Victimized Twice:

Abuse of Nursing Home Residents, No Criminal Accountability for Perpetrators

Disability Rights California, Investigations Unit
1330 Broadway, Suite 500
Oakland, California 94612
510.267.1200
www.disabilityrightsca.org

April 2010

Victimized Twice:
Abuse of Nursing Home Residents, No Criminal Accountability for Perpetrators

Contributors

Disability Rights California Investigations Unit Staff:

Pamila Lew, Staff Attorney
Jung Pham, Staff Attorney
Ricardo Jauregui, Senior Investigator
Paul Duryea, Senior Investigator
Leslie Morrison, Director

Disability Rights California Experts:

Paul Greenwood, J.D.
Diana Koin, M.D.

Staff Acknowledgment:

Robin Rosenzweig
Disability Rights California
Editing and Production

Cover Photo by Ricardo Jauregui, Senior Investigator

TABLE OF CONTENTS

Executive Summary **1**

Introduction **3**

California's Abuse Reporting and Response System **5**

A. Elder Abuse and Dependent Adult Civil Protection Act 5

Table: Reporting System for Abuse in Long Term Care Facilities 6

B. The Players 7

1. Long Term Care Ombudsman 7

2. Local Law Enforcement and District Attorneys 9

3. Bureau of Medi-Cal Fraud and Elder Abuse 11

4. Department of Public Health, Licensing and Certification 12

Scope of Resident Abuse in Skilled Nursing Facilities **15**

A. Skilled Nursing Facilities 15

B. Vulnerability of Skilled Nursing Facility Residents 15

C. Statistics Confirm Abuse 16

D. Abuse Goes Unanswered 17

Problems with California's System of Abuse Reporting and Response **19**

A. Choice in Reporting 19

B. Challenges for Prosecutors in Court 19

Disability Rights California's Investigations **23**

Table: Disability Rights California Cases 23

Findings and Conclusions 29

1. Incidents of criminal abuse by staff against nursing home are not promptly reported 29
2. Reports are often made only after an internal investigation..... 30
3. Abuse reports are made by the facility administrator, not the staff with direct knowledge as required by law 30
4. Reports of criminal abuse are frequently made to the long term care ombudsman and are never referred to law enforcement..... 31
5. Criminal investigations are not thorough and often produce insufficient evidence for prosecution 31
6. Cases that make it into the criminal justice system are not rigorously investigated or prosecuted 32

Recommendations..... 35

1. California's Mandated Reporting Act must be amended to require immediate reporting to law enforcement and the ombudsman 35
2. The BMFEA must assume a leadership role in addressing crimes against dependent adults and elderly residents in SNFs 36
3. Facility administrators and mandated reporters must be held accountable for complying with the Mandated Reporting Act 37
4. The State of California should develop a system for reporting and tracking abusive care staff..... 38
5. Courts should prioritize elder and dependent adult abuse cases 39
6. The California Office of Emergency Services should encourage the development of specialized prosecution units to address elder and dependent adult abuse 39

Disability Rights California Experts..... 41

Endnotes..... 42

Executive Summary

Nursing homes have become an indelible part of our health care landscape. These facilities provide 24 hour inpatient skilled nursing and supportive care to residents whose disability or condition necessitate the availability of skilled nursing care on an extended basis. It is estimated that over 40% of Americans will use a nursing home at some point in their lives and, as the population of individuals 65 years of age and older grows, the demand for skilled nursing care is not expected to decrease in the next two decades.[1]

Unfortunately, the United States General Accounting Office[2] and others confirm that nursing home residents are often victimized by the very caregivers with whom they are entrusted. Much of the abuse rises to the level of criminal conduct. Yet, few cases are reported to or investigated by law enforcement and even fewer are criminally prosecuted.

Simply put, crimes against nursing home residents are less likely to be reported, investigated, and prosecuted than crimes against individuals living in the community. They are often treated as licensing or administrative matters and not as crimes. It is time to highlight and address biases and lapses in the abuse response system to ensure that nursing home residents are provided equal access to the criminal justice system and equal protection from criminal abuse by caregivers.

This report describes 12 cases of physical and sexual abuse of nursing home residents by caregivers and traces the handling of these crimes through California's abuse response and criminal justice systems. The cases were gleaned from licensing citation reports issued by the State's Department of Public Health (DPH) which confirmed the facts and determined the facility was liable for resident abuse.

Based on our investigations, Disability Rights California finds:

1. Incidents of criminal abuse by staff against nursing home residents are not promptly reported.

2. Reports of criminal abuse are often made only after an internal facility investigation.

3. Abuse reports are made by the facility administrator, not by the staff with direct knowledge, as required by law.

4. Reports of criminal abuse are frequently made to the long term care ombudsman and are never referred by long term care ombudsmen or others to law enforcement.

5. Criminal investigations are not thorough and often produce insufficient evidence for criminal prosecution.

6. Cases that make it into the criminal justice system are not rigorously investigated or prosecuted.

Disability Rights California recommends:

1. California's Elder Abuse and Dependent Adult Civil Protection Act must be amended to require the immediate reporting of abuse and neglect of dependent adults and elders to law enforcement and the long term care ombudsman.

2. The Bureau of Medi-Cal Fraud and Elder Abuse must assume a leadership role in addressing crimes against dependent adults and elderly residents in skilled nursing facilities.

3. Facility administrators and mandated reporters must be held accountable for compliance with the Mandated Reporting Act.

4. The State of California should develop a system for reporting and tracking abusive care staff.

5. Courts should prioritize dependent adult and elder abuse cases.

6. California's Office of Emergency Services should encourage the development of specialized prosecution units to address dependent adult and elder abuse.

Introduction

Disability Rights California is the independent protection and advocacy system for California.* Established under federal law to protect the rights and interests of persons with disabilities, both Congress and the State of California have granted Disability Rights California the unique authority to investigate allegations of abuse and neglect involving Californians with disabilities.[3] Disability Rights California investigations focus on systemic issues related to abuse and neglect, including those that indirectly support a culture of abuse or neglect and that challenge or diminish the effectiveness of the current system of response.

California's mandated abuse reporting system identifies entities that are responsible for receiving and investigating reports of abuse and neglect involving dependent adults and elders. California's Elder Abuse and Dependent Adult Civil Protection Act (the Mandated Reporting Act)[4] requires that designated individuals involved with vulnerable elders and dependent adults immediately report incidents of known or suspected abuse or neglect to first responders, such local law enforcement, county Adult Protective Services and/or the county long term care ombudsman. In turn, these first responders are required to make secondary reports to others in the abuse response system, including the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA), the local district attorney, and the Department of Public Health. Disability Rights California is not the first responder or primary investigator of abuse or neglect.

Over the past two years, Disability Rights California investigated 12 cases of abuse of nursing home residents by staff to discern how the incidents were treated by the abuse response and criminal justice systems. These cases are described throughout this report, based on facts obtained during Disability Rights California's investigations and from the Department of Public Health citation reports. Pseudonyms have been used for the names of all individuals and nursing facilities described in the case summaries to protect resident confidentiality.

In order to better understand these systems and their response to abuse reports, Disability Rights California staff interviewed many individuals involved in the abuse response and criminal justice system, including long term care ombudsmen, representatives from the BMFEA, a law enforcement official, and a retired judge who presided over cases in an Elder Abuse Court. Disability Rights California

* Disability Rights California was previously known as Protection and Advocacy, Inc.

referred 10[†] of the cases to Dr. Diana Koin, a physician practicing in the field of geriatric medicine and an expert in elder and dependent adult abuse, and Paul Greenwood, a nationally recognized attorney who leads the Elder Abuse Prosecution Unit for the San Diego District Attorney's Office.[‡]

All of the 12 cases involved facts indicative of criminal abuse. Yet, nearly half were never reported to law enforcement. Ten cases were reported to the ombudsmen but reporting often lagged for several days. Several cases either involved more than one victim or multiple incidents involving the same victim. In only three cases were criminal charges filed; two cases involved separate incidents with different victims perpetrated by the same staff person; the third case involved multiple incidents of sexual assault involving the same victim over a period of weeks. In the end, in each case prosecutors reduced the felony charges to misdemeanor offenses, and sentences were minimal.

Our investigations indicate that incidents of abuse of nursing home residents by care staff were handled not as criminal matters but as licensing or employment concerns. Reports to entities in the abuse response and criminal justice systems were delayed; evidence was not gathered; investigations lagged or were never initiated; victims died while awaiting justice; and in at least one case, the assailant moved on to another care facility. It is likely that these cases are representative of many others.

Laws are seemingly in place to protect victims and to ensure that incidents are promptly reported and investigated and that prosecutors have the necessary tools to pursue assailants who prey on this vulnerable population. Yet, the system has failed. Like child abuse and domestic violence in years past, it is time to underscore that abuse of nursing home residents by care staff is a crime and for the abuse response and criminal justice system to make their response to these events a priority.

---

† Two cases were not reviewed by the experts because Disability Rights California became aware of the incidents following their consultation.

‡ Any views or opinions expressed by Paul Greenwood or Dr. Koin in this report constitute his or her personal opinion and do not represent the views or opinions of the San Diego District Attorney's Office or any other agency or organization with which either is affiliated. Their opinions are based on the documents and evidence that they reviewed.

California's Abuse Reporting and Response System

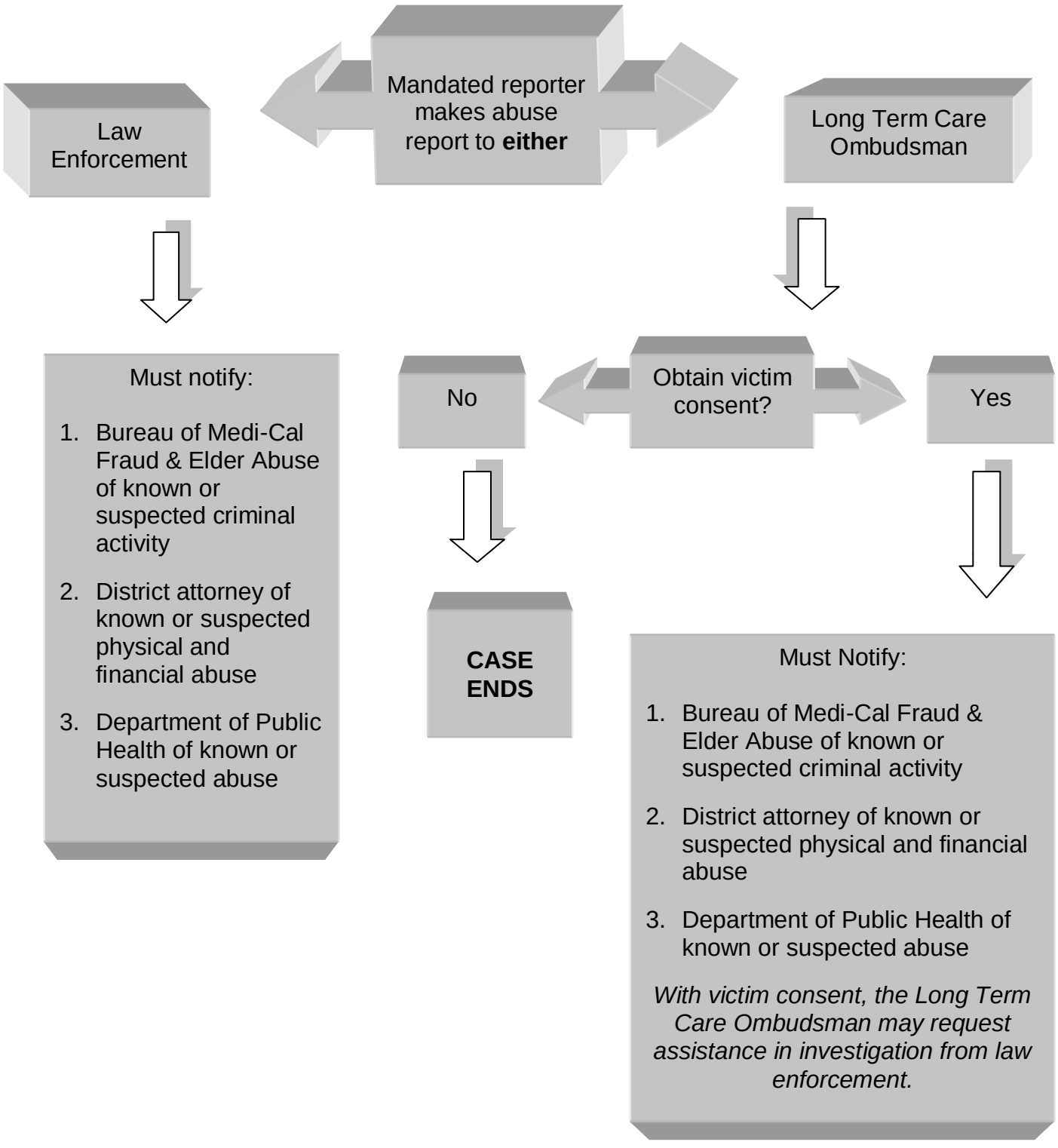
A. Elder Abuse and Dependent Adult Civil Protection Act (the Mandated Reporting Act)

In California, the Elder Abuse and Dependent Adult Civil Protection Act[4] (the Mandated Reporting Act) outlines the system for reporting and investigating allegations and incidents of abuse and neglect of vulnerable adults with disabilities and elders. The Mandated Reporting Act requires any person who has full or intermittent responsibility for the care or custody of a dependent adult or elder[§] to report immediately or as soon as practicably possible incidents, learned of during the scope of employment, that reasonably appear to be physical abuse. This includes incidents directly observed by, reported by the victim to, or based upon knowledge of the mandated reporter. Reportable incidents include physical abuse, which encompasses sexual assaults (like rape and sodomy), abandonment, isolation, financial abuse, and neglect.[5] As defined by law, almost all acts of physical abuse delineated in the Mandated Reporting Act are criminal in nature and may be prosecuted.[6]

If the abuse occurs in a nursing home, the care staff witnessing the incident or who learns of the abuse (i.e., the mandated reporter) must notify either the local long term care ombudsman or the local law enforcement agency. No prior investigation by the staff is expected or required. The long term care ombudsman or law enforcement is required in turn to report the incident to the Department of Public Health (DPH), the local district attorney and the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA).

§ A dependent adult means, "any person between the ages of 18 and 64 years … and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age." It also includes, "any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility." Welf. & Inst. Code § 15610.23. An elder means any individual age 65 or older. Welf. & Inst.Code § 15610.27.

Reporting System for Abuse in Long Term Care Facilities
as Required by Welfare & Institutions Code Section 15600 *et seq.*



B. The Players

1. Long Term Care Ombudsman

The Office of the State Long Term Care Ombudsman was established by the California Department of Aging in 1979 pursuant to the State Older Californians Act and the Federal Older Americans Act.[7] Its mission is to advocate for the dignity, quality of life, and quality of care for all residents in long term care facilities. The Federal Administration on Aging administers the Ombudsman Program and has indicated that it is their long standing policy that ombudsmen serve as advocates for residents of long term care facilities such as skilled nursing facilities (SNFs) or nursing homes.[8] This includes resolving quality of care issues involving elders and dependent adults.

In California, ombudsmen are given the additional responsibility of receiving and verifying complaints of abuse and neglect. Mandated reporters are required to either notify the long term care ombudsmen or law enforcement of incidents of known or suspected abuse or neglect in long term care facilities, including nursing homes or SNFs.[9]

Months of Abuse for Five Residents

Three male certified nursing assistants (CNAs) working the swing shift in a SNF ridiculed and repeatedly abused five male residents for months. Dennis Mathis (78 years old) had left sided paralysis which made it difficult for him to speak and necessitated his dependence on staff for bathing and toileting. For weeks, the CNAs physically assaulted and sexually battered Mr. Mathis, pinching him on his nipples and penis and twisting the skin on his arms. He was forced to eat feces from his adult briefs. Several times in the preceding months, Mr. Mathis confided to another staff member that he was afraid that one of his assailants would kill him.

Lester Walters, a 56 year old male with mental retardation and cerebral palsy living at the same facility, also endured weeks of abuse. The CNAs were in the habit of giving him cold showers and hitting him on the head with the soap bottle. Staff paraded him naked and soaking wet back to his room in front of others. Another resident, who had stitches on his eyebrow from a fall, was pinched several times on the healing wound and asked if it hurt.

The involved CNAs generally provoked and harassed two other residents: maliciously pinching them and twisting their nipples, startling one awake from a slumber, hiding the other resident's TV remote late at night and then turning up the TV volume very loudly so the resident had to get out of bed to turn the volume down. The CNAs took videos and photographs on their cell phones of some abusive incidents and showed them to other staff members. The abuse was witnessed by at least three other staff. No one at the facility reported the abuse as is required by law until much later.

According to ombudsmen interviewed for this report, they are not "finders of fact" or trained criminal investigators. Their responsibility is to verify the resident's complaint and determine if, in their lay opinion, they suspect abuse. If so, they are required by state law to then notify the district attorney of physical abuse and the BMFEA of criminal activity.

Delayed Investigation Leads to Failed Evidence Collection

Luis Aguilar is a 41 year old man with multiple physical disabilities, including head trauma and associated memory problems. Late one night, a staff member noticed blood on his mouth and a cut to his upper lip. She asked him what had happened. Luis answered that a male CNA had hit him with a closed fist and then slapped him on the face.

The facility launched its own investigation but failed to photograph the injury and only conducted a cursory physical assessment. According to Dr. Koin, Disability Rights California's medical expert, "When people are hit, the mouth is injured internally from contact with the teeth. If a person is struck, then not only does the external lip show some evidence of injury, but the tissue, the mucosa inside the lip shows damage. The facility incident report states clearly that there was a cut with discoloration at the affected site."

Two days later, the facility administrator notified the ombudsman but did not call law enforcement even though Luis' description of the event qualified as an assault. The facility doctor evaluated Luis five days later and found no evidence of injury, not surprising given the time delay.

Ultimately, the facility concluded that the injury was a result of chapped lips or poor oral hygiene, both of which, according to Dr. Koin, indicate resident neglect if true. Dr. Koin disputes this conclusion, finding the description of the injury in the incident report is consistent with a blow to the mouth, not chapped lips.

Federal law, however, prohibits such reporting absent victim consent. Under federal law, the ombudsman is barred from revealing the identity of the victim unless he or she consents to release that information or by court order.[10] Thus, the federal restriction makes it impossible for the ombudsman to cross report possible criminal abuse to law enforcement, the local district attorney, and the BMFEA unless the victim provides consent.

California is unique in assigning the job of investigating abuse and neglect to the ombudsman. Other states assign this important responsibility to other agencies that are not bound by the confidentiality provisions of the Older Americans Act.[11] While almost all other states have designed systems that ensure that criminal conduct is reported to law enforcement,

California has not, leading to the practical assurance that facilities can meet their abuse reporting mandate while ensuring that their reports will never reach law enforcement.

Ombudsmen describe significant challenges in obtaining resident consent, primarily stemming from capacity issues and concerns about retaliation. The California Senate Office of Oversight and Outcomes issued a report in November 2009 about challenges hampering the effectiveness of ombudsmen in responding to allegations of abuse and neglect in long term care facilities.[11] In that report, the Senate Office found that ombudsmen receive resident consent in fewer than 25% of cases. Physical and mental impairments typically may make it difficult for nursing home residents to communicate their consent. Cognitive impairments may negate a victim's legal capacity to consent. Victims may fear reprisals by the perpetrators or his or her associates among the staff. They may also fear that they will be removed from the facility for causing "trouble."[2] Family members who can give consent on behalf of the resident may also hesitate out of concern that their loved ones will be evicted from the facility, leaving them to find alternatives to properly care for the displaced resident.

Crimes and the Mandated Reporting Act

The Mandated Reporting Act defines physical abuse by listing a series of crimes including: assault; battery; assault with a deadly weapon or force likely to produce great bodily injury; sexual assault; rape; lewd conduct; sexual penetration; and inappropriate use of physical or chemical restraint or psychotropic medication. The definitions for each (except for the use of restraint) cite the corresponding California Penal Code provision, underscoring that all of these acts of abuse are crimes and could be criminally prosecuted.

Recognizing the special vulnerability of elders and dependent adults, the California Legislature made it a separate crime to willfully cause an elder or dependent adult unjustifiable physical pain or mental suffering. Penal Code § 368. Any person having the care or custody of an elder or dependent adult and who willfully causes or permits the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered may be guilty of a misdemeanor or felony. Great penalties may apply depending on severity injury (including death) and the age of the victim.

2. Local Law Enforcement and District Attorneys

A mandated reporter may report an incident of known or suspected abuse or neglect to the local municipal police department and/or county sheriff's

Uncontrolled Wheelchair Ride

Harriet Thorton (97 years old) and Clara Trudeau (84 years old) were two frail female residents who used wheelchairs for mobility. According to Dr. Koin, "Wheelchairs are a part of the lives of patients, akin to spectacles and hearing aids. They are an intimate part of a patient's ability to navigate in the world." Ms. Thorton has osteoporosis (fragile, brittle bones that can break easily) and a history of compression fractures. Ms. Trudeau has range of motion limitations and partial loss of movement of her leg and neck.

On two separate occasions, the facility's activity assistant pushed the women forcibly in their wheelchairs and then released the wheelchairs, causing the residents to sail down the corridor and slam into the wall. The activity assistant then walked away, leaving the women unattended, essentially immobile and unable to move themselves from away the wall. When asked about the incident, Ms. Thorton answered, "It really bounced me back." Ms. Trudeau's knees were injured and she felt "afraid."

The activity assistant had a record of performance issues for which she had been disciplined. She was terminated following these wheelchair incidents. The facility reported the abuse to the ombudsman and the DPH.

Disability Rights California prosecution expert, Paul Greenwood, would not have hesitated to have filed felony charges in both of these cases because the "circumstances were likely to cause great bodily harm." Describing the activity assistant as a "bully, pushing two defenseless victims," Mr. Greenwood said, "When you're pushing a wheelchair down the corridor, it definitely can be treated as a dangerous weapon." Ultimately, the local district attorney filed misdemeanor charges of abuse of an elder. Penal Code § 368(c). The activity assistant got two years probation and paid a $150 fine. She remained eligible to work elsewhere until she was criminally convicted.

department. Law enforcement officers are trained criminal investigators. They bring a level of expertise, authority, and impartiality to investigations. Police officers and crime investigators gather evidence to determine whether a crime has been committed. As with crimes in the community, they should be notified of any allegation suggestive of criminal conduct and physical or financial abuse involving nursing home residents. Yet, many reports of abuse of nursing home residents never reach law enforcement even though the incident may involve a crime.[2]

The Mandated Reporting Act further requires local law enforcement to report all cases of known or suspected physical abuse to the local district attorney's office in the county

where the abuse occurred.[12] Indeed, all acts of physical abuse constitute crimes punishable under the California Penal Code. In reality, prosecutors receive few reports of abuse of nursing home residents.

3. Bureau of Medi-Cal Fraud and Elder Abuse

The Mandated Reporting Act requires that the BMFEA be notified by the ombudsman or local law enforcement of all cases of known or suspected criminal activity.[13] The BMFEA is a division within the California Department of Justice that investigates and prosecutes cases of fraud, abuse and neglect by nursing home employees. Comprised of prosecutors, special agents, and forensic auditors, the BMFEA may bring charges against an individual perpetrator or a facility. In cases of resident abuse, the BMFEA may refer cases to the local district attorney, work jointly with or assist local district attorneys in their prosecution of cases, or prosecute cases in lieu of or when a district attorney's office declines to prosecute.

Rough Handling

Horace Nugent (79 years old) was totally dependent on staff for his activities of living. His cognitive skills and decision-making were severely impaired. Mr. Nugent became agitated one day while two staff members were attending to his personal care.

According to the witnessing staff member, one CNA hit Mr. Nugent twice on the back of this head with an open hand and then held Mr. Nugent's jaw with his hands as Mr. Nugent lowered himself into the wheelchair. When confronted, the CNA responded, "Do not tell me what to do." The witnessing staff member waited several days before reporting the incident to facility administrators. Later, Disability Rights California investigators learned that the witnessing staff member was harassed and pressured by her peers to recant her allegations. The alleged CNA assailant was terminated but remains certified and is eligible to work in other care facilities.

The BMFEA also is mandated to provide trainings to local law enforcement and prosecutorial personnel in investigating and prosecuting crimes against dependent adults and elders, and representatives from the DPH, Department of Social Services, Adult Protective Services and long term care ombudsmen in evaluating and documenting criminal abuse against dependent adults and elders.[14] Training must include determining when to refer instances of abuse for possible criminal prosecution.[15]

The BMFEA receives relatively few referrals from ombudsmen or from law enforcement. Instead, the BMFEA receives most of its referrals from the Licensing and Certification Division of the DPH. During one recent reporting quarter, the

BMFEA received 83 abuse or neglect referrals from the DPH and only 14 from ombudsmen.[16]

According to the BMFEA representatives interviewed for this report, referrals from the DPH are citation reports and not the initial complaint filed with the DPH. Thus, many potential cases are never referred to the BFMEA and those that are referred are months old, having gone through a complete DPH investigation and citation review.

4. Department of Public Health, Licensing and Certification

The Licensing and Certification Division of the DPH is responsible for ensuring that SNFs comply with state laws and regulations as well as federal requirements for facilities accepting Medicare and Medi-Cal. This includes conducting onsite inspections and responding to complaints of abuse, neglect, other possible regulatory infractions, and critical events reported by the facility. The Aide and Technician Certification Section of the DPH certifies nurse assistants (CNAs) and investigates reports of abuse by CNAs. The DPH maintains a publicly accessible online database that contains information about a CNA's certification status, searchable with the CNA's name and certification number.

No Sexual Assault Examination, No Case

Agnes Reston was an 82 year old woman with paralysis from a stroke and memory deficits. One evening, she told two housekeeping staff that she had been raped the night before by the CNA who was just walking past. The housekeepers reported it to the charge nurse who did nothing. The following day, the facility administrator was notified of the rape allegations when Ms. Reston's daughter complained.

The facility physician ordered a sexual assault examination but it was never conducted. According Dr. Koin, "She deserved a trip to the emergency room where there would be [sexual assault response team] nurses to examine this patient. Particularly, since she had memory loss and would not be able to supply much information, a sexual assault examination might help clear the air about what happened. If there is a decision to not take someone to an emergency room for a sexual assault exam, it needs to be very clearly documented about why."

Ultimately, the district attorney and the BMFEA declined to prosecute due to lack of sufficient corroborating evidence, evidence that may have been obtained during a sexual assault examination. The alleged assailant, a temporary, fill-in (registry) employee, was asked to not return to the facility but remains eligible to be employed elsewhere. The charge nurse who failed to report the incident was terminated.

CNA Returns to Work and Confronts Victim

Matilda Chapman is a 71 year old woman with multiple health problems, but no impairments with memory or communication. Ms. Chapman requires assistance with bathing. One morning, the male CNA assigned to give her a sponge bath touched her nipples. When he then asked if he could fondle her breasts, Ms. Chapman said, "No." Describing the incident later, Ms. Chapman recalled, "It was very disturbing, made me feel vulnerable."

Ms. Chapman reported the incident to the facility's Director of Nursing. However, the CNA was allowed to return to work two days later and was assigned to care for the same residents. He confronted Ms. Chapman about her reporting of the incident. She said, "I told him I had to report him. I was afraid he might become aggressive."

Two days after Ms. Chapman told staff about the assault, the facility administrator notified the ombudsman but not law enforcement. The ombudsman never reported to incident to the BMFEA and no criminal investigation was ever conducted.

The DPH conducted an investigation, including sending a letter to the CNA inquiring about events rather than interviewing the CNA in person. The letter explained the victim's story, thereby giving the suspect advance notice and the time and opportunity to develop his own version of the facts. Paul Greenwood found this investigation approach "outrageous." Rather than meet with investigators, the CNA moved out of the country. The CNA database, searchable by the public with a CNA's name and certification number, no longer has any record of this individual.

Under the Mandated Reporting Act, the ombudsman or law enforcement receiving an initial abuse report is required to notify the DPH of any case of known or suspected abuse occurring in a long term care facility.[17] SNFs are also required to self-report to the DPH unusual occurrences that threaten the welfare, safety, or health of residents.[18] In any case involving a threat of imminent danger of death or serious bodily harm, the DPH must make an onsite inspection or investigation within 24 hours of receipt of a complaint.[19] In the case of lesser complaints, the DPH has 10 working days to conduct an onsite inspection or investigation.

Scope of Resident Abuse in Skilled Nursing Facilities

A. Skilled Nursing Facilities

This report focuses on physical and sexual abuse of nursing home residents by care staff. SNF is a licensing category for health care facilities that provide 24 hour inpatient skilled nursing and supportive care to patients whose primary need is the availability of skilled nursing care on an extended basis.[20] At a minimum, this includes physician, nursing, dietary, pharmaceutical services, and an activity program.[21] SNFs provide care to individuals with disabilities and the elderly needing both long term care and temporary assistance while recovering from illness or injury.

In 2007, there were 1,197 SNFs in California, with a total of 115,158 beds. It is anticipated that the population of individuals 65 years of age and older will double by the year 2025.[1] At a minimum, public health experts anticipate a steady demand for SNF beds along with an increase in other long term care options such as supervised residential assisted living facilities and in-home service supports.[22]

The Whirlpool

Roger Marmont had skin like "wet tissue paper." Despite his fragile skin condition, nursing staff decided to give him a whirlpool bath. As he was being helped into the tub, Mr. Marmont sustained a large, bleeding skin tear from his armpit to his wrist. Unsure about whether to proceed because of the gaping open wound, the CNAs consulted with the nurse on duty who instructed them to continue to bath Mr. Marmont. Once he touched the water, Mr. Marmont experienced excruciating pain ("10 on a scale of 1 to 10"). He became upset and yelled to get out of the whirlpool.

As the CNAs turned off the jets, they noticed two new skin tears. One later recalled, "It was something I had never seen before. His skin just opened up." Mr. Marmont described the ordeal. "It was horrible! I had no control! I felt like I was drowning! I yelled to get out! They took their sweet time."

His cries of pain were overheard by a visitor to the facility who made an anonymous report to the DPH. The facility never reported the incident and maintains that this was not resident abuse or neglect. Dr. Koin and Paul Greenwood disagreed, finding it willful neglect if not outright physical abuse.

B. Vulnerability of Skilled Nursing Facility Residents

Nursing home residents are particularly vulnerable to abuse because of their frailty and dependence on others. Many have chronic conditions that impair their ability to perform basic activities of daily living such as toileting, bathing, and eating without assistance, thereby limiting their ability to defend

themselves from abuse. Additionally, many nursing home residents have cognitive impairments such as Alzheimer's disease or other types of dementia which can interfere with their ability to recognize and report abuse.[23]

Further contributing to the vulnerability of nursing home residents is the private and insular nature of SNFs themselves. SNFs are closed from public view, except for the occasional visitor. Residents may have limited access to telephones and limited means to privately contact individuals outside the facility about conditions. Thus, acts of abuse are not as likely to come to the attention of others outside the facility.

Repeated Sexual Battery/Assault

Catherine Roberts is a competent and articulate 61 year old woman but with medical conditions requiring skilled nursing care. One morning, a facility administrator walked into her room and found a male CNA lying on top of Ms. Roberts, groping her naked body. Ms. Roberts described trying to push him away but his body was very heavy and she couldn't move. The administrator immediately called 911.

Ms. Roberts told police investigators that the CNA had sexually assaulted her nearly 30 times in the two months, including at least four incidents of digital penetration. She had been too embarrassed to tell anyone about the assaults.

Some acts of physical abuse are reflexive in nature, occurring when care staff become frustrated and react with a violent act that is not generally premeditated.[24] Numerous studies have concluded that stressful working conditions in SNFs, including understaffing, long hours, and difficult and combative residents, can trigger episodes of physical abuse. [25] Licensing audits by the DPH reveal that most SNFs in California are chronically understaffed.[1] CNAs, the prime caregivers for residents, are overworked and underpaid.[26] All these factors contribute to an environment ripe for abuse.

C. Statistics Confirm Abuse

Sociologists examining nursing home abuse have posited that physical abuse is not simply a matter of "isolated, well-publicized incidents," but instead could be a "regular occurrence in institutional life."[27] In 2008, the California Office of the Long Term Care Ombudsman (LTCO) received nearly 2,600 complaints of abuse and neglect of SNF residents by facility staff, including 1,418 complaints of physical abuse and 359 complaints of sexual abuse. The year before, the LTCO received over 2,500 complaints.[28] Similarly, in 2007, the Licensing and Certification Division of the DPH received 4,542 allegations of patient abuse directly by the SNF administrators.[29]

D. Abuse Goes Unanswered

While the numbers of complaints of abuse are alarming, they likely underestimate the gravity of the problem. Experts estimate that for every case of abuse that is reported, as many five go unreported.[30] When surveyed, nursing home residents admitted to keeping problems to themselves for fear of retribution.[27,2] For those who do complain, conditions such as dementia cause others to discount the veracity of their reports.

Delays in Reporting & Response

Luis Aguilar reported being hit on the mouth by a staff member and had an injury to his mouth consistent with his allegation. As described on page 8 above, the facility delayed two days before reporting the incident to the ombudsman and four days in reporting it to the DPH. DPH records indicate that the BMFEA was notified 6 days after the initial allegation surfaced but the BMFEA's investigation report documents receiving notice nearly three weeks later, assigning an investigator two and a half weeks after that, and making a site visit after another week and a half – nearly one and a half months after Luis told staff he had been assaulted.

Given Luis' memory issues, the healing of the injury, and the lack of forensic evidence collected by the facility (such as photographs), such a delay ensured that supporting evidence would not be available. Records indicated that BMFEA investigators initially interviewed the facility administrator and Director of Staff Development but did not interview the victim until nine days later. Eventually, the BMFEA closed the case due to lack of corroborating evidence.

The federal government has examined the problem of nursing home abuse. In 2002, the United States General Accounting Office (GAO) published a report[2] about resident physical and sexual abuse by nursing home employees. The GAO found that 1) allegations of abuse are frequently not reported promptly, 2) local law enforcement are seldom summoned to nursing homes to immediately investigate abuse allegations; 3) few allegations of abuse are ultimately prosecuted; and 4) safeguards at the state and federal levels are insufficient to protect residents from abuse. These delays compromise the quality of evidence, hinder investigations, and ultimately frustrate and undermine criminal prosecution.

Problems with California's System of Abuse Reporting and Response

A. Choice in Reporting

The Mandated Reporting Act offers a mandated reporter the option of either notifying the long term care ombudsman or law enforcement of complaints about abuse and neglect in nursing homes. Overwhelmingly, reports of abuse are referred to the ombudsman. Several of the ombudsmen interviewed for this report have speculated that facility administrators prefer to report to the ombudsman to limit the liability that could result if law enforcement was notified instead. Others interviewed for this report attributed the preference to the familiarity that facility community has with the ombudsman. This option in reporting sets up a system and culture whereby incidents of criminal abuse are treated as licensing or administrative matters, not crimes.

B. Challenges for Prosecutors in Court

The United State Supreme Court case, *Crawford v. Washington*, 541 U.S. 36 (2004), made it more challenging to prosecute abuse when the victim may become

Deaths of Victims Halts Prosecution

Chuck Feldman was an 87 year old man with bilateral hip replacements and dementia. When Mr. Feldman complained to staff that he was cold in his room, the CNA turned off the heat, slapped him in the face, and told him to "shut up." Mr. Feldman recalled, "I thought I was gonna freeze to death."

Two days later, Geraldine Hamm, an 89 year old woman living in the same facility, reported that the same CNA slammed her right hip during a transfer. Ms. Hamm had bilateral hip replacements. When she complained to the CNA, "Oh, you hurt me," the CNA ignored her. Later when changing her adult briefs, the CNA slapped her on the same hip. Days later, Ms. Hamm still had difficulty walking as a result of the abuse. Her roommate, who was present in the room at the time of the assault, described witnessing other abusive interactions involving this CNA.

Both physical assaults were reported to the BMFEA. The BMFEA investigator told Disability Rights California that she felt that it was "a good case" for prosecution but, in the interceding months of the investigation, both Mr. Feldman and Ms. Hamm died of unrelated causes. Because the two victims were thought to be the only witnesses to the abuse, prosecutors chose not to file criminal charges because they lacked sufficient corroborating evidence. In the aftermath of *Crawford*, prosecutors cannot rely on hearsay statements from the victims about the abuse. The CNA was terminated and received an administrative warning from the CNA licensing board with a 24 month diversion (e.g. probation). She currently works at another SNF.

unavailable to testify by significantly limiting the admission of hearsay evidence. Prior to *Crawford*, if a victim or witness in a criminal proceeding was not available to testify in court, prosecutors could introduce videotaped or prerecorded statements made by victims and witnesses, as long as certain evidentiary conditions were met.[31] The U.S. Supreme Court in *Crawford* held that this practice was unconstitutional because it denied a criminal defendant the right to confront his or her accusers. Because out-of-court statements made by a frail nursing home resident regarding an incident of abuse are strictly limited, prosecutors must hasten bringing these cases to court. The longer a case is delayed, the less likely it is that witnesses or the victim may be available to testify. Without the testimony of a witness or the victim, a criminal prosecution can similarly perish.

CNAs Never Prosecuted

In the case involving the three CNAs who abused five male residents over the course of months (see page 7 above), facility administrators notified the DPH and the ombudsman once the abuse came to light. The facility did not directly report these crimes to law enforcement, despite the egregious nature of this abuse.

Despite physical evidence and ample availability of witnesses, the District Attorney's office declined to file charges, citing lack of evidence. Believing that the District Attorney had prosecuted the case, the BMFEA closed their investigation.

Paul Greenwood concluded otherwise saying, "Given the records I reviewed, without hesitation, I would file this case. I'm seeing crimes all over the place here, certainly sexual battery and willful neglect. There may be others related to unlawful taking of photographs and parading of a naked resident. I also wonder about evidence of a conspiracy between the various male nurses' aides." Mr. Greenwood qualified his opinions by observing that he was limited to the records he was able to review, and that there may be additional evidence or documents that could have impacted on a particular prosecutorial agency's decision to proceed as it did.

All three perpetrators were terminated and, eventually, their CNA certificates were revoked based upon the same evidence of abuse. The ringleader obtained employment as a caregiver for a non-medical, in-home service provider in Las Vegas. Because he had never been convicted of a crime, a criminal background check by his employer as a condition of hire came back "clean."

The American Prosecutor's Research Institute (APRI)[**] surveyed local prosecutors and concluded that many believe that elder abuse cases are too difficult to prosecute.[32] In its report, the APRI identified the following challenges:

- Insufficient physician experts in geriatrics and abuse;
- Lack of knowledge and training in elder abuse issues;
- Limited availability of services for victims;
- Misunderstanding and apathy among judges, prosecutors and law enforcement; and
- Poor coordination across service agencies.

The APRI found that the elder advocacy community had little faith in local prosecutors' offices to effectively combat elder abuse. They particularly attributed this to the lack of training and organization of prosecutors' offices to tackle the cases, a lack of involvement in public outreach and education, and a lack of victim advocacy services.

[**] The APRI is a division of the National District Attorneys Association that provides training and technical assistance to state and local prosecutors.

Disability Rights California's Investigations

Disability Rights California investigated 12 cases involving abuse of nursing home residents by facility staff. The cases were selected from reports of abuse substantiated by the DPH through their complaint investigation process. These cases are summarized in the table below.

Victim[††]	Event	Reported to LTCO?	Reported Directly to Police/ Sheriff?	Reported to BMFEA	Possible Crime	Outcome	Criminal Sentence
Luis Aguilar	Hit on mouth by staff	2 days later	No	By DPH 1 day after DPH notified; BMFEA reports receiving notice 2 weeks later	Assault [Penal Code § 242]	Staff terminated; certification revoked later for another crime.	None
Matilda Chapman	Sexual fondling of breasts	2 days later	No	No	Sexual battery [Penal Code § 243.4]	Staff terminated; licensing board issued warning.	None
Chuck Feldman	Slapped on face	1 day later	No	By DPH on same day DPH notified	Battery against elder [Penal Code § 243]	Staff terminated; 24 mo. diversion; later employed in another SNF.	None
Geraldine Hamm	Slammed and slapped on hip	Same day	Yes	By DPH on same day DPH notified	Battery against elder [Penal Code § 243]		

[††] Pseudonyms have been used throughout this report for all the names of individuals and nursing facilities described in the case summaries to protect resident confidentiality.

Victim[††]	Event	Reported to LTCO?	Reported Directly to Police/ Sheriff?	Reported to BMFEA	Possible Crime	Outcome	Criminal Sentence
Amanda Henry	Allegation of rape	6 days later	No	Unknown	Rape of an adult with a disability incapable of giving consent [Penal Code §261(a)(1)]; Sexual battery [Penal Code § 243.4]	Staff terminated; LVN who failed to report was terminated.	None
Dennis Mathis and four others	Pinched nipples & penis; twisted skin on arms; made to eat feces out of brief	1 day later	No	By DPH 1 day after DPH notified; BMFEA reports receiving notice 5 days later	Sexual battery [Penal Code § 243.4]; Unlawful taking of photos; Conspiracy	Staff terminated; certifications revoked; names added to National Abuse Registry.	None
Roger Marmont	Skin tears from being forcibly bathed in whirlpool	No	No	Unknown	Elder & Dependent Adult Abuse [Penal Code § 368]	Retraining of staff on resident rights.	None
Horace Nugent	Slapped on face; grabbed jaw	4 days later	No	By DPH over 2 months later	Battery against elder [Penal Code § 243]	Staff terminated.	None
Agnes Reston	Allegation of rape	1 day later	1 day later	By DPH 1 day after DPH notified	Rape of an adult with a disability incapable of giving consent [Penal Code § 261(a)(1)]	Charge Nurse who failed to report terminated.	None

Victim[††]	Event	Reported to LTCO?	Reported Directly to Police/ Sheriff?	Reported to BMFEA	Possible Crime	Outcome	Criminal Sentence
Catherine Roberts	Repeated sexual assault	Unknown [Adult Protective Services removed resident from facility]	Immediate	By DPH 1-3 days after DPH notified	Felony lewd conduct by caretaker - 3 counts [Penal Code § 288(c)(2)]	Staff terminated; certification revoked; Plead to misdemeanor Penal Code § 288(C)(2).	180 days jail & 4 years probation
Clara Trudeau	Shoved in wheelchair, slamming against wall	1 day later	No	By DPH 3 days after DPH notified; BMFEA investigator received assignment 9 months later	Felony assault with force likely to cause great bodily injury [Penal Code § 245]	Terminated; Plead to misdemeanor Penal Code § 368(c).	2 years probation and $150 fine
Harriet Thorton	Shoved in wheelchair, slamming against wall	1 day later	No	By DPH 3 days after DPH notified; BMFEA investigator received assignment 9 months later	Felony assault with force neglect likely to cause great bodily injury [Penal Code § 245]		

Disability Rights California consulted with Dr. Diana Koin, a physician practicing in the field of geriatric medicine and an expert in elder and dependent adult abuse, and Paul Greenwood, a nationally recognized attorney who leads the Elder Abuse Prosecution Unit for the San Diego District Attorney's Office. Each reviewed facility and DPH investigation records obtained by Disability Rights California during the course of our investigation.[‡‡] These experts concurred that the cases

[‡‡] Any views or opinions expressed by Paul Greenwood or Dr. Koin in this report constitute his or her personal opinion and do not represent the views or opinions of the San Diego District Attorney's Office or any other agency or organization with which either is affiliated. Their opinions are based on the documents and evidence that they reviewed.

involved dependent adult or elder abuse and that the facts were indicative of criminal conduct.

Of the 12 cases investigated, nine of the staff accused of abuse were CNAs; one was a licensed nurse and one was an activity assistant. In 11 cases, the facility administrator reported the incident, not the witnessing mandated reporter. This is in direct contravention of the law. In 11 cases, the staff were terminated or suspended.

Half of the cases involved either multiple victims in the same facility and/or multiple incidents of abuse involving the same victim by the same alleged assailant(s). This is consistent with research that shows that there is gross underreporting of abuse and that the few cases that are reported are the tip of the iceberg.[23]

Plea Agreement

In the case involving Catherine Roberts who was sexually assaulted nearly **30 times** in the **two months** (see page 16 above), the police were immediately notified following discovery of the abuse. She was interviewed at length by law enforcement investigators, who found Ms. Roberts highly credible in her accounts of the assaults, neither exaggerating nor minimizing what occurred.

The CNA was initially charged with multiple felony counts of sexual abuse, but the District Attorney ultimately offered him a deal prior to preliminary hearing. The assailant pled no contest to a single **misdemeanor** charge with 180 days of jail time and 4 years probation. According to Paul Greenwood, "This is very serious conduct which deserved a felony conviction. I didn't see any facts that might discourage prosecution or airing the evidence at a preliminary hearing. What he got was too light a sentence and too light a conviction." The CNA's certification was revoked.

Even though all of the cases involved facts indicative of criminal abuse, only three of the cases were reported directly to law enforcement; two of the three cases were not reported immediately. Cases not reported directly to law enforcement cause delays in the initiation of criminal investigations. Nearly half were never reported to law enforcement. Almost all of the cases were reported to the ombudsmen. But, citing confidentiality, the local ombudsmen offices were unwilling to confirm if they referred any of the cases to law enforcement.

The records suggest that the BMFEA was notified by the DPH, not by either the ombudsman or law enforcement as required by the Mandated Reporting Act. The BMFEA investigated all nine cases referred to them, but did not prosecute any of the cases.

Criminal charges were filed in only three cases, one of which involved incidents against two residents perpetrated by the same staff person. The other case involved multiple incidents of sexual assault involving the same victim. In the end, prosecutors reduced the felony charges to misdemeanor offenses, and sentences were similarly minimal.

Findings and Conclusions

1. Incidents of criminal abuse by staff against nursing home residents are not promptly reported.

There are delays in reporting incidents of abuse at every step of the reporting process, ultimately jeopardizing the likelihood of successful prosecution. Victims delay in reporting abuse events. Some fear retaliation or humiliation. Some have disabilities or impairments that affect their awareness of the incident and/or impede their ability to report the abuse. Some wait until a trusted family member visits whom they can confide in. Even after they make a report, some victims are not believed.

Facility staff delay in reporting abuse events. The Mandated Reporting Act requires suspected, reported, or known incidents of abuse to be reported "immediately or as soon as practicably possible." Only two of the cases that Disability Rights California investigated were reported on the day they were discovered. Five others were reported the following day. The remaining cases had more extended reporting timelines. During this delay, evidence is too often lost. Residents are bathed. Linens are washed or thrown away before physical forensic evidence is collected. Delaying even 24 hours fails to meet the mandated reporting requirement.

Cross reports to criminal investigators, including local law enforcement and the BMFEA, are significantly delayed or never occur. In the cases described in this report, BMFEA notification lagged for days. All of these delays increase the likelihood that evidence will be contaminated or lost and individual recollections will diminish.

Once external investigators receive a report of abuse, they delay in launching an immediate investigation. Days lapse before investigators arrive at the facility to gather evidence and take statements. During the intervening time, memories faded and physical evidence is compromised. In many of these cases, the local district attorney and the BMFEA declined to prosecute because there was insufficient corroborating evidence gathered, evidence that may have existed if investigators had been immediately involved.

2. Reports are often made only after an internal investigation.

Nursing home staff often report an abuse incident internally up the chain of command within the facility rather than simultaneously reporting to outside investigators. This prompts an internal investigation or allegation verification, referred to by Dr. Koin as "the internal investigation scam." Internal investigations not only delay reporting to outside investigators, but also may inadvertently taint possible evidence or tip off the alleged perpetrator.

The internal investigation process means that some incidents may not be reported to outside entities, depending on the outcome of the internal investigation. As described by one ombudsman, "The supervisor investigates and decides it didn't happen."

3. Abuse reports are made by the facility administrator, not the staff with direct knowledge as required by law.

When external investigators are notified, it is rarely by the staff with direct knowledge (i.e., the mandated reporter) but rather a facility administrator who does so often after conducting an internal investigation. This is in contradiction with the Mandated Reporting Act which requires immediate reporting by the individual with direct knowledge of the facts. In only two of the cases contained in this report were the reports made directly by the mandated reporter.

Facility administrators may lack important detailed information and may have an interest in presenting the information in such as way as to minimize the serious nature of the conduct and limit the facility's possible liability. Key facts may be inadvertently disregarded or misconstrued. The facility administrator may minimize or be reluctant to reveal critical details to investigators to protect the facility from liability.

Although the BMFEA has developed a mandatory training video about the Mandated Reporting Act for all nursing home employees, they report that "facility administrators will instruct them to the contrary. The facility administrator makes the determination about whether an incident is reportable. So reports made are siphoned through the facility filter." It instills a culture of responding to abuse as administrative concerns rather than serious criminal matters.

4. Reports of criminal abuse are frequently made to the long term care ombudsman and are never referred to law enforcement.

While the Mandated Reporting Act permits reporting to either the ombudsman or law enforcement, in the case of a possible crime, reports should be made directly to law enforcement. Law enforcement has unique expertise in conducting criminal investigations and gathering evidence. Yet, many reports of abuse of nursing home residents never reach law enforcement even though the incident may involve a crime. Only seven cases described in this report were ever reported to law enforcement and only three were reported directly, even though all of the preliminary reports involved allegations of criminal abuse.

According to Paul Greenwood, "For all of the cases [contained in this report], I would recommend follow-up by a trained law enforcement investigator. You need someone with a trained eye and mannerism to do the follow-up. In only three cases were police actually called directly. The rest were analyzed and investigated by in-house investigators or by the DPH investigators who look at things [facts and evidence] differently from the way law enforcement would."

5. Criminal investigations are not thorough and often produce insufficient evidence for prosecution.

The criminal investigations in most of the cases included in this report were cursory at best and produced insufficient evidence for prosecutors to proceed. Physical evidence was not collected. Witnesses or other potential victims were not interviewed. Victims were not sent for independent forensic exams. In addition to examining the point of reported injury, such exams may reveal other suspicious marks or breaks in the skin and other areas of tenderness indicative of other abuse or neglect. As these cases show, incidents of abuse are rarely singular events but often involve repeated abuse of that victim and/or involve abuse of other residents.

It is essential that victims are interviewed promptly by law enforcement. In two of cases investigated by the BMFEA, so much time lapsed that the victims died before they were interviewed and the cases were then dropped. Promptly interviewing victims and obtaining testimonial statements in these cases is particularly critical given the *Crawford* evidence restrictions.

Officers often respond first to the facility administrator and avoid interviewing or discount information provided by the victim and other resident witnesses. According to one ombudsman, "[Law enforcement] has a bias against victims as

reliable reporters. They are not listened to and not heard. Residents are written off all the time. They interview staff."

Resident allegations should not be discredited merely because the resident has cognitive impairments or a disability that may impact the accurate reporting, including date and time. People with cognitive limitations should be thoroughly physically examined immediately when they come forward, even if they report that the incident happened days ago. A resident's experience of the passage of time may be distorted from living in an isolated institutional environment. A resident may report that an assault happened two weeks ago, when in fact it occurred yesterday.

Investigators also fail to interview other potential resident witnesses. At least half of the cases in this report involved either multiple victims and/or multiple incidents of abuse. This supports victim research that incidents of abuse are rarely isolated events, but rather represent a pattern of abusive conduct that is ignored or passively tolerated by either victims or the system. It is essential to interview other residents to determine if they have been victimized themselves and if they have observed or have information about the incident at hand. Promptly and vigorously investigating isolated incidents is essential to gathering sufficient evidence for prosecution and possibly uncovering a pattern of abuse.

6. Cases that make it into the criminal justice system are not rigorously investigated or prosecuted.

While acknowledging the significant intricacies of prosecuting a criminal case, the outcome in these 12 cases was disappointing at best. Of the 12 cases described in this report, nearly half were never reported to law enforcement; nine were reported to the BMFEA; five were referred to the local district attorney. Referrals to the BMFEA lagged days or weeks following the initial report. Once notified, the BMFEA took days before initiating an investigation into an abuse referral and, ultimately did not file charges in any of the cases that it investigated.

Half of the cases in this report involved the same defendant(s) who had assaulted either multiple victims at the same facility in the similar manner or the same victim multiple times. The net result was the conviction of only two perpetrators. The most egregious case, involving three CNAs who tormented and tortured five male residents in one facility over a period of weeks, was never prosecuted.

In the two cases that were prosecuted, the criminal defendants pled to greatly reduced criminal charges with minor penalties. The CNA who molested and

sexually assaulted Ms. Roberts nearly 30 times in two months, plead to misdemeanor lewd conduct, served six months in jail and was released on 4 years probation. The staff member who assaulted two residents, sending them flying down in the hall in their wheelchairs to crash into the wall plead to misdemeanor assault of an elder. She got two years probation and paid a $150 fine.

Training and expertise in prosecuting abuse cases may be a contributing factor in the outcome of these prosecutions. The BMFEA is required to provide training to local law enforcement, prosecutorial personnel, and ombudsmen about investigating and prosecuting crimes against elders and dependent adults. Unfortunately, the BMFEA has not offered these training in the past two years. Such training is important since nursing home abuse cases differ from other criminal prosecutions, particularly given the challenges posed by the victims' disabilities and/or advanced age and related cognitive and physical difficulties. The BMFEA administrators informed Disability Rights California that they plan to offer a statewide conference in the coming year. As of the date of this report, the date of the conference had not been announced.

Many district attorney offices lack elder prosecution units. Prosecuting elder abuse cases requires more time to investigate. Recent state budget cuts have trimmed district attorney positions and cut the funding of discrete elder abuse units and training of district attorneys in prosecuting elder abuse cases.

Recommendations

1. California's Mandated Reporting Act must be amended to require immediate reporting to law enforcement and the ombudsman.

As the cases contained in this report demonstrate, the Mandated Reporting Act essentially assures that abuse allegations will either never be reported to agencies in the criminal justice system or will be reported too late to allow for the rigorous investigation that is necessary to support prosecution. The Mandated Reporting Act must be amended to require that incidents of abuse and neglect be reported **immediately** to **both** law enforcement and the ombudsman.

The language in the Mandated Reporting Act that permits reporting of known or suspected abuse or neglect "as soon as practicable" is vague and invites reporting delays. This language should be deleted. Mandated reporters must be required to report all incidents immediately.

Currently, mandated reporters are offered the option of either notifying the long term care ombudsman or law enforcement of complaints about abuse and neglect in long term care facilities. It is essential that mandated reporters no longer be permitted to fulfill their reporting obligation by only notifying the ombudsman. Most incidents of abuse rise to the level of possible criminal conduct and should be treated as crimes. Permitting reports of possible criminal conduct to be made to lay investigators reduces the gravity of the offenses and may allow criminal conduct to continue undeterred.

Disability Rights California recognizes the important role the ombudsman serves as advocates for residents of long term care facilities. They are familiar with residents and the facility culture. They may be able to quickly identify resources and strategies to address and resolve some of the social and environmental issues related to an incident of resident abuse. Therefore, it is prudent for the mandated reporter to continue to simultaneously notify the ombudsman of suspected, alleged or known resident abuse, but not to assign to them the additional primary responsibility of incident investigation.

Involving law enforcement in abuse investigations opens the possibility that trends or patterns of criminal conduct in a facility can be identified. Often, the incident that is finally reported may be only the first of many involving other residents. As observed by Dr. Koin, "These cases are just the tip of the iceberg about what really is going on. This one victim is just one. There will be more."

2. The BMFEA must assume a leadership role in addressing crimes against dependent adults and elderly residents in SNFs.

The BMFEA is uniquely situated to assume a leadership role in ensuring the prompt reporting, investigation, and criminal prosecution of abuse in SNFs. The BMFEA is currently mandated to receive reports from law enforcement or long term care ombudsmen of all known or suspected criminal activity involving nursing home residents, investigate and prosecute cases, collect and analyze information on a statewide basis of cases of abuse and neglect, disseminate conclusions to local law enforcement agencies and to regulatory and licensing authorities, and conduct training of law enforcement, prosecutors, ombudsman, and others. With these existing responsibilities and accompanying expertise, the BMFEA is ideally positioned to provide the necessary statewide leadership that will focus on nursing home resident abuse, promote reforms, and ensure criminal prosecution when appropriate.

The primary responders to an abuse allegation in a SNF should remain the local law enforcement agency. Law enforcement entities are located in close proximity to the facility and can respond immediately to reports of abuse. The BMFEA is not structured to investigate incidents immediately. Law enforcement officers are likely familiar with local resources should they be required, including accessing sexual assault examinations and victim services.

The Mandated Reporting Act requires that law enforcement notify the BMFEA of all known or suspected criminal activity involving nursing home residents. The BMFEA should pursue strategies for reinforcing this cross report requirement. The BMFEA should collect information regarding timely cross reporting by law enforcement in the data that the BMFEA already maintains. The BMFEA can offer focused training or assistance to law enforcement entities with lapses or delays in cross reporting and/or conducting investigations.

The BMFEA should investigate allegations of abuse not acted upon by law enforcement rather than the ombudsman. The BMFEA can serve as backup investigators, lending expertise or assuming primary responsibility for the investigation when local law enforcement declines to pursue or lags in investigating.

Attempting to address the confidentiality barriers hindering the ombudsman program by shifting this responsibility from the ombudsman to a regulatory entity, such as the Department of Public Health, or social service agency, such as Adult Protective Services, does not sufficiently raise awareness that these incidents are

criminal matters and may continue to support the notion that they are only administrative or social services concerns. The BMFEA has expertise in criminal abuse and neglect investigations and prosecutions and, with their involvement, correctly elevates these incidents to that of serious criminal matters.

As a component of the existing statewide information that it collects, the BMFEA should collect data about the reports that it receives from law enforcement, including the progress and outcome of law enforcement's investigation and the case conclusion. With this data, BMFEA can compile statistical information about the problems related to resident abuse, identifying problematic facilities and possible areas for systemic reform. This information can also flesh out relevant topics and areas of focus for the training programs that the BMFEA is required by law to provide to local law enforcement, prosecutorial personnel, and others. In recent years, the BMFEA has not offered this important training. BMFEA should resume its obligation to provide training, particularly in those jurisdictions that do not have designated staff with expertise in the area of dependent adult and elder abuse.

3. Facility administrators and mandated reporters must be held accountable for complying with the Mandated Reporting Act.

As discussed above, all of the abuse reports in our cases were made by facility administrators, not the direct care staff who initially became aware of the incident and are mandated reporters. Facility administrators must be held accountable for circumventing the Mandated Reporting Act by reporting the incidents themselves.

Nursing home administrators are licensed by the DPH. The DPH should adopt a cross reporting model similar to the process used with CNAs. During the course of a facility complaint investigation, when DPH investigators determine that an administrator has violated the Mandated Reporting Act by reporting the incident themselves to the ombudsman or law enforcement, the finding should be referred to the division of the DPH that licenses nursing home administrators. Sanctions could range from the suspension to termination of a license, depending on the severity of the violation.

Disability Rights California also encourages district attorneys to consider prosecuting mandated reporters who fail to execute their reporting obligations.[33] To date, few cases have been brought. In a national study of Medicaid Fraud Unit prosecutions over an eleven year period (1993-2004), there were only 46 cases where individuals were prosecuted for failure to report.[24] More than a third of these prosecutions were against administrators who failed to report an incident of abuse.

Interviews with experts for this report confirm that prosecutors are reluctant to bring charges against mandated reporters for failing to report resident abuse as required. The mandated reporter may be the only witness to the abuse and his or her testimony is required for a case to proceed. So, in those cases, prosecuting the only witness is not a sensible strategy. However, when the failure to report results in an investigatory delay and an inability to prosecute, as was demonstrated in these cases, it may make sense to hold mandated reporters and administrators accountable for failing to report incidents of abuse as required by law. Some researchers contend that delay or failure to report may be a greater offense than the abuse incident itself because withholding a report involves premeditation or "a degree of conscious effort," whereas abuse is often committed in the heat of the moment.[24]

4. The State of California should develop a system for reporting and tracking abusive care staff.

Disability Rights California's investigations found that both licensed and unlicensed staff committed acts of abuse. While two were criminally convicted, the overwhelming majority were not. Currently, care staff are required to clear a fingerprint background check before being hired or as a term of continued employment. This system matches an applicant's fingerprints with criminal conviction records. Therefore, a background checking system that relies on criminal conviction means that many prospective employers will not discover an applicant's history of abuse unless the applicant was criminally convicted. California should develop a system for the reporting and tracking of care staff with allegations of abuse substantiated by the DPH or other state oversight agencies, including those not resulting in a criminal conviction.

Ideally, the system would include a centralized database where employers could report staff who were terminated from employment because of a substantiated claim of abuse. This system would allow the tracking of unlicensed staff for whom no licensing entity or certification board is providing oversight. To ensure due process, the system should include an appeal process for care staff to challenge their entry into the database. The database would be searchable by all prospective employers in a variety of care settings - from skilled nursing and assisted living facilities to in-home care.

Although the DPH currently maintains an online database[34] that contains information about a CNA's certification status, it requires the user to know the CNA's certification number and is not searchable by name only. This information is likely inaccessible to most members of the public and to some employers who do not have access to the CNA's certification number, including those in other states or

employing the individual in another provider capacity (such as caregivers in residential care facilities). The registry also does not post any information about the basis for disciplinary action taken against the CNA. Disability Rights California recommends that the DPH take steps to correct these deficits.

5. Courts should prioritize elder and dependent adult abuse cases.

Courts should prioritize cases involving abuse of nursing home residents by giving them early trial setting dates. Additionally, courts should use special procedures to obtain and retain for later use the testimony of dependent adults and the elderly who may later become unavailable. In such cases, the examination of the victim (or witness) is conducted by the prosecution and defense in the presence of the judge who rules on all evidentiary matters. The testimony is under oath and transcribed by a court reporter.

Testimony can be obtained in the setting most amenable for the witness, including in a facility. The testimony can be videotaped. If the victim or witness later becomes unavailable for trial through death or illness, the record of this examination can be offered in place of the live court testimony. Adopting this practice enables prosecutions to continue even when the victim or witness is deceased.

Finally, counties should be encouraged to establish specialized courts which handle civil and criminal complaints involving dependent adults and elders. Consolidating all dependent adult or elder abuse and neglect matters into one courtroom enables the judge and other court personnel to develop expertise in the special issues unique to adults with disabilities. These courts often establish expedited processes for moving cases, become familiar with the accommodations this population may require, and develop partnerships with community and social service agencies that can provide advocacy and other victim witness assistance.

6. The California Office of Emergency Services should encourage the development of specialized prosecution units to address elder and dependent adult abuse.

The Office of Emergency Services (OES) should distribute grants to counties to encourage the development of specialized elder and dependent adult abuse units within each district attorney's offices. These specialized units follow a "vertical prosecution model," in which the same attorney handles the same case from filing, through trial, to final disposition. The attorneys in these units receive specialized training to handle the challenges inherent in dependent adult and elder abuse

prosecutions, including working with victims with cognitive impairments and complex medical conditions, and with experts who are familiar with these issues. Smaller jurisdictions may identify and train individual attorneys to gain the necessary expertise to handle these cases. Some jurisdictions had such specialized units, but cuts in funding by OES have lead to their demise in many counties.

Disability Rights California Experts

Diana Koin, M.D.

Diana Koin is the former Director of the Elder and Dependent Adult Abuse Education Program at the California Medical Training Center at the University of California, Davis, a project teaching health care professionals and law enforcement personnel about all forms of interpersonal violence, including dependent adult and elder abuse. Dr. Koin was the first physician in the United States to publish a medical paper describing elder abuse.

Dr. Koin participates on interdisciplinary teams for elder and dependent adult abuse in two large northern California counties. Recently, Dr. Koin co-authored guidelines for health care professionals to identify and respond to elder abuse in health care settings. She is a physician practicing in the field of geriatric medicine with a focus on individuals who are frail or who have disabilities. She is also an Associate Clinical Professor of Medicine at the University of California, San Francisco.

Paul Greenwood, J.D.

Paul Greenwood has served as the Head of the Elder Abuse Unit of the San Diego County District Attorney's Office since 1996. Under his leadership, the Elder Abuse Unit received the California State Association of Counties' Challenge Award for innovation and creativity. Mr. Greenwood received his Bachelor of Laws from Leeds University in Yorkshire, England, and worked as a barrister, then a solicitor of the Supreme Court of England and Wales.

Mr. Greenwood has participated in the prosecution of over 200 felony cases of elder and dependent adult abuse, both physical and financial. He serves as co-chair of the California District Attorney's Elder Abuse Committee. Mr. Greenwood assisted with drafting elder abuse legislation in California. He serves as a national expert and advocate for the rights of elders and dependent adults.

ENDNOTES

[1] Baas, Michelle. (February 2009). Inside California's Nursing Homes: A Primer for Evaluating the Quality of Care in Today's Nursing Home. *California Senate Office of Research*. Retrieved from www.sen.ca.gov/sor.

[2] U.S. General Accounting Office Report to Congressional Requesters (GAO-02-312). (March 2002). *Nursing Homes: More Can Be Done to Protect Residents from Abuse.* Retrieved from http://www.gao.gov; Administration on Aging, Long Term Care Ombudsman National and State Data at: http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/index.aspx.

[3] 42 U.S.C. § 15001 *et seq.*; 42 U.S.C. § 10801 *et seq.*; 29 U.S.C. § 794e *et seq.*; Welf. & Inst. Code § 4900 *et seq.*

[4] Welf. & Inst. Code § 15600 *et seq.*

[5] Welf. & Inst. Code § 15630(b)(1).

[6] Welf. & Inst. Code § 15610.63.

[7] 42 U.S.C. § 3001 *et seq.*; Welf. & Inst. Code § 9000 *et seq.*

[8] 42 U.S.C. § 3058g(a)(3).

[9] Welf. & Inst. Code § 15630(b)(1)(A).

[10] 42 U.S.C. § 3058g(d)(2)(B).

[11] California Senate Office of Oversight and Outcomes, Hill, J. (November 3, 2009). *California's Elder Abuse Investigators: Ombudsmen Shackled by Conflicting Laws and Duties.*

[12] Welf. & Inst. Code § 15630(b)(1)(A)(v).

[13] Welf. & Inst. Code § 15630(b)(1)(A)(iv).

[14] Gov't Code § 12528(h).

[15] Welf. & Inst. Code § 15653.5.

[16] California Department of Justice, Bureau of MediCal Fraud and Elder Abuse. *State Medicaid Fraud Control Units Quarterly Statistical Report, Federal Fiscal Quarter Ending 9/30/2008*.

[17] Welf. & Inst. Code § 15630(b)(1)(A)(i).

[18] Cal. Code Regs. tit. 22, § 72541.

[19] Health & Safety Code § 1420(a)(1).

[20] Health & Safety Code § 1250(c); Cal. Code Regs. tit. § 72103.

[21] Cal. Code Regs. tit. 22, § 72301(a).

[22] Harrington, Charlene, PhD, RN & O'Meara, Janis, MPA. (March 2007). Snapshot: The Changing Face of California's Nursing Home Industry. *California HealthCare Foundation.* Retrieved from http://nurseweb.ucsf.edu/www/ffharrc.htm.

[23] Hawes, Catherine, Ph.D. (June 18, 2002). Elder Abuse in Residential Long-Term Care Facilities: What is Known About Prevalence, Causes and Prevention. *Testimony Before the U.S. Senate Committee on Finance*. Retrieved from http://finance.senate.gov/hearings/testimony/061802chtest.pdf.

[24] Payne, Brian. (June 3, 2008). Elder Physical Abuse and Failure to Report Cases, Similarities and Differences in Case Type and the Justice System's Response. *Crime & Delinquency OnLineFirst.* pp. 1-20.

[25] Sengstock, Mary C., McFarland, Marilyn R. & Hwalek, Melanie. (July 1990). Identification of Elder Abuse In Institutional Settings. *Journal of Elder Abuse & Neglect, 2:1*, pp. 31-50.

[26] Harrington, C., O'Meara, J., Collier, E., Kang, T., Stephens, C. & Chang, J. (April 2008). Impact of California's Medi-Cal Long Term Care Reimbursement Act on Access, Quality and Costs. *University of California San Francisco*. Retrieved from http://nurseweb.ucsf.edu/www/ffharrc.htm.

[27] Pillemer, Karl, Moore & David W. (July 1990). Highlights from a Study of Abuse of Patients in Nursing Homes. *Journal of Elder Abuse & Neglect*, 2:1, 5-30.

[28] California State Annual Long-Term Care Ombudsman Report for Fiscal Year 2006-2007 and 2007-2008.

[29] California Department of Public Health. (January 2009). *Nursing Facilities Complaints and Entity Reported Incidents Summary Counts, Calendar Years 2004 through 2007*.

[30] California Attorney General's Office, California Department of Justice, Bureau of Medi-Cal Fraud and Elder Abuse (2002). *Your Legal Duty, Reporting Elder and Dependent Adult Abuse.*

[31] Evid. Code § 1380.

[32] Miller, Mark & Johnson, James L. (September 2003). Protecting America's Senior Citizens: What Local Prosecutors Are Doing to Fight Elder Abuse. *American Prosecutor's Research Institute*. Retrieved from www.ndaa-apri.org.

[33] Welf. & Inst. Code § 15630(h).

[34] Health & Safety Code § 1337.8.