing the policy that allowed unlicensed staff with minimal training to be "delegated" to provide such

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care to residents as delivery of nourishment or medication through a Gastrostomy tube, management of catheters and ostomies, administering insulin, and daily glucose monitoring under “supervision” of a nurse – although the exact nature of supervision (e.g., amount and nature of training of staff and type and frequency of oversight by RN) is not well-specified. While the latter issue is still being considered by the licensing agency, so far the industry positions have dominated.

An ombudsman’s view of the current state of regulation and elder abuse prevention in her state provides a discouraging coda and, perhaps, a call to arms for reform in residential care. She said:

“I’ve been an ombudsman almost 20 years now. We’ve made no progress in elder abuse prevention in my opinion. I think elders are being assaulted, raped, attacked, beat, whatever on a daily basis in our long term care facilities. And I don’t know how to stop it....I don’t see that we’ve made any inroads.”

4.3 Detection of Elder Abuse – Outreach & Intake

The detection of elder abuse depends on many factors – some within the direct control of government agencies and programs and some, such as under-reporting by various types of potential reporters that are more challenging in terms of public policy. However, another factor that can affect detection of elder abuse is the ease or difficulty potential reporters experience in attempting to lodge a

Smart Intake Training Practice

In Maine and Texas, as part of their training, intake workers participated in “job shadowing” with complaint investigators. This helped them understand more fully the kind of information field investigators need in the intake report.

complaint or report an incident. In general, we found that intake telephone lines were often short-staffed and that there was huge variation in the proportion of calls that were screened out – which raised serious questions about the effectiveness of the process in terms of detection of abuse. Finally, we found significant problems with under-reporting by licensing agencies, APS and the ombudsman program. Fortunately, we also identified some smart practices, as described below.

4.3.1 Outreach

In a subsequent section on prevention of elder abuse, we discuss what the study states did to educate the public about elder abuse, including how to report elder abuse in residential care. In this section, we discuss various outreach activities of the licensing agencies, ombudsman programs and APS.

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Only one of our study states had distinctly poor outreach practices. For example, the website of the state agency that regulates RCFs does not provide any information on how to contact the agency. Moreover, according to a citizen advocacy group in the state, the only means of contacting the department was by submitting an email request form.

While only one state had what seemed to be an significant lack of outreach activities, most agencies in our study states identified few if any activities that they classified as outreach. The most common was that licensure agencies required facilities to post a notice giving the state's toll-free number for reporting abuse or neglect. Similarly, like the Texas licensing agency, several agencies mentioned offering training to RCF provider groups on reporting and investigating allegations of abuse and neglect. The Texas state licensure agency also had an easy-to-identify link on its website to information about reporting abuse.

Smart Outreach Practices

The local ombudsman program in the Dallas, Texas area provided training to incoming classes of paramedics on elder abuse, reporting requirements and processes, and residents' rights.

A North Carolina ombudsman attended resident council meetings in RCFs and provided training on resident's right's and talks with council members about abuse, residents' perceptions of abuse, as well as how to report abuse.

The State LTC Ombudsman Program in Alabama provided large, attractive posters that local ombudsmen can place in RCFs. The poster used large print to inform residents about the ombudsman program and what ombudsmen can do for residents, including helping with any complaint about abuse. It also had contact information and a photograph of the local ombudsman, since residents might recognize a face even if they didn't recall the name.

California ombudsmen provided training on recognizing and reporting elder abuse for EMT's, acute care staff, particularly in the Emergency Department, and other mandated reporters. They also recommend establishing a good relationship with the coroner as a smart practice for detecting abuse.

More Smart Outreach Practices

One of the North Carolina APS caseworkers reported on the Alamance County Adult Mistreatment Awareness Team. The Team held quarterly meetings with law enforcement and other involved agencies, family care home administrators, nursing home facilities, home health agencies, Toast Masters, "basically anybody that ...we had ever gotten a report from or should be receiving reports from [or] that we wanted to educate in the community." They also participated in the Silver Ribbon campaign during May (Elder Abuse Awareness month), getting information on elder abuse and how to report it to the local television stations, the library, community senior centers, and resource fairs.

The Cape Fear Council of Government in North Carolina started a group called "Elder Abuse?" It involved staff from the county Department of Social Services who were adult care home specialists, the local ombudsmen and APS in developing and performing "little skits about what elder abuse and exploitation are" in order to raise community awareness.

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4.3.2 Intake

States had a variety of arrangements for intake, some of which were more conducive to reporting than others. As we noted earlier, we used the National Center on Elder Abuse website to make an initial identification of the relevant agency and, where available, telephone number to call in order to report elder abuse in residential care facilities. It was hardly an ideal process, although at least the NCEA website would provide someone a starting point. Otherwise, those wishing to report an abuse or neglect complaint must find their own way to the relevant agencies and telephone numbers. In our national telephone survey in 2006 of the states and the District of Columbia, as shown in Exhibit 4.3, we found that 14 states did not have a toll-free hotline listed for reporting complaints of elder abuse in RCFs. In addition, 25 states did not have a hotline that was “manned” by a person 24-hours a day, 7 days a week. However, our visits to the project study states provided considerably more detail about how intake was organized and worked – and how it did not work.

4.3.2.1 Intake Process

Critical differences exist in the ways that the study states handled intake. First, some states had a centralized intake process, with one agency or division having responsibility for all intake calls on elder abuse in residential care. Other states had multiple access points for persons wishing to report allegations of elder abuse in RCFs, including the licensing agency, the ombudsman program, APS and, in some cases, the MFCU. Finally, one state had intake functions at the state level in multiple agencies and intake at county agencies as well.

Study states were not evaluating intake decisions that screened out some complaints or facility incident reports from further on-site investigations or referral to other agencies for victim services.

A second structural difference in the intake process was whether the agency doing intake used generalists, who would field calls for a variety of programs (such as Children’s Protective Services (CPS) as well as APS or the all aging services regulated by the licensure agency). Some agencies instead hired intake specialists who concentrated on elder abuse and neglect complaints.

Exhibit 4.3 State Arrangements for Intake of Elder Abuse Reports/Complaints

Feature	Yes	No
Toll-free hotline for reporting	37	14
Hot-line manned 24 hours a day/7 days a week	26	25

2006 telephone survey of all states and DC, using the agency and phone number identified by NCEA

Smart Intake Practice

In New Mexico, on weekends, nights and holidays, when the state-wide intake call center is closed, any call that comes in was automatically transferred to one of two cell phones. Two staff persons were on-call to answer the cell phones. They were authorized to screen a call in or out for investigation and could call one of the 18 regional APS supervisors with any allegation that was classified as an emergency or “immediate jeopardy” issue and required prompt attention from an APS caseworker.

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In one study state, complaint investigators expressed concern about their state's practice of having intake staff take complaints for a range of programs. They argued that the generalists were not particularly well-versed in any one program. As a result, the complaint investigators felt that they often had to "backtrack" to get some of the initial information they needed to decide whether to accept the report as a case and, if accepted, what priority to assign to the case in terms of the scheduling of an investigation. As one complaint investigator noted of the intake process:

"I only have the information I have at my fingertips to make a decision. So I think that by being so diversified the way we are and the fact that maybe the intake worker doesn't have the experience in residential care or assisted living, or with ... the rules...[to] know all of the types of questions you need to ask....I'm not blaming intake...It's just the nature of the business. It can impact assignments. We could be missing things."

Another issue was that intake staff often made decisions about what are referred to as "incident reports," which are facility-generated reports of abuse or injury to a resident. In many states, intake staff were responsible for deciding whether these incident reports have been adequately handled by the facility and can be screened-out" for agency investigation or referral to APS or the ombudsman program services to the victim. Often, the default judgment was to screen these incidents out, even when the facility found that abuse had occurred.

Finally, only one state systematically monitored the intake process. However, even including this study state, we did not find any intake agency that conducted an independent field assessment of calls that were screened out in order to determine whether the decision was a correct ("valid") one or whether the screening criteria used by the state were reliably used by intake staff. This was a serious deficiency.

Smart Intake Practice

As part of "Zero Tolerance of Elder Abuse," a multi-pronged initiative launched by the Governor, New Mexico established a unified intake site, the Aging and Disability Resource Center. This provided a single intake point and integrates several existing Aging and Long-Term Services programs. It was a "one-stop" resource for older persons, persons with disabilities, and their family members and advocates. The Center had nearly 30 telephone staff to answer calls. They received about 10,000 calls a year on their in-state toll-free telephone line related to elder abuse, neglect and exploitation, and callers were directed to one of eight specially-trained staff. Calls that were screened-in for investigation were written up and electronically sent to one of 24 APS offices statewide. However, the staff could also refer a caller to other aging services, such as a benefits counselor, legal services, or the LTC ombudsman program, since many people who needed APS services also needed other services. In addition, if the eight APS intake staff at the Resource Center were busy with calls, one of the other 20 call-takers at the Center could initially handle the call and transfer the information to the specialist intake staff for follow-up. The website for the Resource Center also provided a PDF "Benefits Counseling Desk Reference" with useful contact information for seniors and people with disabilities that could be downloaded at no charge (see www.nmaging.state.us/Resource_Center.html).

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4.3.2.2 Accessibility and Responsiveness

States also differed significantly in the accessibility and responsiveness of intake to potential reporters. In all of the study states, the licensing agency had primary responsibility for investigating allegations of abuse or neglect in RCFs/ALFs. Ombudsmen had responsibility for responding to a resident or family member's complaints – or to allegations that might be filed anonymously about elder mistreatment or quality problems at an RCF. The role of APS in our study states was much more circumscribed. First, APS only investigated complaints about abuse if (1) the alleged perpetrator was external to the facility (e.g., not staff or another resident) or (2) if the facility was “legally unlicensed” (e.g., state licensure law allowed facilities with fewer than 6 beds to operate without a license). Thus, we concentrated on understanding more about the performance of the intake processes at the licensure agencies.

We identified several practices that seemed antithetical to effective detection:

- No toll-free hot-line to report abuse;
- Abuse hot-lines were not manned 24-hours a -day/ 7- days a week;
- Hot-lines that were not monitored for calls that come in on nights, weekends and holidays;
- Hot-lines that were under-staffed so that calls routinely went into voice-mail; and
- Screening criteria designed to reduce staff workload without an on-going evaluation of the effectiveness of the screening criteria, particularly in terms of the calls that were screened-out of agency investigation.

“You need to be able to get the information [from intake] right off the bat and get in there as soon as possible. When you get back to the referent, the referent may have panicked or their recall may not be as clear or there may just be some deliberateness...to just minimize it - because they are concerned about retaliation toward their loved one in that facility. [Intake]...sometimes that may be the only opportunity you get to hear the information.”

Licensure agency complaint investigator

One APS administrator identified having too few intake staff as a barrier to effective detection and investigations.

“Intake frequently has answering machines instead of people. Not being able to get someone to take the report is a problem. It delays response to even serious abuse cases.”

In one of our study states, the RCF licensing agency reported that it did not have a toll-free hotline for people to report elder mistreatment during regular work hours. The agency's website did not have any link on its “face” page that used the words “elder abuse” or “personal care homes” – the designation used in that state for RCFs. Instead, someone wanting to report abuse or neglect was required to discern and follow a

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somewhat obscure pathway to find out about how to report a complaint. A search may have led someone to an icon for “*Services for Older [Citizens].*” Under that, one might click on “*Personal Care Homes*” and from that to “*Getting Help with Complaints.*” The agency website then suggested that the first step for a resident or family member was to “talk directly to your personal care home ... administrator.” The website noted that the department was “always here to assist you” and suggested a complainant could contact one of the department’s regional offices “during business hours.” The voicemail for the Regional Offices asked the caller to leave a message or contact the local Area Agency on Aging or, if it were an emergency situation, to call the toll free Complaint Hotline. Such a process might easily overwhelm an untutored individual.

In one study state, only one intake staff person was available for all types of complaints concerning abuse of RCF residents, and this intake person also answered the phone and performed other administrative duties for the licensing agency. In another study state, the intake person was also clerical staff. According to APS caseworkers and ombudsmen in these two states, as well as licensure agency complaint investigators in one of the two states, having only one person doing intake was inadequate. In both states, other agency staff said that many calls went to voicemail and that callers often had to wait several days to receive a return call in which their complaint would be formally recorded. Thus, this understaffing led to delays in the start of investigations and often discouraged callers. In both of these states, the intake telephone line was in operation only during business hours five days a week. In one of the states, the after-hours message did not even suggest that callers contact law enforcement, APS or the ombudsman. In both states, there was no monitoring of the intake line’s voicemail messages during nights, weekends or holidays.

In another study state, the licensing agency had a toll-free hotline for intake and was tasked with intake of allegations about abuse in licensed RCFs. The line was manned only between 8:30 and 4:00 during the work week, and calls went to unmonitored voice-mail thereafter. As with most of the study states, voice-mail was monitored during business hours only. Complaints screened-in for investigation that involved residents of RCFs were faxed to the relevant county Department of Social Services (or APS at the county level, if applicable) the next business day after the intake. Most counties in this state also had their own intake lines for abuse complaints. Both APS caseworkers and county-level DSS complaint investigators liked the flexibility and responsiveness offered by this multi-level offering of intake sites; however, several were concerned about the lack of consistency across the counties in screening criteria and the huge variation in the proportion of calls screened-in

Smart Practice – Timeliness of Intake and Referral

The Texas licensing and regulatory agency had a special unit devoted to intake. Its intake staff did “real-time” data entry into the intake and referral data base. As a result, if an initial intake call was not completed or more information were needed, the intake and referral form could be called up and completed by someone else. In addition, the MFCU had access to this database and could accompany a complaint investigator to the facility, as well as monitor in real time the nature of complaints, investigator workloads, and so on.

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for investigation (e.g., variation from 30% of calls screened-in by one county to 85% screened in by other counties). Most felt this variation was associated with differences in the training and knowledge of intake workers and with the application of screening criteria that were aimed at controlling workload rather than true differences in the nature of the calls. Unfortunately, there had been no evaluation of the reasons for this variation and the effectiveness of screening criteria.

4.3.2.3 Screening at Intake

There was considerable variation across the study states in how the decision was made about whether to screen a complaint or allegation in for either additional information gathering or for referral for investigation. There was considerable variation across and, in some cases, within states in the rates of reports that were screened in for investigation.

There was significant variation in the proportion of reports or complaints about elder abuse or neglect that were screened-in for further action. In one project study state, the rates varied from 30% of calls screened-in for investigation to 85% screened in. In another study state, the variation across regional offices in the proportion of complaints screened-in for investigation ranged from 40% to 70%.

Intake workers used non-standardized screening criteria. In one study state, APS Administrators said intake was a problem in part because there was no centralized intake line at the state-level, and many of the abuse complaint calls were made to county agencies. Staff in those agencies, who were not APS staff, often used screening criteria that APS felt were inappropriate. A state-level administrator gave an example of a call that was screened -by intake staff and not referred to an APS caseworker because of the county intake worker’s misunderstanding of the factors that made an adult “vulnerable” and thus eligible for protective services. The APS administrator said:

“This was frustrating. There was a resident of an adult care home alleging that he was being sexually assaulted by the administrator. And, he had a friend who lived in a local nursing home, and...he got to see that friend [by riding]...a bike from his adult care home to the nursing home. And when I... [inquired]... [name of intake staff] told me that they had screened this report out for Protective Services because [the intake worker thought] the resident wasn't disabled or vulnerable because he could ride his bike from the adult care home to the nursing home.”

Effect of Definitions on Screening: Abuse, Neglect and “Intent.” APS caseworkers also noted that confusion or disagreement over the definitions of abuse and neglect created a barrier to reporting, investigating and resolving some cases. Caseworkers noted that some people require that the act be “intentional” to meet the definition of abuse or neglect. This has proved to be a major barrier in terms of elder abuse, as illustrated by the following cases.

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- An RCF resident was found with a huge pressure ulcer (7" x 7" and down to the bone) and died shortly thereafter from septicemia. APS and the licensure agency staff argued that this was a case of extreme neglect. The local district attorney took the case to trial, but the jury hung on the “willful intent” phrase in state law defining abuse and neglect of a vulnerable adult.

- As noted earlier, in another state, the abuse complaint investigator visited a facility in which a resident had lost 60 pounds since being admitted to the assisted living facility a

None of the intake agencies interviewed reported that they conducted an independent field assessment of calls that were screened out in order to determine whether the decision was a correct one or whether the screening criteria used by the state were reliable.

few months earlier. This weight loss occurred despite the fact that he did not have cancer or any other wasting or terminal disease. However, he did need help with eating, requiring oversight and cuing/reminders at meal time because of moderate dementia. The investigator found that the facility was short-staffed and that the resident did not receive any

assistance at meal times. The investigator cited the facility, but her supervisor overturned the citation, arguing that there was no evidence of intent to harm the resident.

- A medical examiner (ME) we interviewed discussed a complaint about abuse from a family whose grandmother had died as a result of sepsis from pressure ulcers. The ME noted that the resident did have six Stage Four pressure ulcers – the most severe type and that they had caused the fatal case of septicemia. However, he concluded that there was no abuse (or neglect). The ME argued that the facility had too few staff to turn and position the resident and carry out the frequent wound care procedures but that this did not constitute abuse or neglect because there was no “intent” to kill the resident.

- Finally, we heard of several cases in which residents with Alzheimer’s disease or other dementias physically or sexually abused other residents. However, police often told ombudsmen or licensure investigators that there was nothing they could do, since there could be no finding of “intent” for a perpetrator with dementia. Further, in most of those cases, the licensing agency did not cite the facility for failing to put in place practices that would have prevented or minimized aggressive behaviors by some residents or protect other residents.

Requiring that an act be “intentional” to constitute abuse or severe neglect hampers investigations, resolution, and prosecutions.

Screening to Control Workload. In one state in which APS played an active role in residential care, APS caseworkers were carrying a very heavy caseload. In this state, caseworkers said they usually carried a caseload of 50 – 60 active cases in many counties.

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APS staff also had guardianship cases, which could take considerable time. These caseworkers reported that if they substantiated the intake complaint, they “kept the case.” Other participants in the APS caseworker focus groups noted that supervisors often set screening questions and criteria in order to control workload, particularly when the agencies were “short-staffed.” One participant said that many abuse complaints were screened out, that is, excluded from any investigation because of insufficient staff to handle the cases. Another case worker reported that supervisors set criteria to triage complaints, assigning only the most apparently serious incidents to a caseworker and excluding the others because of short-staffing.

One APS caseworker noted that in her state, “the manpower to work the cases is not there.” Caseworkers and complaint investigators from most of the states concurred. As one observed about the effect of staff shortages on intake and referral, “The supervisors are in triage mode...I mean we can only run so far and work so hard.”

The result of these resource constraints and resulting variations in caseload and screening criteria can be seen in one state in which there was tremendous variation across the counties in the proportion of cases screened in or “out” – from 30% of calls being screened in for investigation in one county to 85-90% of calls being screened in by another county. In another project study state, the state-wide average for calls screened in was about 60%, but the range was from a low of 40% to a high of 70% among the local offices.

Abuse and Neglect Cases Screened-Out Because of Facility Action. In several of the states, RCF/ALFs were required to report and investigate alleged cases of abuse or neglect. In one study state, the licensure surveyor/complaint investigators reported that the centralized intake worker is instructed to “screen out” any cases – even if they were substantiated by the facility - if it was “*clear that the facility has addressed the issue.*” Thus, for example, if the facility

In many of the states, if an RCF reports a case of abuse, even a substantiated case, the complaint intake agency screens these cases out and does not refer them for investigation by agency staff or refer them to APS, the ombudsman, police or the MFCU if the facility reports that it has addressed the issue.

dismissed a staff perpetrator or the person quit, the cases is considered “handled” by the agency. The agency administrator said that they screened such cases in for investigation only “*if there seems to be a pattern.*” However, neither this administrator nor the associate administrator was able to specify how an intake operator would be able to identify a facility with a pattern of abuse or neglect cases. In addition, neither APS nor the MFCU in that state were aware that a relatively high proportion of calls to the abuse intake line were screened-out and not reported

to the MFCU or referred to the MFCU.

This policy of not investigating or acting in some way on abuse cases reported by facilities – typically referred to by agencies as “incident reports” – has serious implications. It may mean, for example, that a staff person who has abused a resident is free to work in another

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setting with vulnerable adults (or children) because the case has never been investigated by a state agency and the person placed on a registry of individuals banned from working in health care settings. In addition, screening-out such cases may mean that APS or ombudsmen are not notified of the abuse (or the allegation) and are thus unable to visit with the resident who was abused to determine whether she or he needs additional assistance, such as counseling or relocation.

4.3.3 Problem of Underreporting

Prior research indicated that under-reporting of elder abuse is widespread. Residents and family members tend to under-report because they fear retaliation by the facility or a staff person, because they think complaining is futile – that nothing will change, because they don't recognize something as abuse (or neglect), or because they don't know how or where to report (Broyles, 2000; Bowers et al., 2003; Pettee, 1997). Staff in facilities don't report for many of the same reasons. In addition, research has shown under-recognition of abuse and underreporting among health care professionals (Burgess, Ramsey-Klawnsnik & Gregorian, 2008; Kleinschmidt, Krueger & Patterson, 1997; Pettee, 1997; Pillemer & Finkelhor, 1988; Ramsey-Klawnsnik et al., 2007; Tatara, 1990; Wolf, 1988).

This under-reporting is obviously a concern, and only a few state agencies and consumer advocacy groups had developed initiatives to educate the public, with particular emphasis on potential reporters. However, we did not address underreporting by any groups other than under-reporting among the agencies with primary responsibility for detecting, investigating and resolving cases of elder abuse in residential care.

Under-Reporting by Licensing Agencies. First, as noted, some level of under-reporting in at least one of our study states occurred at the mandate of the licensing agency. The intake division, under the direction of the licensing agency, screened out and did not report all substantiated cases of abuse or neglect (a) for further investigation or (b) for follow-up by APS or the ombudsman program. The agency acknowledged screening-out substantiated abuse and neglect if the "incident" report came from an RCF and the facility's incident report indicated that the facility had taken "appropriate" steps to resolve the problem. One troubling feature of this was that none of those cases were referred to APS or the ombudsman program so that someone could visit the resident victim to verify the facility's report or determine whether the resident needed

Smart Practice – QA

The Texas agency that does complaint intake created a customer satisfaction survey for complainants, except residents (to protect their privacy) or providers who are filing incident reports. However, agencies, such as ombudsmen, APS, home health agencies, and others that called the intake line and made a report received a survey. The intake agency sends out about 180 surveys per month and achieves a return rate of 14 to 15%. The overall customer satisfaction ratings were in the mid-90's on a scale of 100. These reporters are also given a one-page sheet that described the process and tells them what is going to happen.

"We can't investigate what licensing doesn't tell us about."

APS Caseworker

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counseling, wanted to move to another facility, or required other services as a result of the abuse or neglect.

Additional Research Needed. Whether intake units and licensing agencies in other study states routinely screened out reports of abuse and neglect that come from facilities (“incident reports”) is unknown. Further, we do not know the degree to which intake sections failed to refer these events – and the residents involved – to the ombudsman program and APS. However, this was a potentially serious area of under-reporting of abuse cases and under-referral of older persons who had been abused to post-abuse counseling and services.

Interviewees spontaneously reported that the licensing agency was not referring facility incident reports and possibly other complaints to APS or the ombudsman program in three of our study states. In one of these states, an APS regional administrator noted:

“Facilities are supposed to report ‘incidents’ of abuse, but the RCFs send them to... [the licensing agency] and not to APS. Licensing - they don’t send the facility reports to APS unless they don’t have the resources to respond in a timely fashion. And then we don’t really investigate the case or initiate casework with the resident; we just do a safety check.”

APS staff in another state responded in a similar way.

“Before the change [consolidating all intake calls and assigning them to the licensing agency], we investigated a lot of cases of abuse in RCFs. A lot. Now, we never get calls to visit a resident. Really, for workload, this is a good outcome, because we don’t have the staff [needed] to take on more cases. But I wonder what happened, how many people out there [in RCFs] still need our services.”

It is important to learn whether other intake sections in licensing agencies screen out substantiated abuse and neglect cases if the intake report came from an RCF and the RCF had handled the incident “appropriately.” This screening policy – coupled with a decision not to refer these cases to APS or the ombudsman program – depresses estimates of abuse incidence and may deprive elders of needed counseling and services.

MFCU Best Practice Weakened By Under-reporting. Another consequence of one licensing agency’s intake policy to screen-out facility incident reports and not refer or identify substantiated abuse cases was damage done to the AG’s proactive approach detecting and preventing abuse.

In this state, the unit in the AG’s office that handled healthcare fraud and abuse believed it was receiving copies of the intake forms for all reports of abuse or neglect. It used information in these reports to create a large database on suspected perpetrators and facilities

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in which abuse, neglect and drug diversion might be happening. These data were then analyzed to identify patterns of complaints involving individual facilities, as well as complaints against individual staff members – whether or not they were substantiated. The healthcare fraud unit used the complaint data to target facilities for investigation of its practices if, for example, it found a pattern of resident-to-resident abuse or potential drug diversion occurring in the facility. Similarly, it could look for patterns of allegations of abuse or neglect against an unlicensed staff person and follow that person across employers, using state Department of Labor information. The MFCU did that with one unlicensed staff person suspected of drug diversion in an RCF but against whom a case could not be made. The MFCU chief investigator followed him across employment in other healthcare settings to a nursing home in which the investigator examined resident medical records and worked with the facility and local police to increase drug surveillance in the facility. As a result of this proactive approach, the staff person in question was apprehended stealing the residents’ pain medications. However, we discovered that the intake unit of the licensing agency failed to report a high proportion of the abuse cases to the MFCU. It did not report facility incident reports, even when they substantiated abuse or neglect, and it did not report complaint calls that it “screened out” and did not investigate. This failure to report all incidents or complaints compromised this MFCU’s proactive approach to detecting and preventing abuse and neglect.

Failure to Refer. The failure of intake in one agency to cross-report to other agencies is serious. In several study states, respondents from APS, licensing agencies, and the ombudsman program spoke of “turf wars” between licensing and APS agencies. In several states, licensing administrators and staff tended to view APS as irrelevant because of their limited role in residential care facilities. APS, on the other hand, criticized the licensing agency for failing to refer individual cases to APS and for a lack of timeliness in the licensing agencies’ intake and investigations. In two states, respondents in APS spoke with dismay about the effect of recent “streamlining” of the states’ processes so that there was only one intake line and it did not automatically cross-refer abuse complaints to licensing and APS. Ombudsmen were also concerned about not getting referrals about residents who has been abused or neglected. As one ombudsman said:

“We don't get any referrals from licensing now. Everyone says it is to 'make better use of resources.' But we had enough staff to do it before. I hope that abuse cases are being investigated properly now – and that someone is looking out for each resident. But I don't know...I worry in particular about the cases we used to see of residents in assisted living who really needed nursing home care. Who will look after their needs now? I don't think anyone is trying to move them to a higher level of care – even if they need it.”

In one state, a group of APS caseworkers discussed the dramatically reduced number of case investigations they were now doing in RCFs. As one noted:

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“We used to do a lot of investigations in residential care homes. Now, we almost never get a case.”

She looked at her colleagues, who were nodding in agreement.

“Don’t get me wrong – we don’t have enough staff now to do the number of cases we used to in those facilities. But I wonder – where did those cases go?”

Another caseworker added:

“We can’t investigate what licensing doesn’t tell us about.”

APS caseworkers in another state agreed. As one noted:

“We [APS] were pulled out a year ago from doing investigations in nursing homes and assisted living. That is a sour note for me. But it was a resource decision at top levels.”

Some MFCUs in the study states also spoke of the importance of referrals from intake – and of having those referrals communicated to the MFCU in a timely fashion. As one Assistant Attorney General said:

“In the criminal investigation arena...what became apparent was that if information came and sat somewhere, it was worthless...[Y]ou have to pass the information on. It has to move on to people who might know the significance.”

Under-Reporting by APS. As noted above, in many (but not all) of the study states, respondents reported problems in the relationship between APS and the licensing agencies. In part, this was a product of the different roles and orientation of the two agencies. The focus of the licensing agencies is on determining whether there has been or still is a violation of the licensure regulations. The focus of APS is on the wellbeing of the individual resident and, as one APS administrator explained, on *“evaluating the need for protective services”* rather than investigating allegations of abuse or neglect. This is discussed at greater length in the next section on investigations. However, the point here is that ombudsmen and licensing agency staff, as well as APS caseworkers and administrators, argued that APS did not always accept cases of abuse or neglect of residents of RCFs.

First, in our study states, APS largely confined its role to accepting and investigating allegations of abuse only if the alleged perpetrators were from “outside” the facility. This was usually policy established in state law or in Memoranda of Understanding (MOU) between APS and the licensing agency. Thus, APS would accept cases in which a family member was

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the alleged abuser but would not accept a case if the abuse was committed by a staff member or another resident. Those cases were viewed as the purview of the licensing agency.

Second, as an ombudsman explained, APS often screened out “real” cases of abuse and neglect if APS concluded that the resident or a family member was capable of making plans or arrangements to keep the resident safe. APS traditionally has regarded licensed facilities as “safe” environments. Thus, even if a resident had been abused, if APS or their intake staff felt the resident was not impaired in decision-making, was not physically vulnerable, or had a family member available, APS might screen the case out and not investigate. The same was true in many cases, according to some APS staff, if the facility reported the abuse and “handled” it. In other words, APS might feel that in such cases there was no need for APS to get involved, even if abuse occurred, if in APS’ view the resident did not need protective services.

Third, in some of the project study states, there was considerable shuffling of responsibility between the licensing agency and APS when it came to abuse and neglect in unlicensed facilities, as discussed in Section 4.6. However, at best the disagreement in at least one study state, over who was responsible for investigating reported abuse and neglect in unlicensed facilities delayed investigations. At worst, many cases of abuse and severe neglect cases were not investigated by any agency if the incidents occurred in unlicensed facilities.

“Dealing with the prohibition against reporting - it’s more important than the Elder Justice Act. I mean, who cares if we have a *definition* of elder abuse if we still can’t report it?”
Ombudsman

Under-reporting by Ombudsmen. We also found under-reporting of incidents of abuse and neglect by ombudsmen (Administration on Aging, 2000; Tatara, 1990). In part this was because of ombudsman views of their role. In a national survey of state and local, one-third of the ombudsmen (36%) reported that they viewed their role as resolving complaints with the facility. They would file a complaint about abuse only if they had been unable to resolve the complaint with the facility. Another four percent of ombudsmen reported that they would resolve problems between the resident or family and facility without ever filing a complaint (Hawes, Blevins, & Shanley, 2001). Ombudsmen also discussed the fact that some did not view their role as reporting abuse but rather as one of advocating for the resident and making an arrangement between the facility and resident or family that resolved the issue.

The somewhat larger issue in terms of under-reporting of abuse was related to the role and responsibilities of ombudsmen as defined in the Older Americans Act (OAA). Under the OAA, an ombudsman may not report an incident of abuse or neglect without the resident’s consent. If the resident – or the designated health care decision-maker for the resident – does not consent, the ombudsman may not report the case to the licensing agency, APS, or law enforcement with any identifying information.

There was considerable disagreement among the ombudsmen about this, particularly since in the study states, ombudsmen were mandatory abuse reporters under state law. Several

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expressed their concern and identified the OAA provision as a major barrier to effective detection, investigation and resolution of elder abuse in RCFs and an impediment to their doing their job of protecting residents. Several ombudsmen discussed their frustration and the need to resolve the conflict between reporting abuse and the OAA provision:

“How can I protect the other residents in a facility that has an abusive aide if I can't report the abuse that happened to one resident because she won't consent [to reporting].”

These sentiments were echoed by many ombudsmen in our study states and in the national focus groups. As another ombudsman said of the prohibition against reporting abuse without a resident's consent:

“It's more important than the Elder Justice Act. I mean, who cares if we have a definition of elder abuse if we still can't report it?”

Some ombudsmen were also troubled by the implications of the OAA provision as it applied to residents with Alzheimer's disease or other dementias. They felt the requirement of getting the residents “permission” to investigate and refer instances of abuse or neglect was a significant barrier. One ombudsman explained the issue and her frustration:

“If I can't get permission from a resident, I'm supposed to end the investigation because of the OAA requirements. How can we protect demented people who can't give consent?”

Another ombudsman in the group agreed:

“The Older Americans' Act does not take into account people who might become demented. There is no provision for it. It's all about as long as they're human beings they have a right to choose. By not giving *consent* to report, they aren't not choosing [to report]; they are just not able to [give] consent.”

One ombudsman described a case she thought illustrated the conundrum ombudsmen found themselves in with respect to obtaining consent from the resident before reporting. A nursing home resident with dementia reported to the ombudsman that she had been raped during the night. However, her daughter had a durable power of attorney for health care decisions, and she was out of town and could not be reached. Incidents involving rape must be medically reviewed quickly to preserve any biological evidence. Obtaining a court order would have delayed the collection of this type of evidence, possibly compromising any criminal proceedings. The ombudsman felt she had been put in a terrible situation, as had the resident.

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“But without her consent, which she could not legally give, according to my supervisor, I was supposed to not report.”

Just as some ombudsmen were troubled by the OAA prohibition, other ombudsmen believed that it was an important policy that honors the rights of residents and must be preserved. One State ombudsman argued:

“We're in a horrible situation here. This [*being mandatory reporters and designated as “first responders” for abuse complaints*] is a responsibility that we should never have been given because we work at the request of the resident and do what they want us to do. We shouldn't be abuse investigators. We shouldn't be mandated reporters because of this conflict....For residents in a nursing home or residential care facility, we may be the only people who respect the resident's preference....The Older Americans Act should be followed...The Congressional intent, acting at the request of the resident, is there for a reason and should be honored.”

Smart Practices by Ombudsmen Aimed at Improving Reporting.

Ombudsmen reported different ways to handle this conflict. Some felt that federal law in the OAA trumped state mandatory reporting law and felt comfortable following the OAA. Some believed that if they could resolve the situation with the facility (e.g., discharging an abusive staff person; providing additional training on verbal abuse to staff) to the satisfaction of the resident and, if present, the resident's family, they did not need to report the abuse. Others argued that even if the resident would not permit the ombudsman to speak with the facility

Other Ombudsman Smart Practices on Reporting

Some State LTC ombudsman gave the local ombudsmen cell phones with the capacity to take automatically dated photographs so that they have physical evidence of what they have seen in the facility.

The New Mexico State LTC Ombudsman arranged for her local staff ombudsmen to attend training with the state licensure surveyors – who also conducted RCF complaint investigations. This accomplished three things. First, it introduced the surveyors to the ombudsmen and made them known, familiar faces. Second, it increased the investigative skills of the ombudsmen and helped them know how to write up a report to meet the standards used by the complaint investigators. Third, knowing the ombudsmen participated in the same training on surveys and complaint investigations gave the licensing agency staff more confidence in the accuracy of ombudsman reports.

One ombudsman program in California hired a retired policeman to be an ombudsman. He has provided training to other ombudsmen on how to interview and collect what law enforcement will recognize as evidence. He also trained them about how to write up reports in the language used by police and sheriffs' departments.

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administrator, much less anyone else, they should respect the resident's wishes and not refer the case to licensing or APS.

Some ombudsmen, however, said they would first try to convince the resident to give their consent, offering to make whatever arrangements were needed to make the resident feel safe from retaliation. Other ombudsmen adopted different approaches.

- They asked the caller other than a resident to report directly to APS or licensing, and, if relevant, reminded the caller that he or she was a mandatory reporter.
- One ombudsman said she tried to find out who else might have observed the abuse or who might have been told about event and convince that person to report.
- Several ombudsmen said that even if they could not report the name of a resident involved in a specific incident to licensing, APS or law enforcement, they could provide the name of the facility and details of the type of abuse that was involved and hope that law enforcement or licensing would follow up with an investigation that would identify and resolve any problems at the facility.
- One ombudsman said that if she witnessed evidence of serious physical abuse when visiting a resident, she would take a photo of the resident and send it with a report to law enforcement or licensing.
- If the allegation involved sexual or physical abuse that was criminal in nature, one ombudsman was unwilling to let the incident go unreported, even if the resident did not consent. She would ask the police (with whom she had a good working relationship) to meet her at the facility and conduct a joint visit. This seemed to work, since law enforcement does not need the resident's permission to investigate.
- An ombudsman said she had been concerned about a few RCFs in which drug diversion and abuse occurred and theft seemed widespread. She was successful in getting the police to work with one facility to install a hidden camera to observe the place where drugs were stored. At another facility, she persuaded the police to set up a "sting" that identified staff who had been stealing from residents.

Potentially Smart Practices

Several ombudsmen said that they would work to address the resident's concerns about reporting in an effort to get the resident to allow the ombudsman to report the case to other agencies. If the resident continued to resist, however, they respected resident's decision. At the same time, they noted that they would seek out other residents and staff to see whether they could find someone who was in a position to know about the abuse and was willing to file a complaint or report.

It is important to note that some of these approaches would not be approved or used by many ombudsmen who argued that providing information that would help identify a resident who did not consent to reporting violates that resident's rights.

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Discounting Ombudsman Reports. Several ombudsmen argued that their reports of abuse were not taken seriously by the licensing agency and, sometimes, by law enforcement. As one ombudsman argued:

“Our opinions are deeply discounted. We’ve even offered to sign affidavits. Go on record. Sometimes I wonder why I do what I do. If I go in and witness one nurse aide taking care of 42 residents and neglecting to care for pressure ulcers or see verbal abuse, but unless someone [a resident] complains...nothing happens.”

Several ombudsmen noted that they have a particular problem with licensing agencies. The ombudsman may see evidence of abuse, such as bruises, when they visit the resident immediately after the event. However, the complaint investigator may not conduct an on-site investigation for days or even weeks after the original incident. Others felt that law enforcement tended to disregard or downplay their reports because ombudsmen do not have training in criminal investigations. Recognizing this, some ombudsmen have adopted practices intended to ensure that other agencies and law enforcement take their reports more seriously, as described in the “smart practices” sidebar.

Under-reporting by Mandated Reporters. *Facilities and Staff.*

Across our study states, study participants noted under-reporting by mandated reporters. Many discussed the reluctance of staff to report abuse and identified two primary reasons. First, they said staff fear losing their job if the report, believing that the administrator will be able to identify the source of a report. Second, staff were reluctant to report on a colleague – either because they did not want her or him to lose a job or because they feared a confrontation if the colleague discovered who made the report.

“We have to educate the public on what abuse is.”

Ombudsman

A licensing agency administrator said:

“Some RCF staff have been told they will lose their job if they speak to an ombudsman.”

Local Ombudsman

“I think it’s really just a lack of recognition. I think in some facilities it [abuse] becomes the culture and people don’t recognize that this is abuse and I think that’s a big issue....Part of our

training challenge is to really say, what is it, what do we need to be doing about it.”

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Other mandatory reporters. As noted earlier, several prior studies of mandatory reporters have noted that health care personnel often failed to report suspected abuse (Kleinschmidt, Krueger & Patterson, 1997; Pettee, 1997; Pillemer & Finkelhor, 1988; Ramsey-Klawnsnik et al., 2007; Tatara, 1990; Wolf, 1988).

Consistent with these study findings, respondents in our study concurred about under-reporting. Staff from licensing and APS agencies argued that it was often a lack of knowledge among mandatory responders that explained a failure to report. As one said:

"A friend of mine who is a hospital social workers was told by the hospital not to report [a suspected case of abuse by facility staff] because the hospital did not want to get involved."
APS Caseworker

"Paramedics, fire, police, anyone who doesn't make the cross report, usually it's not because they're not willing to. A lot of times...they don't know what we are or what we do. They kind of vaguely heard about us. They don't have the same video they have to watch...[on elder abuse and how to report]. They just have yet another thing they have to report, and [they] don't...remember to do it."

One agency charged with investigating abuse cases in residential care said law enforcement is not always aware that their department has this responsibility. One investigator noted:

"Law enforcement will say they don't know who to report to. Even though we're listed on their report form [a standardized form for use with elder abuse cases]. But law enforcement may not even know to use the form. There is no standard for law enforcement involvement."

Ombudsman Smart Practices

- As noted earlier, one ombudsman program in California hired a retired policeman to be an ombudsman. He provided training to local police departments about state elder abuse law, what forms police should use when investigating these cases, and tips on how to investigate in residential care and with frail, elderly residents.
- Several ombudsmen programs across the country consistently provide training on elder abuse to all new classes of police officers.

An ombudsman who was a retired police officer noted the same problem. As he observed, police know what the forms are for cases of child abuse because they receive extensive training on child abuse. However, not all police departments in the state had the same kind of training on elder abuse.

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APS caseworkers also identified a lack of information as a reason for underreporting. She noted that people may be observing abuse but not be aware that it is abuse and a violation of state laws aimed at protecting the elderly. An APS administrator concurred, arguing that more public education is needed, as is the case with child abuse. She asserted:

"We need to bring the issue to a point where it [elder abuse] is always on someone's mind. Someone who sees a child being abused, you recognize it. You question it if you're in the grocery store and you see someone. At some point elder abuse has to get there."

Another participant said that some mandatory reporters ignored their responsibility because they did not want to become involved in what might turn into a malpractice case or other legal proceeding. Another study conducted for the National Institute of Justice found this to be true of physicians who practiced in nursing homes and residential care facilities, either as medical directors or physicians for individual residents. When asked about "abuse," geriatricians participating in focus group interviews said they were disinclined to report abuse to the regulatory agencies identified in state law either because they felt it would "not do any good" or might embroil them in a malpractice suit (Bowers, Hawes & Burger, 2003).

Under-reporting by Residents.

One of the problems identified by all types of participants in our study was underreporting of abuse by residents and resident families. They identified several reasons for this, most of which are supported by other studies (Broyles, 2000; Hawes, Blevins & Shanley, 2001). They include:

"It's bad enough to be a resident in a residential facility -- [and] to then to think that you'll be targeted or thrown out [if you complain]...is awful."

Ombudsman

- First, ombudsmen and complaint investigators uniformly argued that residents and families believed that if they complained, the facility would be able to determine who lodged a report. Thus, residents and families were reluctant to lodge a complaint because they feared retaliation by the facility or staff against the resident.
- Second, residents and family members in two other studies reported that they did not report abuse because they felt doing so was futile – that nothing positive would happen if they complained (Broyles, 2000; Hawes, Blevins & Shanley, 2001). Ombudsmen who participated in our study also noted that **"under-reporting is associated with the feeling that nothing will be done."**
- Third, ombudsmen said that in residential care, residents and families were often unaware of their rights and of how to lodge a complaint, a report substantiated in an earlier survey of a national sample of ALF residents (Hawes et al., 2000).
- Fourth, in two different states, ombudsmen discussed the fact that Medicaid waiver program payment rates were low for ALFs and RCFs. They felt that some residents and

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families were reluctant to report abuse or neglect because they feared being discharged if they complained. In another state, ombudsmen also mentioned fear of discharge as a factor that prevented residents and families from reporting abuse or neglect. Also, residents and family often believed that another facility would not be any better than the current RCF and thus were disinclined to complain. Finally, ombudsmen reported that residents often feared a complaint might mean the RCF would close and that they were reluctant to leave the friends and familiarity in the current facility.

Another factor associated with under-reporting was less related less to resident or family reluctance to report than to resident reports being ignored. Ombudsmen noted the reports or complaints are often ignored or discounted if the report is, as one ombudsman put it, **“perceived as being from someone whose reality is compromised because of dementia or mental illness.”** The ombudsmen in another study state argued that APS caseworkers often met with the RCF administrator before meeting with the resident, and the administrators were able to convince the APS worker that the resident was “confused.” Several respondents noted that **“mental health reform has left a lot of mentally ill in these homes, and mentally ill residents are not taken seriously.”**

4.4 Investigation of complaints/allegations

As described in the preceding section, there was significant under-reporting of abuse and neglect across the spectrum of mandatory reporters and residents and family members. In addition, while there were some smart practices in outreach and intake activities – the crucial first steps in detecting abuse – they are critically flawed in many of the agencies whose staff we interviewed. Thus, the systems for detecting abuse and neglect are identifying only some of the actual events. Unfortunately, we found that even if an allegation of abuse makes it through the reporting process, it is not clear that a satisfactory outcome will occur because of problems with the investigation processes. These problems included:

- Lack of training for staff on how to conduct abuse investigations and, specifically, on forensic investigations
- Too few staff
- Over-reliance on facility investigations
- Lack of timeliness in investigations, and
- Inadequate coordination among agencies.

4.4.1 Training Needs

The administrators and staff of various agencies involved in investigating allegations of elder abuse reported that at least three types of training were needed: (a) training about what elder abuse is; (b) training about how to investigate abuse complaints; and (c) training about cognitive impairment and mental illness. In addition, several administrators noted that they lacked the funds to hold as many training sessions as they needed to provide to staff and, in some cases, lacked the funds to allow staff to travel to training sessions.

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Training of Staff. Respondents argued that facility staff needed more and better training about what constitutes abuse. In most of the states, respondents identified low staffing levels and inadequate staff training as contributors to elder abuse and neglect in RCFs. As noted earlier, most states have minimal training requirements for staff in residential care, and the average amount of training unlicensed staff reported receiving was 16 hours (Carlson, 2005; Hawes, Phillips & Rose, 2000; Mollica & Johnson-Lamarche, 2005). Moreover, even when

abuse prevention training was mandated and provided by a state agency, licensing agencies and ombudsmen reported that facilities did not always use the materials they provided. In addition, many respondents argued that facility staff particularly

Smart Practice

North Carolina APS Administrators reported that as part of a reform effort in the state, an APS Task Force developed a Clearinghouse model in which state-of-the-art APS Tools were made available on their website. These related to intake processes, evaluations for both domestic and facility settings, risk evaluation, interviewing witnesses, and other related topics.

needed training on how to address the needs of residents with psychiatric conditions, including dementias, who exhibit challenging behaviors or resist care. They noted that with untrained or poorly trained staff, such resident behaviors may lead to abuse by staff.

Respondents also argued that law enforcement – police, prosecutors and judges – needed education about what constitutes elder abuse and the specific state laws prohibiting such abuse. Moreover, staff in the Offices of the Attorneys General in two states reported that police need education about the fact that abuse is going on in RCFs and training in how to investigate crimes in residential long-term care facilities. They also asserted that prosecutors need to receive and provide additional training. Several respondents noted that prosecutors often rejected the evidence offered by APS or ombudsmen and seemed to expect the regulatory staff who investigated complaints to present evidence of abuse that met the standard of “beyond a reasonable doubt.” However, regulatory staff never received the kind of training that would allow them to put together that kind of case.

Potentially Smart Practice

According to state licensing officials, the California Department of Justice mailed a training curriculum and video on elder abuse to all RCFs. Facilities were required to provide this training on elder abuse to all staff members within 60 days of their employment at the facility.

Unfortunately, when licensing agency surveyors checked records during their inspections, they frequently found that the facility had not used these materials and that the staff had not received the required training on elder abuse.

Some respondents argued that law enforcement agencies were becoming more familiar with the issues of elder abuse but that most of their focus and training was about abuse or neglect of older people living in the community and the cases brought to them by APS. Respondents

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in the aging network argued that prosecutors generally had little knowledge of residential long-term care facilities, particularly RCFs. They reportedly knew little about the existence of such facilities or the laws governing them and the care that residents should receive. However, as one Assistant Attorney General noted, police and prosecutors need to know “some basic stuff.” This includes the nature and content of the regulatory requirements, that “there are some type of resident assessments and plans of care or service plans that should be followed, medication records, and so on.” Moreover, the AG noted that prosecutors need to understand that “*there is a whole level of regulatory oversight that is helpful to the resolution of cases and how to access that.*” This would include the licensing, ombudsmen, and APS agencies or programs, as well as abuse registries for health care personnel and state licensing boards.

Forensics and Investigative Techniques. Respondents from all types of agencies reported a need for more training on elder abuse and neglect, including how to investigate allegations and how to interact in a productive way with the police. Some respondents noted that the training they received was, as one put it, “pretty lame.” Respondents from licensing agencies reported that because of short-staffing in the agencies, they spend all their time in the field, doing investigations. Thus, they are unable to participate in any training after the basic training they received when starting the job as new staff. The following statements illustrate what we heard from the staff in licensing agencies who were charged with investigating allegations/complaints about abuse and neglect:

“I’ll be the first to say that I feel relatively inadequate in investigating. I’m not really sure how far I can take it. I’m not the police... So can I sit them across the table and do you sit there for eight hours with just water and bread? I’m not knowledgeable about that.”

“They all gave us about an hour [on elder abuse] and then they throw us out into it.”

“It goes beyond abuse and neglect...I don’t think any of us has any training on complaint [investigations]. What do you do? We have to learn by osmosis and asking some of the folks who’ve been around awhile.”

“I started in September of last year and [10 months later] I still have yet to go to basic training.”

Smart Practice

Ombudsmen in New Mexico and some in California routinely carried cameras or camera phones into RCFs. If they were responding to a complaint about abuse, they were able to take time-stamped photographs of any visible injury. They could then share this evidence when they referred the complaint to licensing or law enforcement.

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“They don't even discuss the nuts and bolts of how you handle writing an [investigative report] for complaints. Much less the issue of what kinds of questions you're allowed to ask and how pushy you're allowed to be.”

“We receive very little training, mostly procedural basic training. Out of a two day recent training, there were only two hours on investigation.”

“We [one group of field complaint investigators] are charged with investigating abuse - the most serious allegations. We get 40 hours of training at onset of job, but most of us have had none since then. We basically learn from each other.”

In addition, some respondents, particularly ombudsmen, requested free training on elder abuse and how to interact with police. The noted that if training is not free, many ombudsmen and others would be unable to because of agency resource constraints. Ombudsmen noted that this was particularly critical since many agencies relied on volunteers to make initial visits and are then responsible for referring a case to the police. However, many volunteer ombudsmen **“don't feel they have the training...to do investigations.”**

Respondents also noted that many small and rural agencies, including those in which counties have some responsibilities for inspections, ombudsmen or APS, lack the resources to provide or pay for training.

Comparison to training available for Child Protective Services (CPS). We frequently heard from APS staff that their units compared unfavorably in terms of resources, support, and training provided to CPS units. In one state, APS workers noted that CPS staff receive “a lot” of training on medical issues and evidence, as well as co-training with police officers.” However, they reported that this did not occur for the APS units, and that they needed forensic training. In another state, APS workers said that mandatory CPS training in their state lasted for five or six weeks, while there was no mandatory training and no specific training on elder abuse for APS workers. One APS caseworker said:

“So you fly by the seat of your pants and trial and error, and learn what works and what doesn't, and hope you get it right.”

Training for physicians and law enforcement. We heard reports from several states of hospital staff and physicians who were reluctant to acknowledge and address reports of rape

Potentially Smart Practice

The Maine Elder Death Analysis Review Team (MEDART) is beginning to fulfill a requirement that all members of law enforcement get at least two hours of training on elder abuse.

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when it involved elderly residents, particularly if the resident had some type of cognitive impairment. This was reported by ombudsmen and APS staff from several different states.

"To most local prosecutors, residents [of RCFs] are invisible. People in facilities are invisible even...[to] the people who are doing the training on elder abuse."

Attorney with the AG's Medicaid Fraud Control Unit

One APS caseworker said that in her experience, physicians at hospital emergency departments generally did not want to "do rape kits" if the victim was unable to communicate verbally or had some level of cognitive impairment. One physician said he "didn't want to traumatize" the victim since she might not recall being raped and would find the testing traumatic. Another said that if

the victim had memory problems, **"what was the point of doing a rape kit since she won't remember it [the rape] happened."** In another case, in which facility staff discovered a son sexually abusing his mother and sent the mother to the hospital, a police officer said there was no reason to gather evidence of the rape, since **"they wouldn't [be able to] substantiate [the allegation of rape] due to the victim's inability to testify."** Most of the respondents felt that law enforcement personnel would take a very different view if the rape victim had been a child who was unable to testify or identify her attacker. All respondents noted the need for training for prosecutors and judges.

4.4.2 Workload

As noted earlier, all of the respondents (except one administrator) from all of the agencies reported a lack of adequate resources to carry out their responsibilities. Further, they said this was a major barrier to effective quality assurance and to detecting and resolving elder abuse in residential care. As noted, the ratio of surveyors at the licensing agencies – most of whom also do complaint investigations – was dismal, as shown in Exhibit 4.4. Three factors made these ratios particularly troubling.

First, some of the states reported an increase in complaints about elder abuse and severe neglect in licensed RCFs. Also, reports are increasing about abuse and neglect in unlicensed facilities in some of our study states. In one state, agency staff reported a significant increase in what are classified as "Priority 1" cases, that is, those

involving immediate jeopardy to the resident or residents. Another state was experiencing the same phenomenon, with a reported 33% increase in Priority 1 cases from 2005 to 2006. As the licensing agency administrator explained, this was an unplanned workload increase that meant greater challenges for the agency in meeting the specified timelines for response and

Exhibit 4.4 Ratio of Licensure Agency Surveyors to RCFs in Six Study States

1::50	1::72
1::52	1::83
1::70	1::100

Based on reports in interviews or from state reports provided during 2007 and 2008.

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investigation. The ombudsman program in a third state also reported that it was receiving more reports, in particular more “intense” cases of elder abuse in recent years.

Another factor was that staff were sometimes siphoned off the complaint investigation units and assigned different tasks. In two states, the agencies started new programs and staffed them by simply transferring staff out of the investigations unit. In one state, the survey unit responsible for complaint investigations lost about one-third of its staff to a new quality improvement initiative. In the other state, the elder abuse investigators lost half their staff to a new unit doing background checks for health care personnel. The respondents recognized the value of each of the new initiatives but were critical of the fact that these new tasks were accomplished at the expense of elder abuse and neglect investigations. One investigator noted that the result is that they now have 40 abuse investigators doing investigations in 58 counties and for 7,500 RCFEs. She and her colleagues reported that it was becoming “much more difficult” to get investigations of elder abuse cases done in the mandated 90 days. One argued of state budget cuts for the agency:

“Now they're discovering they cut into the bone, not the fat. Changes are made based on money rather than on what's best for clients.”

Another elder abuse complaint investigator noted that these cuts in staffing have not only made it difficult for the investigations to be completed in a timely fashion; they have also reduced the ability of the unit to undertake activities aimed at preventing the occurrence of abuse in the first place. She noted:

“Now, we are a reactive department, not a proactive department.”

Smart Practice

In North Carolina, there was a state-level initiative called SAFE in Long Term Care, which was a strategic alliance focused on elders in LTC facilities. Under the auspice of the North Carolina Justice Academy, the SAFE in LTC initiative developed a three-day curriculum to provide police and sheriff investigators with information on aging, basic interview skills to use with frail elders and persons with dementia, a session on LTC explaining the differences between nursing home, adult care homes, assisted living, and continuing care retirement communities. The training also identified key players and resources for law enforcement in detecting, investigating and resolving abuse, including the ombudsman program, APS, the licensing agency and the AG’s office. Staff from the AG’s office led two sessions on all the criminal statutes that a police officer could use to charge a perpetrator and a session on collecting forensic evidence for assault cases on LTC facilities. The Justice Academy conducted a pilot in 2005, 8 courses in 2006- 2007, and scheduled 3 courses for 2008.

There was no special funding for this initiative. Thus, it involved collaboration between the AG’s office, the ombudsman program, APS, the licensing agency, emergency medicine departments in several hospitals, local DA’s, some police officers, some health care providers, and one LTC provider association. As the State LTC Ombudsman noted, “The goal here is to teach law enforcement officers how to maximize their opportunity to get good information from a frail, older person instead of writing them off.”

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Second, surveyors were often responsible for a variety of activities, including complaint investigation, annual surveys of licensed facilities, and inspection and checking the background and capacity of facilities applying for a new license. In some states they also handled intake complaint calls and facility incident reports. In other states, the staff who investigate complaints of elder abuse are specialized as complaint investigators but are also responsible for a wide variety of facilities, such as child care, mental health, and substance abuse facilities, as well as RCFs. As one investigator put it, **“We are a ‘jack of all trades’ and master of none.”**

Third, other agencies are reporting similar workload problems. As noted earlier, none of the study states had the ratios of ombudsmen to facility beds that the Institute of Medicine (IOM) study recommended. For example, in one study state, there were approximately 190 (paid) staff ombudsmen for between 12,000 and 13,000 RCFs for the elderly and nursing facilities. This gave the LTC ombudsman program a ratio of one ombudsman to 2,700 beds rather than the IOM recommendation of 1:2,000. This ratio was particularly troubling since it was a state in which the ombudsman had significant additional responsibilities, including being mandated first responders for reports of elder abuse. APS agencies also reported having too few staff, having to screen-out cases (or put cases on waiting lists), and having high staff turnover.

Smart Practice

Because of concerns about the rising acuity and heavy care needs of RCF residents in Alabama, the licensing agency now uses Registered Nurses (RNs) as surveyors in assisted living facilities. These RNs bring a higher level of education and training to assessing the care being provided and to investigating complaints about abuse and neglect.

4.4.3 Timeliness of Investigations

Criteria for assigning investigation priority. All of the agencies had some type of classification (e.g., Priority 1, 2 or 3) that was assigned to reports or complaints at the intake stage and specified the time-frame for investigation of the complaint. In the facility licensing agencies in five of the study states, the agencies used identical criteria to those mandated for the federal nursing home complaint process. These federal guidelines were used to identify those cases that warranted a response within 48 (or fewer) hours and those that could be completed in a more generous time frame. In these licensing agencies, Priority 1 was the designation for reports or complaints that represented immediate jeopardy or serious harm for the resident.

Timeliness of investigation. In the states in which the licensing agency for RCFs was the same as the agency that licenses and certifies nursing homes, there was a clear timeline in policy about the need for a response within 24 to 48 hours for cases involving serious harm or immediate jeopardy. However, there were problems with this in practice.

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First, despite having established time frames for initiating different types of complaint investigations, respondents in most of the states reported that the licensing agencies often failed to meet those timelines – largely because of having too few complaint investigators. This was particularly true for any complaints about abuse or neglect that did not involve sexual abuse, physical abuse that caused significant harm or risk of harm, or neglect that placed the resident at immediate jeopardy of significant harm. In those cases, investigations lagged for weeks or even months – sometimes until the next annual licensure survey.

Second, the reliance on facility reports often delayed or replaced the investigation by the licensing agency, even in cases of abuse. For example, in one study state, RCFs were required to phone in an incident report to licensing within 5 calendar days. In another state, RCFs were required to report the occurrence of a serious incident within 24 hours, except on weekends, when they could report on the next working day. However, a complete written report on an incident, no matter how serious – from violent death to a resident “elopement”¹⁵ – was not required for seven days. Many of the staff responsible for investigations – and all of the law enforcement staff we interviewed – were concerned about the delay caused by this reliance on facility investigations. Law enforcement, in particular argued that this made it nearly impossible for the police to do a proper forensic investigation. However, other specialized investigative units were also critical of this delay. (In most states, facilities were supposed to call the police immediately if a resident had been sexually abused or physically assaulted; however, it was unclear whether this occurred. Moreover, such incidents were seldom reported to the police if a resident was the perpetrator of the assault.)

In one study state, a specialized unit was charged with investigating allegations of elder abuse. Moreover, staff in this unit received 40 hours of training about how to conduct a forensic investigation. However, this unit was not designated as a “first responder” to receive and respond to allegations of elder abuse. Instead, the licensing agency or ombudsman programs received the initial reports and referred cases to this unit. As a result, and particularly if there was a delay while waiting for the facility to submit a report, there was often a significant time lag between the occurrence of the alleged abuse and referral of the case to this investigative unit. As one staff person from this agency noted:

“By 10 days, the information can be gone. It would make a better case if someone responded immediately.”

Finally, most states reported that they were having difficulty making the timelines the agency had set for completing abuse and neglect complaints. Some said they were meeting the standard for cases involving immediate jeopardy; however, it was not clear whether the agencies started their “clock” when the abuse was reported to the agency by a facility or whether it waited until it received an incident report. Moreover, the field staff said that there were usually significant delays in investigations of all other abuse and neglect complaints. This was almost completely attributed to workload issues.

¹⁵ Elopement is the term of art for a resident who wanders away from the facility or purposely leaves. Some licensing staff referred to this as “going AWOL.”

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4.4.4 Over-reliance on Facility Investigations

As noted above, waiting for the facility’s report on an incident often delayed any formal investigation by a state agency. However, in some cases, facility incident reports about abuse were never investigated by any state agency. In some states, if the agency concluded that the facility incident report was satisfactory and the facility had “handled” the problem, no investigation by state personnel was required. In more than one study state, if the facility reported an incident of abuse on the intake line (or faxed in a report) and assured the intake agency that the facility has “resolved” the incident (e.g., fired the staff person, changed the resident’s roommate), the

state licensing agency determined that the incident will be “screened out” and not assigned for an on-site investigation by the agency. This appeared to

Smart Practice

The North Carolina health care registry developed materials for facilities on how to conduct investigations when they had allegations of abuse and neglect involving staff.

be true even if the facility substantiated the incident as abuse. In addition, in at least one state, the agency did not report the “incident” to the ombudsman program or APS for follow-up. This meant that no one outside the facility actually talked with or observed the resident involved in the abuse incident. Further, this meant that the resident did not receive any assessment to determine whether she or he needed counseling or possibly a move out of the facility in which the abuse occurred. In addition, it meant that a staff person involved in abuse might not be identified if he or she left voluntarily or was fired and the facility and licensing agency considered that this outcome meant the case had been “handled”

Finally, as noted earlier, in one of the study states, the section of the Attorney General’s (AGs) office that handled elder abuse cases believed that it was receiving data on all intake calls. However, in fact, they were not receiving information on a substantial number of intake calls – ones the agency felt the facility had handled adequately. This substantially hampered the agency’s proactive approach to identifying patterns of allegations at facilities or involving a particular staff member and targeting such facilities or individuals for additional investigation by the trained law enforcement personnel in the AG’s office.

Additional Research Needed. It is important to find out the extent to which agencies rely on the results of facility investigations when complaints of abuse are involved. Further, research is needed on how comprehensive and accurate facility investigations are. Research is also needed to learn how the facility deals with perpetrators (staff or residents) and, if staff, the person is listed on the state’s registry and is barred from employment facilities.

4.4.5 Coordination and Cooperation among Agencies

In theory, people living in RCFs should be well-protected by the process for licensing facilities and detecting, investigating, and resolving complaints about elder abuse and neglect. Three agencies have some type of responsibility: the agency that licenses facilities; the long-term care ombudsman program; and Adult Protective Services. Moreover, in some states, the

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Attorney General’s office, usually the Medicaid or Healthcare Fraud Control Unit, has responsibility for investigating and prosecuting elder abuse cases in residential care facilities. Further, physical and sexual abuse are crimes, and local law enforcement agencies have jurisdiction. Thus, structurally, multiple agencies are involved and responsible for performing part of the task of detecting, investigating, resolving and preventing elder abuse. The reality, however, is more complex.

“APS does not do any preventive work, and they ‘screen-out’ cases frequently, especially if they think the resident or one of the family members is capable of making plans or arrangements to keep the resident safe. In these kinds of cases, APS take the position that there is no need for APS to get involved.”

Ombudsman

Each of these agencies has a distinct role. The licensing agency is responsible for developing and implementing the standards or regulations that govern the performance of RCFs. They are also responsible for monitoring the performance of these facilities and ensuring that RCFs are in compliance with existing regulations. Moreover, the licensing agencies all assume responsibility for investigating complaints, including allegations of abuse and neglect.

APS has responsibility for all older people living in the community, and in some states this extends even to nursing homes. It does include people in residential long-term care “community” settings and focuses on ensuring that the elders are not being abused, neglected or exploited financially and that they are in a protected and safe environment.

The long-term care ombudsman program, authorized under the Older Americans Act, has staff and volunteers who are advocates for residents of nursing homes, board and care homes, assisted living facilities and similar residential long-term care facilities. This includes

The formal picture for protection of residents seems promising, with multiple agencies having responsibilities for detecting, investigating, resolving and preventing elder abuse in RCFs. However, the reality is more troubling as a result of at least three factors: lack of resources, distinct roles, and poor communication.

responding to and helping resolve complaints, helping set up resident and family councils, providing training to facility administrators and staff on residents’ rights and similar issues related to resident well-being. As the Administration on Aging (AoA) notes, ombudsmen “work to resolve problems of individual residents and to bring about changes at the local, state and national levels that will improve residents’ care and quality of life” (AoA,

2009). Ombudsmen are also designated as mandatory reporters of elder abuse, and in one of our study state, the ombudsman program is designated as one of the “first responder” agencies – that is, the identified agency to which an allegation of elder abuse in residential care should first be made.

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While the formal picture of agency responsibilities seems promising, the reality is more troubling as a result of at least three factors: lack of resources, distinct roles, and poor communication and coordination.

We discussed the lack of resources in an earlier section; however, it is worth noting several times that this is a significant barrier to effective detection and prevention of elder abuse in residential long-term care settings. Inadequate resources made it nearly impossible for agencies to carry out their primary responsibilities, much less quality improvement or elder abuse prevention initiatives. While agencies described some innovative practices, they were often limited in scope or difficult for agencies to maintain in the face of mounting fiscal pressures at the state level. In more than one state, respondents – particularly field staff – reported a decline in the scope and quality of their innovative activities during the last few years. In other states, innovative programs have been abandoned or cut-back due to resource constraints.

Respondents in all of the study states discussed the impact of inadequate resources on their ability to complete their investigations in a timely manner, and most were critical of the intake process for the same reason – too few staff to effectively do the job. However, they also reported that they were unable to be proactive in undertaking efforts to prevent abuse and neglect – from offering specialized training programs on such topics as residents’ rights, dementia care, and behavior management – to other quality improvement initiatives. For example, one study state required a standardized resident assessment that guides the development of a service plan for each RCF resident and that serves as the basis for the facilities’ case mix adjusted payment system. For some time after initiating this, the licensing agency nurse surveyors provided consultation to the facilities about how to assess residents and how to link that information and to develop an appropriate service plan for the resident. Moreover, they helped facilities use a set of quality indicators (based on the assessment data) to compare their performance to that of other facilities and identify ways to improve their performance. This quality improvement initiative has apparently been curtailed as a result of cutbacks in funding. The parent department for the licensing agency still pursues other quality improvement initiatives, such as offering telephone consultation to RCFs with a psychiatric nurse about how to manage residents with behavior problems and identifying a set number of areas for targeted quality improvement. However, in this state, as in most of the study states, we had the impression that the upper reaches of agency administration were unaware of the extent of frustration felt by their field staff responsible for investigating complaints of elder abuse and neglect.

“Now, we are a reactive department, not a proactive department.”

Licensing agency surveyor/
complaint investigator

Another factor that may have limited the collaboration and communication among the agencies was the very different roles assigned to each agency. Instead of having multiple agencies involved with all aspects of elder abuse and its impact on RCF residents, we heard of a failure to communicate and collaborate across agencies – and assignment of blame for

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problems in detection and investigation of abuse and neglect by staff in one agency to the policies and processes of the other agencies in the study state.

APS and complaint investigators for RCFs reported routine collaboration in only one state, where they attended each other's training and sometimes conducted joint visits to residential care facilities to investigate abuse complaints. In other states, licensing agency staff were often critical of the relatively limited role assumed by APS. Licensing and ombudsman programs noted that APS generally assumed that RCFs, because they were licensed, constituted a "protected or safe environment." In fact, they often moved people who had been abused in the community into such settings. Further, APS staff acknowledged that they viewed their role as restricted to abuse in which the alleged perpetrator was not a resident or staff member of a licensed RCF. As a result, RCFs attracted little sustained attention from APS.

"APS does not see themselves as advocates for all residents in a facility; they only focus on one case."
Ombudsman

In addition, licensing agency staff argued that even if APS were called into an RCF, they viewed their responsibility as determining whether the individual resident needed to be moved to another facility. Licensing staff and administrators in several study states argued that APS seldom called them about conditions in a facility, even if conditions were such that they felt compelled to move the resident to another RCF.

Finally, there was some discussion of the role of APS with respect to unlicensed homes. In one state, the licensing administrator reported that APS and the ombudsman program were good partners when the licensing agency needed to close a facility or move residents out of an illegally unlicensed facility. The agencies cooperated effectively in finding another setting for the residents being moved and in minimizing the difficulties often associated with such transfers. However, in another state, APS and licensing experienced greater conflict. APS took the position that it was only responsible for investigating allegations or complaints about "legally" unlicensed facilities – that is, those that because of their small size or the services they offered were not required to be licensed as a matter of state law. APS argued that the licensing agency was responsible for any complaints or problems associated with "illegally" unlicensed facilities. However, it became apparent that, with hundreds of unlicensed homes in the state, individual facilities were tossed back and forth between the agencies if a complaint came in to the intake line – as each agency tried to determine the facility's status and the locus of agency responsibility.

"We don't even get...actual referrals anymore from [licensing]. I'm going to assume there's stuff going on out there that we really don't know about that is a legitimate adult protective [services] issue, but we can't investigate what licensing doesn't tell us about."
APS Caseworker

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APS staff were often critical of the licensing agency. In one APS focus group, the participants agreed that there was **“no communication between licensing and APS.”** They noted this was particularly troubling because in that state, the licensing agency and CPS had a computer program that linked the two programs, so that when they were placing a child in a facility, CPS could find out whether there had been problems with the home they were considering. They said that previously there had been similar communication between licensing and APS but that either as a result of resources or a “turf warfare,” there was now little real communication and collaboration between APS and licensing.

In some states, APS and ombudsmen were critical of the licensing agencies because those agencies focused only on whether RCF violated regulatory standards. Some licensing agency staff also noted the limitations of this approach, resulting in a focus – *not on whether a resident had been abused but on whether the facility had appropriate “policies” and processes in place that were intended to prevent or address instances of abuse.* As a result, licensing agencies often failed to sanction a facility – or a direct perpetrator – if the facility had achieved “paper compliance” with regulations and had adequate policies in place (e.g., required background checks completed) and a staff perpetrator had quit or been fired.

Few licensing regulations specified the facility’s responsibility if a resident was the perpetrator. The critics also noted that licensing agencies often failed to call APS or ombudsmen when there was an incident or allegation of abuse – even when substantiated by the facility or the agency.

Smart Practice

The Texas and Maine State Ombudsman met quarterly with regulatory agency staff to discuss and share general concerns or, in Maine, to discuss specific RCFs about which they had concerns.

There was a surprising lack of formal Memoranda of Understanding (MOUs) between these agencies. Often they were “in the works,” but the lack of these is emblematic of the frayed lines of consistent, formalized communication and coordination that were common. Many study participants argued that the poor communication between agencies was a major barrier. Some felt that HIPPA laws meant that agencies were unable to share information about a victim, although there was no apparent consistency in how HIPPA this and other rules related to communication were interpreted. Study participants argued that such issues could be more easily addressed if there were regular meetings between the agencies and if there were formal MOUs that clarified these issues. On the other hand, we heard of examples of informal communication and collaboration, particularly between the ombudsman program and the other agencies.

The final issue that arose with respect to agency coordination and cooperation dealt with the role of the ombudsman program. As noted earlier, the Administration on Aging (AoA) has charged the ombudsmen to be advocates for residents of nursing homes and RCFs. AoA also specified that in addition to helping resolve problems of individual residents, ombudsmen should work “to bring about changes at the local, state and national levels that will improve residents’ care and quality of life” (AoA, 2009). It is this latter requirement that has occasionally caused difficulty for the programs at the state level.

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If ombudsmen advocate for higher standards of care or more use of sanctions against facilities, the program may engender opposition from the politically powerful nursing home or residential care home industry.

The ombudsman program may also find itself in conflict with the Governor and his or her Administration if the ombudsman criticizes the performance of the agencies that regulate nursing homes and RCFs. We heard specific examples that illustrated these dangers during our site visits. In one of our interviews, APS administrators said that the Governor had forced the State LTC Ombudsman to moderate her criticism of the RCF industry and of the licensing agency based on quality problems that had gone unaddressed in several licensed and unlicensed facilities. In another state, the State LTC Ombudsman had been critical of the nursing home industry and of the low use of fines by the state regulatory agency. As a result, three ombudsmen had been forced out because of

political pressure brought by the nursing home industry, which has been a major campaign contributor to the Governor. Several respondents discussed the political power of the industry – and the danger of speaking out on any deficiencies in the Administration’s policies or practices (e.g., the Governor’s budget cuts that led to less than annual inspections). Thus, the ombudsman program was sometimes politically vulnerable if it vigorously carried out its job of advocating for reforms and those changes involved either a new regulatory burden for the industry or criticism of other agencies in the Administration. All of the ombudsman programs made efforts to be cooperative and collaborative with their sister agencies, and by and large, the other agencies were positive about the ombudsman program. However, several of the ombudsmen in the national focus groups and some in the study states spoke of the challenging balancing act they had to perform.

Potentially Smart Practice

The Maine Ombudsman program was organized as a free-standing not-for-profit agency, rather than a government agency that was part of the Governor’s administration. It still received federal and state funds, but it supplemented those with charitable contributions. It reported to a board of community leaders. The State Ombudsman noted that this organizational structure freed the program to be frank with the Governor and the legislature about what was working and what was not in terms of policies and agency performance.

“That gives us a lot of freedom....I really feel strongly ombudsman programs need to have that arms-length distance because you have to be able to criticize state government.” She noted, however, that when seeking changes, their initial attempts have involved working cooperatively with the licensing agency or APS. This independent setting for the ombudsman program sounded like a smart practice; however, we do not know of any research that has evaluated the effectiveness of this approach.

4.5 Resolution of complaints/allegations

Resolution of abuse cases involves how agencies and law enforcement deal with perpetrators, including agency collaboration with law enforcement, and addressing the needs of victims.

4.5.1 Dealing with Perpetrators

Study participants discussed abuse cases that involved perpetrators who were facility staff, other residents, and family members. In addition, in some cases, participants felt that the facility was involved because of poor practices and policies. Regardless of the type of perpetrator or the role of facilities, respondents were very critical and frustrated by what they felt were weak or failed policies aimed at resolution.

4.5.1.1 The Role of Facilities in Abuse and Use of Penalties

In all of the study states, some licensing agency complaint investigators and some ombudsmen voiced criticism of the way the licensing agencies handled cases. As one complaint investigator noted, **“the regulations are antiquated and need teeth.”** A surveyor from a different state who had worked for the licensing agency for several years expressed the feelings reported by several respondents – that the process had moved from protection of the clients, the residents, to accommodation of the facility license holder.

“The process is supposed to be client-based, but it has become license-based -- helping the licensee get and keep their license is now...[the agency] focus. The department is reactionary rather than preventive. Our oversight responsibilities have eroded.” Licensing agency staff, State #1

In another state, a licensing agency staff member argued that the standards were insufficient to support citations and penalties for abuse and neglect. She argued that she believed this was, in part at least, attributable to the perception that RCF residents are able to protect themselves.

“We don't see as many citations for actual service delivery because of the nature of the regulations. There is...[a] sort of implied thing that...individuals in assisted living are somewhat independent so they can exercise a great deal more control over what they are doing and what happens to them.” Licensing agency staff, State #2

Another surveyor/investigator in this second state expressed a frustration shared by colleagues across many of the study states – that the staff charged with enforcement did not support the staff who investigated complaints about neglect and abuse.

“Some days...you work really hard at protecting someone you felt like was in danger and it gets to enforcement. Regardless of how many times

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you've rewritten [your findings] for them...the next day you find out it's been completely thrown out. So...you still have a resident in an assisted facility who hasn't been tube fed in six weeks, has lost 65 pounds. And yet I have to wipe my hands clean and walk away."

Licensing agency staff, State #2

In a third state, staff from the licensing agency also said that the agency's enforcement power had dropped tremendously. In this state, the investigator argued, the agency had raised its standard and "the burden of proof is so heavy for us" in abuse cases. Further, staff from this agency were critical of the penalties they could use. For example, some reported that they could not write a deficiency that carried a penalty for failure to train staff – something that might prevent abuse. Even when they could impose a fine, the size of the penalty was "laughable," in the view of licensing agency staff and ombudsmen.

"We can cite for lots of things but can only write CMP [civil monetary penalties or fines] for a few things. And the CMP for a death is only \$150.00 per person. The provider industry...said that the small facilities will be put out of business if CMPs are [imposed] or too large. Face it, our backbone is brittle when it comes to the industry."

Licensing agency staff, State #3

The low fines authorized in State #3 contrasted with another state in which the financial penalty for a serious violation – one causing death or serious physical harm – could be as high as \$20,000 for an RCF. However, ombudsmen and agency staff who investigated complaints reported that the state licensing agency often ignored their findings on abuse, neglect and poor care and seldom imposed fines as large as those allowed by law.

Licensing agency staff and ombudsmen in several states noted that the providers were politically well-connected and powerful. They argued that the response of the agencies was to "soft-peddle" citations and enforcement penalties. As one abuse investigator said:

"We do an investigation and turn it in, and the department says [to the facility?] 'Well, don't do it again.' Why do we keep giving clearances to these people?"

Licensing agency staff, State #4

In another state, the head of the AG's unit that handled abuse cases also expressed concern about recent changes in the state's RCF regulatory system.

"[Our state] had the best assisted living regulations in the country seven or eight years ago...and they torpedoed them. They're not the same."

Assistant Attorney General, State #5

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In nearly all of our focus groups, licensing agency and ombudsman program staff spoke of the political power of the industry as a major impediment to stronger standards and more effective enforcement of those standards.

4.5.1.2 Staff as Perpetrators

Even when staff members were the perpetrators of abuse, the system did not seem to work well. Unlike the case with nursing homes, there is no federal legislation specifying that a staff member should be barred from working in an RCF if he or she had been found to have abused or neglected a resident. As a result, states varied in how they addressed such staff members in residential care.

It was difficult to determine how abuse cases were resolved when a staff person was the perpetrator. Most study states did not maintain data on the outcomes. Thus, this issue warrants additional research.

In one state, we were told of two basic problems. First, the enforcement arm of the licensing agency was characterized by the field staff as generally unwilling to pursue cases. The other staff agreed with one surveyor who explained the issue as follows:

“We go up there, and we do all this work -- the leg work [in the investigation]. We get everything we need and we bring it back -- and enforcement doesn't want to do their portion of it because it's going to take a little effort. I just got a referral on a CNA [certified nursing assistant] in an assisted living [facility] who admitted she hit a resident. There was a written statement, and there were witnesses. She hit a resident. I made the referral [to enforcement], but they didn't want to do the...case because I didn't see her hit the resident...They wanted to know 'Which way did her hand go back?' What difference does that make? We're not going to see it. We're not there....We go in after the fact and gather whatever evidence we can, but then they won't uphold it.”

In this same state, stakeholders also noted the reluctance of the prosecutors and judges to impose significant penalties on staff who've committed elder abuse. The lead investigator for the MFCU said in a lot of abuse cases, if there was an injury to an RCF resident, the perpetrator would receive **“deferred adjudication and maybe a hundred dollar fine. I mean, that's the way it is across the state.”** In this study state, deferred adjudication was basically probation, and the person must wait two years after completing his/her deferred probation before attempting to clear his/her record, unless it was a felony, in which case, the waiting period is five years. Thus, unlike the case with federal law governing nursing home staff that bars abusers from employment, in residential care, an abuser is not

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barred and may have his or her record expunged after completing a period of probation/deferred adjudication.

In the other states, there were apparently few cases of staff in RCFs that were referred to local law enforcement or, where relevant, to the MFCU. Further, it was unclear whether or not the staff were barred from employment in any other health care facility as a result of committing abuse in an RCF. However, there was some evidence that there was often a significant time delay between the incident and the conclusion of the administrative hearing required before someone is banned. One investigator commented on this:

“By the time we close out an investigation and it leaves our desk, it takes 2 years before it goes to administrative hearing. At least 1 to 1 ½ years. ”

Additional Research Needed. Additional research is needed to understand the time elapse between the report of the incident, the investigation, the finding, and the conclusion or resolution in substantiated cases. If a significant time delay occurs, the perpetrator – whether a staff member or a resident – would have the opportunity to abuse other residents in the original or a new facility. It is also important to know whether a sizeable proportion of cases were not substantiated and why. It is possible that false allegations or complaints are made, but the more likely explanation is weaknesses in the investigation process and the standard of proof used by the agency. Finally, it would be useful to know the proportion of incident reports that deal with an allegation of abuse in which a staff person was the perpetrator.

4.5.1.3 Residents as Perpetrators

According to ombudsmen in our national focus groups, one of the most difficult issues was dealing with resident-on-resident physical or sexual abuse. During the site visits, ombudsmen and licensing agency complaint investigators said that many facilities and some licensing agencies did not think the facility should be held responsible for resident-on-resident abuse. Ombudsmen also noted that most facility staff had little training or knowledge about the causes and neurological effects of Alzheimer’s disease and other dementias or how to interpret and manage behaviors by residents whose judgment and memory were impaired. As a result, they said, resident-on-resident abuse and “theft” – the rummaging through clothing and taking other residents’ possessions -- was an all-too-common occurrence. The same was true of residents with persistent and severe mental illness and aggressive behaviors. States were increasingly discharging people from state mental institutions into RCFs, but relatively few were placed in facilities specially staffed and licensed for care of persons with psychiatric illnesses. Thus, according to ombudsmen, when incidents occurred, facilities’ typical responses were to increase the resident’s psychoactive medications or discharge the resident to another setting or, in some cases, to use physical restraints.

When there was serious injury or sexual assault, the police were reportedly seldom called by facilities. When they were called, the police often felt stymied by the lack of a safe alternative setting for resident perpetrators with Alzheimer’s disease or other dementia who needed a facility’s protective oversight, care and services. Jail did not seem like a reasonable

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alternative. In addition, when the perpetrator was an elderly resident with intellectual impairment, law enforcement often took the view that no crime had been committed because the requisite “intent” to injure the victim was missing.

The same was true for residents with persistent and severe mental illness. Many RCFs housed elderly residents with persons whose main diagnosis is psychiatric. This mixture of frail elders with persons who have persistent and severe mental illness can be a problem in terms of physical abuse, intimidation, and psychological abuse in terms of cursing at and threatening others. An ombudsman told us of a case in which a resident with mental illness was raping elderly females in the RCF. The police were called by the ombudsman, who had convinced staff to report the assaults, which they had witnessed. The police came but said that it was pointless to arrest the perpetrator, since the prosecutor would decline the case on the grounds that a mentally ill person, by definition, lacked the requisite intent. As a result, the police removed the perpetrator from the facility, but they took him to a homeless shelter and released him. In another case we heard about, a mentally ill man had set fires in a series of RCFs. After each event, he was admitted to a nearby state mental hospital for a short stay to “stabilize his medications,” after which he was released back into the residential care community. He eventually set a fire in which five other residents were injured and two were killed.

Finally, respondents in several study states reported that the corrections departments were increasingly releasing older prisoners to RCFs. There was no quantifiable data on how frequently these former prisoners caused problems; however, a licensing administrator and some ombudsmen told of incidents of abuse in which the former prisoners were the perpetrators and elderly residents were the victims.

Additional Research and Policy Development Needed. Significant additional research is needed. First, states need to determine the types of individuals who are residing in their RCFs, the degree to which they house mixed populations, the prevalence and nature of abuse, and how facilities handle these incidents. Second, state officials need to consider whether their policy should allow releasing individuals from state mental hospitals and prisons to community residential care facilities that house frail older persons is appropriate. Third, additional research is needed to identify appropriate settings and care patterns for residents with any history of abusive behaviors. Related to this, states should consider demonstrations with formal evaluations to determine the kinds of settings, services and staffing that are needed for residents who exhibit aggressive or intimidating behaviors or what is referred to as “socially inappropriate behaviors,” from smearing feces to disrobing in public. Fourth, research is needed on how to communicate this information to facilities and to make them responsible for implementing behavior management practices and adequate staff supervision to prevent resident-on-resident abuse.

Current practices of discharging or chemically or physically restraining resident “perpetrators” once an incident has occurred are inadequate. Care and services and settings are needed that protect their rights and attend to their care needs but that also addresses the physical and psychological welfare of victims or potential victims.

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4.5.2 The Role of Law Enforcement

In our interviews, participants discussed the role and performance of four parts of the law enforcement system, broadly defined: the MFCUs or their functional equivalent in the AG's office; police and sheriffs' departments; prosecutors; and judges.

MFCUs. In all the states, the MFCUs or health care fraud units in the Office of the Attorney General had formal responsibility for Medicaid fraud and elder abuse in nursing homes. In some study states, the MFCUs had responsibility for elder abuse cases involving residents of RCFs, but in other states, they limited their role to elder abuse in nursing homes. Among the MFCUs that had responsibility for elder abuse in all residential LTC settings – nursing homes and RCFs, there was significant variation in the level of activity. For example:

- In one study state, the MFCU had a staff of experienced law officers and RNs who were former nursing home surveyors. However, only one assistant AG was assigned to the unit to prosecute cases. Further, in cases involving elder abuse that did not also include a case of Medicaid fraud, the MFCU's formal role was limited to participating in the investigation and prosecution only if invited to do so by local prosecutors. MFCU staff provided training on elder abuse, forensic investigation techniques in these settings, and similar topics to prosecutors in cities and counties around the state. However, the investigative staff expressed frustration or dismay at the lack of knowledge and willingness to prosecute elder abuse cases if they involved RCFs or residents with some type of cognitive impairment. These investigators also reported that an increasing number of complaints reported to them by licensing agency staff, ombudsmen, and family members were about elder abuse in residential care. One of the nurse investigators said that she had not tallied up the settings involved but was under the impression that the majority of reports or complaints about abuse and neglect in the last year or two were about RCFs. The investigators also sometimes reviewed the complaint and incident reports to identify potential "prosecutable" cases. They were also increasing their presentations on elder abuse in LTC at state-wide and regional meetings of prosecutors and judges. Despite their skills and commitment, however, few local prosecutors invited them to join or assist in prosecutions.
- In California, the AG's office had been exceptionally active "a couple of years ago," according to ombudsmen. The AG's office had a very public campaign on reporting and preventing elder abuse. It also developed training videos on elder abuse that were

Smart Practice

The Maine health care fraud unit had MOUs with all other agencies involved in detecting, investigating and resolving allegations of elder abuse. The unit established a process by which all the other agencies would routinely send their intake and referrals to the unit so that the unit could look for patterns or identify instances that warranted further investigation by their staff.

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distributed to residential LTC facilities for use in training staff, and it also had an impressive website with substantial information and links to resources on detection and prevention of elder abuse. However, during our interviews in that state, respondents from the licensing agency and ombudsman program said that the level interest in the topic within the AG's office had significantly decreased in the months prior to our site visit.

- In Maine, the equivalent of the MFCU in the AG's office was very active in the area of elder abuse. Some of this unit's activities have been described elsewhere in this report, such as: (a) creating a dataset on all complaints, alleged perpetrators, and facilities in which the abuse occurred; (b) analyzing the data to determine whether there were any patterns across staff or facilities that suggested the need for an investigation by that office or for training on prevention; (c) tracking staff members accused or convicted of elder abuse (including drug diversion) as they moved from one healthcare setting to another, using information from the Department of Labor in order to monitor for any new incidents. This unit was also very knowledgeable about how to use the medical or related records in a facility to determine whether there was a risk for or potential evidence of abuse (e.g., residents who had break-through pain at the end of shifts or soon after they were supposed to have received their medication). Similarly, staff in this unit had a sophisticated understanding of how to use information in the resident assessment and service plan. For example, an assessment that indicated the resident was bedbound and received assistance with bed mobility and transfers was unlikely to have acquired bruises and contusions on her face and trunk as a result of flinging herself repeatedly against the bedrails. The Assistant AG in charge of this unit sent their detectives to training conducted by the RCF licensing and nursing home regulatory agency. Her goal was to ensure that the unit's detectives would understand what the settings were, the characteristics of the residents, the care process, and so on, including knowing what records were available to them in the facility and what the information in those records meant.¹⁶ As she noted, **"The local police officer wouldn't necessarily know that the MDS assessment might say that the person is non-ambulatory. So when the facility staff says the...[resident] got up and fell and injured**

Smart Practice

In California, one of the Area Agencies on Aging (known as "triple As" or AAA) funded a detective in the county sheriff's department. This detective worked with the AAA to conduct educational sessions on elder abuse in order to raise community awareness of elder abuse, frequency of reporting, and knowledge of available resources for victims. In addition, the detective provided training to ombudsmen on how to identify potential abuse and conduct preliminary investigation of complaints.

¹⁶ Like all states, Maine required use of the Minimum Data Set (MDS) to assess all nursing home residents and develop their plan of care. Unlike most other states, Maine also requires the use of a comparable MDS-RCA in their residential care facilities. Maine used these data to monitor some aspects of quality in the facilities, to set case-mix adjusted payment rates, and the state required that facilities use the MDS information to develop care or service plans.

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herself, you'd say 'Well, wait a minute, they don't get up'." The unit also sends their investigators to other trainings that include information on elder abuse and neglect. In addition, the unit provides training for AGs and local prosecutors.

Additional Research Needed. We found too much variability among the MFCU offices we interviewed to attempt a generalization about how effective they were or about the role they played in investigating or prosecuting cases of elder abuse. Thus, additional research is needed on the roles MFCUs play, the resources they have, and how they interact with the other agencies that detect and investigate elder abuse and with local law enforcement. This is particularly important since one MFCU was very proactive, and several of them used well-trained, former nursing home surveyors to investigate cases of elder abuse in RCFs. Thus, there are probably lessons to be learned that might help other MFCUs operate more effectively in terms of elder abuse in residential care facilities.

Smart Practice

In California, staff who investigate complaints of physical or sexual abuse in RCFs are trained as "peace officers." They said that this enables them to write investigative reports and present evidence in language that is familiar to police and prosecutors.

Local Police and Sheriff Departments. Staff from the licensing agencies, APS and ombudsman programs all reported that relationships with the police and sheriff departments were improving, with police demonstrating greater interest and knowledge of elder abuse in general and of abuse issues in residential care in particular. Because of their responsibilities for elder abuse among community-dwelling elderly, APS caseworkers and agencies seemed to have the most well-established relationships with police. However, in the study states, the other agencies reported that they were finding more responsiveness and initiative from law enforcement. At the same time, they reported significant variation across law enforcement jurisdictions in the level of knowledge and interest in pursuing cases of elder abuse in RCFs.

Law enforcement officials also reported that they were now more engaged in cases of elder abuse in nursing homes and residential care facilities. They also noted that ombudsmen had been particularly helpful in offering training in the police academies on RCFs and nursing homes, the characteristics of residents, the nature of elder abuse in these settings, and special issues related to interviewing residents and staff in long-term care facilities.

The one complaint members of law enforcement expressed about ombudsmen dealt with their failure to report some cases. Ombudsmen discussed at some length the conflict between their mandate under state law to refer reports of elder abuse in nursing homes and RCFs to the licensing agencies and law enforcement and the mandate under the Older Americans Act (OAA) to report only with the resident's consent. Law enforcement reported that the ombudsmen often provided reports that did not include the victim's name or details that might identify the resident. This made it nearly impossible for them to investigate the cases.

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Additional Research Needed. Our site visits were in the state capitol since that is where the agency administrators were located and where we could bring together the complaint investigators, APS caseworkers, and local ombudsmen for focus groups. As a result, we interviewed the law enforcement officials in those cities. It seems unlikely that they were representative of all law enforcement agencies.

Further, respondents from the other agencies suggested that there was variability across different jurisdictions in the receptivity of law enforcement to cases of elder abuse. Some argued that law enforcement personnel in rural areas were particularly lacking in information about elder abuse and willingness to investigate such cases. Thus, we recommend additional research on the attitudes and roles played by police and sheriff's departments in cases of alleged physical or sexual abuse in RCFs.

Respondents were considerably less positive about the performance of most prosecutors when it came to elder abuse, neglect and exploitation. They argued that in general, prosecutors did not understand elder abuse or residential care settings. They did not translate elder abuse to the other kinds of physical violence, such as rape or assault, which they routinely prosecuted. Further, the study participants noted that prosecutors seldom had investigators in their office who were familiar with the elder abuse

Smart Practice – Hiring Retired Policeman as Ombudsman

In California, ombudsmen were designated in state law, as “first responders” to receive reports of elder abuse in nursing homes and RCFs. The ombudsmen were very proactive in interacting with police and elder death review teams, where they existed. One local ombudsman program hired a retired police officer as an ombudsman. The ombudsmen said this significantly strengthened the program's relationship with law enforcement. First, he taught investigative skills to the other ombudsmen and educated them about how and when to refer a case to the police. He also taught the ombudsmen how to write reports and document their initial findings in a way that met the forensic standards used by the police (e.g., using cameras to document injuries) and how to work with the coroners and medical examiners. He also met with the police and new classes of recruits on a regular basis. He said this helped establish and maintain good relationships between the ombudsman program and the police and sheriff's departments. Third, he helped educate the police about the laws on elder abuse and special factors affecting investigations in RCFs and interviews with frail elders, some of whom may have some level of memory impairment. He noted that there were standardized investigative report forms for use in cases of child abuse and elder abuse but that law enforcement personnel often knew only about the child abuse forms. Thus, he informed police about the existence of these seldom-used forms and provided them with a laminated sheet with key points on elder abuse (e.g., statutory language, police forms to use, key contacts in the aging network). Fourth, in his previous position with the police department, he learned how write reports so they were useful to prosecutors. He argued that it was important for ombudsmen and police to understand the elements of a crime in any abuse case they were investigating, because the prosecutor needed those addressed if the case was to be taken to court. He said that one of the most useful things he could teach ombudsmen and police investigators was “the value of jury instructions” and how to include the relevant evidence of elder abuse in the investigative reports. He also reported that he helped maintain good relationships and cooperation by writing letters to the police chief and the policemen that commended police investigators for their excellent performance on specific elder abuse cases.

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statutes, with the special challenges of interviewing older persons, and with the features of RCFs that must be understood in order to gather evidence and interview witnesses. Some ombudsmen and licensing agency staff argued that they believed prosecutors were often motivated by the desire for headlines, since theirs were typically elective offices, and that elder abuse cases were time-consuming, difficult to prove in court, and “not sexy.”

Smart Practices - Elder Death Review Teams. The study participants noted that there were some situations in which prosecutors were active in elder abuse cases, particularly in those localities in which an elder death review team had been formed. Elder Death Review Teams used a multidisciplinary approach to identifying and investigating suspicious deaths. The generally brought together medical examiners, police, prosecutors, APS, and ombudsmen, as well as geriatricians and other health care professionals to review deaths thought to be associated with elder mistreatment. In addition to Elder Death Review Teams, prosecutors were becoming more involved. The National College of District Attorneys has been involved in the development of training curricula on elder abuse prosecution. Thus, the situation may improve across the nation, but in most of our study states, much work remained to be done. Respondents in three of the study states described significant efforts to increase the involvement of prosecutors.

California was particularly noteworthy. Ombudsman estimated that there were Elder Death Review Teams in 13 or 14 of the 58 counties. In addition, there was an Elder Abuse Committee in the California District Attorneys Association. In terms of prosecutions, California has taken a leadership role in the country, in part because of the energy and leadership of Paul Greenwood, Deputy District Attorney (DA) and head of the Elder Abuse Prosecution Unit in San Diego. He noted that when he was given the task of establishing an elder abuse prosecution unit in 1996, the DA’s office rarely filed elder abuse charges. In testimony before the U.S. Senate, Mr. Greenwood described the increase in successful prosecutions and attributed the unit’s success in part to a multidisciplinary approach to elder abuse cases, outreach to law enforcement, APS, ombudsmen, and the ME’s office. He also described outreach efforts to raise public awareness and reporting.

Maine ombudsmen and APS also cited their state-wide Maine Elder Death Review Team (MEDART) as a smart practice. It was funded initially in part by a grant from the American Bar Association. Members included staff from the AG’s health care fraud unit, the sheriff’s association, the ombudsman program, the licensing agency, state police, victim services, mental health, and APS. MEDART reviewed processes for detecting, investigating and resolving elder abuse. Team meetings focused on one to two issues at each meeting and were also attended by a geriatrician and staff from the Medical Examiner’s office. They reviewed deaths associated with elder mistreatment *after* the criminal process had taken place. The focus was on conducting a systemic review of cases to examine the process to see whether there was a failure at any point in detection, investigation, or resolution of the case.

Finally, we noted the efforts of the North Carolina Justice Academy to provide outreach and training to law enforcement and prosecutors about elder abuse and to introduce them to the aging network, APS, and the licensing agencies for facilities. (*This was described at greater length above in a sidebar.*)

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4.5.3 Addressing the Needs of Victims

One of the issues raised by ombudsmen from around the country in our national focus groups was the lack of services for elderly victims who reside in RCFs. Moreover, the ombudsmen noted that they did not have training in how to offer such support and services. This has not been a major focus of victim services offered by

Smart Practice

A local ombudsman program in California applied for and received a foundation grant to provide counseling and supportive services to RCF residents who were victims of physical or sexual abuse.

law enforcement either. However, a few exceptions do exist. **SMART PRACTICE:** The Archstone Foundation funded a model offering comprehensive services to elderly crime victims through the San Diego Family Justice Center and has funded community-based multidisciplinary teams addressing elder abuse, the expansion of forensic centers, and delivery of coordinated services to victims of abuse.

Additional Research and Funding Needed. Research is needed to identify effective methods of counseling and providing supportive services for RCF residents who have been victimized, and funding is needed to expand these services.

4.6 Prevention

There was very little concerted effort aimed at prevention of elder abuse in RCFs. The three most common activities were criminal background checks, healthcare personnel registries, and training for facility staff.

"Abuse Prevention - Ha. We are slapping on band-aids and putting out fires."

Licensing Agency Investigator

In most states, if there was a criminal background check for RCF staff, the facility was required to inquire about a prospective employee and the report went back to the facility. This sometimes meant that the facility made decisions about whether the staff person's criminal record included crimes that would prohibit employment in a healthcare facility. It also meant that the results of criminal background checks were not routinely shared with any state agency, including any nurse aide or healthcare personnel registry. However, even in states in which a state agency conducted the background checks, the system was flawed, according to our respondents.

In one study state, a regulatory agency was responsible for conducting mandatory criminal background checks for all staff in RCFs. The same unit that investigated abuse cases also conducted these criminal records checks on staff. However, they noted that the unit of the Bureau that reviewed the records and decided on whether or not the person could be employed in an RCF did not make consistent decisions, as one investigator noted: **"They may exclude someone for something minor but clear them when it's major."** Another investigator said that approximately 60% of her cases where a criminal record was

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found involved drug arrests, “and these people are still working in the facilities [with an exemption from the state law that prohibits criminals from working in health care settings]. She continued, “We can pull their exemption at any time but we don’t utilize that. We are reactive. We wait until some abuse occurs, some drug diversion that gets reported.”

In some of the study states, there was no mandatory personnel registry or background check for unlicensed or uncertified staff who worked in RCFs. Other states did have health care personnel registries of some type. However, there was considerable variation in the requirements across the study states. One state had a healthcare personnel registry that covered staff in nursing homes, RCFs, and home health agencies. All providers were required to check the registry to see whether a potential employee had been barred from employment, and all staff found to have abused or intentionally neglected a resident or client in any setting were to be barred from employment in health care settings. Another state had one registry for licensed and certified personnel and a second Misconduct Registry for unlicensed and uncertified staff. A third state required that facilities check the Nurse Aide Registry if the facility was hiring a Certified Nursing Assistant (CNA). However, no abuse or misconduct registry existed for staff who were not CNAs, and RCFs were not required to check on the background of such potential employees.

Even where there was some type of registry, respondents noted significant weaknesses with their operation and with their ability to protect residents from abuse. First, staff from the licensing agency reported that they did not routinely monitor facilities to ensure that they had checked each employee against the registry list. Further, since many of the states were not conducting annual surveys, it would be difficult for them to enforce the use of the registries in a timely fashion. Second, the regulations did not require the same background or registry checks for contract or agency staff who work in RCFs. Third, licensing agency staff and ombudsmen argued that the rules were inconsistently applied on crimes that barred someone from employment and that the regulations governing RCFs were insufficient to prevent hiring someone who had previously been found to have abused or neglected a resident in an RCF or another setting. For example, one MFCU investigator noted that RCF staff, if prosecuted for abuse, were often given deferred adjudication, basically a probation that, when satisfied, could allow the person to avoid a formal conviction, making them eligible to work in facilities again. In addition, in some states where there was no registry requirement for RCFs, facilities were allowed to hire someone who was listed on the Nurse Aide Registry for CNAs and barred from working in nursing homes. Finally, APS caseworkers in two study states noted that they had identified RCF staff members who were on the Child Protective Services registry for abusing or neglecting their children. In fact, one ombudsman noted that RCFs were one of the state-approved training and work sites for people who have had children removed from their homes and were participating in welfare-to-work programs.

Smart Practice – Prevention through Training. Several respondents reported that they conducted training for facility staff that was aimed at preventing abuse and neglect. For example, the Maine Health Care Fraud Unit in the AG’s office did training on drug diversion and made a video on the topic in collaboration with the Board of Nursing. Several of the

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ombudsman programs reported offering training to facilities on elder abuse, dementia, and managing resident behaviors. For example, the North Carolina State LTC ombudsman said that their elder abuse prevention training was **“the real strength of our program.”** She noted:

“We do hundreds and hundreds of sessions of elder abuse prevention trainingWe're pretty creative. We do the sensitivity to losses associated with aging to try to help staff understand visual loss, hearing loss...and how these impairments impact...behavior so that they understand a lot of things that their...[residents] do are not intentional and on purpose.....[We try] to help them understand dementia behaviors and how to intervene and redirect and...do the proactive things that would keep them from potentially abusing them or slapping...[residents] around. ”

Additional Research Needed. Unfortunately, little systematic research has been conducted on the causes of elder abuse in residential care settings. Until the causes and correlates of elder mistreatment are well-understood, it will be difficult to effectively prevent such abuse.

4.7 Unlicensed Facilities

Unlicensed facilities were common in at least three of our study states. In most states, the state provides a supplemental payment to RCFs for the room, board and care of residents who are recipients of Supplemental Security Income (SSI). However, in three study states, there was no state supplement. Most observers believed that this encouraged the emergence of unlicensed homes willing to accept SSI alone to house low-income residents.

In one study state, APS conducted a study that estimated that there were about 200 unlicensed facilities in a state with only slightly more than 400 licensed RCFs. All of the licensed RCFs were private-pay facilities. The licensing agency had the will but not the resources to close these unlicensed facilities or bring them into compliance with the life safety code and health regulations. As a result of their manpower limitations, including the time of an attorney, the agency was able to pursue closure against only two or three unlicensed facilities a year.

In another study state, ombudsmen and APS estimated that there were several hundred unlicensed homes, but there was no reliable count. These homes flourished in the larger cities, particularly those that had significant populations of poor elders and persons with mental illness who had been released from state mental hospitals. The general attitude of state mental health agency officials appeared to be, as one official put it, that residing in an unlicensed facility was **“better than living under a bridge.”** Because of scandals about the conditions in these facilities, some state legislators called for stricter oversight by the state agency that regulated RCF facilities. Bills were introduced to require such licensure in 2008 and 2009, but both the Office of the Attorney General (OAG) and the department that

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licensed facilities estimated that hundreds, perhaps thousands, of facilities were involved and that licensure activities aimed at these facilities would impose significant new costs on state government. (The AG received only nine referrals for enforcement actions related to licensed and unlicensed assisted living facilities in 2008, a small number for a state with more than 1,000 RCFs).

There is no realistic hope in two of the study states that much progress will be made in compelling unlicensed facilities to become licensed without a major policy change. In the absence of licensure, these facilities and their residents received little or no oversight from state agencies. In one of the states, when there was a complaint about abuse or neglect in these facilities, the responsibility for the investigation becomes a “football” passed back and forth between APS and the licensing agency as they debate whether the home was legally unlicensed (the responsibility of APS) or illegally unlicensed (the responsibility of the licensure agency). Moreover, ombudsmen did not have any responsibility for residents in unlicensed homes – unless they were operating under a special grant to fund these activities. Thus, residents in these facilities were at special risk for abuse and neglect.

Section 5. Conclusions

In this section of the report, we discuss our conclusions in terms of public policy, training, and research. We also discuss the limitations of the study.

5.1 Policy Conclusions

In political science, states are often referred to as “policy laboratories.” The concept is that the variations we see in state policies and their effects can inform federal policy and provide examples to other states. Certainly, this has been true in such areas as health policy reform, with some of the states providing models that may guide the debate on national policy. It has also been true to some extent in assisted living and residential care, with Oregon leading the way in the early 1990s on assisted living regulation and on aggressive use of this sector to reduce use of nursing homes. However, states have shown great variability in the role they defined for assisted living and in the regulatory systems they developed. While we can document the variations, there has been less systematic study on the effects of these variations on such issues as quality of care, quality of life, abuse and neglect.

In our study, we found considerable variation in how states approached detecting, investigating, resolving and preventing elder abuse in RCFs. However, one constant we found was a tremendous shortage of resources among the licensing agencies, LTC ombudsmen programs, and APS agencies in our study states. The licensing agencies and their complaint investigators, APS caseworkers, and state and local ombudsmen all provided evidence of workload and resource constraints that prevented them from carrying out their responsibilities as effectively as possible. In fact, this was cited by all but one of the study participants as a major barrier. The effects of these resource constraints were seen in all areas of the process, weakening the ability of states to detect, investigate and resolve allegations of elder abuse and provide care and services to elderly victims. These constraints and deficiencies included:

- Workload demands that meant facilities were not surveyed at least annually;
- Screening of intake calls about abuse and neglect to control the workload of complaint investigators;
- Over-reliance on facility incident reports and internal “resolution” of abuse cases;
- Delays in investigations that made it difficult to substantiate cases and left residents unprotected;
- Agency inability to offer more training to staff on forensics and effective investigative techniques, and inability to reimburse staff for travel to training;
- Divisions of responsibilities among agencies that seemed to have more to do with reducing workload for the agencies involved than with using the distinct talents and training of each agency to protect residents from being abused or neglected;

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- Large-scale abdication of responsibility for what happens to vulnerable populations in unlicensed RCFs;
- Inadequate resolution of cases in which the perpetrators were staff or other residents; and
- Failure to provide needed counseling and support to residents who had been victimized.

While the obvious cause of many of these problems was resource constraints among the agencies, this lack of resources may be an indicator of the low priority given to elder abuse and residential care by policymakers at all levels – local, state and national. The cries for reform tend to come on the heels of well-publicized scandals, and most legislative reform attempts have died on the altar of fiscal notes addressing the cost of the new policies. As many of our study participants noted, this stands in stark contrast to the case of child abuse in which federal and state policymakers have responded with funds and legislation, and mandatory reporters are well-schooled in their reporting obligations. While the child abuse and domestic violence sectors are far from perfect, they are certainly more advanced than what is found in the case of elder abuse. Changing the priority the public and policymakers give to elder abuse and to residential long-term care settings is not a technical issue; it is instead, an act of recognizing the problem and assembling the political will to do something about it.

At the same time, policymakers can take a series of concrete intermediate steps. First, they should address the training needs identified by study participants and discussed below in Section 5.2. Policymakers also need to commission relevant research, as described in greater detail in Section 5.3.

Finally, federal policymakers – from the Congress to the Administration – need to recognize that states do not have sufficient resources and, in some cases, sufficient political will to address these issues. Thus, the federal government should become more involved – in sponsoring relevant research, in funding the development and provision of needed training, and in providing some uniformity across the nation in standards and federal financial support for surveys and abuse and neglect complaint investigations in RCFs.

5.2 Training Needs

As noted throughout the report, there are significant training needs. Some are summarized in Exhibit 5.1. Complaint investigators, ombudsmen, and to a lesser extent, APS staff need more training on their authority, when and how to involve law enforcement, investigative techniques, including forensics, and how to write reports so that they support the recommendation of the investigator, ombudsmen or caseworker, and can be effectively used by law enforcement and prosecutors. Police, prosecutors and judges also need additional education and training on the nature and consequences of elder mistreatment, on residential care settings, on the special issues related to elderly persons as victims, witnesses, and

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perpetrators. Finally, training on how to recognize and prevent elder mistreatment is needed for facility owners, operators and staff.

Exhibit 5.1 Summary of Training Recommendations	
Population	General Content
Facility owners, operators & staff	Residents rights and mandatory reporting requirements
	The causes or precipitators of abuse by staff and how to prevent abuse and neglect arising from these factors
	How to manage resident behaviors – both those that may precipitate aggression or rough treatment by staff AND those behaviors that endanger and injure other residents
Surveyors, complaint investigators, APS, ombudsmen	The nature of their authority to investigate, interview suspected perpetrators
	Investigative techniques, forensics
	How to write reports that substantiate their conclusions
	How to structure their reports to support prosecution, when appropriate and how to testify
Police and prosecutors	The relevant law on elder abuse and how laws on rape and assault apply to residential care setting
	The nature and consequences of elder abuse
	Information about the aging network and how to work with it
	Information about residential LTC settings, their responsibilities
	How to interview frail elders and people with cognitive impairment

5.3 Research Recommendations

The report presents our recommendations for additional research in several topic areas. Some of the key research topics we recommend are shown in Exhibit 5.2. It is clear that substantial additional applied research is desperately needed. For a start, research is needed to describe the current mix of residents in RCFs. While a national study is being designed by RTI International, funded by the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), this is just a start. Such research is also needed to produce state-level estimates, so that states can tailor their policies and the requirements for facilities that will meet the needs of that resident population and protect the wellbeing of the elderly and disabled residents. Currently, in most states, the licensure standards, survey process, complaint investigation process, and compliance mechanisms are not tied to the nature of the resident population or their vulnerability to abuse and neglect.

Other research should be aimed at identifying and examining the underlying causes of elder abuse and neglect and how to more effectively prevent such mistreatment. Research is needed that focuses on examining and evaluating existing processes for preventing abuse, as well as

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for detecting and investigating elder mistreatment. Research is also needed to determine whether what appear to be smart practices are effective. In addition, research is needed on how to achieve effective and sustained implementation of effective practices. This would include everything from staff training policies aimed at improving care and reducing abuse to improving reporting, investigations, prosecution of cases, and interventions/services for victims.

Additional research and policy are needed to address the issue of under-reporting. Resident fears and unwillingness to report abuse must be understood and addressed, perhaps with lessons from the domestic violence arena. However, the issue may be more complex because residents are living in the environment in which the abuse occurred and may have no realistic way to exit. Similarly, research and more effective policies are needed to address under-reporting by mandated reporters – from staff in RCFs to EMTs, hospital personnel, health care providers, and so on. Policymakers, the AoA, and state and local ombudsmen also need to confront directly the conflict faced by ombudsmen between the mandates of conscience, the requirements of state law, and the requirements of federal law with respect to reporting instances of elder abuse to state licensing agencies and law enforcement.

5.5 Limitations of the Study

The findings of this study are necessarily limited by the fact that we conducted in-depth site visits in only six states and collected only limited additional data on other states. Thus, what we found may not be generalizable. In this regard, we would note two facts. First, we selected states based on expected variation among them. However, even in what we expected to be “good” states with effective mechanisms in place to detect, investigate and resolve elder abuse in RCFs, we found significant problems – including lack of resources that hampered their performance. Second, some of our findings were consistent across all of the study states. In any event, even if the problems we found were localized in these particular study states, they should be addressed. Additional research of this type in other study states may clarify the scope and nature of the problems involved in detecting, investigating and resolving cases of elder abuse in residential care facilities.

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Exhibit 5.2 Summary of Research Recommendations

To determine the prevalence of elder mistreatment in RCFs, whether it varies across types of facilities (e.g., ownership, staffing, resident case mix) or states, and factors associated with such variation

To identify the underlying causes of abuse, neglect and rough treatment by staff and effective interventions to prevent such elder mistreatment

To identify the causes and predictors of resident-on-resident abuse and effective interventions; To determine how to effectively manage the care of residents who exhibit physically aggressive, intimidating or sexually inappropriate behaviors

To examine the impact of housing frail elders with paroled prisoners and with younger persons with mental illness and how to handle this situation

To understand the sources of resident and family reluctance to report elder mistreatment and how to address these concerns

To identify facility practices that minimize elder mistreatment and facilitate reporting

To determine how to educate and persuade mandatory reporters to recognize and report abuse

To examine the impact of elder mistreatment of all types of cognitively impaired and cognitively intact residents and identify appropriate victim supportive services

To determine which aspects of state systems (e.g., licensure standards, inspection processes, sanctions, complaint investigations, ombudsmen program support, APS program support) minimize elder mistreatment and whether these can be replicated

To determine how facility incident reports are handled and what steps are taken to resolve these cases and refer to appropriate agencies

To examine the criteria used to screen calls about elder abuse or neglect and determine what happens to calls or facility incident reports that are “screened out” of agency investigation

To examine in depth the processes used to investigate abuse and neglect complaints and incident reports from facilities – such as whether there is an on-site investigation, the timeliness of the investigation, the training and qualifications of investigators

To determine rates of substantiation for complaints of elder abuse and neglect and how and why they may vary across states or agencies

To determine the degree to which substantiated cases of abuse reported by facilities are referred to APS or ombudsmen for follow-up services to the victim

To examine how cases of resident-on-resident abuse are handled by RCFs & the regulatory process

To determine the amount of time between an incident and resolution, including the time elapse in substantiated cases involving staff and the barring or other outcome for staff

To examine the outcomes/resolution of abuse cases – in terms of the facility, perpetrator, and victim

To examine the use of the healthcare personnel registries and their effect in preventing abuse

To examine the role of the MFCUs and features associated with greater effectiveness

To identify barriers to effective involvement with law enforcement in cases of abuse

To identify barriers to effective action by prosecutors and how to overcome those challenges

Research on the “smart practices” we identified to determine their effectiveness and utility in other states and settings – and to identify additional smart or “best practices”

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