Chapter 8

Equipping California Long-Term Care Ombudsman Representatives for Effective Advocacy: A Basic Curriculum

RESPONDING TO ELDER AND DEPENDENT ADULT ABUSE IN LONG-TERM CARE FACILITIES

Curriculum Resource Material for
Local Long-Term Care Ombudsman Programs

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I. THE ROLE OF THE LONG-TERM CARE OMBUDSMAN IN PREVENTING ELDER AND DEPENDENT ADULT ABUSE AND NEGLECT

The Older Americans Act[1] created the Long-Term Care Ombudsman Program to protect the health, safety, welfare, and rights of older people who live in long-term care facilities. These facilities include nursing facilities and residential care facilities for the elderly.

- Skilled nursing facilities (SNFs): Commonly referred to as "nursing homes," these facilities provide skilled care under the supervision of medical professionals.

- Residential care facilities for the elderly (RCFEs): Also referred to as "board and care homes" or "assisted living facilities," these facilities provide housing, meals, and personal services in a home-like atmosphere. RCFEs serve people who are no longer able to perform all their activities of daily living but who do not require medical care.

In addition to their federal mandate, Ombudsman representatives in California are mandated to investigate reports of abuse or neglect in long-term care facilities. These facilities include:

Licensed Long-Term Health Care Facilities (Health & Safety Code, Section 1418:

- *skilled nursing facilities*
- *intermediate care facilities*
- *intermediate care facility/developmentally disabled*
- *intermediate care facilities/developmentally disabled habilitative*
- *intermediate care facilities/developmentally disabled—nursing*
- *congregate living health facilities*
- *nursing facilities*
- *pediatric day health and respite care facilities*
- *distinct part of the hospital that provides skilled nursing facility, intermediate care facility, or pediatric day health and respite care facility services*

Licensed or Unlicensed Community Care Facilities (Health & Safety Code, Section 1502(a):

- *Adult day program*
- *Adult residential facility*
- *Social rehabilitation facility*

[1] Older Americans Act, Title I, §102; Title III, §307; Title VII, §721

Licensed Adult Day Health Care Facility (Health & Safety Code, Section 1570.7)

The California Welfare and Institutions Code (WIC)[2] require certain service providers, including most professionals who work with elders and dependent adults, to report the abuse of persons aged sixty-five and over and of dependent adults. The law covers abuse and neglect that takes place both in long-term care facilities and in the community. The following agencies accept and investigate reports:

Ombudsman representatives are mandated to accept and investigate abuse and neglect in long-term care facilities

Adult Protective Services (APS) accepts and investigates reports of abuse and neglect perpetrated upon elders and dependent adults residing in private homes and apartments

Law enforcement may respond to reports of abuse and neglect that occur in either setting

Conditions for Reporting

Mandated reporters must report if:

- They have observed abuse or neglect
- They have knowledge of incidents that reasonably appear to be abuse or neglect
- They are told by an elder or dependent adult that he or she has been abused
- They reasonably suspect that abuse or neglect has occurred

Failure to report is a misdemeanor punishable by not more than six months in county jail, by a fine of not more than $1000, or both. Willful failure to report serious abuse can result in stronger penalties.

Mandated reporters must report abuse or neglect by telephone immediately and by written report, within two working days, using the form entitled Report of Suspected Dependent Adult/Elder Abuse (SOC 341).

Under certain circumstances, Ombudsman representatives and other mandated reporters are not required to report physical, mental, or medical injuries observed in long-term care facilities. These include situations in which the mandated reporter knows:

- There is a proper plan of care
- The plan is being property executed

[2] Elder and Dependent Adult Civil Protection Act, California Welfare and Institutions Code §§15600

- The physical, mental or medical injury occurred pursuant to the care provided under the plan
- The mandated reporter reasonably believes that an injury was not the result of abuse

These exceptions, however, only apply to certain categories of mandated reporters who have access to plans of care and who have the training and experience necessary to determine whether the specified conditions have been met. In the interest of ensuring the protection of residents, Ombudsman representatives are strongly encouraged to report all forms of abuse and neglect (when they have the consent of the resident or the resident's legal representative or the Ombudsman directly witnesses the abuse) and to urge others to do so. People who report abuse and neglect are immune from civil liability unless they act in bad faith or with malicious purpose.

II. TYPES OF ABUSE FOUND IN LONG-TERM CARE FACILITIES

When elder abuse occurs in long-term care facilities, the offenders may be other residents, visitors or individual staff members. Abuse by personnel may be the result of inexperience, lack of skills, immaturity, anger, poor impulse control, pathology or greed. Abuse and neglect in facilities, however, may also result from systemic problems such as insufficient resources devoted to resident care, fraud, poor supervision or management, or negligence. When abuse is attributed to these causes, the offenders may include management or corporate owners.

Definitions of abuse and neglect in long term care facilities vary depending on the source and the purposes for which the definition is used. Elder abuse and neglect in long-term care facilities is addressed under several state and federal codes, statutes and regulations. For example, the WIC defines the forms of abuse that must be reported under the state's mandatory elder and dependent adult abuse reporting laws. The Penal Code contains definitions used by law enforcement in determining whether crimes have been committed. Elder abuse in long-term care facilities is also in California's Business & Professional Code, Health and Safety Code and Government Code. For definitions relating to specific reportable acts, crimes and violations, refer to the appropriate codes or source documents.

Physical abuse is force that results in bodily injury, pain or impairment. Crimes associated with physical abuse include assault, battery and force likely to produce great bodily injury. Physical abuse may be committed by family employees of long-term care facilities, other residents or acquaintances. The use of physical and chemical restraints for the convenience of staff in nursing homes is a violation of federal and state residents' rights. The punitive use of restraints is a form of battery.[3]

[3]Elder and Dependent Adult Civil Protection Act, California Welfare and Institutions Code §§15610.63

Sexual abuse is forced or non-consensual sexual contact with an older person or dependent adult. It includes sexual assault and battery, lewd or lascivious acts, rape, incest, sodomy, oral copulation, or penetration of a genital or anal opening by a foreign object. It also includes sexual contact with any person who lacks sufficient decision-making capacity to give consent.

Verbal and Mental Abuse means subjecting a person to threats, harassment or other forms of intimidating behavior that causes fear, humiliation or emotional distress. In long-term care facilities, it also includes retaliatory statements from staff toward residents who complain. Residents of residential care facilities may be threatened with eviction or being transferred to nursing homes.

Financial abuse includes theft and/or the illegal or improper use of an older person's or dependent adult's funds, property or resources. It often involves inducing people with diminished mental capacity to sign deeds, wills or powers of attorney to benefit offenders. Elders are also frequent targets of telemarketing scams and "identity theft," which is the use of information such as Social Security numbers to gain access to victims' finances or to take out loans. "Sweetheart scams" are crimes in which an offender uses deceptive romantic overtures to gain access to an older person's assets.

Many residents of nursing homes have their finances managed by family members. Family members may misuse or mismanage residents' assets or fail to pay their Medi-Cal Share of Cost. The latter is considered to be abusive to the resident (as well as to the facility and the government) because it can jeopardize the older person's residency, his reputation, expose him to verbal abuse or other more subtle adverse actions by facility staff members. It may also be considered Medi-Cal fraud. Family members who are delinquent in paying the share of cost frequently stop visiting residents to avoid pressure or confrontation. Misguided efforts by families to preserve or "hide" assets from Medi-Cal may also negatively affect older resident.

Neglect is the failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a like position would exercise. This includes failure to provide medical care for physical and mental health needs; failure to assist in personal hygiene; failure to prevent malnutrition or dehydration; and failure to protect residents against health and safety hazards.

The effects of neglect are often life-threatening. Failure to provide adequate nourishment to frail individuals can quickly lead to dehydration or malnutrition. When people who are unable to turn over by themselves are not assisted in doing so, they may develop pressure ulcers (also known as bedsores, pressure sores or decubitus ulcers) which, when left untreated, can septic.

Failure to provide adequate assistance or medication can lead to accidents or the exacerbation of illnesses.

Although the offenders in most neglect cases investigated by Ombudsman representatives are long-term care facilities or their staff, Ombudsman representatives may also become involved in investigations involving neglect by family caregivers or paid caregivers in the community. These individuals are expected to exercise the same degree of care "that a reasonable person in a care provider position would exercise."

Neglect may be unintentional or intentional. Unintentional neglect may occur when caregivers lack the necessary physical strength or stamina, emotional stability, maturity or skills to provide adequate care. Intentional neglect is the willful withholding of needed care out of malice, indifference or for financial gain (e.g. the perpetrator wants to hasten the person's death because he stands to inherit).

Self-neglect is the failure of an individual to provide for his or her own basic needs. It is often associated with mental health problems such as depression, substance abuse, mental illness, or cognitive impairment. In some situations, unconventional lifestyle choices or the effects of poverty are mistaken for self-neglect. When self-neglecting individuals refuse help, it can pose troubling clinical and legal challenges to the professionals and advocates involved. These individuals must balance the self-neglecting person's right to self-determination against society's obligation to protect those who are unable to protect themselves. Service providers must further evaluate the potential hazards a self-neglecting person poses to others. For example, if a self-neglecting person allows his dwelling to become extremely deteriorated, it may endanger neighbors.

Residents of long-term care facilities have the right to refuse treatment. Some choose to do so even when they believe that the treatment will prolong suffering. A person refusing treatment must, however, have sufficient capacity to make the choice. Those who do not should be assigned surrogate decision-makers.

Isolation and the Violation of Residents' Rights is not acceptable. Residents cannot be deprived of their basic civil rights. These include the right to privacy, confidentiality, to exercise choice, to associate with people they choose to, and to participate in religious activities.

Institutional Abuse and Neglect includes substandard care that harms residents. It also includes unlawful, unfair or fraudulent business acts or practices; negligence; willful or repeated violations of regulations relating to the operation or maintenance of a long-term care facility, and knowingly presenting (or causing to be presented) false claims for money, property or services.

Ombudsman representatives typically receive reports of institutional abuse and neglect from hospitals, emergency medical personnel, medical providers and residents' family members and friends. Reports from residents and employees of long-term care facilities are less common.

Abduction is taking elders or dependent adults from their residences and preventing them from returning home. Family members or friends may attempt to remove residents from long-term care facilities when it is not in the best interest of the residents, or when it poses a danger to them. This may be accomplished using force, coercion or undue influence. Some residents may lack sufficient mental capacity to consent to these moves, and/or the person removing them may lack authority to do so.

Abandonment is when someone who has responsibility for the care or custody of an elder or a dependent adult deserts or willfully forsakes that person under circumstances in which a reasonable person would continue to provide care and custody. Family members may leave an older individual in a long-term care facility, and subsequently fail to visit or assist with key decisions affecting the resident's care. This form of abandonment is sometimes accompanied by financial abuse (the family gains access to the older person's assets after the older person has been left in the facility).

III. CONDUCTING AN INVESTIGATION

Reports of abuse in long term care facilities may come from family members, employees, other residents or victims. These individuals may report the alleged abuse during the Ombudsman's routine visits or by phone or office visit. The purpose of an Ombudsman's investigation is to verify abuse and focus on the victims' needs. It does not take the place of a criminal investigation. If criminal abuse is suspected, it should be reported to law enforcement. Because an investigation may result in future legal action, Ombudsman representatives should carefully document their findings, remembering that records may be used in legal proceedings.

No two Ombudsman investigations are alike. The steps and strategies that are appropriate in a given case depend on many factors including the wishes of the victim, the capabilities of the victim and perpetrator, the level of danger, and the level of urgency. The steps and strategies enumerated in this section are presented as guidelines; Ombudsman representatives should exercise flexibility and judgment in tailoring investigations to specific circumstances.

Steps in Conducting an Investigation

1. Always ask residents for permission to collect information. If the resident has a conservator, the conservator should be contacted for his or her consent (this requirement can be waived if the conservator is unavailable in three

working days or if the conservator is the alleged abuser).

2. Interview witnesses, including other residents, employees who were on duty when the alleged abuse occurred, family members and other service providers who have information about the resident.

3. Review medical records. Whenever possible, this should be done with the resident's permission. However, California law allows the Ombudsman to access medical records for residents who are unable to give written or verbal consent. Things to look for when reviewing medical records:
   - **Face sheets** provide information that can be extremely valuable in investigating abuse, neglect, and suspicious deaths. They contain information an Ombudsman may need to reach family members, physicians, social workers, and others who have critical information. Face sheets also contain baseline information on residents' cognitive status. If a resident has already been discharged from the facility, it provides the date of the discharge and the location to which that person was discharged. Face sheets also contain information about deceased residents' deaths, including the principal and any other contributing causes, the signature of the physician involved, and morticians' receipts which show where the decedents' bodies were taken.
   - **Medication records** provide information on the drugs prescribed to residents including their names, dosages and when they are to be administered. Medication records are typically laid out in grid format where each prescribed medication (and the dose and frequency) is listed along the left-hand margin. It is helpful to know the codes that are typically used to indicate when drugs are to be administered:

     - PRN: as needed
     - QD: daily
     - QOD: Every other day

     Across the page are columns for each day of the month. When a nurse administers the medication, he or she initials the corresponding box on the chart. If the routine medication is not given as ordered, the responsible nurse must document the reason and sign the back of the form. Nurses must also document why PRN (as needed) drugs are given. Medication records are extremely valuable in assessing whether prescriptions are administered as directed.

   - **Progress notes** are written by physicians, therapists, social workers, dieticians and others. They indicate residents' current symptoms, the results of examinations, and plans of care. They can be useful in indicating how well a facility has responded to a resident's daily needs.
   - **Nurses' notes** are extremely important because they provide an ongoing narrative account of residents' conditions and progress. They typically include information about residents' physical and mental status; their

ability to conduct activities of daily living; their social interactions with staff, family and other residents; and their reactions to treatment. Nurses' notes also show unusual activity or change in daily habits.

- **Care plans** are lists of residents' problems and how they are being addressed by facilities. They are important investigative tools because they document that a facility's staff is aware of problems and has established individualized protocols for each resident. They can also alert Ombudsman representatives when staff has not followed the plan or when residents' needs are not being met. They can further reveal when residents are refusing treatment and other factors that impact residents care.

4. Collect additional evidence and information. Examples include:
   - Client's history prior to admission including the reason for the placement and arrangements that have been made for the resident's care and finances
   - County recorders' records (e.g., in financial abuse cases, it may be necessary to determine whether property has been transferred)

5. Assess and document signs and symptoms of abuse and neglect (see *Identifying Signs and Symptoms of Abuse).*

6. Assess risk factors associated with abuse and neglect (see *Assessing Risk Factors)*

7. Assess and document indicators of diminished mental capacity (see *Assessing Diminished Mental Capacity and Undue Influence).*

8. Assess and document indicators of undue influence (see *Signs and Symptoms of Undue Influence).*

Strategies in Conducting Investigations

- Inform the resident that you will not reveal his identity without his permission. Be realistic, however, in explaining to a reluctant victim that it may be impossible to prove (and stop) the abuse without revealing his identity or confidential information. As part of the conversation, inform him that other residents may also be experiencing abuse or neglect. Several victims or the members of a resident council may be willing to come forward as a group.
- Inform residents that retaliation by the facility or its staff is against the law.
- Interviews with residents should be conducted in safe, quiet, neutral settings, away from alleged abusers.
- Schedule the interview for a time when the resident is at his or her best (consult with trusted family members, other residents or staff to ascertain when this is).
- Ask open-ended, non-leading questions.
- Physical assessments should be made by physicians or health practitioners

who have training in identifying abuse.

- Establish how victims refer to topics being discussed. For example, in an investigation of alleged sexual abuse, find out how the victim refers to relevant body parts and sexual acts. Use the victim's terms during the interview.
- Avoid communicating disgust, disappointment, shock, disapproval or embarrassment.
- Begin the interview with general and non-threatening topics and then move to more specific and sensitive topics.
- Take complete and objective notes (e.g., use direct quotes and document empirical evidence) recognizing that case notes may be subpoenaed for civil or criminal court cases.
- In some cases, it may be advisable to have a third party present during an investigation to ensure that the resident feels safe (e.g., a female patient may be more comfortable if another woman is present during an interview with a male Ombudsman) or to avoid spurious allegations of impropriety.
- It may be advisable to use audiotapes, videotapes or photographs to document abuse or neglect, particularly when time is of the essence (e.g., the resident is scheduled to go home). When possible, seek the help of physicians, emergency medical personnel or others who are trained in collecting evidence. Always obtain the resident's or legal representative's consent. Always record the date, witnesses and circumstances in which photographs and recordings are taken.
- Be careful not to "tip off' a facility when an investigation is imminent, thereby giving personnel time to conceal evidence.

Identifying Signs and Symptoms of Abuse and Neglect

Signs and symptoms of abuse and neglect may include physical indicators such as injuries or bruises. They may be behavioral clues including how victims and abusers act or interact with each other. Many of the indicators listed below can be explained by other causes (e.g., a bruise may be the result of an accidental fall) and no single indicator can be taken as conclusive proof. Ombudsman representatives should look for patterns or clusters of indicators that suggest problems.

Physical Abuse

- Sprains, dislocations, fractures or broken bones
- Bums from cigarettes, appliances or hot water
- Abrasions on arms, legs or torso that resemble rope or strap marks
- Fractures of long bones and ribs
- Internal injuries evidenced by pain, difficulty with normal functioning of organs, and bleeding from body orifices
- Bruises -- The following types of bruises are rarely accidental:

    - Bilateral, or "matching" bruises on both arms may indicate that the person has been shaken, grabbed or restrained
    - Bilateral bruising of the inner thighs may indicate sexual abuse

  - o 'Wrap around" bruises that encircle a person's arms, legs or torso may indicate that the individual has been physically restrained
  - o Multicolored bruises indicate that the person has sustained multiple traumas over time

- Injuries healing through "secondary intention" (indicating that the victim did not receive appropriate treatment)
- Signs of traumatic hair and tooth loss
- Injuries are unexplained or the explanations are implausible (they do not "fit" with the injuries observed)
- Family members provide different explanations for how injuries were sustained
- A history of similar injuries and/or numerous or suspicious hospitalizations
- Victims are brought to different medical facilities for treatment to prevent medical practitioners from observing patterns
- Delays between the onset of injury and seeking medical care

Sexual Abuse

- Vaginal or anal pain, irritation or bleeding
- Bruises on external genitalia, inner thighs, abdomen or pelvis
- Difficulty walking or sitting
- Stained or bloody underclothing
- Sexually transmitted diseases
- Urinary tract infections, particularly where patterns are observed (e.g., a resident has repeated infections, or several residents in the same room have infections)
- Inappropriate sex-role relationships between victims and suspects
- Inappropriate, unusual or aggressive sexual behavior, particularly when it has been recently acquired
- Signs of psychological trauma including excessive sleep, depression or fearfulness

Financial

- Visitors ask residents to sign documents the residents do not understand
- Unpaid bills, including fees to the long-term care facility
- New "best friends" who take an interest in the older person's finances
- Legal documents, such as powers of attorney, which the older person did not understand at the time he signed them
- Unusual activity in the older person's bank accounts including large, unexplained withdrawals, frequent transfers between accounts or other activity that the older person cannot explain
- The care or property of the elder is not proportionate to the size of his estate
- A caregiver expresses excessive interest in the amount of money being spent

on the older person

- Belongings or property are missing
- Suspicious signatures on checks or other documents
- Absence of documentation about financial arrangements
- Implausible explanations about the older person's finances are given by the elder or the caregiver
- The elder is unaware of or does not understand financial arrangements that have been made for him
- The scope of treatment a resident has been receiving is reduced

Psychological

- Berating, ignoring, ridiculing or cursing a resident
- Threats of punishment or deprivation
- Significant weight loss or gain that cannot be attributed to other causes
- Stress-related conditions including elevated blood pressure
- The perpetrator isolates the elder or dependent adult emotionally by not speaking to, touching or comforting him
- The elder or dependent adult is depressed, confused, withdrawn, emotionally upset or non-responsive
- The elder or dependent adult cowers in the presence of the abuser or exhibits unusual behavior typically associated with dementia (e.g., sucking, biting, rocking)

Neglect

- Weight loss that cannot be explained by other causes
- Lack of toileting that causes incontinence, which results in residents' sitting in urine and feces, increased falls and agitation, indignity and skin breakdown
- Pressure ulcers. Although certain types of pressure ulcers are common and difficult to avoid (e.g., where bony protuberances support body weight in residents who have peripheral vascular disease, diabetes, stroke, and dementia), other ulcers cannot be readily excused. For example, ulcers on heels, ankles and knees suggest residents have been left for long periods with inadequate padding or repositioning
- Personal hygiene is neglected
- Lack of assistance with eating, drinking, walking, bathing, and participating in activities
- Requests for personal assistance are unheeded

Self Neglect

The physical indicators of self-neglect are similar to those of neglect. In addition:

- The older person or dependent adult will not (or cannot) accept help that is offered
- The individual refuses needed medical care or treatment

- The resident suffers from dementia, depression or substance abuse

Violation of Rights

- Residents are prevented from participating in social, religious or community activities
- Residents are prevented from receiving visitors or associating with others by mail or telephone
- Residents are not treated with consideration, respect and dignity
- Residents do not have privacy when receiving treatment and personal care
- Voicing grievances and suggesting changes in policies leads to punitive or retaliatory action
- Residents' clinical and personal records are disclosed to third parties (other than a physician, legal representative or Ombudsman) without their consent

Institutional Abuse or Neglect

- Failure to adequately document residents' care and condition
- Failure to implement physicians' orders
- Failure to notify a physician if there are changes in a resident's condition
- Gaps in a residents' files
- Alleged abuse is not reported to proper authorities
- Preventable injuries and health problems
- Patterns of poor care including an excessive rate of falls, malnourishment and pressure ulcers
- Medical staff do not make required rounds
- Foul odors from urine and fecal matter
- Loose handrails or other hazards
- Dilapidated living quarters
- Infestation of pests (rats, cockroaches)
- Mildew
- Broken windows
- Discharge or medical records not appropriately maintained
- Insufficient staff
- Discrepancies between documented care and care that is actually received
- Lack of adequate care plans and resident assessments
- Incorrect body positioning, which leads to limb contractures and skin breakdown
- Ignoring call bells or cries for help
- Not placing residents' funds in interest-bearing accounts when required
- Stealing or embezzling residents' money or personal property

Abduction

- The older person or dependent adult is moved without his consent. This includes the removal of persons who lack capacity to give consent
- The older person or dependent adult is prevented from returning to his residence

Abandonment

- The older person or dependent adult is left unattended in a public setting or hospital emergency room
- A caregiver moves away or quits without making arrangements for care
- Family members place an older person or dependent adult in a long-term care facility and fail to visit, make payments, or assist in making necessary decisions affecting the individual's care
- The caregiver is locked out of a home or facility.

Assessing Risk Factors

The research on elder abuse and neglect suggests that certain factors or conditions are predictive of abuse. This means that the presence of these factors increases the likelihood that abuse will occur. Although these factors are not diagnostic, they suggest the need for further monitoring. Ombudsman representatives should watch for and document risk factors.

The caregiver:

- Has behavioral problems
- Is financially dependent
- Has mental/emotional difficulties
- Has an alcohol or substance abuse problem
- Has unrealistic expectations regarding needed care or about the care receiver's abilities
- Lacks understanding of the care receiver's medical condition

The care receiver:

- Has been abused in the past
- Has experienced family or marital conflict
- Lacks understanding of his or her medical conditions
- Is socially isolated
- Lacks social support
- Has behavior problems

Conducting Investigations in Residential Care Facilities

Most reports of abuse and neglect in residential care homes come from family members, social workers, and staff of acute care hospitals. Some people who work in facilities are not aware of their mandatory reporting responsibilities. It is incumbent upon the Ombudsman to observe signs of abuse during routine visits.

Defining neglect and abuse in residential care facilities can be difficult. There are no federal standards of care comparable to those that pertain to nursing homes. Although California regulates residential care facilities, they are not clearly defined or extensive as some would like.

Ombudsman representatives face a variety of challenges in investigating complaints of abuse in residential care facilities, including:

- Distinguishing neglect from the effects of chronic illnesses
- The state does not require facilities to meet specified staffing requirements, which makes it more difficult to hold facilities accountable for providing adequate staff support
- Operators can evict residents if they can show that a resident's care needs exceed allowed limits. The Ombudsman must therefore proceed cautiously, in consultation with Community Care Licensing, so that interventions do not result in eviction or other retaliatory actions. These concerns must be weighed against the need to hold accountable those facilities that have demonstrated a pattern of neglect.

Reviewing Files

Under California law, residential care facilities must maintain files on all residents. The state further spells out what information must be contained in the files including:

- Medical assessments
- Face sheets
- Pre-placement appraisals of residents
- Prescribed medications

In investigating suspected abuse or neglect, Ombudsman representatives should look for the following:

- All required information is present
- Gaps in documentation
- Documentation that the resident has received care from other service providers
- Facilities' failure to notify residents' physicians of changes in their conditions (as required by the state)

Conducting Investigations in Nursing Homes

Residents of nursing homes rarely report abuse or neglect. Some are too incapacitated to understand that they are being abused or to communicate it. Others fear retaliation. Nursing home staff is also frequently reluctant to report abuse; some are exempted from reporting under certain circumstances (see Page 6). This makes it imperative that Ombudsman representatives learn to recognize and report abuse that they observe.

In addition to looking for the signs and indicators of abuse and neglect to individuals, Ombudsman representatives should be aware of indicators of poor

care, including:

- An excessive number of residents in bed, restrained in wheel chairs, and wearing hospital garb instead of their own clothing
- Odor of urine
- Inattentive staff
- Staff breaks are excessive in number and duration and result in residents being left without supervision

Ombudsman representatives can access residents' medical records with the consent of the resident or his legal representative. They are further permitted to access medical records when verbal or written permission cannot be obtained because the resident is incapacitated and lacks a representative (or if the legal representative is unresponsive). When reviewing residents' records, look for:

- Failure to follow established protocols (e.g., a nurse's notes containing observations that should trigger a reassessment).
- When investigating suspicions of malnutrition and dehydration, review the daily log of food and fluid intake for entries that appear to be inaccurate or "rote" (not based on actual observations).
- Explore whether "refusals to eat," in reality, reflect the failure of a facility to provide assistance.

IV. DIMINISHED MENTAL CAPACITY AND UNDUE INFLUENCE

Mental Capacity

Ombudsman representatives often need to make judgment calls about residents' level of understanding. Determining whether or not abuse or neglect has occurred may involve making assessments about residents' capacity to perform particular mental tasks. Residents' cognitive abilities may also dictate appropriate plans of action.

Assessing mental capacity can be complicated, requiring consultation with physicians or mental health professionals.. Diminished mental capacity may result from medication interactions, fear, malnutrition or dehydration. Because Ombudsman representatives play a critical role in identifying cognitive problems and alerting others to them, it is important that they understand some general "rules of thumb" in assessing capacity.

Mental capacity is a cluster of skills, which are generally divided into the following categories:

- Alertness and attention. This is the ability to pay attention and concentrate. It includes knowing who you are, where you are, and the approximate date and time of day.
- Information processing. To process information, a person must be able to recall certain information, understand and communicate with others, recognize familiar objects and people, understand and appreciate quantities; and be able to reason, plan, organize, and carry out actions.

- Coherent thought processes. Compromised thought processes are demonstrated by severely disorganized thinking, hallucinations, delusions and uncontrollable, repetitive, or intrusive thoughts.
- The ability to modulate mood and affect. Deficits in this area are demonstrated by inappropriate and persistent states of euphoria, anger, anxiety, fear, panic, depression, hopelessness, despair, helplessness, apathy or indifference.

Different mental skills are needed to perform different mental tasks. For example, to give a gift, a person must understand and appreciate quantities. Consequently, assessing capacity requires that one look for "functional" limitations or deficits; it is not enough to simply look for signs of the deficits listed above. Rather, in making an assessment, one must determine how the deficit harms the person or renders him vulnerable to abuse or neglect.

In abuse cases, it is often necessary to determine whether a resident is capable of:

- Accepting or rejecting needed help
- Accepting or rejecting medical treatment
- Signing a document such as a power of attorney
- Giving a large gift to a new friend or acquaintance
- Creating a trust or joint tenancy that affects inheritance
- Putting cash into an annuity with one child as the beneficiary
- Hiring a care manager
- Deeding property
- Signing a car over to another person

Ombudsman representatives are encouraged to document the signs of diminished mental capacity listed below. Whenever possible, indicate how the impairment affects the resident's daily activities.

The resident:

- Is not alert
- Cannot concentrate
- Does not know where he is or the approximate date or time of day
- Is unable to recall things he has just been told
- Cannot understand what is being said
- Cannot communicate verbally or in other ways
- Cannot recognize familiar objects and people
- Cannot understand and appreciate quantities
- Cannot reason logically, plan, organize, or carry out actions
- Appears to have disorganized thinking
- Has hallucinations, delusions, or uncontrollable, repetitive or intrusive thoughts

- Demonstrates pervasive, persistent, or recurrent euphoria, depression, anger, anxiety and fear

When in doubt, get help from your Ombudsman Program Coordinator. If you believe that a person's safety or property is in jeopardy as a result of impairment, discuss the situation with the Ombudsman Program Coordinator, the resident's physician, the facility's social worker, etc.

Undue Influence

The ability to exercise choice may also be affected by psychological manipulations or control exerted by others. Undue influence refers to the psychological control that a stronger person exerts over a weaker person to get the weaker person to do something he would not have done otherwise. Undue influence is a process that typically occurs over time. Cunning manipulators may endear themselves to vulnerable persons, gain their trust and foster dependency to gain compliance. Whereas victims of coercion typically feel pressured to do what they are told, victims of undue influence may not even be aware that they are being manipulated. They may willingly comply with perpetrators' demands and even defend perpetrators to others.

Little is known about undue influence in long-term care facilities; however, the extreme vulnerability of residents and the loss of control that many residents experience suggest that this form of control warrants serious consideration by Ombudsman representatives. Although undue influence is extremely difficult to prove, courts are increasingly coming to recognize this form of abuse. Ombudsman representatives should learn to recognize and document its signs and symptoms.

Signs and Symptoms of Undue Influence

- The abuser isolates the older person by discouraging or preventing visits, phone calls and letters
- The abuser fosters dependency by withholding assistive devices, failing to provide food or medical care, or preventing the elder from receiving support or assistance that would enhance his independence
- The abuser asks the vulnerable person to sign documents, such as powers of attorney and deeds, and discourages or prevents him from seeking advice from third party advisors
- The abuser tries to convince the vulnerable person that friends, family members or caregivers have malevolent motives and cannot be trusted. This is sometimes referred to as creating a "siege mentality"
- A "gift" is not commensurate with the relationship. For example, the elder gives an expensive car to a "friend" he has just met
- The manipulator fosters a sense of powerlessness so that the elder looses confidence in his competence

Persons at Risk for Being Unduly Influenced
People with certain conditions or traits are particularly vulnerable to undue influence. This includes people who:

- Have diminished mental capacity
- Have serious health problems
- Are taking medications that affect their cognitive status
- Are depressed
- Are alone without support
- Have lost their independence
- Are under stress
- Are anxious or fearful
- Have suffered recent losses, including the loss of a spouse, home or friend

V. CASE RESOLUTION

Once an investigation has been completed, the Ombudsman will take one of several steps. If the abuse or neglect cannot be verified, the Ombudsman should complete his report, stating any conclusions and supporting reasons.

All verified cases must be reported to the appropriate licensing agency (with the consent of the resident). When the Ombudsman has the resident's consent to do so, they may refer the case to the appropriate law enforcement agency as appropriate. Additional interventions that the Ombudsman may pursue depend on multiple factors including victims' wishes and cognitive capacity, the extent and severity of the abuse or neglect, whether others are affected, and facilities' willingness to take action to stop the abuse. In some instances, the Ombudsman may assist facilities to develop and implement plans to stop the abuse and neglect, and prevent future abuse. In other cases, the Ombudsman may refer victims, their representatives or family members to appropriate agencies for follow-up services or assistance. The following principles serve as a guide in making decisions about interventions.

Practice Principles
In resolving abuse and neglect complaints, Ombudsman representatives adhere to a set of professional standards and practice principles. Foremost among these is respecting residents' constitutional right to personal **autonomy.** Autonomy, which comes from the Greek word for "self rule," is the ability to make informed choices, free from coercion and based on one's own personal beliefs and values. It presumes that all adults have decision-making capacity and assures them the right to **self-determination** in all areas of their lives.

Following this principle, Ombudsman representatives always initially take an "expressed wish" approach to advocacy. This means that whenever residents have the capacity to express their wishes regarding whether or not they want to proceed with a complaint or accept offered services, those wishes will be respected. If a resident is unable to express his wishes, the Ombudsman will

turn to a "best interest" mode of advocacy in which he makes judgments, usually in consultation with the resident's family or friends (if there are any), about the client's best interest.

Ombudsman representatives also look for service options or interventions that cause the least disruption or change in a resident's circumstances and maximize his independence and freedom. They provide opportunities for residents to exercise choice and decision-making to as great an extent as possible. To that end, they strive to provide interventions that are voluntary and which least impede the individual's freedom, even if the resident chooses freedom over safety.

Resolving abuse and neglect may at times involve "trade-offs" between freedom and safety. Making decisions about the appropriate course of action can be extremely difficult. Ombudsman representatives are encouraged to discuss complex cases with their Ombudsman Program Coordinator and other colleagues.

Reporting

In addition to their responsibility to investigate reports of abuse they receive from others, Ombudsman representatives are also required by law to report certain types of abuse and neglect they observe. This is extremely important as residents in facilities are unlikely to report abuse themselves. Some are unaware that they are abused or neglected as a result of cognitive impairment.

There are several reasons for reporting. It ensures that all cases receive needed follow-up by those who are best equipped to resolve problems and meet victims' needs. In addition, information is collected and used to identify systemic problems, so that they can be corrected. Accumulated information also contributes to the public and professionals' understanding of the extent and nature of abuse, and informs policy makers about the need for services and policy reform.

The Ombudsman Program Coordinator makes referrals of reports of abuse and neglect to state licensing agencies and other entities on a form entitled *Complaint from the Long-Term Care Ombudsman* (CDA 223). Long-term care facilities are also required to report abuse complaints they receive to licensing. Ombudsman representatives should make sure that facilities are aware of these reporting responsibilities and should follow up to ensure that facilities comply. Cases involving criminal abuse should be reported (with the consent of the resident or legal representative) to law enforcement or the state Bureau of Medi-Cal Fraud and Elder Abuse.

State Licensing Agencies

Community Care Licensing Division

This Division of the California Department of Social Services inspects and licenses all residential care facilities in California. When problems are reported, the Division conducts an investigation, generally within ten days. If the problem is substantiated, the division may direct the facility to address the problem and works with the facility to develop a plan of correction. Afterwards, the Division must re-inspect the facility to ensure it has corrected the problem by the date set in the plan of correction. The Division may also assess a fine on the facility.

Licensing and Certification Division

This Division of the California Department of Public Health (CDPH) routinely inspects nursing homes to ensure that they meet minimum quality and performance standards. When problems are discovered, the Division can direct the facility to address the problems and pay a monetary penalty to the State. In addition, the CDPH surveys facilities for the Centers for Medicare and Medicaid Services (CMS), which is a component of the federal government's Department of Health and Human Services. If problems persist, the government can also deny payment to nursing homes that serve Medicare and Medi-Cal beneficiaries, assign managers, or install a state monitor. If the facility does not correct problems, CMS may terminate its agreement with the facility. The facility would no longer be certified to provide care to Medicare and Medi-Cal beneficiaries.

Reporting to state licensing agencies does not relieve local Ombudsman representatives of their responsibility to investigate reports of abuse and neglect. Substantiation of a complaint requires a greater legal burden of proof. Licensing's inability to substantiate a complaint does not necessarily mean that a problem does not exist. Regardless of whether or not the licensing agency substantiates the complaint, other services may still be needed from the Ombudsman. For example, additional visits may be needed to allay victims' fear of retaliation. Investigations by local Ombudsman representatives may be conducted concurrently or in cooperation with state agencies.

The National Ombudsman Reporting System (NORS) was created to track complaint patterns and trends on a local, state, and national level. Every complaint received must be coded into one of the 119 NORS complaint codes. For the purposes of NORS, if through the Ombudsman's fact gathering, interviews, and investigation of the complaint he determines that the circumstances appear to be generally accurate, the Ombudsman should verify the report of abuse that the program has received.

Referrals to Law Enforcement

In addition to reporting to state licensing agencies, Ombudsman must report criminal abuse and neglect to law enforcement agencies (with the consent of victims). Abuse should be reported to the appropriate local Police Department

or Sheriff in the following situations:

- A criminal act has been committed. The criminal charges associated with elder abuse and neglect include assault, battery, theft, fraud, sexual assault, larceny, forgery, reckless endangerment, embezzlement, violations of consumer protection statutes, and many others. California also has a special criminal statute specifically for elder abuse and neglect, Penal Code Section 368, which takes into account factors like the heightened potential for death, injury, and the impact of crimes against frail victims as well as the fact that abuse is often committed by family members and other persons who are in positions of trust.
- A client is at risk of losing assets (e.g., the client has signed a Power of Attorney and the perpetrator has access to accounts).

Bureau of Medi-Cal Fraud and Elder Abuse

The Bureau, which resides within the California Attorney General's Office, investigates and prosecutes Medi-Cal provider fraud and violations of state laws pertaining to fraud in the administration of the Medi-Cal program. The Unit also reviews complaints of resident abuse and neglect (where the facility or its employees are responsible) and the misappropriation of resident funds in facilities. A referral to the Bureau should be concurrent with one by the Ombudsman Program Coordinator to the appropriate state licensing agency. The Bureau has 3 units:

The **Violent Crimes Unit** investigates and prosecutes physical abuse committed by individual employees against residents of long-term care facilities, including homicide, kidnapping, rape, false imprisonment, and assault and battery.

The **Facilities Enforcement Team** investigates and prosecutes the corporate entities that are responsible for poor care in skilled nursing facilities and residential care facilities. Institutional neglect or substandard care includes failure to provide medical care for physical and mental health needs, failure to attend to hygiene concerns failure to prevent malnutrition and dehydration, and falsification of resident charts.

Operation Guardian is a multi-agency task force that was established to conduct surprise, on-site inspections of California's skilled nursing facilities. The group identifies violations of federal, state and/or local laws designed to protect residents. It includes regulatory and law enforcement officials, including district attorneys, fire marshals, building code inspectors, health inspectors, geriatric care specialists, and Ombudsman representatives.

***Working with Facilities to Improve* Care**

If an investigation indicates that abuse or neglect has occurred, Ombudsman representatives take action to stop the abuse and neglect. In addition, they must:

- Inform the facility of their findings
- Remind the facility about its responsibility to report to the appropriate state licensing agency
- Work with state regulatory agencies to improve care (this is particularly important in addressing neglect within residential care facilities to ensure that victims are not evicted as a result of abuse complaints)
- Ombudsman representatives can request care plan meetings in nursing homes. During these sessions, which residents should attend, Ombudsman representatives should be proactive in asking the facility how their care plan for the resident will be modified to address the concerns raised.

Working with Residents and their Families

Ombudsman representatives do not take the place of specialized professionals such as physicians, nurses, and social workers, but rather, serve as "brokers and coordinators" of services. They educate residents about available services, counsel them about the benefits and limitations of various options, arrange for (or assist in arranging for) services, and provide follow-up to ensure that problems are resolved. They may educate residents and families about the following options that are available to them:

Conservatorship

Conservatorship is a mechanism by which a court appoints a person to handle the financial and/or personal affairs of individuals who are unable to protect themselves as the result of disability. Stopping abuse to residents of long-term care facilities may involve establishing a conservatorship, providing information or guidance to a conservator, or revoking a conservatorship when the conservator has failed to meet his or her responsibilities.

There are two types of conservatorship in California:

- **Conservatorship of the person** refers to the handling of an individual's personal needs through the provision of medical care, food, clothing and shelter
- **Conservatorship of the estate** refers to the management of financial resources and assets

The Probate Court appoints conservators in situations in which the following criteria are met:

- The proposed conservatee lacks sufficient mental capacity to manage his affairs and to resist undue influence
- The person is at risk for abuse, neglect and exploitation
- A conservatorship can prevent abuse from occurring

The first step in initiating a conservatorship is to determine who is willing and available to serve. Conservators may be family members or private professionals. The Public Guardian is considered the "conservator of last resort" for people who need conservators, do not have family members available, and who cannot afford to hire private professionals.

Under California law, probate court investigators review all proposed conservatorships and make recommendations to the presiding judge. The reports are based on investigators' personal observations of the proposed conservatees and interviews with others. Court investigators are also charged with ensuring proposed conservatees' due process rights. They explain the court process to them and inform them of their rights, which include the right to oppose the proceeding and to object to the proposed conservator. Court investigators may recommend that legal counsel be appointed to represent a proposed conservatee.

Conservatorship may be appropriate in the following abuse situations:

- To stop abuse when severely impaired victims are unable to grasp the severity of their situation and refuse needed services
- Family members are quarreling over the custody or assets of an impaired elder
- Adult children want to claim inheritances prematurely or influence their older family members to make new wills
- Less restrictive legal devices, such as durable powers of attorney or trusts, have been misused.

Probate Court Investigators also investigate allegations of abuse by conservators. Persons who suspect abuse can contact the Court Investigator to discuss the situation and describe their concerns.

Stopping Abuse Involving Powers of Attorney

A power of attorney is a document with which one person (the “principal”) grants authority to another (the “agent”, or “attorney-in-fact”) to act on the principal’s behalf with regard to the principal’s property, personal care or health care. It gives the agent the power to manage, dispose of, or sell the principal’s property or to use the property as security to borrow money on the principal’s behalf.

A durable power of attorney is a type of power of attorney that “endures” after the onset of capacity. A durable power of attorney must contain language stating that it is intended to be durable (i.e., “This power of attorney shall not be affected by the subsequent incapacity of the principal.”). Without this provision, the power of attorney is “non-durable” and terminates once the principal becomes incapacitated. Executing a durable power of attorney allows a competent elder to choose a trustworthy person to handle his affairs and continue to do so even if the principal becomes incapacitated. The power may become effective at the time it is signed or, in the case of a “springing power of attorney”, at a specified

time or event in the future (e.g., the durable power of attorney will "spring" only if and when the principal becomes incapacitated).

At present there is little oversight of powers of attorney and the following abuses are becoming increasingly common:

- The requirements for signing are not met (e.g., the power of attorney must be signed in the presence of a notary public or by at least two witnesses, the attorney-in-fact may not act as a witness, etc.)
- The principal was coerced or tricked into signing the document
- The principal lacked sufficient mental capacity at the time he or she signed it (the principal must understand the document at the time of signing regardless of the type of power of attorney)
- The attorney-in-fact uses the power after it has terminated (the principal has become incapacitated and the power is not a durable one)
- The attorney-in-fact uses the power of attorney for purposes other than those for which it was intended
- The agent transfers the principal's property to himself without specific authorization in the power of attorney
- The agent does not act solely in the interest of the principal
- The agent has failed to keep the principal's property separate and distinct from his own

The following actions can be taken to stop abuse of powers of attorney. It should be noted, however, that all of the available options entail difficulties. Prevention is clearly the best remedy. Whenever possible, legal assistance sought in establishing power of attorneys to reduce the risk of abuse.

Remedies for Abuse of Powers of Attorney

- Revoke the power of attorney. A principal can revoke the power of attorney at any time as long as he has sufficient mental capacity to do so.
- If the principal is aware of the abuse, inform him of his right to revoke the power and assist him to do so. Revocations must be made in writing. The agent must be notified that the power has been revoked
- If the principal is not aware of the abuse, provide him with the evidence that has led you to suspect abuse (e.g., cancelled checks, etc.)
- With the consent of the resident, report to law enforcement. An agent who transfers the principal's property to himself without authorization may be prosecuted for fraud and/or embezzlement. If the principal is 65 years of age or older at the time the property was transferred without authority, the agent may also be prosecuted for elder abuse under Penal Code Section 368.
- Refer the victim to the Title III B Legal Services Provider. Each Ombudsman program has a memorandum of understanding with their local Title III Legal Services Provider for the provision of legal consultation and representation for residents of long-term care facilities. The Probate Court can be petitioned to force the agent to account for his handling of

the power of attorney.

Advocacy

Ombudsman representatives are also encouraged to prevent abuse and neglect through advocacy. This may include:

- Advocating for additional staffing, supervision, training, and resources
- Participating in local planning initiatives
- Assisting families establish family councils

VI. REFERRALS TO OTHER AGENCIES

Adult Protective Services (APS)

APS accepts and investigates reports of abuse and neglect of elders and dependent adults that are committed in private homes and apartments. Ombudsman representatives should contact APS in the following situations:

- When an Ombudsman has received a report of abuse that occurred in the community (the report came to the Ombudsman by mistake)
- When residents of long-term care facilities report to the Ombudsman that they were abused while they were living in the community
- A resident of a long-term care facility is going to return to the community and is at risk for abuse in the community
- APS has worked with the resident in the past or is likely to work with him in the future and has information that is essential to the successful resolution of the case
- The Ombudsman is working with a resident of a long-term care facility whose perpetrator is in the community and may abuse others

Elder Death Review Teams

As a result of Senate Bill 333 (Escutia, Chapter 301, Statutes of 2001), the California Penal Code (Article 2.7, Section 11174.4, et seq.) was amended to allow counties to establish Elder Death Review Teams (EDRTs) to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communications among persons who perform autopsies and persons involved in the investigation or reporting of elder abuse or neglect. The membership of EDRTs consists of the following individuals: experts in the field of forensic pathology; medical personnel with expertise in elder abuse and neglect; coroners and medical examiners; district attorneys and city attorneys; adult protective services staff; public administrator, guardian, and conservator staff; county health department staff who deal with elder health issues; county counsel; county and state law enforcement personnel; local long-term care ombudsman representatives; community care licensing staff and investigators; geriatric mental health experts; criminologists; representatives of local agencies that are involved with oversight of adult protective services and reporting elder abuse or neglect; and legal professional associations of persons referenced above. As of July 2007, 14 counties had established EDRTs. Please consult with your Ombudsman Program Coordinator to determine if your county has an EDRT.

Title III B Legal Services Providers
These Older Americans Act programs provide legal consultation, advice, referrals, and representation to elders. Staff attorneys represent elders in cases involving financial, physical and/or emotional abuse. They also provide assistance in securing restraining orders, powers of attorney, and public benefits programs.

Probate Court Investigators, Superior Court
Probate court investigators investigate all proposed conservatorships and allegations of abuse by conservators. In some cases, court personnel may investigate abuse involving powers of attorney.

Public Guardian/Conservator
The Public Guardian/Conservator serves as probate "conservator of last resort" (when others are not available) for elders and dependent adults who are at risk for physical or financial abuse. The Public Guardian/Conservator also serves as the representative payee for elders and mentally impaired persons who have mental health case managers.

California Advocates for Nursing Home Reform (CANHR)
CANHR is a statewide citizen advocacy group that is dedicated to improving the quality of care for long-term care residents. The agency provides referrals to attorneys who are experienced in elder abuse litigation and estate planning. The agency also assists with complaints, provides pre-placement counseling, provides assistance in developing family councils, and collects and disseminates information on the quality of care in nursing homes throughout California.