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Author: Catherine Hawes, Ph.D., Anne-Marie Kimbell, Ph.D.

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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.
Anne-Marie Kimbell, Ph.D.
The School of Rural Public Health, TAMU 1266
Texas A&M Health Science Center
College Station, Texas 77843-1266**

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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.

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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

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

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

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
Licensing standards	More extensive requirements for RCF staff training, including training on managing behaviors and residents rights	51
	Mandated uniform resident assessment to guide care planning and generate additional RCF payments for heavy care residents	55
Outreach	Ombudsmen provide training on residents' rights, recognizing and reporting elder abuse to paramedics, EMTs, ED & hospital staff	58
	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
Intake	Job training for intake staff involves "job shadowing" with abuse complaint investigators	57
	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
Training for ombudsmen to identify & document elder abuse, neglect	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 ombudsmen 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

