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ADDRESSING ABUSE, NEGLECT, AND
SUSPICION OF CRIME AGAINST
NURSING HOME RESIDENTS
POLICY CONSIDERATIONS & PROMISING PRACTICES

THE LONG TERM CARE COMMUNITY COALITION
WWW.NURSINGHOME411.ORG



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LONG TERM CARE COMMUNITY COALITION

Advancing Quality, Dignity & Justice

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Introduction

Incidents of abuse and neglect present a major problem in nursing homes and assisted living facilities. Each year, many thousands of residents become victims of abuse and neglect by facility staff and, even, fellow residents.

According to a 2014 report from the U.S. Department of Health and Human Services Inspector General (IG),¹ an astounding one-third of Medicare beneficiaries are harmed within, on average, 15.5 days of entering a nursing home. The IG also found that 59 percent of these incidents were likely preventable. Similarly, a 2018 federal report² identified 23,000 cases of “critical incidents” in Medicaid assisted living facilities in just 22 states in 2014. The fact that this analysis only included a minority of states and only focused on Medicaid assisted living (a small portion of assisted living) indicates that the frequency of critical incidents—including sexual abuse, physical abuse, and verbal abuse—is actually much higher.

To improve accountability for resident abuse and neglect in nursing homes, the 2010 Affordable Care Act (ACA) instituted a requirement that everyone who works in a facility (including administrative staff, care staff, and contractors) report any suspicion of a crime against a resident.³ If the crime involves serious bodily injury to any resident, the report must be made immediately but not later than two hours after forming the suspicion. In the absence of serious bodily injury, the report must be made within 24-hours.⁴

Unfortunately, as a result of ignorance about these requirements and lack of enforcement, these important protections have, largely, gone unrealized. In 2017, CNN reported on the horrific stories of thousands of residents across the United States who were sexually assaulted in their nursing homes. Some of the perpetrators had even assaulted multiple residents before being investigated and arrested.⁵ For example, the CNN report noted that an 83 year old resident, Sonja Fischer, had been raped by her male caregiver, George Kpingban, in a Minnesota nursing home. Court documents showed that Kpingban had been suspended three times while the nursing home investigated claims of sexual abuse.⁶

Despite strong resident protections stemming from the federal Nursing Home Reform Law and the Elder Justice Act, many cases of abuse and neglect, as well as crimes, elude detection and accountability.

¹ DHHS Office of Inspector General, *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries*, OEI-06-11-00370 (February 2014). Available at <https://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

² Government Accountability Office, *Medicaid Assisted Living Services: Improved Federal Oversight of Beneficiary Health and Welfare is Needed* (Jan. 2018), <https://www.gao.gov/assets/690/689302.pdf>.

³ SEC. 1150B. [42 U.S.C. § 1320b–25] (b). Available at https://www.ssa.gov/OP_Home/ssact/title11/1150B.htm.

⁴ For more information, see LTCCC’s *Policy Brief: Requirements for Reporting to Law Enforcement When There is a Suspicion of a Crime Against a Nursing Home Resident*. Available at <https://nursinghome411.org/policy-brief-reporting-nursing-home-crime/>.

⁵ Ellis, Blake and Hicken, Melanie, *Sick, Dying, and Raped in America’s Nursing Homes*, CNN. Available at <http://www.cnn.com/interactive/2017/02/health/nursing-home-sex-abuse-investigation/>.

⁶ *Id.*

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The persistence of horrible cases such as that of Ms. Fischer shows that much more needs to be done to realize essential protections in the lives of residents.

How to Use This Report

This report provides an overview of the federal requirements in place to protect residents from abuse, neglect, and crimes. To address the persistence of these problems in the lives of nursing home residents, it identifies promising policies and practices to improve reporting and/or address ongoing abuse, neglect, and crime.

For ease of use, the report is broken down into the following sections:

1. Definitions of abuse and neglect, including ways in which abuse and neglect may occur;
2. Federal laws and regulations that address nursing home abuse, neglect, and suspicion of crimes against residents; and
3. Promising practices and initiatives that address resident abuse and neglect.

Our website, www.nursinghome411.org, has complementary tools and resources to help implement the promising practices identified in this report, as well as fact sheets and issue alerts on essential nursing home quality and safety standards. We hope that readers find the report and resources useful in addressing abuse and neglect in their facilities.

Background Information

What are Abuse and Neglect?

According to the Centers for Medicare & Medicaid Services (CMS), abuse is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.”⁷ Neglect, in contrast, is defined as “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.”⁸ Although neglect encompasses a fairly broad definition, abuse can be divided into various forms, such as emotional, psychological, verbal, physical, and sexual abuse:

- **Physical abuse** – Physical abuse is the infliction of pain or injury on a person. Some examples include slapping, pinching, shoving, rough handling, or inappropriately using drugs or physical restraints. Signs of potential physical abuse include bruises, wounds, cuts, restraint or grip marks.
- **Psychological abuse** – Psychological abuse may include the inappropriate use of antipsychotic drugs, staff members not addressing resident needs in a timely/appropriate manner, and staff taking advantage of resident’s cognitively impaired state.
- **Emotional abuse** – Emotional abuse may include aggressive or hostile behavior/attitude towards a resident, staff speaking to residents with disrespect or contempt, and staff ignoring residents or leaving them socially isolated. Signs of emotional abuse include

⁷ CMS Regulations and Guidance: State Operations Manual Appendix Q, 42 CFR Part 488.301. Available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf.

⁸ *Id.*

emotional distress or agitation; being extremely withdrawn, non-communicative, or non-responsive; acting nervous or fearful; and unusual behaviors (such as rocking back and forth or hitting oneself).

- **Sexual abuse** – Sexual abuse may include inappropriate sexual/physical contact and staff using sexually-explicit language towards residents. Signs of sexual abuse include torn, stained, or bloody underclothing; unexplained vaginal or anal bleeding; and bruises around the breasts or genital area.

How Can Abuse or Neglect Occur?

There are many ways in which residents may become victims of abuse and neglect. Following are a few examples of situations that have a significant potential of involving abuse and/or neglect:

- **Inappropriate physical contact** – Staff members may inappropriately touch or make other physical contact with a resident, which could lead to emotional distress or physical injuries, such as bruises and wounds.
- **Falls** – Residents who are not provided appropriate monitoring or care services are susceptible to falls and resulting injury. Examples include: when a resident wanders a facility at night; a resident whose call bell goes unanswered and gets up herself to go to the bathroom; and a resident who is not properly secured or cared for while using a wheelchair or Hoyer lift.
- **Pressure ulcers** – Insufficient care and monitoring, including basic repositioning, can result in the development of pressure ulcers which, if not treated in a timely and effective manner, can be life-threatening.
- **Wandering** – In the absence of appropriate monitoring and safeguards, residents may wander within or outside of the facility. Injuries can result from entering a dangerous area of the facility (such as a stairwell) or being exposed to dangerous or treacherous conditions outside of the facility.
- **Chemical restraints** – Staff may use antipsychotic drugs on residents, particularly those with dementia, in order to sedate or restrain them.⁹
- **Infections** – Residents may develop or contract infections due to staff not addressing resident wounds or utilizing standard sanitary practices.
- **Malnutrition** – Residents may not be receiving nutrition in accordance with their needs or care plans. Residents may appear to have lost weight or seem dehydrated.
- **Fraud & theft** – Facility staff, family, or friends may take advantage of a resident's personal and/or financial information or misappropriate a resident's possessions.
- **Isolation** – Facility staff may use isolation, or the threat of isolation, as a form of discipline or punishment. Examples include locking a resident in a room, placing a resident who uses

⁹ The inappropriate use of antipsychotic drugs and other psychotropic medications is widely acknowledged to be a persistent problem. Antipsychotic drugs carry a "Black Box" warning from the U.S. Food and Drug Administration because they are highly dangerous for elderly individuals with dementia and are not clinically indicated for so-called dementia-related psychosis. For more information on this issue, visit our Dementia Care & Antipsychotic Drugging page, <https://nursinghome411.org/learning-center/dementia-care-antipsychotic-drugging/>.

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a wheelchair in a room or area that is isolated from other residents or activities, or withholding access to facility activities such as the TV room, gym, or other activity spaces.

Why are Abuse and Neglect Not Well Addressed?

There are many reasons why an incident involving abuse or neglect may not be properly addressed. Following are some possible reasons why those in the nursing home community (including staff, residents, families, and ombudsmen) may not take steps to identify and address resident abuse and neglect:

- **Lack of awareness of an event** – Individuals may be unaware that an incident of abuse and neglect has occurred in the facility, or may not immediately categorize an incident as one of abuse and neglect.
- **Lack of education on abuse and neglect** – Due to a lack of awareness or training, individuals may not be equipped to identify an abusive or neglectful situation or, even when they do understand that something is wrong, do not believe or understand that it is something that merits—if not requires—action.
- **Lack of proper communication** – Staff that witness an incident involving abuse and neglect may not communicate with other staff members, other residents, or families about it. Staff may choose to keep potential cases of abuse and/or neglect to themselves, or may inaccurately report the circumstances of the incident to other staff members (such as the severity of the situation and level of harm). The facility and staff may also not report instances of abuse and neglect to appropriate agencies, such as the state survey agency, law enforcement, or adult protective services (APS).
- **Self-protection** – Staff may cover up abuse or neglect to protect themselves from punishment.
- **Dereliction of duty** – Staff may cover up, disregard, or willfully under-estimate the seriousness of abuse or neglect to avoid spending time reporting cases.
- **Lack of understanding of rights** – There may be a lack of understanding among residents, families, and advocates of their right to be free from abuse and neglect.
- **Fear of retaliation** – Residents, families, and staff may choose not to report cases of abuse or neglect because they are afraid of retaliation. Staff may fear losing their jobs. Residents, and their families and advocates, may fear the resident being harassed or receiving a lower quality of care.



Although there may be many reasons why individuals do not report cases of abuse and/or neglect, federal laws and regulations have imposed clear reporting requirements on facilities, staff, and other covered individuals. These requirements are detailed in the Nursing Home Reform Law, the Elder Justice Act, and their implementing regulations.

Federal Requirements

Reporting Abuse & Neglect

All nursing home residents have the right to be free from abuse and neglect.¹⁰ According to the federal Nursing Home Reform Law, every state must have a process for “the receipt and timely review and investigation of allegations of neglect and abuse . . . by a nurse aide of a resident . . . or by another individual used by the facility in providing services to such a resident.”¹¹ The Reform Law’s implementing regulations clarify that all alleged violations of abuse and neglect standards must be reported to the nursing home administrator and to state officials, including the state survey agency, within specified timeframes:

[I]mmediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury¹²

The regulation’s Interpretative Guidance, which provides sub-regulatory clarification of the requirements, further states that an individual or entity reporting an alleged violation does not have to characterize an event as abuse or neglect. Rather, in a measure designed to increase reporting by staff members who are afraid of retaliation or unsure about whether abuse or neglect has occurred, the Guidance clarifies that nursing home staff must report and take action if they can “reasonably conclude” that the potential for noncompliance with the federal requirements exists.¹³

Weak enforcement of the nursing home standards of care means that resident abuse and neglect all too often go unrecognized or poorly remedied.

Addressing Abuse & Neglect: Challenges

While the Reform Law and its implementing regulations have set clear standards for nursing homes and states to follow on abuse and neglect, ongoing under-enforcement of the federal requirements have weakened the impact of these resident protections. CMS’s 2015 Nursing Home Data Compendium indicates that more than 95 percent of all instances of noncompliance are cited as causing neither harm nor immediate jeopardy to the resident’s health, safety, or well-being.¹⁴ Stated differently, only about five percent of all nursing home deficiencies are identified as having caused any harm to the resident.

While deficiencies may be mischaracterized as causing “no harm,” inspection reports all too often describe real resident pain, suffering, humiliation, and even death. For instance, a

¹⁰ 42 C.F.R. § 483.12(a).

¹¹ 42 U.S.C. § 1395i-3 (g)(1)(c).

¹² 42 C.F.R. § 483.12(c)(1).

¹³ *Id.*

¹⁴ CMS, *Nursing Home Data Compendium 2015 Edition*. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

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nursing home in New York State received a “no harm” citation after failing to secure a resident in her wheelchair while she was being transported, causing her to fall backwards, hit her head, and suffer from a hematoma and a lack of oxygen.¹⁵ Sadly, the failure in properly enforcing the nursing home standards means that there is a lack of accountability for resident abuse and neglect because nursing homes rarely face financial or other penalties for such “no harm” deficiencies.

Reporting Suspicion of a Crime against a Resident

Despite strong federal requirements to ensure that residents are free from abuse and neglect, these problems persist. To help address this, the Elder Justice Act (EJA), passed in 2010 as part of the Affordable Care Act (ACA), includes important provisions that require all “covered individuals” in nursing homes—including administrators, owners, care staff, and contractors—to report suspected crimes against a resident to both the state enforcement agency and law enforcement.

Similar to the federal nursing home abuse and neglect standards, the EJA has detailed reporting requirements. Under the law, every covered individual must report “any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.”¹⁶ The law likewise mandates covered individuals to report suspected crimes within specified timeframes:

If the events that cause the suspicion . . . (A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and (B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.¹⁷

Covered individuals who fail to adhere to the mandates of the EJA are subject to significant penalties, including a civil money penalty up to \$300,000 and exclusion from participating in federal health programs, such as Medicare and Medicaid.¹⁸

Reporting Crime: Challenges

Though the requirements of the EJA are robust, there have been several challenges that have inhibited its implementation. First, although the EJA is a federal requirement, crimes exist and are defined under local, state, and federal law. Thus, there aren’t clear and concise national requirements for what does or does not have to be reported. To help address this, CMS

¹⁵ Long Term Care Community Coalition & Center for Medicare Advocacy, *Elder Justice: What No Harm Really Means for Residents*, Vol. 1, Issue 7. Available at <https://nursinghome411.org/elder-justice-no-harm-newsletter-volume-1-issue-7/>.

¹⁶ 42 U.S.C. § 1320b–25(b).

¹⁷ 42 U.S.C. § 1320b–25(b)(2).

¹⁸ 42 U.S.C. § 1320b–25(c).

recommended that facilities “[c]oordinate with the facility’s State and local law enforcement entities to determine what actions are considered crimes in their political subdivision.”¹⁹

Second, although the EJA was intended to provide increased training for surveyors, specifically through the National Training Institute for Surveyors, there has been a lack of federal funding to carry out these activities. According to the Congressional Research Service (CRS), “[s]imilar to other newly authorized grant programs under the ACA, implementation of new grants and activities under the Elder Justice Act has been hampered by the lack of federal discretionary spending for authorized activities, which is subject to the annual appropriations process.”²⁰

Third, the EJA lacks a formal legal response against abuse and neglect. As the CRS notes, “[i]t does not include a criminal justice response which would address the prevention, detection, and prosecution of elder abuse crimes under various Department of Justice (DOJ) authorities and administration.”²¹

General Definitions and Examples of Crime

Following are some general definitions and examples of crime. As noted above, crimes are defined under federal, state, and local laws. Nevertheless, there are four widely recognized categories of crime:

- **Personal crimes** – Personal crimes result in physical or mental harm to the victim. Assault, battery, false imprisonment, kidnapping, rape, and homicide are all examples of personal crimes.
 - **Assault:** “[A]ny intentional act that causes another person to fear that she is about to suffer physical harm. This definition recognizes that placing another person in fear of imminent bodily harm is itself an act deserving of punishment, even if the victim of the assault is not physically harmed.”²²
 - **Battery:** “[A] physical act that results in harmful or offensive contact with another person without that person's consent.”²³
 - **Criminal threat:** “A criminal threat involves one person threatening someone else with physical harm. The threat must be communicated in some way, though it doesn't necessarily have to be verbal. A person can make a threat through email, text message, or even through non-verbal body language such as gestures or movements. However, some states require written or verbal threats, and in those states gestures are not enough.”²⁴

¹⁹ CMS Memorandum: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act, 2011. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf.

²⁰ Congressional Research Service, *The Elder Justice Act: Background and Issues for Congress*, 2017. Available at <https://fas.org/sgp/crs/misc/R43707.pdf>.

²¹ *Id.*

²² Bergman, Paul, *Assault, Battery, and Aggravated Assault*. Available at <https://www.nolo.com/legal-encyclopedia/assault-battery-aggravated-assault-33775.html>.

²³ Cornell University, Legal Information Institute, *Battery*. Available at <https://www.law.cornell.edu/wex/battery>.

²⁴ Theoharis, Mark, *Criminal Threats*, Criminal Defense Lawyer. Available at <https://www.criminaldefenselawyer.com/crime-penalties/federal/Criminal-Threats.htm>.

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- **Property crimes** – Property crimes occur when a perpetrator interferes with the victim’s right to use and enjoy his or her property. Larceny, robbery, embezzlement, and false pretenses are all examples of property crimes.
- **Inchoate crimes** – Inchoate crimes are incomplete crimes, meaning that the perpetrator(s) took a substantial step towards completing the crime but the crime was never actually completed. Attempted murder, attempted rape, attempted robbery, conspiracy, and solicitation are all examples of inchoate crimes.
- **Statutory crimes** – Statutory crimes are prohibited by statute and include both personal and property crimes. Statutory rape and public intoxication are examples of statutory crimes.²⁵

For more information about the specific elements of any given crime in your community, please refer to the state laws online (via the state’s website, the Library of Congress (<https://www.loc.gov/law/help/guide/states.php>), or a reliable provider, such as www.findlaw.com).

The remainder of this report highlights promising policies and practices that have been used to improve identifying and addressing, abuse, neglect, and crimes against residents.²⁶

Promising Responses to Address Abuse, Neglect & Suspicion of a Crime

As discussed above, challenges continue to impede the realization of federal requirements protecting residents from abuse and neglect. To help address these challenges, various entities across the country have taken steps to help their states and communities recognize, understand, and prevent cases of abuse, neglect, and crimes against residents. Following are some of the initiatives that LTCCC has identified as having promising components for improving compliance with the federal requirements and reducing resident harm. In addition to a brief summary, each section includes key features that we have identified as potentially useful for replication or adaptation.

[E]ntities across the country have taken steps to help their states and communities understand, recognize, and prevent cases of resident abuse and neglect, as well as crimes against residents.

U.S. Department of Justice Elder Justice Initiative: Law Enforcement Resources

The Department of Justice’s (DOJ) Elder Justice Initiative provides a number of valuable resources for law enforcement and others to identify—and respond effectively to—elder abuse.²⁷

²⁵ Justia, *Types of Criminal Offenses*. Available at <https://www.justia.com/criminal/offenses/>.

²⁶ Note: This report focuses on non-financial abuse, neglect, and crimes. Though misappropriation of resident property, financial exploitation, and other theft crimes are serious, they are beyond the scope of this report.

²⁷ U.S. Department of Justice Elder Justice Initiative, Law Enforcement Resource Page. Available at <https://www.justice.gov/elderjustice/law-enforcement-1#LE1>.

Key Features

The DOJ's numerous, detailed law enforcement resources include:

- [The Elder Abuse Guide for Law Enforcement \(EAGLE\)](#).
 - Includes succinct guides for identifying and acting on different types of abuse (emotional, financial, sexual, physical, and elder neglect)
 - Checklists for first responders and evidence collection
 - Links to state statutes
 - Tips for effective interviewing of older adults (including those with memory loss)
 - Information on documenting pressure ulcers and more.
- State law enforcement elder abuse sample protocols; and
- Elder abuse training resources.

Center of Excellence on Elder Abuse & Neglect: 368+ Mobile App

The Center of Excellence on Elder Abuse & Neglect, at the University of California, Irvine, School of Medicine, has developed a mobile app “[t]o help California law enforcement in their work responding to abuse of elders and dependent adults (vulnerable adults with disabilities).”²⁸

Key Features

As noted on the Center's website, multidisciplinary teams helped create useful features, including:

- Abuse, neglect and financial exploitation warning signs (such as “[w]hat to look for in the home environment, caretaker behavior, elder/dependent adult behavior, medical markers”);
- Easily referenceable summary of Penal Code 368, dealing with crimes against elders, dependent adults, and those with disabilities, as well as other crimes that can be “used in conjunction with a PC 368 arrest;”
- Quick tips on common concerns, such as dementia, witnesses with dementia, role of caregivers, and injuries; and
- Contact information of relevant agencies for “cross-reporting and for providing assistance to the victim.”²⁹

Arkansas Department of Health and Human Services: Incident & Accident Next Day Reporting Form

The Arkansas Department of Health and Humans Services, Division of Medical Services Office of Long Term Care, created a [form](#) to help residents and families report “allegations of resident

²⁸ Center of Excellence on Elder Abuse, *368+ Elder and Dependent Adult Abuse Guide for CA Law Enforcement*. Available at <http://www.centeronelderabuse.org/368elderabuseca.asp>.

²⁹ *Id.* Note that Penal Code 368 refers to “Crimes Against Elders, Dependent Adults, and Persons with Disabilities.” For the text of the law, see http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=368&lawCode=PEN.

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abuse, neglect, and misappropriation of property or injuries of an unknown source by individuals providing services to residents in long term care facilities for next day reporting.”³⁰

Key Features

The state’s form:

- Facilitates mandatory next-day reporting to relevant entities/agencies and
- Contains interactive sections that facilitate meaningful responses.

Iowa Health Care Association: Elder Justice Act Explanation and Tool Kit

The Iowa Health Care Association (IHCA) offers documents, such as *Facility Suspected Crime Report*, *Reporting Letter to Law Enforcement*, *Notice of Rights and Responsibilities under the Federal Elder Justice Act*, and *Policy & Procedure for Reporting Suspected Crimes*, aimed at helping facilities adhere to the federal reporting requirements.³¹ These documents are publicly available and found in the IHCA’s [tool kit](#).

Key Features

The documents provide:

- Succinct summaries of the Elder Justice Act requirements;
- Links to custom documents that facilities may use to adhere to federal regulations; and
- Links to a memo that the Iowa Department of Inspections and Appeals has created to inform state law enforcement agencies that they are to “expect an increase in reports from long term care facilities.”³²

State of Michigan: Website on Reporting Elder Abuse

The state of Michigan has online instructions on how to report suspicion of crimes involving abuse, neglect, and/or exploitation. The state’s [website](#) displays phone numbers for the 24-hour adult protective services hotline, Michigan Protection and Advocacy Services, Inc., and attorney general’s 24-hour health care fraud hotline.³³

Key Features

The website provides:

- Succinct definitions of abuse, neglect, and exploitation and
- Easy access to the phone numbers of relevant agencies to report abuse and neglect.

³⁰ Arkansas Department of Health and Human Services Division of Medical Services Office of Long Term Care: Incident & Accident Next Day Reporting Form, Available at <https://humanservices.arkansas.gov/about-dhs/dms/long-term-care-information-for-providers/forms>.

³¹ Iowa Health Care Association (IHCA), *Reporting of reasonable suspicions of crimes in LTC*. Available at https://www.iowahealthcare.org/userdocs/Documents/EJA_Toolkit_article.docx.

³² *Id.*

³³ State of Michigan, *Reporting Elder Abuse*. Available at https://www.michigan.gov/som/0,4669,7-192-29941_30590-46053--,00.html.

Connecticut Legislative Commission on Aging: Study of Best Practices for Reporting and Identification of Abuse, Neglect, Exploitation and Abandonment of Older Adults

The Connecticut Legislative Commission on Aging's [2016 report](#) is the result of a study on "best practices for reporting and identification of the abuse, neglect, exploitation and abandonment of older adults."³⁴ It describes the roles of various state intervention "partners... who work to address elder abuse, offer protective services, promote the rights of older adults, conduct investigations, prosecute crimes, collect data and develop promising practices."

The report provides recommendations to further efforts to prevent, detect, and intervene on issues of abuse, neglect, and exploitation of older adults and persons with disabilities. Its recommendations include establishing "an elder abuse resource prosecutor in the Office of the Chief State's Attorney" and establishing "parameters for reasonable caseload standards for the state's Department of Social Services Protective Services for the Elderly program (PSE)."

Key Features

The report:

- Provides useful and succinct definitions of elder abuse, neglect, and exploitation according to state agencies and federal regulations and
- Identifies promising initiatives to combat elder abuse, such as the development of Voluntary Consensus Guidelines, which are national guidelines to determine "effective APS [adult protective service] response across all states" and formalizing training of mandated reporters on issues such as "elder abuse red flags" and procedures for reporting.

Weill Cornell: Emergency Department Vulnerable Elder Protection Team

Weill Cornell Medicine Emergency Department (ED) has been developing and implementing "an ED-based multidisciplinary consultation service to improve identification and provide comprehensive medical and forensic assessment and treatment for potential [elder abuse] victims."³⁵ Researchers used focus groups to help develop the multi-disciplinary intervention. The researchers conducted focus groups with "18 different disciplines who work with [their] patients, including social workers, attending and resident EM physicians, radiology

³⁴ Connecticut General Assembly, *Study of Best Practices for Reporting and Identification of Abuse, Neglect, Exploitation and Abandonment of Older Adults*, 2016. Available at https://www.cga.ct.gov/age/related/20130101_Reports,%20Briefings%20&%20Updates/2016%20Study%20of%20Best%20Practices%20for%20Reporting%20and%20Identification%20of%20Abuse,%20Neglect,%20Exploitation%20and%20Abandonment%20of%20Older%20Adults.pdf.

³⁵ Rosen, Tony, et. al., "Emergency department provider perspectives on elder abuse and development of a novel ED-based multidisciplinary intervention team," *Emergency Medical Journal* (Volume 35, Issue 10). Abstract available at <https://emj.bmj.com/content/35/10/600>.

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technologists, patient escort, geriatricians, nurses, mid-level providers, psychiatrists, and scribes.”³⁶

The [Focus Groups Topic Guide](#) shows the specific script that the moderator read to the participants. As the guide indicates, sessions were 30-45 minutes, during which a moderator asked a number of questions related to addressing abuse and neglect. Question types varied from directly asking the participant about his/her understanding and awareness of abuse and neglect in the facility, to asking participants about their perception of using a multi-disciplinary approach to addressing elderly abuse and neglect. Answers to the moderator’s questions were confidential.

The findings from the focus groups, as reported in the researchers’ [2018 study](#), showed that providers did not routinely assess elder abuse and provided 10 reasons for this failure, including “lack of knowledge or training, no time to conduct an evaluation, concern that identifying elder abuse would lead to additional work, and absence of a standardized response.” Based on these focus groups, the study was able to conclude that “[a]n ED-based multidisciplinary consultation service has potential to impact care for elder abuse victims.”

Key Features

The focus groups:

- Utilized specific questions that address problems in recognizing abuse and/or neglect;
- Challenged participants to think about their own perceptions and assumptions about abuse and neglect prevention;
- Ensured that all participants involved in the training session actively participated to better equip all in addressing abuse and neglect issues;
- Used a group setting with participants from multiple disciplines to discuss questions related to abuse and neglect;
- Asked questions based on different perspectives of abuse and neglect issues; and
- Allowed for the development of new interventions.

Archstone Foundation: Elder Abuse and Neglect Initiative

In 2006, the [Archstone Foundation](#) implemented a five-year, \$8 million initiative to decrease the prevalence of abuse and neglect in the state of California. The initiative provided for multiple projects in five related fields: Education and Training for Mandated Reporters, Financial Protection Projects, Forensic Centers/Center of Excellence, Systems Change, and Convening and Technical Assistance.

The objectives of this initiative included improving the identification of abuse and neglect, as well as well advancing systemic change in way the California handles cases of abuse and neglect. For instance, the Foundation’s five-year report notes that “[t]he purpose of the education and training projects was to increase the number of professionals who can identify

³⁶ Weill Cornell Medicine Geriatric Emergency Medicine, Emergency Department Provider Perspectives on Elder Abuse and Development of a Novel ED-Based Intervention Team. Available at <https://nyceac.org/wp-content/uploads/2018/07/VEPT-Focus-Groups-Topic-Guide-v4.pdf>.

elder abuse and neglect and assist victims of elder abuse.”³⁷ Further adding that “[t]he projects pilot-tested curricula and trained mandated reports, such as Adult Protective Services (APS) workers, clergy members, emergency medical technicians, and medical and dental professionals.”³⁸

Key Features

The initiative:

- Worked towards a greater amount of mandatory reporting and increased awareness of elder abuse and neglect in California;
- Maintained “seniors’ quality of life after suffering from financial elder abuse and greater capacity to provide higher quality services and ensure project sustainability;”
- Used a multimedia approach to educate and train appropriate groups about abuse and neglect;
- Specified a yearly goal to decrease abuse and neglect in the state;
- Developed a coalition of advocates across the U.S. to address abuse and neglect among the elderly; and
- Held a statewide summit for advocates to discuss “critical issues and create a plan for future action.”

Massachusetts Office of the State Auditor: Performance Audit of the Executive Office of Elder Affairs

The Massachusetts Office of the State Auditor completed a performance audit of the Office of Elderly Affairs (EOEA) in 2018.³⁹ The audit describes initiatives to improve elder abuse and neglect prevention and solutions, including an elder abuse hotline, as well as clear protocols for responding to and reporting elder abuse and neglect.

Key Features

As the audit report highlights, the MA Office of Elderly Affairs:

- Provides options to immediately report cases of abuse and neglect;
- Requires immediate response from Protect Services for Adults (PSA);
- Ensures that reports are properly screened so as not to miss any cases;
- Requires physical assessment of residents to check for signs of abuse or neglect; and
- Allows for service plans to be developed according to individual needs based on assessment of mental and physical health.

³⁷ Archstone Foundation, *Elder Abuse & Neglect Initiative: Defining the Future, 5 Year Report*. Available at http://archstone.org/docs/resources/ElderAbuse_5YrReport_Final_090711.pdf.

³⁸ *Id.*

³⁹ MA Executive Office of Elder Affairs (EOEA), *Official Audit Report for the period July 1, 2015 through June 30, 2017*. (2018). Available at <https://www.mass.gov/files/documents/2018/10/09/201800043a.pdf>.

Tri-Valley: Elder Abuse Centralized Intake Unit & Crisis Intervention Program

[Tri-Valley, Inc.](#), an adult protective services (APS) organization in Massachusetts, has an elder abuse hotline that individuals can use to report any instances of abuse and/or neglect.⁴⁰ The agency clarifies that it is “mandated to take reports of abuse in its 25 town area,” and lists other types of mandated reporters (such as physicians, nurses, and social workers). The service is available 24-hours a day, seven days a week.

The agency also has a Crisis Intervention Program for anyone over 60 years old. The program is designed to help older adults with “problem resolution around evictions, hoarding, substance abuse, addiction, credit card debt and non-compliant behavior.” The agency adds that “this program helps alleviate pressure on the community’s resources and manpower by addressing crises that the community might otherwise have to address.”

Key Features

The Program:

- Provides an easy method for reporting incidents of abuse or neglect;
- Connects people to the state’s [Elder Abuse Mandated Reporter Form](#) that individuals can use to submit complaints to Tri-Valley; and
- Extends assistance, in the form of the Crisis Intervention Program, to older adults that need helping addressing instances of abuse and neglect stemming from evictions.

NYC Elder Abuse Center: Multidisciplinary Teams to Address Elder Abuse

The [NYC Elder Abuse Center](#) (NEAC) focused on developing and implementing multidisciplinary teams (MDTs) to address elder abuse throughout New York City.⁴¹ According to NEAC, they “regularly bring together professionals from diverse fields (e.g., social work, medicine, law, nursing and psychiatry) and systems (e.g., criminal justice, health care, mental health, adult protective services, aging network)” to work on elder abuse and neglect issues. Professionals in the community can bring “complex elder abuse cases to the MDTs to receive recommendations on assessment and interventions from the teams.”

Key Features

The multidisciplinary teams:

- Promote greater communication and relationship-building among those involved in dealing with abuse and neglect issues;
- Train individuals from various professional backgrounds who may deal with victims of abuse and neglect;
- Provide connections among members of different fields to address the common goal of preventing abuse and neglect among elderly populations; and
- Serve a wide range of purposes, such as teaching and training.

⁴⁰ See <https://www.trivalleyinc.org/in-home-services/protectivecrisis-intervention/>.

⁴¹ NYC Elder Abuse Center, *Multidisciplinary Teams: Overview*. Available at <https://nyceac.org/clinical-services/mdts/>.

Recommendations

Summary of Key Best Practices

Following is a summary of best practices based on the abuse, neglect, and crime initiatives LTCCC identified above.

- **State-based Instructions and Tools**—States should develop publicly available instructions for reporting suspected abuse, neglect, and crimes to appropriate state and federal agencies. These instructions should be supported by additional resources to help facilitate reporting, including an explanation of the federal and state requirements, contact information for relevant agencies (e.g., the state survey agency, the state Medicaid Fraud Control Unit, police department(s), the Long-Term Care Ombudsman Program, and adult protective services), and easily accessible reporting forms.
- **State and Law Enforcement Cooperation**—Stakeholders on the state level (including the survey agency, resident advocates, the LTC Ombudsman Program, and the aging network) should engage local law enforcement to overcome ignorance about the rights of nursing home (and assisted living) residents to have access to law enforcement services; the rights of individuals living in residential care to be free from abuse, neglect and crime victimization (just as those who live outside of facilities); as well as the ability – and duty – of law enforcement to visit a facility when there is an allegation of abuse, neglect, or crime and speak directly to residents, families, and those who work with them.

Additional Information and Resources

This report provides a framework for understanding abuse, neglect, and potential crimes against residents, as well as some ways in which policymakers and stakeholders have tried to better address these longstanding problems. We encourage residents, families, providers, policymakers, and other stakeholders to use the information provided in this report as a basis for developing practicable and beneficial policies and practices in their communities. In addition to the programs and studies linked to above, LTCCC has developed a range of free resources and materials that can be used to better understand residents' rights and to identify and address abuse, neglect, and suspicion of a crime against a resident. Please visit LTCCC's [Learning Center](https://nursinghome411.org/learning-center/) to access these resources: <https://nursinghome411.org/learning-center/>.