

PROTECTION OF NURSING HOME RESIDENTS

FINAL REPORT

GOVERNOR STEVEN L. BESHEAR



CABINET FOR HEALTH AND FAMILY SERVICES

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Executive Summary

A recent series of newspaper articles centered upon the issue of neglect and abuse incidents in nursing homes. The articles allege among other things:

- That incidents result in few prosecutions;
- That local prosecutors indicate that they are rarely notified of Type A citations; and,
- That local police and coroners are rarely notified of nursing home deaths or serious injuries, meaning physical evidence is not collected.

The newspaper reports question whether the Commonwealth has the appropriate policy and statutory framework necessary to protect vulnerable adults in nursing homes. To that end, in a letter dated July 21, 2010, Governor Steven Beshear requested Secretary Janie Miller of the Cabinet for Health and Family Services to determine if state government's efforts can be improved. He directed the Secretary to assemble appropriate parties for a thorough review of how the Cabinet interfaces with other state agencies to protect nursing home residents and determine if there are opportunities for improvement.

In conducting the review the Secretary charged the Office of the Inspector General, the Department for Aging and Independent Living, the Department for Community Based Services and the Department for Medicaid Services to review current statutes, Memoranda of Agreement, regulations and policies related to adult abuse and neglect and to provide findings and recommendations resulting from the review.

Additionally, the Cabinet received input from representatives of various local and state agencies, as well as advocates, to hear their concerns, observations and recommendations. Those external contacts included:

- Kentucky Attorney General Jack Conway
- The U.S. Attorneys Offices
- Kentucky Commonwealth and County Attorneys (through the Attorney General)
- Representatives of the Kentucky Association of Police Chiefs
- the Kentucky State Police
- representatives of advocates for nursing home residents
- representatives of long term care industry associations
- the Institute for Aging
- the Director of the Protection and Advocacy Division within the Department of Public Advocacy (Justice Cabinet)
- the Kentucky Coroner's Association (the coroners had to cancel a scheduled meeting and were unable to reschedule prior to the due date of this report, but a meeting is being rescheduled and an addendum will be added, if necessary).

As a result of the Cabinet's internal review and input from state and local partners as well as consumer and industry advocates, some common themes began to emerge. Those common themes form the basis for many of the Cabinet recommendations included in this report. For the reader's convenience, all documents submitted are included in the Appendices of this document.

The Cabinet for Health and Family Services wishes to acknowledge and thank the various organizations, other state agencies, and representatives of the advocacy community, for committing their time to meet and offer their thoughtful comments and insights.

Report on Neglect and Abuse Issues in Nursing Homes

A recent series of newspaper articles reported that Type A Citations in nursing homes result in few prosecutions and local prosecutors indicated that they are rarely notified of Type A citations. According to these articles, local police and coroners are rarely notified of nursing home deaths or serious injuries. The articles also report that the Attorney General can investigate but cannot prosecute crimes involving nursing home residents without permission of commonwealth attorneys. In reviewing prosecutions that did occur, the newspaper reports that few nursing home employees are convicted when a resident is hurt or dies because of abuse and neglect; fewer still go to jail. According to the newspaper, police or coroners are not typically called in the event of nursing home deaths, physical evidence is not collected. Multiple jurisdictions exist for local law enforcement allowing incidents of neglect and abuse to slip through the cracks. These reports raised questions that needed to be examined to assure that the Commonwealth has the appropriate policy and statutory framework to protect vulnerable adults in nursing homes.

Below is a brief description of the statutory and regulatory framework to set context for the discussion later in the report. Following this is a discussion of the perspectives and information from meetings between Cabinet officials and key stakeholders and advocates regarding policies and practices, and recommendations to improve the state response to abuse and neglect of nursing home residents.

Statutory and Regulatory Framework

There are multiple state and federal statutes in place which together form the basis for protections of individuals in long-term care facilities. These statutes provide regulatory oversight for care provided in licensed health care facilities, provisions for reporting and investigating adult abuse, law enforcement requirements for investigation and prosecution of adult abuse, and the establishment of a state Long Term Care Ombudsman Program. Situations of adult abuse or neglect can arise and become evident through a number of events, thus, investigations can begin almost anywhere along the regulatory or administrative processes. The role of law enforcement and prosecutors in the investigation and prosecution of criminal allegations of caretaker abuse and neglect is another part of the system of protections afforded. Additionally, the court system is involved as necessary to issue restraining orders or protective orders, and for court proceedings in the prosecution of alleged crimes.

Within the Cabinet for Health and Family Services (CHFS), the Office of Inspector General is responsible for the licensing of all health care facilities, including long-term care facilities. Regulations have been promulgated by the Cabinet which contain the various standards and requirements to be met in order for long-term care facilities to be licensed and continue to conduct business in Kentucky. Under contract with the federal government, specifically, the Centers for Medicare and Medicaid Services (CMS), the Office of Inspector General also performs inspection surveys necessary to determine a facility's compliance with federal conditions of participation in the Medicaid and Medicare programs.

The Department for Community Based Services (DCBS), within CHFS, is the state agency responsible for receiving reports and conducting investigations of all allegations regarding caretaker or custodial abuse, neglect, or exploitation under KRS Chapter 209. Reports of

caretaker/custodial neglect, abuse, and exploitation are investigated and are either substantiated or unsubstantiated. These investigations can relate to individuals residing in their home, the home of others, or in alternative settings, such as group homes, and assisted living or long-term care facilities. As a part of this statutorily required process, reports of alleged neglect or abuse are sent to the appropriate law enforcement agency (most commonly local law enforcement), and the county or Commonwealth attorney, the Office of Attorney General, the Office of Inspector General, the Long Term Care Ombudsman, and/or other appropriate agencies, such as Department for Behavioral Health, Developmental and Intellectual Disabilities for state-operated facilities that serve individuals with developmental disabilities, and professional licensing agencies.

The agency which receives a report of adult abuse, neglect, or exploitation is to take action as appropriate based on the agency's role. The DCBS, through the Adult Protective Services Branch, conducts the investigation, which includes interviews, assessment of risk and safety factors, and identification, where possible, of the perpetrator. As a result of the investigation, the allegation will either be substantiated or unsubstantiated. Protective services are provided as warranted by the facts of each individual case if allegations are substantiated. DCBS coordinates with law enforcement as necessary in investigations.

The Long Term Care Ombudsman Program, housed with the Department for Aging and Independent Living within CHFS, serves as an advocate for the rights of residents residing in long-term care facilities. This Program operates with four (4) full-time staff in the central office, and 15 district staff contracted through the Area Agencies on Aging. Volunteers are also recruited and trained to help in the visitation and advocacy. These programs work to resolve problems of individual residents and bring about changes to improve resident's care and quality of life.

The Office of Attorney General (OAG) has various divisions that work to protect adults in long-term care facilities; however, the primary focus of the OAG is to investigate criminal allegations of caretaker abuse and neglect in Medicaid-funded long-term care facilities. Through the Office of Medicaid Fraud and Abuse Control (MFCU) within the Office of Attorney General, authority exists to investigate complaints of abuse or neglect in Medicaid-funded facilities. However, the MFCU does not have jurisdiction to represent the Commonwealth in the prosecution of criminal cases. County attorneys or Commonwealth attorneys have the authority and responsibility to review cases for potential criminal activity to determine whether to prosecute a case.

Law enforcement officials, including county sheriffs, municipal police chiefs, local police agencies, and the Kentucky State Police, are notified by DCBS of all allegations of adult abuse and neglect for appropriate investigation and apprehension of perpetrators. Law enforcement officials work with county or Commonwealth attorneys to prosecute alleged perpetrators.

The following input was received from key stakeholders.

Attorney General

Attorney General Conway, in addition to discussing several issues with prosecutors, provided a description of the role of the Attorney General in investigating and prosecuting adult abuse. Additional suggestions made by the Attorney General include examination and discussion

regarding stiffer penalties for abuse of elders and failure to report suspected abuse. Involving coroners in investigations of nursing home resident deaths and autopsies are also recommended as important tools in prosecuting homicides. The Attorney General also recommends tightening the notification process of suspected neglect and abuse.

Prosecutors indicated they received the referrals from DCBS, but generally were allowing law enforcement to complete their investigation before taking action. Once investigations are completed, prosecutors in urban areas generally had one individual designated to prosecute these cases. Smaller offices generally relied upon the elected official or his staff for these cases. Prosecutors commented that an autopsy on individuals whose death was due to suspected neglect or abuse rarely occurs, but they agreed that it would be helpful for the coroner to be called and autopsies performed. Prosecutors, like many others, recommend additional training for local law enforcement officers. Standards and requirements for multi-disciplinary team approaches to investigations, notification of coroners in suspicious deaths, and notification of local prosecutors only when a substantiated finding of abuse is made, were additional improvements recommended by prosecutors.

The United States Attorneys stated that while the primary role to regulate nursing homes and prosecute discreet incidents of abuse and neglect lies with state authorities, a substantial portion of the payments for long term care derives from federal dollars, through the Medicaid or Medicare program. The United States may have civil remedies available to it in the case of facilities that consistently deliver care at far below acceptable standards of quality. They are prepared to work cooperatively with the Cabinet to identify appropriate cases for consideration in this regard.

Law Enforcement

In meeting with state and local law enforcement, it was acknowledged that multiple parties have jurisdiction to respond to reports of neglect or abuse but that ownership of the case is generally worked out at the local level. Local law enforcement suggests that the timeliness of the referrals, the availability of dedicated Adult Protective Services (APS) staff, trained staff, and inclusion of the coroner in investigations of suspicious deaths would provide an improved focus that is needed at the local level. Timely receipt of the report of potential abuse or neglect by the Cabinet's Department for Community Based Services (DCBS) and a strong working relationship between law enforcement and DCBS staff is necessary to assure consistent, timely investigations. Additionally, law enforcement noted that offices with dedicated DCBS APS workers as contrasted with non-designated workers, provide good working relationships and better communications and better outcomes. The establishment of threat levels or protocols for adults should be similar to that available in the investigation of child abuse. Local and state law enforcement recommends that DCBS APS workers receive additional forensic training in the investigation and interview process to assist in adult investigations. Multi-disciplinary teams, like those that exist for child abuse and neglect investigations, comprised of medical personnel, law enforcement, the coroner, and DCBS investigators, all with appropriate forensic training is the recommended model. Also, law enforcement suggests that specialty equipment such as cameras and recorders for OIG surveyors and DCBS abuse investigators, for the development of evidence, would improve the ability to gather evidence for the proper investigation and

prosecution of crimes. State and local law enforcement agree that coroners should be called in all cases of unexpected nursing home deaths.

State law enforcement also recommends that the Office of Inspector General (OIG) staff should be trained to recognize that in carrying out their regulatory function, the potential for identification of criminal acts exists and that surveyors should be trained in preservation of evidence. Written policies and procedures are necessary so that administrative investigations can be delayed pending the completion of criminal investigations.

Advocates

Nursing home advocates focused not only on the need for effective models for identification and investigation of potential neglect and abuse, but on the care received in nursing homes, the adequacy of staffing levels within nursing homes and methods of expanding education and awareness of families and patients regarding how to determine if quality care is being provided and how to obtain resolution regarding complaints. Advocates suggest that ill-equipped investigators at all levels, including state regulatory, APS, and law enforcement result in poor investigations that result in the lack of prosecution of cases. Advocates indicated that the Commonwealth attorneys will generally prosecute only those cases with the potential of a conviction and convictions result from cases where trained staff investigates the crime. Advocacy groups suggest the use of video cameras and other electronic surveillance devices in nursing homes to assist in the documentation of events. They also recommend that all first responders, EMS, firefighters, police, ombudsman, clergy, APS workers, nursing home employees, ERs, etc. be adequately trained to detect potential neglect and abuse. Increased staffing, training and support for frontline regulatory surveyors and abuse investigators who are most likely to be in a position to identify and cite poor quality care were also suggested by advocates. Care should be taken to assure that licensing and regulatory policy is thorough, transparent, and strong with regard to nursing home staffing and other patient protections. Training was recommended to build investigators skills in communication, interviewing, and investigating neglect and abuse of seniors and individuals with disabilities. The state Long Term Care Ombudsman Program should be adequately staffed and strengthened to ensure the public's accessibility to Ombudsman services. General public education strategies are needed to ensure that families of patients understand what quality care is and what they can do about reporting and rectifying poor care.

Nursing home advocates also recommend that specific attention be given to the needs of patients with Alzheimer's and other disabilities which impair the patient's ability to cognitively respond and communicate. This population has increased vulnerability to neglect and abuse and requires nursing home care where staff is specifically trained to care for and protect this population.

Some advocates made recommendations regarding the establishment of a single accountable governmental organization as contrasted with the many agencies involved today. All advocates recommend safeguards, such as background checks, random drug testing, adult abuse registry and other mechanisms should be employed to assure that employees working with and around nursing home residents do not have a history of criminal behavior. They suggest that education, transparency and accountability are hallmarks of high quality care systems.

Nursing Home Representatives

Industry representatives recommend that the Cabinet must review staffing and turnover issues within the OIG as well as increasing training and re-training of staff. The Cabinet for Health and Family Services should examine existing memoranda of agreement to ensure that the Cabinet is identifying any gaps in reporting and investigating neglect and abuse, and is supporting efforts of facilities, ombudsman and others to identify and investigate neglect and abuse. Education and training of nursing home staff is necessary to highlight their responsibility to identify and report neglect and abuse. Consistency from OIG surveyors would maximize the Cabinet's opportunity to conduct thorough quality assurance reviews that include the potential to identify and investigate abuse and neglect. The recent enactment of the Elder Justice Act (EJA), Title VI of the Patient Protection and Affordable Care Act, imposes new requirements on nursing homes to detect, report, and prevent elder abuse, neglect, and exploitation. The EJA is designed to address crimes committed against older persons using a multidisciplinary approach, raise national awareness of elder justice issues, and apply resources to the efforts of individuals, organizations and government entities confronting elder abuse and neglect on the front lines of health care. Because of the expansion of entities within EJA that must report if a "reasonable suspicion" exists, it is anticipated that state and local law enforcement agencies may see substantial increases in the numbers and types of reports received.

Differing definitions of neglect and abuse at the federal and state levels add complexity to information and evidence gathering tasks in an abuse and neglect investigation. Review of these definitions should be undertaken to understand their operational meaning and determine if standardizing terms would reduce lag time and improve the detection and investigation of neglect and abuse.

CHFS Departments

Additionally, four (4) of the Cabinet's departments completed in-depth reviews of statutes and regulations to identify any gaps and weaknesses of existing policies and procedures relating to the detection and investigation of adult nursing home neglect and abuse and to identify circumstances where actions would improve our ability to combat adult neglect and abuse. Findings and recommendations of this internal review are included in the report. Some changes have already been or are in the process of being implemented.

Conclusions

During the course of the review, some common themes emerged in the discussions about the necessary components inherent in a quality system of long term care. It was pointed out that Kentucky has already identified and implemented many of the components of a model for addressing neglect and abuse of children. Those same components are critical to bring together the elements of a system necessary to prevent, detect, investigate and prosecute adult neglect and abuse. Some of these elements include mandatory reporting, multi-disciplinary investigative teams, dedicated staffing units, forensically trained staff, post-event review panels, and public education and awareness. These common themes served to form the basis of the recommendations included in this report. This review has been an important, initial step to

assure the proper foundation is in place to support detection, investigation and prosecution of the crimes against adults in nursing homes. Our most vulnerable citizens, many of whom reside in a nursing home, deserve our care and support to assure that they may live graciously and with dignity.

This review was complicated by a common misconception from some participants, and as reported by the newspaper articles, about Type A citations. A Type A citation is a function of the legislative framework found in KRS Chapters 216 and 216B, for the licensure and regulation of health care facilities. This citation is issued for an event which presents an imminent danger to any resident of a long term care facility and creates substantial risk of death or serious mental or physical harm to a resident. Only small percentages of Type A citations for nursing homes relate to adult abuse and neglect; most Type A citations relate to regulatory violations of established policies and procedures, such as record-keeping and documentation. The legislative framework for mandatory reporting and notification to responsible agencies for allegations of adult neglect and abuse is found in KRS Chapter 209. Under this statute, the Department for Community Based Services is the state agency responsible for receipt of reports of allegations of adult neglect and abuse and for notification to law enforcement and the Attorney General's office.

Lastly, this report includes recommendations that can be implemented expeditiously and will make substantial improvements relatively soon and without the need for legislative or budgetary actions. Additional information was provided by several of the participant organizations and those documents are included in the appendices to the report.

Recommendations

The following are short-term actions recommended for consideration by Governor Beshear. These recommendations will serve to improve the detection, investigation and prosecution of neglect and abuse of nursing home residents. Recommendations are grouped into three (3) categories that will: improve the Commonwealth's investigative response, enhance agency coordination, and enhance transparency and the safety and quality of life for vulnerable citizens.

Improve the Commonwealth's Investigative Response Systems

1. **Recommendation:** *Improve intake and agency notifications of suspected adult abuse and neglect.*

Rationale: Based on a random sample of adult protective services (APS) cases reviewed and phone interviews conducted with Centralized Intake Team supervisors, it was found that inconsistent practice exists related to notifying "authorized agencies" when an APS investigation is initiated. Current DCBS policy directs staff to send a copy of the DPP-115 Reporting Form to all "authorized agencies". There is inconsistency across DCBS service regions as to who exactly is responsible for sending the initial notification. In some regions, the Centralized Intake Teams are responsible for sending the DPP-115 and in other regions the APS investigative staff is responsible for sending this notification. From a quality perspective this local discretion allows for inadvertent failure to provide proper and timely notification. The Centralized Intake Teams within the Department for Community Based Services (DCBS) will use a standard protocol to strengthen the process of disseminating the initial notification of allegations of neglect or abuse in accordance with KRS Chapter 209.

2. **Recommendation:** *Establish regional specialized APS teams within DCBS.*

Rationale: The DCBS budget and funding creates an on-going challenge to provide sufficiently staffed designated APS teams across the state. As a result, APS team members carry investigatory caseloads significantly higher than their Child Protective Service (CPS) counterparts. Compounding this is the research finding by Teaster, A Week in the Life of KY Adult Protective Services (APS) (Teaster et al. 2010), that APS investigations involving caretaker neglect require significantly more time to investigate. The investigations often occur in long term care settings and involve complex medical issues, multiple interviews, and coordination with other investigatory/regulatory entities. Designated APS teams should be developed, maintained and supported in each DCBS Service Region. APS supervisors will maintain an appropriate mixture of APS cases assigned to each investigatory staff member in order to facilitate the best case work possible and keep caseloads at appropriate levels.

3. **Recommendation:** *Establish joint investigative teams.*

Rationale: The OIG and DCBS, as the lead investigative agencies, will establish investigative teams to respond to abuse and neglect reports in long term care facilities.

The current MOA between DCBS and OIG allows for the sharing of pertinent information including copies of investigative reports concerning the abuse and neglect of adults residing in a long term care setting. These teams will take action to disseminate key elements pertaining to the sharing of information across agency lines contained in the current MOA to front line staff. Information housed by two separate agencies within the Cabinet will be shared with one another providing more robust information which can be used to more effectively investigate neglect and abuse of the nursing home resident and nursing home facility practices.

A multidisciplinary team design as permitted in KRS 209.030(6)(a)(b) is not consistently achieved statewide. The lack of multidisciplinary teams sometimes results in a duplication of interviews and review of medical records, as well as disparate outcomes or findings. As joint investigative teams are formed, DCBS and OIG will begin exploring the development of local multidisciplinary teams to involve other investigative agencies per KRS Chapter 209. It is noted that the effectiveness of joint and multidisciplinary teams is not simply having two investigators on the scene, but it is the information sharing, collaboration and follow-up efforts that facilitate thorough and effective investigations.

4. **Recommendation:** *The Cabinet will explore, along with the Kentucky Coroners Association, the State Medical Examiner, and local coroners, ways to improve communications, increase the sharing of information, and involve coroners more directly in investigations.*

Rationale: The role of the coroner is critical to a complete investigation.

5. **Recommendation:** *Increase training of long term care surveyors.*

Rationale: OIG surveyors are not required to have training related to these issues on a regular basis. The OIG will develop a training program and begin surveyor training by March 2011. This training will relate to:

- the prevention and identification of abuse, neglect and misappropriation of property;
- determining when to report to licensure/certification boards; and
- federal and state reporting requirements related to neglect and abuse(42 CFR 483.13 (c)(2), 42 CFR 483.13(c)(4), KRS Chapter 209, KRS Chapter 620, KRS 72.020 and the Elder Justice Act of 2009).

6. **Recommendation:** *Explore the cost and efficiency of purchasing investigative technology.*

Rationale: Specialty equipment such as cameras and video recorders aid in the documentation and preservation of evidence. This will improve the ability of investigators to prepare cases for prosecution. The Civil Monetary Penalty (CMP) Fund is a potential source of revenue for these one-time expenditures. The CMP fund is comprised of federal fines collected from Long-Term Care facilities found to be in

noncompliance with applicable federal standards. Penalties collected must be applied to the protection of the health or property of residents of long term care facilities that the state or the Centers for Medicare and Medicaid Services (CMS) finds noncompliant. An adequate balance must be maintained to cover the costs of transferring residents in the event of one or more facility closures. Funds from the CMP account also support the Long Term Care Ombudsman Program. Annual collections from penalties vary widely from year to year. In FY 04 and FY 05, collections were slightly under \$600,000 each year. In FY 09, collections were unusually high—over \$5 million. In FY 10, collections were approximately \$2 million. The recurring revenue stream is probably closer to one to two million annually. CHFS presently expends about one million per year for the LTC ombudsman program and other uses (facility closures, training). Another \$700,000 in CMP funds has been allocated as the match requirement in the Commonwealth’s recent application for a federal grant for the development of a uniform background check system using fingerprinting.

Enhance Agency Coordination

- 7. Recommendation:** *The Elder Abuse Committee should be revitalized in order to carry out its statutory functions.*

Rationale: KRS Chapter 209.005 requires the Cabinet to operate an Elder Abuse Committee. The statute lists the required composition of the Committee, including all relevant departments and offices of the Cabinet, and area agencies on aging, law enforcement and prosecutors.

The stated purpose of this committee is to “address issues of prevention, intervention, investigation, and agency coordination of services on a state and local level through interaction with local groups or entities that either directly or indirectly provide services to the elder population”. Among its duties, the committee shall “recommend model protocols for the joint multidisciplinary investigation of abuse, neglect and exploitation” and “recommend practices to ensure timely reporting of referrals of abuse, neglect and exploitation”.

The Committee has experienced declining attendance by members in recent years and could be re-energized with a distinct purpose. This committee’s broad representation and the ability of the Cabinet to add members or develop ad hoc workgroups make it a good vehicle to explore the development, support and maintenance of true local multidisciplinary investigative teams. It could serve as the mechanism for the Cabinet’s review and summation of actions and status of reports the Cabinet has sent to appropriate law enforcement and investigatory agencies, as required by KRS 209.030(12). It could also serve as a review function to identify systemic issues and enhance the state’s investigative and administrative response to elder abuse, neglect and exploitation. It could mirror the existing state Multidisciplinary Commission on Child Sexual Abuse, see KRS 431.650-670.

The Committee could be expanded and re-purposed to provide input regarding issues and implementation of recommendations addressed in this report.

8. **Recommendation:** *Explore the development of local multidisciplinary adult abuse and neglect teams.*

Rationale: Currently KRS 209 states the multidisciplinary teams should coordinate “to the extent practicable”. The Cabinet will explore mechanisms to facilitate this approach in each county with the local DCBS worker as the team leader. This will encourage thoughtful discussion of these issues, allow people in the community to become involved in identifying these issues, and encourage more training on elder abuse issues. Multidisciplinary teams may also be effective in identifying systemic issues through post-case reviews.

9. **Recommendation:** *Establish electronic data sharing among appropriate agencies.*

Rationale: There is inconsistent feedback from law enforcement and other “authorized agencies” concerning the disposition of APS cases referred for possible criminal investigation and prosecution. Current DCBS practice directs staff to notify all “authorized agencies” via the DPP-115 Reporting Form at the onset of a protective service investigation and send a Notice of APS Findings at the conclusion of a investigation; however, there is no formalized mechanism in place for “authorized agencies” to provide DCBS with any feedback concerning the disposition of APS cases referred to them. As a result DCBS is often unaware of the status of APS cases referred to law enforcement and the courts. The use of an electronic DPP-115 saves time for all agencies involved, provides better documentation and provides a ready vehicle for communicating case disposition. DCBS, OIG, Kentucky State Police, and municipal and county law enforcement representatives should be convened to explore completion of the electronic DPP-115 initiative.

10. **Recommendation:** *Establish a tracking system for referral of Type A citations.*

Rationale: This system will document who receives notice of the Type A citations so the OIG nurse inspectors can follow up with those individuals. This would enable the Cabinet to easily ascertain the status of a Type A at any time.

11. **Recommendation:** *Review and revise memoranda of agreement among appropriate agencies to insure coordination of information and activities by CHFS agencies which will improve the responsiveness of the Cabinet.*

Rationale: Lack of current, formal agreements between the multiple agencies charged with the protection of our most vulnerable adults reduces successful coordination and communication. Memoranda of Agreement (MOAs) between various government agencies are outdated. Conducting frequent reviews of these inter-agency agreements would actively assist in a uniform and coordinated response, as well as re-affirming the Cabinet’s overall commitment to ensuring quality services are delivered effectively.

The Office of Inspector General (OIG), Department for Community Based Services (DCBS), Long Term Care Ombudsman Program (LTCOP), Department of Aging and Independent Living (DAIL), and Department for Medicaid Services will develop a comprehensive communication plan and Memorandum of Agreement that ensures timely and accurate notification of appropriate parties (both internal and external) regarding licensure and survey deficiencies and initiation and notification of alleged neglect and abuse occurring in nursing homes. The agreement will ensure coordination and communication between departments of the Cabinet regarding citations and substantiations of neglect and abuse. It is suggested that protocols be developed for the following:

- The development and maintenance of an authorized agency contact list including OIG, Medicaid, OAG, DCBS, DAIL, Office of Attorney General (OAG), the Division of Protection and Advocacy (P & A) and the Cabinet’s Office of Communications;
- The timely distribution of all pertinent OIG-issued citations to all authorized agencies;
- Regularly scheduled and ad hoc face-to-face meetings during the pendency of a provider’s 23- day termination track to inform and apprise all authorized agencies of provider status, including providers on the federal Centers for Medicare and Medicaid Services (CMS) “special focus facilities” list;
- The timely notification of an OIG finding of Immediate Jeopardy and the placement of a provider on a 23-day termination track; and
- Processes for notification to authorized agencies of reports and investigations of alleged adult neglect and abuse through the DPP-115 form.

Effective communication is needed among leadership of the various agencies responsible for addressing allegations of abuse, neglect, and exploitation of our vulnerable adults. Formalizing these processes at the Cabinet level will improve responsiveness and reduce duplication of responsibilities.

12. **Recommendation:** *Provide training for law enforcement agencies on elder abuse and neglect issues.*

Rationale: The Medicaid Fraud Control Unit (MFCU), within the Office of Attorney General, has conducted several trainings for local law enforcement and coroners. This should continue. The MFCU has reached out to the Department of Criminal Justice Training (DOCJT) in order to assist in developing a course for law enforcement recruits. Also, the MFCU is conducting training at this year’s conference of the Coroner’s Association. The Cabinet, OAG, and other agencies will work collaboratively to develop training tools for use by local law enforcement.

13. **Recommendation:** *Provide training for prosecutors on elder abuse and neglect issues.*

Rationale: At the request of many of the local prosecutors interviewed, the MFCU has spoken to the Prosecutor's Advisory Council and requested that additional training be included at next year's Kentucky prosecutors conference. The Cabinet, OAG, and other agencies will work collaboratively to develop training tools for use by local prosecutors.

14. **Recommendation:** *Assure referrals to appropriate professional licensure and certification boards.*

Rationale: Inconsistencies were identified when referring to the licensure/certification boards of persons found to have abused/neglected an individual. By November 1, 2010, the OIG will implement its newly drafted policy regarding referrals to other entities which ensures that information regarding malfeasance perpetrated by staff of facilities is referred consistently to appropriate professional licensure and certification boards.

15. **Recommendation:** *Develop a "Best Practices Toolkit" for nursing home closures.*

Rationale: Coordination of multiple agencies during a nursing home closure is critical. Nursing Home closures are an unfortunate but sometimes necessary event for facilities that cannot meet the requirements under CMS guidelines. Facilities also make the voluntary decision to close, most often due to financial difficulties. Efforts to coordinate activities of the participating agencies (OIG, DCBS, OAG, and the LTCOP) need improvement. Closures and transfers can lead to "transfer trauma", the name given for the sudden decline and sometimes death of a resident when the environment, routine, and familiar faces suddenly change. The resident becomes disoriented, depressed, and their overall functioning begins a steady decline.

Enhance Safety, Quality, and Transparency

16. **Recommendation:** *Amend licensure regulations to require in-service training on abuse and neglect for all long term care facility staff.*

Rationale: There currently is no requirement for facility staff training on prevention, identification, or reporting adult abuse, neglect or exploitation.

17. **Recommendation:** *Publish Statements of Deficiencies issued by the OIG.*

Rationale: By law, each provider must make all OIG survey results, deficiencies identified and Type A citations issued available to members of the public. This information is available to the public, but not in user-friendly modes. The OIG will develop an on-line, web-based program to contain statements of deficiencies for nursing homes by December 1, 2010. This tool, already under discussion and development, will be available to the public, in addition to the Long Term Care Ombudsman Program. The Cabinet should also explore other methods to accomplish these goals which may include

the development of consumer handbooks specifically designed for residents and families. This will help to raise awareness of systemic deficiencies identified in nursing homes that can have a direct impact on resident quality of life.

18. **Recommendation:** *Develop training on special care necessary for residents with cognitive impairments.*

Rationale: Inadequate resources for persons with cognitive impairment exist. This results in residents being forced to move or relocate to facilities far from their families and communities and all too often can force them into facilities in neighboring states for their LTC needs. The Cabinet should work with representatives of appropriate associations to develop and coordinate training and education related to the needs of persons with cognitive impairments. This can be coordinated through a stronger partnership between the LTCOP, the Alzheimer's Association, OIG and the long term care industry.

19. **Recommendation:** *Explore the options for and efficacy of expanding the regional ombudsman program.*

Rationale: Funding is a major concern for the Long Term Care Ombudsman Program (LTCOP) given the scope and magnitude of services performed on behalf of all residents of long term care facilities. In FY 08, Kentucky reported a lower than average amount of funding for services per bed and ranked 34th of the 50 states in regards to funding for LTCOP services. The Civil Monetary Penalty (CMP) Fund may also be explored for this purpose.

20. **Recommendation:** *Explore the development of a self-protection training program for nursing facility residents.*

Rationale: No formal elder abuse prevention training exists that is targeted toward the resident. While the LTCOP and APS provide regular education, awareness and training on the signs, symptoms, and legal mandate to report abuse for professionals and concerned citizens. There is currently no training being conducted specifically designed for the residents. Therefore, residents are not consistently informed on how they can be a proactive partner for themselves and other residents in the fight against elder abuse and victimization. The Kentucky State Police has been approached regarding the possibility of creating and implementing a training program similar to their neighborhood watch program, but in a long-term care facility. KSP has existing expertise in creating interests and empowering "neighbors" to watch out for each other and could quickly adapt existing training.

**Cabinet for Health and Family Services
Department for Community Based Services**

Adult Protective Services-Review Methodology

Prior to the passage of KRS Chapter 209 in 1978, the protection of vulnerable adults in Kentucky was often based on the capacity of local jurisdictions to enforce existing criminal statutes as it related to individuals who suffered abuse or neglect at the hand of a caretaker. With the passage of this legislation, Kentucky defined adult as “a person eighteen (18) years of age or older who, because of mental or physical dysfunctioning, is unable to manage his own resources, carry out the activity of daily living, or protect himself from neglect, exploitation, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services;...” (KRS 209.020(4)). This definition provides one of the most expansive statutory protections for vulnerable adults in the nation.

Adult Protective Services are offered to all vulnerable adults in Kentucky and this review will focus mainly on those individuals who meet the definition of “adult” who reside in an alternate care facility. Although DCBS often substantiates abuse, neglect or exploitation against perpetrators of these acts, there is currently no process in place to provide these individuals with “due process” protections.

This review will provide an expansive description of current program requirements, training and collaborative efforts. Recommendations for enhanced partnerships and practice changes will be detailed. In order to satisfy the intent of the review, staff reviewed all statutes, administrative regulations, policies and trainings related to the role of DCBS APS as it applies to the protection of nursing home residents. Additionally, current practice related to DCBS staff and partnering agencies was explored. Investigative and casework data were reviewed in order to better comprehend current parameters of population, investigative function and provision of ongoing services.

Data on adults served by DCBS are entered into the TWIST system to include adult demographic data, relationship data such as victim status or relative status, and DCBS process data such as referral dates and disposition of the case. Data are available to staff for case management through weekly and monthly reports. These reports track, for example, the completion status and disposition of investigations and assessments, the numbers served in different categories such as under age 60 years and over age 60 years, and allegations present in the case. The APS Calls FACT sheet is an example of a summary data report including information on all investigations and assessments completed in a recent year. TWIST administrative data can also be used for trend analysis, comparative studies, and other research efforts. DCBS staff also review cases and compare the casework to expectations for case work quality using the CQI-CARES review tool.

The Adult Safety Branch of the Division of Protection and Permanency (DPP) reviews cases and consults with field staff and partnering agencies on a regular basis related to investigations in alternate care facilities. These reviews are prompted in a variety of ways including the statewide Continuous Quality Improvement (CQI) process and ad hoc requests from the DCBS

Commissioner or regional management. For this review, a random sample of investigations was analyzed related to the frequency of APS notification to partnering agencies.

Adult Protective Services-Applicable Statutes and Regulations

KRS 209.005 directs the Cabinet for Health and Family Services to create an Elder Abuse Committee to develop a model protocol on elder abuse and neglect in the Commonwealth that shall be comprised of various agency representatives that include but are not limited to:

- a) The Department for Community Based Services;
- b) The Department for Public Health;
- c) The Department for Mental Health and Mental Retardation;
- d) The Department for Aging and Independent Living;
- e) The Office of the Inspector General - Division of Health Care Facilities and Services;
- f) The Office of the Ombudsman;
- g) Area Agencies on Aging;
- h) Local and state law enforcement official; and
- i) Prosecutors.

The committee has been active since 2006 in addressing issues of prevention, intervention, investigation, and agency coordination of services on a state and local level through interaction with local groups or entities that either directly or indirectly provides services to the elder population. Since its inception, DCBS has assumed the lead role of this committee. Since 2005 the committee has produced an annual report of their activities, products, and recommendations for public policy to the Governor and the Legislative Research Commission.

KRS Chapter 209, 922 KAR 5:070, 922 KAR 5:100 and DCBS Standards of Practice 4A-B govern the investigation and disposition of reports of suspected adult abuse, neglect and exploitation. While statutes and regulations provide the authority and framework for DCBS involvement in APS, it is the Standards of Practice (SOP) that provides the detailed guidance concerning investigations and ongoing casework. Those sections pertinent to protections for alternate care residents (adults residing in a skilled nursing facility, nursing facility, intermediate care facility, personal care home, and family care home) are summarized as follows:

KRS 209.020(10) defines an investigation to include:

- A personal interview unless the abuse or neglect is possibly the cause of death,;
- An assessment of risk and safety factors;
- Identity of perpetrator;
- As identified by the Office of the Inspector General, instances when a facility has not enforced or identified appropriate actions to protect individuals in the care of the regulated or licensed facility.

KRS 209.030(1) provides that the cabinet (Cabinet for Health and Family Services) is “to have primary responsibility for investigation and the provision of protective services”.

KRS 209.030(5) states what action the cabinet is to take upon receipt of a report;

- Notify law enforcement within twenty-four (24) hours of report. If the report includes information of an emergency situation or a crime, the report to law enforcement is to be immediate;
- Notify all appropriate agencies according to standardized procedures;
- Initiate an investigation; and
- Complete a written report of initial findings and further action, if indicated.

KRS 209.030(6) states the Cabinet should be working with law enforcement and other appropriate agencies, as practicable.

KRS 209.030(7) states that the Cabinet is allowed access to facilities licensed by the Cabinet if investigating an allegation of abuse, neglect, or exploitation. The Cabinet also has access to any financial and health records of the alleged adult victim.

KRS 209.030(8) allows representatives of the Cabinet to investigate allegations of abuse, neglect, or exploitation in a residence of the alleged victim with permission from the alleged victim. Without permission, the representative will need a search warrant showing probable cause.

KRS 209.030(9) states the Cabinet is to provide protective services, within budgetary limitations, if indicated by the investigation and the adult agrees to accept services.

KRS 209.030(10) states that the caretaker will not be allowed to interfere with services the adult has agreed to accept.

KRS 209.040 states any court may approve a restraining order or other injunctive relief with an application from Cabinet staff.

KRS 209.090 states that it is the intent of the legislature that the Cabinet provides the least restrictive services to those adults in need of services.

KRS 209.110(1) states the Cabinet may file for emergency protective orders after attempting to obtain the adults consent.

KRS 209.120 specifies the court actions and findings.

KRS 209.130(1) states the court may order protective services when an adult will suffer immediate and irreparable physical injury or death without the protective services and the adult is incapable of giving consent.

KRS 209.130(2) states that forcible entry may be allowed by the court for the purpose of either providing protective services or moving the adult to another location.

KRS 209.130(3) states the Cabinet must file a petition as soon as possible and the hearing must be held within 72 hours from issuance.

KRS 387.540 states that Cabinet staff will complete an interdisciplinary report, either alone or with others for the court to use when determining disability of an adult at a hearing.

Kentucky Administrative Regulations 922 KAR 5:070 and 922 KAR 5:100 address adult protective services and alternate care for adults respectively. Standards of Practice (SOP) were also reviewed regarding the notification of reports process, investigations, investigation findings, casework, placement and movement of adults.

Adult Protective Services-Training

The Department offers specific coursework at the beginning of an employee's tenure and builds on that foundation for those that routinely perform APS responsibilities. Training includes specific investigative and ongoing service provision functions, including the critical nature of partnerships with formal and informal partners.

Meeting Needs of Vulnerable Adults

Participants learn to identify and assess the service needs of vulnerable adults, including those in need of protective services (adults who have a mental or physical dysfunction), victims of abuse, neglect and/or exploitation, as well as, general adult service requests. The course prepares participants to provide services as necessary to develop appropriate case plans, provide appropriate case management, and prepare for and participate in judicial hearings. Specific focus will include communication and assessment strategies, standards of practice, documentation, utilization of appropriate community resources, alternate care and involuntary adult services. New staff receives this instruction as a component in the Protection and Permanency (P&P) Academy training series

All new Protection & Permanency staff is required to receive this course. Staffs identify indicators of abuse, neglect, and exploitation, formulate assessment and service delivery questions around those indicators. Additional components include the presentation of the Kentucky Revised Statutes (KRS) and APS Standards of Practice (SOP). Participants apply methods of investigation and service delivery using case scenarios. Participants discuss the requirements of authorized agencies outlined in KRS 209.020 (17), reporting requirements to each of those agencies when indicated, and Protection and Permanency requirements upon conclusion of the investigation. Training materials include interviews of residents with dementia who live in a nursing home. Staff discuss different interviewing techniques involved, and illustrate the comprehension of those techniques.

Elder Abuse

Provisions of KRS 194A, require DCBS staff to complete an elder abuse, neglect, and exploitation initial course. It is designed for Protection & Permanency and Family Support staff to increase identification and assessment skills in order to prevent and remedy elder

maltreatment. The course includes future trends of the elder population; an examination of the dynamics and effects of elder abuse, neglect, and exploitation; identification of lethality/risk factors; and, model protocols on providing community resources and victim services for older adults experiencing elder maltreatment.

Participants are introduced to the prevalence of elder maltreatment in the community and alternate care settings. They are also given detailed instruction on specific components of elder maltreatment indicators and reporting requirements. Instructional content includes required actions for the investigative process in an alternate care facility.

Investigations in Alternate Care Facilities

Participants learn to identify and assess the service needs of adults in alternate care facilities, including those in need of protective services. Training participants learn how to complete a protective service investigation and to develop appropriate case plans. Specific focus includes standards of practice, documentation, utilization of appropriate community resources, such as regulatory agencies. Participants gain an understanding of Medicaid charting used in alternate care settings.

All APS staff are required to attend this course. Participants review the specific APS Standards of Practice (SOP) applicable to all alternate care facility investigations. Participants review sample OIG investigations including alternate care staff and resident interviews in order to identify potential indicators of maltreatment and regulatory violations. To better determine potential injury mechanisms specific to these investigations, staff are introduced to durable medical equipment likely to be encountered in nursing homes. Participants also discuss the impact of pressure ulcers including a discussion of observation, recording, and photo-documentation.

Investigations in Alternate Care Facilities: Supports for Community Living (SCL)

Participants learn to identify and assess the services need of adults in SCL residential supported homes. Participants are provided basic information and requirements of the SCL program, application for services and emergency resources, medication record keeping, provider expectations, and incident reporting. The content presented in this training is applied and referenced in the Investigations in Alternate Care Facilities training, specifically how it relates to conducting investigations of adult abuse, neglect, and exploitation at these community facilities.

During this web-based training APS staff review the available SCL services, documentation that may be found when reviewing medical records in those placements, and the regulatory requirements of the Division of Developmental and Intellectual Disabilities.

Working with Adults with Developmental Disabilities

Participants learn to identify and assess the services needs of adults with developmental disabilities. This includes protective services, general adult services, as well as alternate care services. The training prepares participants to provide intake and investigation services for this population: to develop appropriate case plans, and to provide appropriate case management. Specific focus includes strategies to serve these client populations, application of related standards of practice, documentation of interventions, utilization of appropriate community resources, and identification of client issues related to their disability.

All APS staff and CPS and foster care staff providing services to children with disabilities who are likely to transition from Out-of-Home Care (OOHC), receive this instruction. Information is provided on the different types of service interventions, plans and medications for residents with disabilities, and indicators APS staff might assess during visits with those adults.

Collaborative Efforts

As directed in KRS 209.010 the DCBS actively partners with a number of agencies and entities that have a responsibility to respond to the abuse, neglect, or exploitation of adults.

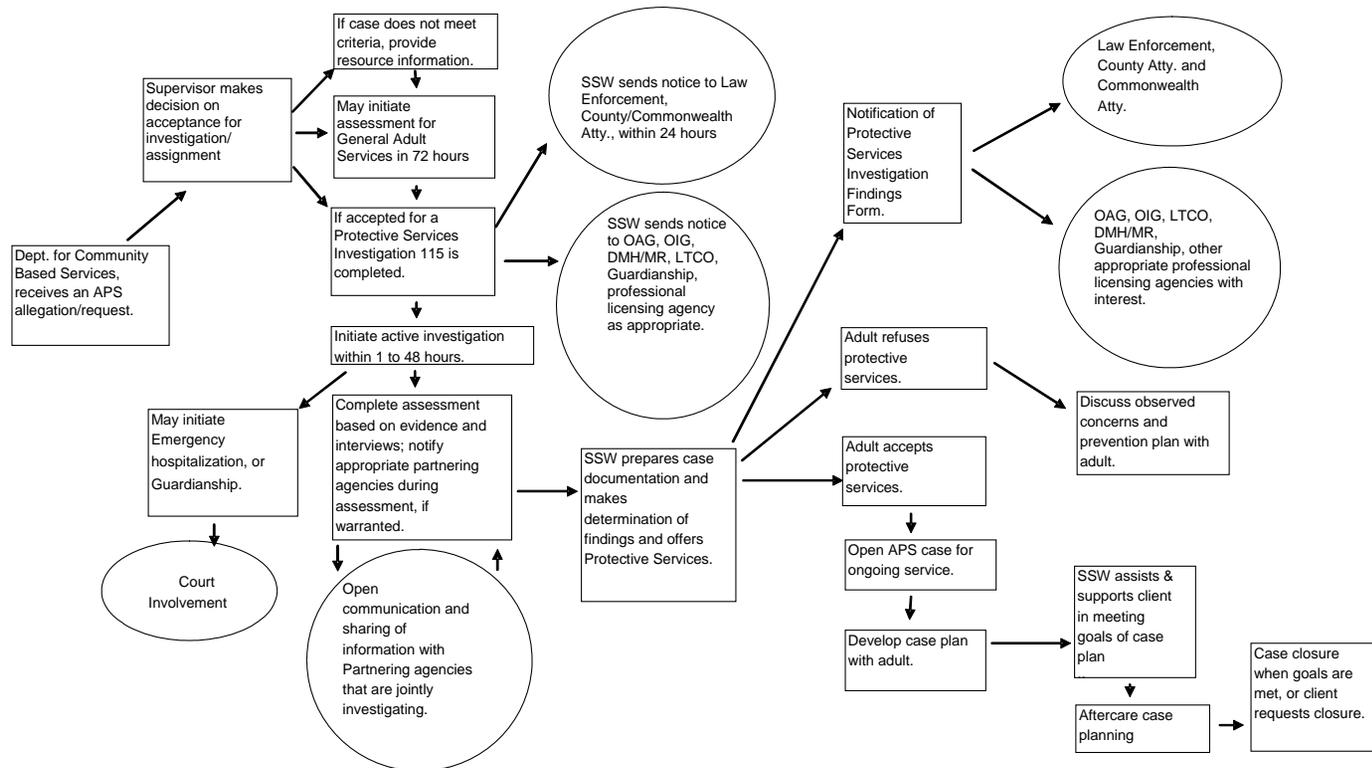
- Local Coordinating Councils on Elder Abuse – At the direction of the Elder Abuse Committee, a Model Protocol for Local Coordinating Councils on Elder Abuse was developed and a statewide network of councils was formed. Currently 29 LCEAA's are operative and cover 110 counties. While these councils are independent from one another and are not funded nor administered through or by the cabinet, DCBS has acted as a resource by facilitating communication, providing material support in the way of public awareness materials and awarded grants, and through membership and participation on the councils. The councils are comprised of professionals from a variety of disciplines as well as members of the public. Their membership and activities are reflective of the communities they serve and their primary focus is the prevention, intervention and resource development designed at ending elder abuse. Of notable interest to this "Special Review", some of these councils have formed Case Review Teams that serve as a forum to engage all of the authorized agencies and interested parties in a review of APS cases for the purpose of identifying the best possible outcomes for the elder and vulnerable adult population. This multidisciplinary approach allows for community specific responses to be developed and fosters infrastructure, builds capacity, strengthens community partner relationships, teamwork and cooperation at the local level.
- Monthly meetings with the Department for Behavioral Health, Developmental and Intellectual Disabilities – In a longstanding practice, DCBS and DBHDID meet monthly in an effort to improve coordination between the agencies. The discussion ranges from specific cases that overlap both systems to macro level issues that require attention. These meetings have proven to be of value in improving outcomes for both the APS and CPS populations.
- Healthcare Advisory Committee (HCAC) –This committee serves as a pulse point for the Do Not Resuscitate (DNR) and End of Life issues that the Guardianship staff faces on a daily basis. The HCAC was the mechanism by which the cabinet protocol around Do Not Resuscitate orders for state wards was developed. From its inception, the HCAC has been a frontrunner in assisting with the DNR process and End of Life quandaries that involve state wards when dealing with physicians, hospitals, long term care facilities and other providers. This includes, but is not limited to; tube feedings, palliative care, surgical intervention, ongoing medical care with a DNR in place, withdrawal of life support, rescinding of DNRs, prevention of medical neglect and more. The HCAC's design to include physicians, DCBS nurses, CHFS legal counsel, DCBS P&P staff, Hospice, Protection and Advocacy, and DAIL Division of Guardianship staff is a critical outlet to review these sundry topics with case

review, workable interventional suggestions, drafting of applicable documents that are user friendly to the provider community and cabinet staff. In a nutshell, the HCAC serves as the conduit for insuring that state wards receive the best care as it relates to End of Life decisions.

- Recently, a collaborative study between the Department for Community Based Services and the University of Kentucky explored *A Week in the Life of APS* (Teaster et al., 2010). This landmark study examined intake through substantiation efforts of APS staff and revealed that, in one week, 167 reports were screened in for investigation. A third of the investigations concerned caretaker neglect (29.5%), 27.3% concerned self-neglect and 9.1% concerned financial exploitation, with the mean age for all subjects of the reports being 76.3 years. Most alleged perpetrators were adult children (37.0%) or staff members of facilities (30.4%). Adult abuse had the highest substantiation rate (44%), followed by self-neglect (36.1%), and caretaker neglect (23.1%). Evaluation of the outcomes of investigations revealed that the risk of abuse and neglect to the individual remained the same for over 62.6% of investigated reports and reduced in 34.7% of cases. The majority of these results were attributed to situations where adults asserted their right to self determination and refused services. As a result, the risk indicated in the report was not impacted. A fifth (20.4%) of reports investigated during the study week returned to APS within a year's time.
- In a second study with the DCBS, a research team at UK examined the efforts of all 32 Local Coordinating Councils on Elder Abuse (LCCEAs) in KY (Teaster & Wangmo, 2007). Data from the study revealed that these councils acted as multidisciplinary teams (i.e., groups of professionals from different professions who come together to address the problem of elder abuse). Services provided by the LCCEAs included providing expert consultation on incidences of elder abuse and keeping members up to date about services, programs, and legislation. To ensure their long-term viability, the research team recommended increasing DCBS coordination and staff support for the LCCEAs, providing them with consistent funding, establishing a clear vision and goals at community and state levels, and devising and collecting uniform and consistent outcome measures from each.
- The DCBS Nurse Consultant/Inspector (NCI) works in a supporting role by providing recommendations to guardianship staff on medically related issues while remaining within the parameters of statutes and Guardianship Program standards of practices as identified by:
 - Advising the guardianship staff with navigating the medical process; including but not limited to, issues and questions related to diagnosis, treatments, medications, surgical procedures, informed consent, translating medical terminology and standards of care.
 - Advising the guardianship staff with implementing SOP 5C.7.8 titled, "Life Saving Measures" also known as Do Not Resuscitate. NCI reviews submitted information to determine if criteria are met. It may be necessary for the NCI to request additional information/documentation to support criteria.
 - Advising the guardianship staff by participation in team conferences regarding medical issues as necessary and depending on NCI availability.

DCBS Adult Protective Services (APS) Process Map

The Department for Community Based Services is statutorily charged (KRS 209.010) with the provision of protective services for adults in need of protective services. This process is accomplished through a multidisciplinary approach outlined in the following diagram.



Findings and Recommendations

1. **Recommendation:** *Improve intake and agency notifications of suspected adult abuse and neglect.*

Rationale: Based on a random sample of APS cases reviewed and phone interviews conducted with Centralized Intake Team supervisors, it was found that inconsistent practice exists related to notifying “authorized agencies” when an APS investigation is initiated. Current DCBS policy directs staff to send a copy of the DPP-115 Reporting Form to all “authorized agencies”. There is inconsistency across DCBS service regions as to who exactly is responsible for sending the initial notification. In some regions, the Centralized Intake Teams are responsible for sending the DPP-115 and in other regions the APS investigative staff is responsible for sending this notification. From a quality perspective this local discretion allows for inadvertent failure to provide proper and timely notification. The Centralized Intake Teams within the Department for Community Based Services (DCBS) will use a standard protocol to strengthen the process of disseminating the initial notification of allegations of neglect or abuse in accordance with KRS Chapter 209.

2. **Recommendation:** *Establish regional specialized APS teams within DCBS.*

Rationale: The DCBS budget and funding creates an on-going challenge to provide sufficiently staffed designated APS teams across the state. As a result, APS team members carry investigatory caseloads significantly higher than their Child Protective Service (CPS) counterparts. Compounding this is the research finding by Teaster, *A Week in the Life of KY Adult Protective Services (APS)* (Teaster et al. 2010), that APS investigations involving caretaker neglect require significantly more time to investigate. The investigations often occur in long term care settings and involve complex medical issues, multiple interviews, and coordination with other investigatory/regulatory entities. Designated APS teams should be developed, maintained and supported in each DCBS Service Region. APS supervisors will maintain an appropriate mixture of APS cases assigned to each investigatory staff member in order to facilitate the best case work possible and keep caseloads at appropriate levels.

3. **Recommendation:** *Review and revise memoranda of agreement among appropriate agencies.*

Rationale: Lack of current, formal agreements between the multiple agencies charged with the protection of our most vulnerable adults reduces successful coordination and communication. Memoranda of Agreement (MOAs) between various government agencies are outdated. Conducting frequent reviews of these inter-agency agreements would actively assist in a uniform and coordinated response, as well as re-affirming the Cabinet’s overall commitment to ensuring quality services are delivered effectively.

The Office of Inspector General (OIG), Department for Community Based Services (DCBS), Long Term Care Ombudsman Program (LTCOP), Department of Aging and Independent Living (DAIL), and Department for Medicaid Services will develop a comprehensive communication plan and Memorandum of Agreement that ensures timely and accurate

notification of appropriate parties (both internal and external) regarding licensure and survey deficiencies and initiation and notification of alleged neglect and abuse occurring in nursing homes. The agreement will ensure coordination and communication between departments of the Cabinet regarding citations and substantiations of neglect and abuse. It is suggested that protocols be developed for the following:

- The development and maintenance of an authorized agency contact list including OIG, Medicaid, OAG, DCBS, DAIL, Office of Attorney General (OAG), the Division of Protection and Advocacy (P & A) and the Cabinet's Office of Communications;
- The timely distribution of all pertinent OIG-issued citations to all authorized agencies;
- Regularly scheduled and ad hoc face-to-face meetings during the pendency of a provider's 23- day termination track to inform and apprise all authorized agencies of provider status, including providers on the federal Centers for Medicare and Medicaid Services (CMS) "special focus facilities" list;
- The timely notification of an OIG finding of Immediate Jeopardy and the placement of a provider on a 23-day termination track; and
- Processes for notification to authorized agencies of reports and investigations of alleged adult neglect and abuse through the DPP-115 form.

Effective communication among leadership is needed for the various agencies responsible for addressing allegations of abuse, neglect, and exploitation of our vulnerable adults. Formalizing these processes at the Cabinet level will improve responsiveness and reduce duplication of responsibilities.

The role of the coroner is critical to complete investigation. The Cabinet will explore, along with the Kentucky Coroners Association, the State Medical Examiner, and local coroners, ways to improve communications, increase the sharing of information, and involve coroners more directly in investigations.

4. **Recommendation:** *Establish joint investigative teams.*

Rationale: The OIG and DCBS, as the lead investigative agencies, will establish investigative teams to respond to abuse and neglect reports in long term care facilities. The current MOA between DCBS and OIG allows for the sharing of pertinent information including copies of investigative reports concerning the abuse and neglect of adults residing in a long term care setting. These teams will take action to disseminate key elements pertaining to the sharing of information across agency lines contained in the current MOA to front line staff. Information housed by two separate agencies within the Cabinet will be shared with one another providing more robust information which can be used to more effectively investigate neglect and abuse of the nursing home resident and nursing home facility practices.

A multidisciplinary team design as permitted in KRS 209.030(6)(a)(b) is not consistently achieved statewide. The lack of multidisciplinary teams sometimes results in a duplication of interviews and review of medical records, as well as and disparate outcomes or

findings. As joint investigative teams are formed, DCBS and OIG will begin exploring the development of local multidisciplinary teams to involve other investigative agencies per KRS Chapter 209. It is noted that the effective of joint and multidisciplinary teams is not simply having two investigators on the scene, but it is the information sharing, collaboration and follow-up efforts that facilitate thorough and effective investigations.

5. **Recommendation:** *Establish electronic data sharing among appropriate agencies.*

Rationale: There is inconsistent feedback from law enforcement and other “authorized agencies” concerning the disposition of APS cases referred for possible criminal investigation and prosecution. Current DCBS practice directs staff to notify all “authorized agencies” via the DPP-115 Reporting Form at the onset of a protective service investigation and send a Notice of APS Findings at the conclusion of a investigation; however, there is no formalized mechanism in place for “authorized agencies” to provide DCBS with any feedback concerning the disposition of APS cases referred to them. As a result DCBS is often unaware of the status of APS cases referred to law enforcement and the courts. The use of an electronic DPP-115 saves time for all agencies involved and provides better documentation and provides a ready vehicle for communicating case disposition. DCBS, OIG, Kentucky State Police, and municipal and county law enforcement representatives should be convened to explore completion of the electronic DPP-115 initiative.

**Cabinet for Health and Family Services
Office of Inspector General**

Description of Review

The Office of Inspector General (OIG) has conducted a review of all existing statutes and regulations that provide for the protection of Kentucky's long-term care residents to determine whether the OIG has fully complied with all requirements and if the existing requirements are adequate to protect the residents of long-term care facilities. The OIG's applicable internal processes were also reviewed. Lastly, all Type A/Type B Citations and Statements of Deficiencies issued by the OIG in 2010 regarding abuse, neglect, and misappropriation of property were reviewed.

Discussion of Current Statutes and Regulations Applicable to Nurse Aide Abuse Registry and Criminal Background Checks

KRS Chapter 216B authorizes the Cabinet for Health and Family Services to license health facilities and health services in the Commonwealth and to establish licensure standards and procedures to ensure safe, adequate, and efficient health facilities and services. OIG is Kentucky's regulatory agency for licensing all health care facilities. In addition, the Centers for Medicare & Medicaid Services (CMS) has a contractual agreement with the OIG to conduct Medicare/Medicaid certification surveys for long term care facilities.

KRS 216.510(1) defines "long-term care facilities" as "those health-care facilities in the Commonwealth which are defined by the Cabinet for Health and Family Services to be family-care homes, personal-care homes, intermediate-care facilities, skilled-nursing facilities, nursing facilities as defined in Pub. L. 100-203, nursing homes, and intermediate-care facilities for the mentally retarded and developmentally disabled."

KRS 216.532 prohibits a long-term care facility from being operated by, or employing any person listed on the nurse aide and home health aide abuse registry.

KRS 216.789 prohibits any long-term care facility, nursing pool providing staff to a nursing facility, or assisted-living community from knowingly employing a person for the provision of direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

OIG has established licensure regulations for operations and services and facility specifications for family care homes, personal care homes, intermediate care facilities, intermediate care facilities for the mentally retarded and developmentally disabled, skilled nursing facilities, nursing homes, Alzheimer's nursing homes, and nursing facilities. In addition, regulations regarding Type A and Type B Citations and the nurse aide abuse registry have been promulgated. Long term care facilities must be surveyed annually and in response to any complaint or allegation received.

Description of Nurse Aide Abuse Registry

OIG maintains an abuse registry which includes a list of nurse aides and home health aides who have received a final order issued by the Cabinet Secretary that substantiates a finding of resident or patient abuse, neglect, or misappropriation of a resident's or patient's property. The registry also includes a list of nurse aides and home health aides who have failed to request an appeal of a preliminary finding of resident or patient neglect, abuse, or misappropriation of a resident's or patient's property. A nurse aide or home health aide whose name was added to the registry after January 1, 1995 may petition the Cabinet in writing for review of a finding of neglect after the passage of one (1) year from the date that the nurse aide or home health aide's name was placed on the registry. Upon receipt of a written request for removal from the registry, the Cabinet Secretary is required to make a determination based on whether the employment and personal history of the nurse aide or home health aide reflects a pattern of abusive behavior, neglect or misappropriation of property, and whether the incident of neglect involved in the finding that resulted in the addition of the nurse aide or home health aide to the registry was likely a singular occurrence. If the Cabinet does not remove the nurse aide or home health aide's name from the abuse registry upon consideration of the grounds stated in the petition for review, the nurse aide or home health aide may request a hearing within thirty (30) days of notification of the Cabinet's decision.

A check of the nurse aide and home health aide abuse registry must be conducted prior to employment in a long-term care facility or home health agency. The Kentucky Board of Nursing (KBN) maintains the nurse aide abuse registry's database. Queries to validate the registry status of nurse aides may be performed on the KBN website: <http://kbn.ky.gov/knar/>, or by requesting a registry status by mail or fax from KBN.

Criminal Background Checks

KRS 216.789 prohibits any long-term care facility, nursing pool providing staff to a nursing facility, or assisted-living community from knowingly employing a person for the provision of direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime. Additionally, the term "direct services" as used above KRS 216.789 is defined by KRS 216.785 as "personal or group interaction between the employee and the nursing facility resident or the senior citizen." Therefore, the OIG has advised that any facility employee who comes into contact with a resident must submit to an in-state criminal record check conducted by the Kentucky State Police or the Administrative Office of the Courts. Additionally, state law (KRS 216.533) prohibits a long-term care facility owned, managed, or operated by the Cabinet's Department for Mental Health and Mental Retardation Services from knowingly employing any person who has been convicted of a felony offense under: (a) KRS Chapter 209 (Protection of Adults); (b) KRS Chapter 218A (Controlled Substances); (c) KRS 507.020, 507.030, and 507.040 (Criminal Homicide); (d) KRS Chapter 509 (Kidnapping and Related Offenses); (e) KRS Chapter 510 (Sexual Offenses); (f) KRS Chapter 511 (Burglary and Related Offenses); (g) KRS Chapter 513 (Arson and Related Offenses); (h) KRS 514.030 (Theft and Related Offenses); (i) KRS Chapter 530 (Family Offenses); (j) KRS Chapter 531 (Pornography); (k) KRS 508.010,

508.020, 508.030, and 508.032 (Assault and Related Offenses); (l) A criminal statute of the United States or another state similar to paragraphs (a) to (k); or (m) A violation of the uniform code of military justice or military regulation similar to paragraphs (a) to (k) of this subsection which has caused the person to be discharged from the Armed Forces of the United States.

The Kentucky State Police and the Administrative Office of the Courts are the two (2) agencies within Kentucky authorized to conduct in-state criminal records checks.

As part of the survey process, OIG staff monitors for compliance with the background checks described in this section by verifying whether long-term care facilities licensed by the OIG have properly secured pre-employment nurse aide and home health aide abuse registry information, and criminal history information on their staff.

On August 9, 2010, OIG submitted a grant application authorized under the Affordable Care Act requesting funding to establish a fingerprint-based background check program in Kentucky. Should funding be granted, additional authority under state law will be needed to require participation by long-term care facilities in the national background check program, provide protection for applicants against misuse of background check information, and protect providers against liability. The proposed background check program should eventually have a rap-back system in place for State law enforcement to immediately notify the Cabinet of any criminal conviction that occurs following an individual's pre-employment background check.

Type A/Type B Citations

If upon inspection or investigation, the OIG determines that a long-term care facility has violated the regulations, standards, and requirements as set forth by the Cabinet pursuant to the provisions of KRS 216.510 to 216.525, or applicable federal laws and regulations governing the certification of a long-term care facility under Title 18 or 19 of the Social Security Act, and the violation has been classified as a Type A or Type B violation pursuant to KRS 216.563 and 900 KAR 2:040, OIG issues a written citation to the licensee of the long-term care facility specifying the nature of the violation, and the statutory provision or regulation alleged to have been violated.

A Type "A" violation means a violation by a long-term care facility of the regulation, standards, and requirements as set forth by the Cabinet (pursuant to KRS 216.563 and 900 KAR 2:040 or the provisions of KRS 216.510 to 216.525, or applicable federal laws and regulations governing the certification of a long-term care facility under Title 18 or 19 of the Social Security Act), which presents an imminent danger to any resident of a long-term care facility and creates substantial risk that death or serious mental or physical harm to a resident will occur. A Type A violation shall be abated or eliminated immediately, unless a fixed period of time not to exceed ten (10) days, as determined by the Cabinet, is required for correction. A Type A violation is subject to a civil penalty in an amount not less than one thousand dollars (\$1,000) nor more than five thousand dollars (\$5,000) for each and every violation.

A Type "B" violation means a violation by a long-term care facility of the regulations, standards, and requirements as set forth by the Cabinet (pursuant to KRS 216.563 and 900 KAR 2:040 or

the provisions of KRS 216.510 to 216.525, or applicable federal laws and regulations governing the certification of a long-term care facility under Title 18 or 19 of the Social Security Act), which presents a direct or immediate relationship to the health, safety, or security of any resident, but which does not create an imminent danger. A Type B violation is subject to a civil penalty in an amount not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) for each and every violation. A citation for a Type B violation shall specify the time within which the violation is required to be corrected as approved or determined by the Cabinet. If a Type B violation is corrected within the time specified, no civil penalty shall be imposed.

A facility that is assessed a civil monetary penalty in accordance with applicable federal laws and regulations under Title 18 or 19 of the Federal Social Security Act shall not be subject to the civil monetary penalties established in KRS 216.557 for the same violation.

KRS 216.560 provides that additional penalties may be assessed for failure to correct the Type A or Type B violation within the time specified.

OIG currently refers all Type A and B Citations to the Attorney General's Office, the CHFS Department of Community Based Services, Protection and Advocacy, the CHFS Office of Communications, and the OIG Division of Audits and Investigations.

During the period January 1, 2010-August 9, 2010, the OIG issued 28 Type A/B Citations, three (3) of which related to abuse/neglect/misappropriation of resident's property.

The OIG reviewed the 28 citations and the statements of deficiencies related to the citations to determine if the OIG followed regulatory requirements and internal policies regarding issuance of citations. The OIG's review included a determination if appropriate referrals were made to the Office of the Attorney General, CHFS Department for Community Based Services, Protection & Advocacy, CHFS Office of Communications, and the OIG Division of Audits and Investigation. The review also included determining if referrals were appropriately made to the nurse aide abuse registry and to the respective licensure or certification boards.

The OIG also reviewed existing federal and state statutes/regulations regarding abuse/neglect to determine if proposed changes are necessary to adequately to protect the residents of long-term care facilities. The following statutes/regulations were reviewed:

42 CFR 488.301 defines the terms "abuse", "neglect", and "misappropriation of resident property" as follows:

"Abuse" is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."

"Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

“Misappropriation of resident property” means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent”.

Definitions of “neglect”, “abuse” and “misappropriation of a resident’s or patient’s property” found in 906 KAR 1:100 (the nurse aide and home health aide abuse registry regulation) mirror the 42 CFR 488.301 definitions.

KRS 209.020 (8) defines “abuse” as “the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. “

42 CFR 483.13(b) states: “The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. “

42 CFR 483.13(c) states: “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.”

42 CFR 483(c) (1) (i) states: “The facility must – (i) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.”

42 CFR 483.13(c) (1) (ii) and (iii) states: “The facility must—(ii) not employ individuals who have been—

- (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
- (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
- (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.”

42 CFR 483.13(c) (2) states: “The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).”

42 CFR 483.13(c) (3) states: The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.”

42 CFR 483.13(c) (4) states: “The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days

of the incident, and if the alleged violation is verified appropriate corrective action must be taken.”

KRS 216.532 prohibits a long-term care facility from being operated by, or employing any person listed on the nurse aide and home health aide abuse registry.

KRS 216.789 prohibits any long-term care facility, nursing pool providing staff to a nursing facility, or assisted-living community from knowingly employing a person for the provision of direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

The OIG has conducted a review of the following eight (8) long-term care state licensure regulations:

902 KAR 20:026. Operations and services; skilled nursing facilities.
<http://www.lrc.ky.gov/kar/902/020/026.htm>

902 KAR 20:036. Operation and services; personal care homes.
<http://www.lrc.ky.gov/kar/902/020/036.htm>

902 KAR 20:041. Operation and services; family care homes.
<http://www.lrc.ky.gov/kar/902/020/041.htm>

902 KAR 20:048. Operation and services; nursing homes.
<http://www.lrc.ky.gov/kar/902/020/048.htm>

902 KAR 20:051. Operation and services; intermediate care.
<http://www.lrc.ky.gov/kar/902/020/051.htm>

902 KAR 20:086. Operation and services; intermediate care facilities for the mentally retarded and developmentally disabled. <http://www.lrc.ky.gov/kar/902/020/086.htm>

902 KAR 20:291. Alzheimer's nursing homes. <http://www.lrc.ky.gov/kar/902/020/291.htm>

902 KAR 20:300. Operation and services; nursing facilities.
<http://www.lrc.ky.gov/kar/902/020/300.htm>

Recommendations

1. **Recommendation:** *Assure referrals to appropriate professional licensure and certification boards.*

Rationale: Inconsistencies were identified when referring to the licensure/certification boards of persons found to have abused/neglected an individual. By November 1, 2010, the

OIG will implement its newly drafted policy regarding referrals to other entities which ensures that information regarding malfeasance perpetrated by staff of facilities is referred consistently to appropriate professional licensure and certification boards.

2. **Recommendation:** *Increase training of long term care surveyors.*

Rationale: OIG surveyors are not required to have training related to these issues on a regular basis. In March, 2011, the OIG will provide surveyor training regarding:

- the prevention and identification of abuse, neglect and misappropriation of property;
- determining when to report to licensure/certification boards; and
- federal and state reporting requirements related to neglect and abuse(42 CFR 483.13(c)(2), 42 CFR 483.13(c)(4), KRS Chapter 209, KRS Chapter 620, KRS 72.020 and the Elder Justice Act of 2009).

3. **Recommendation:** *Publish Statements of Deficiencies issued by the OIG.*

Rationale: By law, each provider must make all OIG survey results, deficiencies identified and Type A citations issued available to members of the public. This information is available to the public, but not in user-friendly modes. The OIG will develop an on-line, web-based program to contain statements of deficiencies for nursing homes by December 1, 2010. This tool, already under discussion and development, will be available to the public, in addition to the Long Term Care Ombudsman Program. The Cabinet should also explore other methods to accomplish these goals which may include the development of consumer handbooks specifically designed for residents and families. This will help to raise awareness of systemic deficiencies identified in nursing homes that can have a direct impact on resident quality of life.

4. **Recommendation:** *Explore the development of a self-protection training program for nursing facility residents.*

Rationale: No formal elder abuse prevention training exists that is targeted toward the resident. While the LTCOP and APS provide regular education, awareness and training on the signs, symptoms, and legal mandate to report abuse for professionals and concerned citizens; there is currently no training being conducted specifically designed for the residents. Therefore, residents are not consistently informed on how they can be a proactive partner for themselves and other residents in the fight against elder abuse and victimization. The Kentucky State Police has been approached regarding the possibility of creating and implementing a training program similar to a neighborhood watch program, but in a long term care facility.

**Cabinet for Health and Family Services
Department for Aging and Independent Living**

Long Term Care Ombudsman Program Review

The Office of the State Long Term Care Ombudsman Program (SLTCOP) is housed within the Department for Aging and Independent Living (DAIL), which serves as the State Unit on Aging (SUA) for Kentucky. The Long Term Care Ombudsman (LTCO) serves as advocates for the rights of residents residing in nursing homes, as well as boarding and personal care homes. Ombudsman work to resolve problems of individual residents, and to bring about changes at the local, state and national levels to improve resident's care and quality of life. Ombudsman work to resolve complaints, to the resident's satisfaction, that affect their health, safety, welfare and rights. The LTCOP is operated in all 50 states under the authority of the Older Americans Act. Although the program is housed within DAIL, it is structured as an independent advocacy agency, solely representing the rights of LTC residents. The Kentucky SLTCOP currently operates with 4 full time state staff with 15 District Ombudsman who are contracted through each of the Area Agencies on Aging and Independent Living (AAAIL). Under the District Ombudsman there are 143 volunteers who act in the capacity of Certified Ombudsman (who can conduct complaint investigations), and 170 Friendly Visitor and Advisory Board Members. Because of the limited number of actual staff for the SLTCOP, it is critical to recruit, train and retain volunteers. The staff and volunteers provide regular visitation and advocacy to each of the 482 long-term care facilities (LTCF) in Kentucky. Currently, there are 34,585 placement beds contained in the facilities.

Presently Kentucky has 294 Skilled Nursing Facilities (SNF), 83 free standing Personal Care Homes (PCH), 95 Family Care Homes (FCH), and 10 free standing Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR), for a combined total of 482 facilities and a total bed capacity of 34,585. Currently, Kentucky facilities average 87-92% capacity on any given day; however, given the projected increases of the aging and elderly population, the capacity is expected to increase. According to the 2000 U.S. Census, the Commonwealth of Kentucky was home to 672,905 persons 60 and older, representing 16.6% of the population. It is anticipated that this population will increase to 1,297,999 persons 60 and older by 2030, representing 26.2% of the population, a 91.4% increase from 2000. In addition to the concerns the baby boomers bring towards the need of additional and quality long term care options, younger nursing home residents are also being admitted. The younger residents tend to be victims of early stroke, heart attack, or brain injury. The state LTCOP recommends that district employees visit their facilities on a monthly basis, which is above the federal mandate of quarterly visits.

While the mandates of the Older Americans Act (OAA) direct the LTCOP to provide focused attention to residents age 60 and older, Ombudsman are also obligated to provide services to all residents living in LTC facilities. The needs and preferences of the younger nursing home residents can vastly differ from those of the more traditional resident, and the LTCO must work to advocate for the wishes of both. The KY LTCOP also serves as a resource for the family members of each of these residents, as well as a resource for all facility staff. The LTCOP is further mandated to provide public awareness and education trainings on long-term care and

elder abuse. Additionally, The SLTCOP is mandated to review, analyze and comment on any policies at the local, state, and national levels that stand to have impact on the lives of those residing in a long-term care facility.

Elder Abuse

The Kentucky LTCOP is a leader in the grassroots coalition of Local Coordinating Councils on Elder Abuse (LCCEA) across the state. Many of the Chairpersons for the LCCEAs are District Ombudsman. All of the LCCEAs are supported through the Area Agency on Aging and Independent Living (AAAIL) and are comprised of various community partners and concerned citizens. These coalitions seek to raise public awareness on elder abuse within their communities and develop education materials and conferences to address the multi-faceted issues of elder abuse.

Recently, multi-agency regional forums were conducted in each of the four Office of Inspector General's (OIG) field offices. They were comprised only of governmental agencies that play a role in the identification, investigation, resource coordination and prosecution of elder and vulnerable adult abuse. Key agencies included LTCOP, OIG, Office of the Attorney General (OAG), Department for Community Based Services (DCBS), Guardianship, Protection and Advocacy (P&A) as well as the AAAIL. The forums seek to identify potential gaps in the coordinated efforts of each governmental agency at the local level, suggest improvements, improve communication, and make improvements to the coordinated efforts of multi disciplinary investigations for cases of suspected elder abuse. At the national level, the State Office of the LTCOP is involved with various organizations to promote awareness of elder abuse, awareness of the issues surrounding LTC, improvement of all state Ombudsman programs, legislative advocacy, and the development of uniform standards of training and structure for all state programs.

Advocacy

The LTCOP is actively involved with advocacy groups in Kentucky; including, but not limited to the following: Kentuckians for Nursing Home Reform, the Kentucky Initiative for Quality Nursing Home Initiatives (KYIQ), and the Kentucky Coalition for Person Centered Care (an industry based group with select governmental agency involvement.) The scope of the LTCOP has the potential for expansion which will provide for improved services and improved quality of life and care for Kentucky citizens residing in any long-term care setting.

Applicable Statutes and Regulations

Under the authority granted through the OAA, 42 U.S.C. 3001 et. seq., the Kentucky LTCOP is the only agency authorized strictly to represent the needs and preferences of all persons residing in long-term care. A complete detail of the SLTCOP can be found in the OAA, Chapter 712. Mandates include the program to be 100% resident focused and driven, thus having the potential of placing the program at odds with partnering government agencies. Specifically, governing authority is as follows:

42 U.S.C. 3058g. Older Americans Act-Long Term Care Ombudsman Programs.

42 U.S.C. 3058i. Older Americans Act-Programs for Prevention of Elder Abuse, Neglect, and Exploitation.

42 U.S.C. 3001et seq. Requires States to Establish and Operate a Long Term Care Ombudsman Program to Protect the Rights of Older Individuals.

910 KAR 1:210. Section 1(4)(6)(10) Section 13 (2)(a) Administrative Regulation Governing the LTCOP.

KRS 205.204. Designates the Cabinet as the State Agency to Administer the OAA in Kentucky.

KRS 209.030- Requires that Reports of Adult Abuse, Neglect or Exploitation be Reported through the DCBS.

KRS 216.535. Defines a Long Term Care Facility as Family Care Homes, Personal Care Homes, Intermediate Care Facilities, Skilled Nursing Facilities, and Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled.

KRS 209.005. Establishes the Elder Abuse Committee in Kentucky.

KRS 216.541(1). Prohibits interference with the Long Term Care Ombudsman in the Lawful Performance of its Official Duties as Set Forth in 42 U.S.C. 3001 et seq.

KRS 216.540(5). Allows the Long Term Care Ombudsman or Designee that has Responsibility Regarding Residents of LTCF have Unrestricted Access to all Long Term Care Facilities.

907 KAR 1:671. Conditions of Medicaid Provider Participation; Withholding Overpayments, Administrative Appeal Process and Sanctions.

KRS 205.8451 through 205.990, 205.624, and 194A.515. Provide that the Cabinet and the Dept. for Medicaid Services (DMS) Shall be Responsible for the Control of Medicaid Provider Fraud and Abuse.

902 KAR 20:036. Operations of Personal Care Homes.

902 KAR 20:041. Operation and services; Family Care Homes.

902 KAR 20:048. Operations of Nursing Homes.

902 KAR 20:051. Operations of Intermediate Care.

902 KAR 20:086. Operation and Services; Intermediate Care Facilities for the Mentally Retarded and the Developmentally Disabled.

922 KAR 5:100. Alternate Care for Adults.

DAIL SOP Chapter 16. Daily operational guidelines for conducting the Long-Term Care Ombudsman Program.

“Effectiveness of the State Long Term Care Ombudsman Programs”, Carroll L. Estes, PhD., Institute for Health and Aging, San Francisco, CA

“Kentucky Elder Readiness Initiative: A Survey of Commonwealth Residents”. Preliminary Statewide Report, November 1, 2007

Kentucky Long Term Ombudsman “Welcome Packet” information
“Best Practices for Nursing Home Closure”

Department of Health and Human Services, Centers for Medicare and Medicaid Services, “Use of Civil Monetary Penalty (CMP) Funds by States. Ref: S&C- 02-42, August 8, 2002, and Ref: S&C-09-44, June 19, 2009.

Older Americans Act of 1965 as amended in 2006

Discussion of Relevant Policy and Procedure

A review of state statutes, regulations, federal law, as well as LTCOP policies and procedures was conducted. In addition, a brief review was conducted for the areas of cross over between the LTCOP, OIG, OAG and DCBS’ Adult Protection Services (APS). The statutes, administrative regulations, DAIL Standard Operating Procedures (SOP), and the OAA listed above were also reviewed. Any additional supporting reports, data, professional opinion papers reviewed for the purposes of this report, are attached.

Oversight for the quality of care and quality of life for residents in LTC, which include personal care home, family care home and nursing facility, rests with multiple agencies, each of which have specific areas for which they monitor.

DCBS is responsible for investigating all allegations regarding abuse, neglect or exploitation of a vulnerable adult under KRS Chapter 209. Their investigations include both in-home and out-of-home settings.

OIG is responsible for licensing and certification oversight of all healthcare facilities. Their investigations and oversight is focused on regulatory violations by the facility. Regulations governing these facilities are as follows: 902 KAR 20:036, 902 KAR 20:041, 902 KAR 20:048 and 902 KAR 20:086. OIG can impose monetary penalties for identified violations. The fines collected are deposited into the Civil Monetary Penalties (CMP) fund. These funds are to be used for programs and services that work to improve the quality of care and the quality of life for residents of facilities. The use of CMP funds are governed under Centers for Medicare and

Medicaid Services (CMS) memos S&C-02-42 (August 8, 2002), and S&C-09-44 (June 19, 2009).

The Office of the Attorney General is responsible for the criminal investigations pertaining to actions committed in a long-term care facility. This function is carried out largely through the Medicaid Fraud and Control Unit of the OAG.

The Department for Medicaid Services (DMS) provides oversight of facilities who are Medicaid providers. Their regulatory authority is governed under 907 KAR 1:671.

Ombudsmen are allowed unrestricted access to residents and unrestricted access to all long-term care facilities under KRS 216.540(5). The Ombudsman is further protected from interference and retaliation during the lawful performance of duties under KRS 216.540(5).

Although federal mandate requires each LTC facility to be visited quarterly, an Ombudsman strives to provide monthly visits. Recognizing that some residents transfer in and out of a long-term care (LTC) facility for physical rehabilitation purposes, the SLTCOP developed a “Welcome Packet” to be delivered to each resident upon admission. The “Welcome Packets” are to be delivered to the resident within two weeks of their arrival to the facility. The packet includes information on Resident Rights, Transfer and Discharge Rights, Understanding the Medicaid system and the DLTCOP, as well as, contact information for the local and State Ombudsman.

Complaints are received in the LTCOP from residents, family members, concerned citizens and facility staff. Once a complaint is received, it is sent to the appropriate district for investigation. If a complaint is received regarding a local Ombudsman, the complaint is investigated by the SLTCOP. Under SOP for the LTCOP, complaints involving quality of care are investigated within two (2) days. Complaints involving threat of discharge or transfer are investigated within five (5) days, unless the impending discharge is scheduled sooner. In that case the complaint is immediately investigated. The SLTCO reviews every report (allegations of abuse, neglect or exploitation) that is referred from DCBS involving a resident of LTC. The reports are screened by the SLTCO to determine if they meet priority status. Cases meeting priority status are flagged and immediately acted upon by the DLTCO. Priority cases include allegations of physical abuse, mental abuse, or serious neglect (such as decubitus ulcers).

Additional safeguards provided by the LTCOP are the multiple trainings provided both in facilities and in communities. Trainings include such topics as Elder Abuse, Resident Rights, Resident Centered Care, and Innovations in Programming.

The SLTCOP has also partnered with the KYIQ to create and implement a “facility to facility” mentoring program. This program seeks to identify facilities that have innovative practices that have proven to have positive impact on the lives of their residents and share those practices with a facility that seeks practice improvement.

Activities of the SLTCOP include the following:

- KY LTCOP has met and exceeded the recommended quarterly visitation for all personal care home, family care home and nursing facilities.
- The SLTCOP began a statewide media recruitment campaign seeking volunteers in the LTCOP. A large number of volunteers were successfully recruited.
- The SLTCOP created and implemented regional multi-agency forums to address the local interdisciplinary response to elder abuse.
- The SLTCO created and produced the first ever national simultaneous campaign addressing elder abuse. The PSAs played in all 50 states and were re-released in movie theaters across the country in May and June of 2010.
- Recognizing the need for increased response time to allegations of abuse, neglect and exploitation of LTC residents, the SLTCOP now reviews every report received from DCBS and is able to screen and label the most serious cases as priority status. The cases are immediately sent to the appropriate district program for follow up and investigation.
- Under the guidance of CMS, OIG maintains a “special focus facility list” for agencies that have demonstrated a pattern of poor performance and poor quality of care. Kentucky was allotted three (3) slots to be included on the list, due to national and state capacity to monitor improvement. Kentucky’s SLTFOP recently implemented an immediate policy that directs the District Ombudsman to conduct on-site, weekly visitation to monitor quality of life and quality of care. The District Ombudsman provides a summary of any concerns to their Regional Ombudsman who in turn, notifies OIG, OAG, and/or DCBS as necessary.

Recommendations

1. **Recommendation:** *Explore the options for additional funding to expand the regional ombudsman program.*

Rationale: Funding is a major concern for the Long Term Care Ombudsman Program (LTCOP) given the scope and magnitude of services performed on behalf of all residents of long term care facilities. In FY 08, Kentucky reported a lower than average amount of funding for services per bed and ranked 34th of the 50 states in regards to funding for LTCOP services. The use of the Civil Monetary Fund (CMP) should be explored.

2. **Recommendation:** *The Elder Abuse Committee should be revitalized in order to carry out its statutory functions.*

Rationale: KRS Chapter 209.005 requires the Cabinet to operate an Elder Abuse Committee; the Committee has experienced declining attendance by members in recent years.

3. **Recommendation:** *Develop training on special care necessary for residents with cognitive impairments.*

Rationale: Inadequate resources for persons with cognitive impairment exist. This results in residents being forced to move or relocate to facilities far from their families and communities and all too often can force them into facilities in neighboring states for their LTC needs. The Cabinet should work with representatives of appropriate associations to develop and coordinate training and education related to the needs of persons with cognitive impairments. This can be coordinated through a stronger partnership between the LTCOP, the Alzheimer's Association, OIG and the long term care industry.

4. **Recommendation:** *Develop a "Best Practices Toolkit" for nursing home closures.*

Rationale: Coordination of multiple agencies during a nursing home closure is critical. Nursing Home closures are an unfortunate but sometimes necessary event for facilities that cannot meet the requirements under CMS guidelines. Facilities also make the voluntary decision to close, most often due to financial difficulties. Efforts to coordinate activities of the participating agencies (OIG, DCBS, OAG, and the LTCOP) need improvement. Closures and transfers can lead to "transfer trauma", the name given for the sudden decline and sometimes death of a resident when the environment, routine, and familiar faces suddenly change. The resident becomes disoriented, depressed, and their overall functioning begins a steady decline.

5. **Recommendation:** *Explore the development of a self-protection training program for nursing facility residents.*

Rationale: No formal elder abuse prevention training exists that is targeted toward the resident. While the LTCOP and APS provide regular education, awareness and training on the signs, symptoms, and legal mandate to report abuse for professionals and concerned citizens; there is currently no training being conducted specifically designed for the residents. Therefore, residents are not consistently informed on how they can be a proactive partner for themselves and other residents in the fight against elder abuse and victimization. The Kentucky State Police has been approached regarding the possibility of creating and implementing a training program similar to a neighborhood watch program, but in a long term care facility.

**Cabinet for Health and Family Services
Department for Aging and Independent Living**

Guardianship Program Review

The Kentucky State Guardianship program is operated by the Department for Aging and Independent Living within the Cabinet for Health and Family Services. The program serves an average of 3,200 active wards, ages 18-104, per year. Guardianship is a legal relationship between a guardian and an adult ward. A guardian is a court appointed person or entity with the duty and power to make personal and/or property decisions for another (the ward). The ward is an adult, 18 years or older, who has been declared by the court to be either wholly or partially disabled, and who is unable either to care for personal needs or to manage personal financial resources, or both. After a jury trial determines that a person is disabled, a judge rules on who should become the guardian. Public guardianship results when the courts appoint a publicly-funded organization to serve as legal guardian, instead of a private citizen or professional organization. A public guardian is usually appointed due to the absence of willing and suitable family members or friends, or the absence of resources to employ a private guardian.

Kentucky has statutory language and case law that makes the state the guardian of last resort, which is why Kentucky's public guardians cannot refuse a guardian appointment. A 1984 case that determined a state guardian may be appointed by the court, even when the state agency is unwilling to serve and had not sought the appointment, had a profound effect on the frequency with which a state guardian has been appointed by the courts to serve the needs of disabled adult wards in Kentucky. Once appointed, staff from the Field Services Branch is assigned to oversee the daily personal needs of the ward and the Fiduciary Services and Benefits Management Branches are charged with the responsibility to manage the financial affairs and benefits of the new ward.

Applicable Statutes and Regulations

The Kentucky State Guardianship Program must adhere to the following federal and state statutes, regulations and policies and procedures.

Federal Statutes

U.S.C.3058g Section 712 (5) Designation of Local Ombudsman entities and Representatives

U.S.C.3058i Chapter 3-Programs for Prevention of Elder Abuse, Neglect and Exploitation

U.S.C.3058i Chapter 3 Section 721-Prevention of Elder Abuse, Neglect, and Exploitation

State Statutes and Regulations

KRS Chapter 387 Guardians-Conservators-Curators of Convicts

910 KAR 2.040 Service Provisions for adult guardianship

KRS Chapter 209 Protection of Adults

KRS 209.030 (11) Operations & Services: skilled nursing facilities statute, section 3&4)
902 KAR 20:026 Operations and Services: skilled nursing facilities (section 3&4)

902 KAR 20:036 Operations of Personal Care Homes (section 3&4)

902 KAR 20:041 Operation and services: family care homes (section 1, 3, 6)

902 KAR 20:048 Operations of Nursing Homes (section 3&4)

902 KAR 20.051 Operations of Immediate Care (section 3&4)

KRS 216 Health Facilities and Services

KRS 216.510 Definitions for KRS 216.515 to KRS 216.530

KRS 216.515 Rights of residents-Duties of facilities-Actions

KRS 216.520 Supplementation of residents' rights

KRS 216.525 Cabinet's duties

KRS 216.540 Persons allowed access to facility during visiting hours-Rights and duties of visitors- Denial of access by resident or administrator-Unrestricted access by employee of Cabinet

KRS 216.547-Public inspection of cabinet inspection reports, service descriptions, listings of rates and charges, and court orders on premises--Duties of Inspector General--Construction of section with respect to Kentucky Open Records Law.

KRS 216.557 Classification of violations-Exemption from state penalty if federal penalty assessed.

KRS 72.025 Circumstances requiring post-mortem examination to be performed by coroner

KRS 446.400 Determination of death

I. SCOPE AND METHODOLOGY OF THE REVIEW

The guardianship review process was conducted by several staff from the field and benefits branches to proactively respond to protection, safety and welfare concerns that potentially could affect guardianship wards. This report is written to reveal areas of strengths and weaknesses within the program with regard to the Type A citations indicating serious physical/sexual abuse and neglect, evidence of incidence and reporting, staffing and accountability concerns and ultimately outline viable solutions to the weaknesses to ensure the wards health, safety and welfare needs are met.

II. DISCUSSION OF RELEVANT POLICY AND PROCEDURE

Kentucky Revised Statutes Chapter 387 defines the jurisdiction (.520); process for determination (.530-.580), types of Guardians, renewal (.610), relief from guardianship (.590-.620); powers and duties of guardians and conservators(.630-.750); and reporting requirements in general (.760-990). The purpose for this legislation outlined under 387.500 states the General Assembly recognizes the (1) “varying degrees of disability” and to ensure those (2) “Person[s] who are only partially disabled must be legally protected without a determination of total incompetency and without the attendant deprivation of civil and legal rights that such a determination requires.”

Specific statutes, regulations and policies that pertain to health, safety and welfare issues and the guardianship program are as follows:

STATUTES

- (1) KRS 387.500 section three (3), “...guardianship and conservatorship for disabled persons shall be utilized only as is necessary to promote their well-being, including protection from neglect, exploitation, and abuse; shall be designed to encourage the development of maximum self-reliance and independence in each person; and shall be ordered only to the extent necessitated by each person’s actual mental and adaptive limitations.”
- (2) With respect to specific powers and duties of a guardian given by the court in section one (1) of KRS 387.660, the guardian is “To take custody of the ward and to establish his place of abode within the state except that, if at any time a guardian places a ward in a licensed residential facility for developmentally disabled persons, the guardian shall, within thirty (30) days of such placement, file with the court notice of the placement, stating with specificity the reasons for such placement, and an interdisciplinary evaluation report detailing the social, psychological, medical or other considerations on which such placement is predicated, a description of the treatment or habilitation programs which will benefit the ward as a result of such placement, and a determination that such placement will provide

appropriate treatment in the least restrictive available treatment and residential program".

- (3) KRS 387.660 Section two (2) "...To make provision for the ward's care, comfort, and maintenance and arrange for such educational, social, vocational, and rehabilitation services as are appropriate and as will assist the ward in the development of maximum self-reliance and independence."

With respect to the KRS statute for **Evidence of Incidence and Reporting**, there is no language which specifically addresses Type A citations, or how to protect the ward when serious physical or sexual abuse or neglect is suspected by the guardian or conservator only that they are to ensure the ward is safe from neglect, exploitation, abuse.

An annual report (KRS 387.670) from guardianship staff is due to the court which must include, physical and social condition, (c) a summary of the medical, social, educational, vocational, and other professional services received by the ward during the reporting period, (d) an outline of the guardian's visits with and activities on behalf of the ward.

REGULATIONS:

The following guardianship regulations exist to protect the health, safety and welfare of the ward's living in long-term care facilities:

1. With regard to serious physical/sexual abuse and neglect the following is addressed in regulations:
 - (1) Under 910 KAR 2:040 Section 8 pertains to Decision Making on Behalf of a Ward. (1) "This section gives guidance to ensure the decisions are made with a) Informed consent, b) Substituted judgment, c) best interest; or d) least restrictive alternative. (2) "The Field Services Branch shall use the following guidelines if making a decision on behalf of a ward: (f) A determination of risks and benefits: (1) While balancing the ward's maximum self-determination; and maintaining the safety of the ward".
 - (2) Pursuant to KRS 387, under 910 KAR 2:040 Section 8:5 in terms of decision making the "The Field Services Branch shall consider the least intrusive, best interest, and least restrictive alternative course of action possible to provide for the needs of the ward".
 - (3) Per 910 KAR 2:040 Section 12:1 of the Guardianship regulations, the Field Services Branch is responsible of ensuring the ward is receiving the least restrictive and highest quality services from the most appropriate provider, in order to do so the staff must have and maintain knowledge of services, providers, and facilities in the community.

- a) "The Field Services Branch shall consider various ancillary and support services and select a provider that best meets the needs of the individual ward" (KAR 2:040 Section 12:2).
 - b) When a client is moved from one placement to another the field staff is required to visit within 30 days of the move, evaluates how the ward is adjusting to the move and make sure the placement is appropriate. A follow-up visit is then required within 90 days to verify that the placement is working and meeting the needs of the ward (KAR 2:040 section 12:5 (1 & 2)).
 - (4) Under the Guardianship Regulations 910 KAR 2:040 in Section 9, Guardianship field staff are required to visit the wards quarterly.
 - (5) Under 910 KAR 2:040 Section 7, "(a) The Field Services Branch shall have someone on call twenty-four (24) hours a day and may have duties such as (2) Securing and giving consent for social services, medical services and living arrangements" and "(3) Securing and granting permission for other needed support services for the well-being of the ward".
2. With respect to the Regulation for **Evidence of Incidence and Reporting**, the following is stated:
- (1) KAR 2:040 Section two (2), Field Services Branch is required to submit an Annual Court Report "within the thirty (30) days of the anniversary date of the guardianship appointment, the Field Services Branch shall submit to the court an annual report on the ward's personal status. In order to complete the annual report the Field Services Branch shall: (a) visit the ward and use an Initial Field Visit Report to assess current physical condition and needs".
 - (2) KAR 2:040 Section 9:2, "If concerns are identified that do not require intervention by regulatory or certifying agencies then the field staff will bring the concerns to the attention of the facilities administrator and develop an agreement for corrective action to be taken".
 - (3) KAR 2:040 Section 9:3, "If the issues identified are regulatory issues related to health or safety concerns, staff are required to report those issues to Office of Inspector General (OIG), Department for Mental Health, Developmental Disabilities and Addiction Services (DMHDDAS), and/or Department for Aging and Independent Living (DAIL)".
 - (4) KAR 2:040 Section 9:4, "The Field Services Branch shall report known or suspected incidents of abuse, neglect, or exploitation to: The Department

of Community Based Services (DCBS), The Division of Protection and Advocacy (DPA), or other appropriate state agency”.

(5) In KAR 2:040 Section 25 addresses the death of a ward and the responsibilities of the field worker.

(a) “If the ward dies in unusual or unknown circumstances, the Field Services Branch shall (a) make a referral to 1. Adult Protective Services (APS), and, County coroner, relative, or other interested party who may order an autopsy and (b) Complete and submit the department Notice of Adult Fatality.” (KAR 2:040 section 25:7) Staff complete form “Notice of Adult Fatality”, edition 3/09

(6) Per KAR 2:040 Section 12:7 of the regulations, “The Field Services Branch shall notify the facility where the ward resides if the ward is listed on the Sex Offender Registry, has committed a sex crime or a crime against a minor, or is otherwise required to be on the registry pursuant to KRS 17.500 thru 17.540.”

FINDINGS AND RECOMMENDATIONS

Significant improvements to the Guardianship standard operating procedures have occurred during the past two years.

Guardianship was transferred to the Department for Aging and Independent Living in June 2008. Since that time numerous changes have occurred in order to improve program operations, improve efficiencies and enhance the care of the wards. Specifically, a strategic study of the entire program was undertaken. Staff from central office and the field participated in the study. Every aspect of the program was reviewed including staff roles, operating procedures and program needs. Based on the study and staff recommendations, staffing patterns and duties have been reassigned, structural changes have been made, operating efficiencies have been identified and options in order to increase the number of field staff have been explored. In addition, new regulations and standard operating procedures have been developed.

In addition, progress has been made regarding specific issues cited in two separate reports by the Kentucky Auditor of Public Accounts. In 2002 and again in 2008 the state auditor’s office conducted an audit of the public guardianship program. Both audits contained significant deficiencies and findings with significant recommendations for improvement. The 2008 audit contained 43 recommendations for improvement. DAIL has worked diligently to address the recommendations and to date has implemented over 80% of the recommendations.

Guardianship policy dictates enhanced oversight of wards placed in Special Focus Facilities. Pursuant to program standards and operating procedures, guardianship staff must visit any facility listed on the federal Centers for Medicare and Medicaid Services

Special Focus Facility List once per week. In addition, at least one field staff from that region must also visit the facility weekly but not on the same day as the supervisor. Each visit must include direct contact with each of the wards at the facility.

New regulatory language implemented in 2009 increased requirements of guardianship staff as it pertains to health, safety and welfare. These regulations were adopted to provide additional protections to wards of the state. These protections involve increased oversight through face-to-face contact, participation in plan of care development and monitoring, 24 hour/7 day availability, reporting of suspected abuse or neglect, etc.

Guardianship staff is required to submit Annual Court Reports. A guardian has a responsibility to report incidences of abuse or neglect to the appropriate agencies for further action. Some of these incidences, after further investigation by other agencies, may lead to citations issued to the facilities. The regulations also provide instructions for the field staff on reporting deaths as a result of an unknown cause.

**Cabinet for Health and Family Services
Department for Medicaid Services**

Review Methods

The Kentucky Medicaid Program reviewed policies and procedures regarding payment for care or quality of care as it relates to licensure deficiencies. The following briefly recaps the results of their review.

The Division of Healthcare Facilities Management met with their Peer Review Organization and their MMIS Vendor to discuss the policies and procedures surrounding the identification of incidents within a Long Term Care Facility. SHPS, Inc., the contracted vendor for the Department for Medicaid Services, is responsible for going on-site and reviewing Level of Care determinations, not to inspect the facility.

Should one of the SHPS review nurses encounter an area of concern, the following steps are taken:

1. The RN completes the *Quality of Care Concern Form*.
2. The RN submits the *Quality of Care Concern Form* to his/her Regional Manager.
3. The Regional Manager reviews and logs the submitted form, then contacts the Department for Medicaid Services.
4. The *Quality of Care Concern Form* and copies of the medical records are then mailed to the Division of Healthcare Facilities Management.
5. The Nurse Service Administrator Long-Term Care –reviews the form and all documentation. The information and a memo are sent to the Director of the Division. The Nurse Service Administrator completes a document review, and then refers the information to the OIG or OAG as appropriate.

The Department has determined that the process could be improved by requiring formal documentation of the process.

The Division of Program Integrity completed an internal audit of their processes. The statutes and regulations for the Division of Healthcare Facilities Management are designed to address the service to hospitals and long-term care facilities and the payments associated with those services. SHPS, Inc., the Department’s vendor, has a policy in place to address incidents identified while their nurses are reviewing charts on-site. The role of SHPS nurses does not include regular, direct patient contact. The statutes, regulations, and procedures for the Division of Program Integrity were reviewed with regard to complaint management. The process includes the following:

1. If staff within the Division of Program Integrity receives a complaint from a caller, they are referred to the OIG Fraud and Abuse Hotline at 800-372-2970. If a written complaint is received the complaint is sent to the Office of Inspector General for review.

2. The Division of Program Integrity receives a report from the Medicaid Fraud Control Unit (MFCU), Office of the Attorney General, detailing the status of all cases received by the MFCU.

The report referenced above contains the status of investigations by the MFCU into the allegation of neglect and abuse. This report and the monthly report of new allegations and referrals will be reconciled. During the quarterly meeting with the MFCU, Program Integrity will discuss any outstanding, unresolved complaints of abuse and neglect to ensure that all data is shared and reported at regular intervals. The Division's internal process is formal, complete and well documented.

**APPENDIX 1: DOCUMENTS SUBMITTED BY ATTORNEY
GENERAL**



COMMONWEALTH OF KENTUCKY
OFFICE OF THE ATTORNEY GENERAL

JACK CONWAY
ATTORNEY GENERAL

August 31, 2010

CAPITOL BUILDING, SUITE 118
700 CAPITAL AVENUE
FRANKFORT, KENTUCKY 40601
(502) 696-5300
FAX: (502) 564-2894

Ms. Janie Miller, Secretary
Cabinet for Health & Family Services
275 E. Main Street, 5W-A
Frankfort, KY 40621

Dear Secretary Miller:

Thank you for the opportunity to participate in the Cabinet for Health and Family Services' review of procedures regarding the protection of nursing home residents from abuse and neglect. As you know, preventing elder abuse and prosecuting those who harm Kentucky's seniors and vulnerable citizens has been a priority of my administration, resulting in increased prosecutions of abuse and neglect-related cases.

At your request, we have compiled the attached document that outlines the current statutes, regulations, and policies that govern the referral and review process we follow in this agency with regard to protecting nursing home residents and the elderly. Also noted are suggestions for possible steps to further strengthen the laws protecting our seniors, enhancing the penalties for certain violations like failing to report abuse, increasing the penalties for elder abuse, and the possible implementation of a tracking system that would insure that the status of a specific case could be ascertained at any given time.

Additionally, given our relationship with the local prosecutors, we agreed to seek their input on this issue as it pertains to their offices and report back to you the information we gathered from them. To accomplish that task, we interviewed a representative sample of prosecutors based on their experience with these types of cases in the past, geographic location, and rural and urban districts/counties. You will see that their feedback to the questions presented is reported in summary form so as not to compromise any pending prosecution or investigation.

I hope that this information is helpful to you in complying with the Governor's request for review of the laws and policies affecting this issue. Please feel free to contact me if we can be of further assistance.

Sincerely,

A large, stylized handwritten signature in black ink, appearing to read "Jack Conway".

Jack Conway
Kentucky Attorney General

Enclosure



Office of the Attorney General
Office of Medicaid Fraud and Abuse Control
Special Report on the Protection of Nursing Home Residents to Secretary of the
Cabinet for Health and Family Services
August 31, 2010

Introduction

Thank you for asking the Office of the Attorney General to contribute to your Cabinet's Special Review of how the Cabinet can work more efficiently and effectively with prosecutors and police in elder abuse cases. We appreciate your commitment to do all you can do to ensure that the thousands of people in nursing homes in the Commonwealth are protected, and we share that commitment. Per your request, we have prepared this report for you to include in your final report to Governor Beshear.

Purpose and scope of report

The purpose of this report is to state the Office of the Attorney General's (OAG) role in nursing home abuse cases, jurisdiction, and record of criminal investigations and prosecutions as it relates to long-term care facilities in the Commonwealth. We will also briefly review the current criminal statutes and report on feedback gathered from County and Commonwealth's Attorneys' offices. Finally, we will list recommendations from the OAG and local prosecutors to assist prosecutors and law enforcement agencies in investigating and prosecuting crimes associated with the abuse and neglect of nursing home residents.

OAG's role and jurisdiction

The Office of the Attorney General has various divisions that work to protect residents in Kentucky's nursing homes. Because the focus of this report is limited to our role in the criminal investigation and prosecution of allegations of abuse and neglect, we will focus on the efforts of the Office of Medicaid Fraud and Abuse Control, but the work of the other divisions is worth mentioning. The Office of Consumer Protection conducts training throughout the Commonwealth through its senior crime colleges. The Office of Special Prosecutions assists local prosecutors when they ask for assistance in prosecuting a case. Often prosecutors within that office take on the prosecution of cases themselves. Also, the OAG commonly assigns victims advocates to provide support for victims and families during the pendency of these cases. The Prosecutor's Advisory Council (PAC) is chaired by Attorney General Conway and, among other things, sponsors valuable training for prosecutors throughout the state. PAC, pursuant to KRS 15.775, has

developed elder abuse training and has distributed an elder abuse prosecutions training video for local prosecutors.

The Office of Medicaid Fraud and Abuse Control (MFCU) has jurisdiction to investigate criminal allegations of caretaker abuse and neglect in Medicaid funded facilities. The MFCU is funded in part by a federal grant pursuant to 42 U.S.C. 1396b(a)(6). The MFCU must comply with the federal regulations and has to report to the federal agency responsible for oversight of the MFCU grant. Pursuant to 42 U.S.C. 1396b(q), the MFCU is mandated to have procedures to review complaints of abuse or neglect in Medicaid funded facilities. The MFCU's jurisdiction does not currently extend beyond Medicaid funded facilities.

While the MFCU has the authority to investigate allegations of abuse and neglect in Medicaid funded facilities, it does not have original jurisdiction to represent the Commonwealth in a prosecution of these cases. That authority lies with the locally elected County and Commonwealth's Attorneys. Therefore, our investigators must take a case directly to the local prosecutors for them to prosecute. Our investigative staff takes these cases to the local prosecutors when they believe that the facts uncovered in their investigation reveal a criminal act. The local prosecutors review the evidence and determine whether or not they will prosecute the case.

In February 2009, the MFCU reorganized the investigative staff into East/West branches. This had the effect of increasing the number of investigators who review abuse and neglect allegations from three to nine. Also, there are two investigative supervisors and an investigative manager who, in addition to their supervisory duties, assign cases to themselves for investigation. Furthermore, the MFCU has a nurse inspector on staff that reviews cases of abuse or neglect and provides his expert opinion regarding these cases.

It should also be noted that the MFCU is based in Frankfort. The majority of our investigators are stationed in either Frankfort or Louisville and do not have the ability to respond to the scene of crimes immediately. That ability lies with the local law enforcement agencies and the Department of Community Based Services (DCBS) employees. That is why it is so vital that they receive timely notice of allegations of abuse or neglect. If they are not permitted to secure the scene, then valuable evidence may be lost and the ability to conduct a criminal investigation that will ultimately lead to a prosecution is severely harmed.

The MFCU also has the jurisdiction to investigate and prosecute provider fraud in the Medicaid system pursuant to 42 U.S.C. 1369b(q), KRS Chapter 194, and KRS Chapter 205. Since January 2008, the MFCU has been awarded or recovered more than \$135 million dollars on behalf of the federal and state Medicaid programs. One of those cases involved a settlement against Omnicare, the largest nursing home pharmacy provider in the nation. In that case, Omnicare paid \$1.37million dollars to Kentucky's state and federal Medicaid programs. It was alleged that Omnicare received kickbacks for having its pharmacists recommend certain drugs to doctors of patients in long-term

care facilities. Additionally, IVAX Pharmaceuticals, Inc. paid over \$272,000 for its role in the kickback scheme. Both companies entered into corporate integrity agreements which are monitored by the federal government. The Commonwealth also filed suit against Johnson & Johnson alleging it paid kickbacks to Omnicare in order to have pharmacists recommend Risperdal as an anti-psychotic for nursing home patients. That litigation is currently pending.

OAG MFCU complaint review process

The MFCU receives complaints from a variety of sources, including but not limited to, DCBS, the OIG, the OAG MFCU TipLine, CHFS Ombudsman, and private citizens. State agencies notifying the MFCU of a complaint are also required by KRS 209.030 to notify local law enforcement. All complaints and referrals received by the MFCU are currently entered into a case management database and are examined by an investigative supervisor within a business day of receipt in order to ascertain whether or not the complaint rises to a level sufficient to support a criminal investigation. If it does not, the complaint is closed with no further action being taken. The type of complaints that are closed generally involve patient-on-patient issues, the MFCU not having jurisdiction to investigate because the facilities are not Medicaid providers, or the allegation is regulatory and not criminal in nature.

If the allegation appears to involve possible criminal activity within the MFCU jurisdiction, the complaint is assigned for either a preliminary or full investigation. A preliminary investigation is intended to seek out sufficient evidence to substantiate the complaint. If the preliminary effort fails to uncover sufficient facts or evidence to justify an investigation, the complaint is closed with no further action being taken, other than an appropriate referral when necessary (i.e. the Kentucky Board of Nursing). If the investigation produces sufficient evidence to support a more comprehensive investigation, the complaint is opened for a full investigation and is assigned to an investigator within the MFCU. If the investigation produces sufficient probable cause and evidence to believe a particular individual committed a criminal offense, the case is brought to the local Commonwealth's or County Attorney. To assist the local prosecutors with their efforts, the MFCU issues a comprehensive Elder Abuse Training Manual to every County and Commonwealth's Attorney.

OAG's MFCU's record of enforcement

Since January 2000 through the end of August 2010, OAG records show the MFCU has initiated 99 criminal prosecutions related to the abuse and neglect of vulnerable adults in Medicaid funded facilities. Since January 2008 to date, the MFCU has initiated 47 criminal prosecutions related to the abuse or neglect of vulnerable adults in Medicaid funded facilities. In addition to these cases, the Office of Special Prosecutions is currently acting as special prosecutor on a case against 3 individuals relating to a non-Medicaid funded personal-care home. Attached is a document provided

by the OAG Office of Communications, which has Internet links to the various press releases issued by the OAG regarding these cases.

Also attached is a list of trainings that have been conducted by the MFCU in recent years and a list of publications issued by the Office of the Attorney General, most of which can be found on our web site at www.ky.ag.gov.

Type A citation investigations

The MFCU treats Type A citations issued by the OIG like other complaints it receives. Once received, they go through the process described above. It is important to note that the *Herald-Leader* articles referenced in Governor Beshear's letter of July 21 only addressed investigations and prosecutions of these types of cases. It did not report our investigations regarding cases not receiving a Type A citation or cases in other Medicaid-funded facilities or group homes.

As the Governor stated in his letter calling for the review of the Cabinet's procedures, it is clear from a review of these cases that the vast majority of these cases are regulatory in nature and do not identify a criminal act. Our office understands that the various agencies within the Cabinet have varying roles. One of the OIG's roles is to survey facilities and issue citations if there are regulatory deficiencies pursuant to 900 KAR 2:040. The issuance of a Type A citation does not necessarily indicate that a criminal act has occurred. The violations resulting in a citation can range from an employee leaving a medicine cabinet open to more serious issues that warrant a criminal investigation from either the MFCU or local law enforcement, which may ultimately result in a criminal prosecution.

To provide some perspective, from our review of the Type A citations cited in the *Herald-Leader* article, fourteen (14) involved personal-care homes that do not receive Medicaid funding and thus do not fall within the MFCU jurisdiction. A similar number involved the elopement of residents that did not allege any criminal act. In total, in thirty seven (37) cases, the MFCU conducted either a preliminary investigation, a full investigation, or had the case reviewed by a nurse inspector. In the majority of these cases, our investigative staff did not find evidence to substantiate a criminal charge. Six (6) people have been charged with a crimes based these cases. Five (5) of those cases were initiated by our office. The remainder of citations cited in the article were either regulatory in nature or did contain allegations of a criminal act.

One issue that was touched on in the *Herald-Leader* articles was the timeliness of reporting by caregivers. This is one of the most important issues facing these cases. If caregivers don't timely report suspected abuse or neglect, then it becomes nearly impossible for DCBS, OIG, local law enforcement, and the MFCU to secure evidence, interview the appropriate witnesses, ensure the scene is not destroyed, and hold the appropriate individuals accountable. We have, unfortunately, recently uncovered several

instances where facility caregivers failed to report suspected abuse or neglect and have ultimately faced criminal charges of failure to report.

MFCU's Relationship with the Cabinet

The MFCU has a good and professional working relationship with several entities in the Cabinet, including both DCBS and the OIG. Our investigators contact OIG nurse inspectors and DCBS workers on a daily basis to gather information, coordinate interviews, and discuss issues surrounding specific cases. Furthermore, our staff regularly meets with members from both agencies in order to share information at regional meetings. However, it is of concern that in some instances that our office did not receive Type A Citations in a timely manner from the cabinet or did not receive citations at all. We do believe that from our conversations with cabinet personnel and with our recommendations below, this issue will be quickly resolved.

Review of Criminal Statutes used to protect nursing home residents

Kentucky prosecutors use a multitude of statutes in order to prosecute criminals for abuse and neglect of vulnerable adults. Obviously, the various criminal offenses contained in the Kentucky Penal Code play a large role in these prosecutions. These include the criminal abuse, theft, wanton endangerment, and homicide statutes to name a few. In addition, KRS Chapter 209, titled "Protection of Adults," plays a vital role. KRS Chapter 209 outlaws the abuse, neglect, and exploitation of vulnerable adults and provides criminal penalties for these violations.

Feedback from local prosecutors

Because of the short timeframe of your request, it was impossible for us to survey the entire population of County and Commonwealth's Attorneys. We were, however, able to contact a representative sample of them to ask a standard group of questions regarding their understanding of the CHFS' processes and to provide any feedback that would be pertinent to your review. Below are the questions asked and a summary of comments below.

1. *Does your office receive notice of DCBS DPP-115 allegations of abuse/neglect complaints when they are made?*

All responded that they do receive either the DPP-115 forms or the DCBS notice of findings.

- a. *Do you take any action on those or do you wait until their investigation is complete?*

Prosecutors generally wait until an investigation by the appropriate agency is complete before they take action, however, some responded that if the facts

warrant, they contact either the DCBS worker or the local law enforcement agency to discuss the matter with them.

- b. Is there a local law enforcement agency receives and investigates these complaints?*

All responded that there was a local law enforcement agency and a Kentucky State Police post that received these complaints. The agency receiving the complaint depended on jurisdictional limits.

2. *Does your office receive notice of allegations of abuse/neglect from the OIG when they are made or do all of them come from DCBS?*

None of the prosecutors remembered receiving anything directly from OIG. Many stated that they receive notice of elder abuse or neglect cases from DCBS in the form of DCBS 115 or notice of findings.

3. *When an investigation is complete and brought to you for prosecution, do you have a designated prosecutor to handle these cases?*

All offices interviewed in urban jurisdictions stated that they had at least one prosecutor who handled all the elder abuse cases. Offices in smaller jurisdictions did not have one prosecutor who handles these cases, but instead the cases were either handled directly by the elected official or one of their assistants.

4. *Have you had any Nursing Home abuse/neglect cases where the coroner has been notified and has conducted an autopsy?*

None of the sample of prosecutors contacted responded that they had a case from a nursing home where an autopsy had been performed.

5. *On cases where the coroner was not notified or did not conduct an autopsy, would it have been helpful to your case(s) if the coroner had been notified?*

All responded that it would be helpful if an autopsy was performed in any death investigation where abuse or neglect is suspected.

6. *Do you feel that the local law enforcement agencies in your area need more training in the area of elder abuse?*

All responded that additional training would be helpful.

7. *Do you have any suggestions on how these procedures can be improved?*

There were several suggestions regarding improvement. These included having set requirements and standards for a multidisciplinary committee to approach these issues, having the coroner notified on every suspicious death, only notifying the local prosecutors when there has been a substantiated finding so their limited time is not usurped by unsubstantiated cases, DCBS making quicker decisions about whether or not to substantiate so that police get involved quicker, flagging the substantiated complaints, and cross training between locals and DCBS. Please see the recommendations listed below.

8. *KRS 209 is the Protection of Adults Chapter. Regarding the criminal acts and penalties described the chapter, do you feel that the Chapter could be improved, better defined, etc?*

All stated they were familiar with the statutes. Most had no recommendations for change beyond what is listed in the response to question 7 above.

9. *The OAG sends an extensive prosecutor's manual on Elder Abuse to the County and Commonwealth's Attorneys every two years. The OAG has also in the past distributed an Elder Abuse training video.*

- a. *Have these been helpful?*

All stated that these had been helpful and several stated that they used them often and actually took the manual to Court with them when prosecuting cases of this nature.

- b. *Do you believe that more training is needed to your offices?*

All stated that more training would be helpful in this area and some suggested that it be included in next year's Kentucky Prosecutor's Conference, organized by the Prosecutors Advisory Council.

Recommendations

The OAG offers the following recommendations for consideration. As in any such proposals, any legislative and/or policy changes should be fully explored to avoid unintended consequences, and all affected constituencies should have an opportunity to weigh in. The Attorney General stands ready to participate in that process.

Increasing the penalty for failure to report suspected abuse, neglect, or exploitation. Currently, KRS 209.990 makes failing to report under KRS 209.030 a Class B Misdemeanor with a penalty of up to 90 days in jail and up to a \$250 fine. The issue here is that a resident of a long-term care facility could very well be abused or neglected and the facility could take a calculated risk that it never be discovered, and thus determine not to report it. Another scenario we have found is the facility not reporting immediately as

required, but conducting their own internal investigation and making their own, watered-down findings in order to avoid reporting. To deter unscrupulous facilities and caregivers from taking these approaches, the penalties should be increased. As stated in other sections of this report, the key to successfully prosecuting these cases is timely notice of events.

Specifying to which entity in the cabinet a report should be made. Currently the statute reads that the report should be made to “the Cabinet.” Cabinet personnel we have spoken with as well as the vast majority of long-term care facilities understand that the appropriate agency is DCBS. However, we have found that some facilities have reported incidents to Mental Health/Mental Retardation (MHMR), for example, but not DCBS. By reporting to MHMR, they have technically complied with the statute (i.e., reported to “the cabinet”) and thus not “failed to report.” We recommend that the statute be amended so that it be made clear that the persons must report the suspected abuse, neglect, or exploitation to DCBS.

Reporting to the Coroner. We recommend amending KRS 72.025 to require caregivers to report all deaths occurring in long term care facilities or deaths occurring shortly after one leaves a long term-care facility. Autopsies are important tools in prosecutions of homicides and when no autopsy is performed, a criminal prosecution is made more difficult. Currently KRS 72.025 requires mandatory reporting to coroners in several instances, but no requirement to report deaths which are the result of abuse or neglect in long term care facilities. The closest provision is section (12) which requires one to report a death from any instance “other than natural.” That leaves the caregiver with broad discretion on reporting a case of potential abuse or neglect.

Forwarding Type A’s, as required by statute to local law enforcement officers and prosecutors. KRS 209.030(5) states that the “cabinet” shall send all allegations of abuse and neglect to the appropriate law enforcement agency and to the local prosecutors. While many of the Type A citations recently reviewed were clearly regulatory in nature, it appears that few of them were being sent to local law enforcement agencies. DCBS has in place procedures for complaint intakes and complaint processing that includes sending the complaints in a timely manner to various agencies. Therefore, a simple way to ensure that the Type A citations are distributed appropriately would be for the OIG to forward all type A citations to the appropriate DCBS office so they can follow their procedures.

Tracking system of referral of Type A citations. We also recommend that the OIG put in place a tracking system to document who receives notice of the Type A citations so the OIG nurse inspectors can follow up with those individuals. This would enable the cabinet to easily ascertain the status of a Type A at any time.

Increasing penalties for elder abuse. The penalties in KRS 209 for abuse and neglect of vulnerable adults are not sufficient given the serious nature of these offenses. It is imperative that our statutes provide both a deterrent effect to prevent these cowardly acts

and sufficient punishment to keep offenders from reoffending. Therefore, we recommend increasing the penalties for elder abuse by taking two steps. First, the penalties should be increased across the board to the next level of classification, for example amending knowing abuse or neglect of a vulnerable adult from class C felony to a class B felony.

More training for local law enforcement agencies. As shown in the attachment, the MFCU has conducted several trainings for local law enforcement and to coroners. This needs to continue. The MFCU has reached out to the Department of Criminal Justice Training (DOCJT) in order to assist in developing a course to be taught to law enforcement recruits. Also, the MFCU is conducting training at this year's conference of the Coroner's Association.

More training for prosecutors. At the request of many of the local prosecutors interviewed, the MFCU has spoken to the Prosecutor's Advisory Council and requested that training be included at next year's Kentucky prosecutor's conference.

Mandatory multidisciplinary training. Currently KRS 209 states the multidisciplinary committees should coordinate "to the extent practicable". We recommend amending that law to make this approach mandatory in each county with the local DCBS worker as the team leader. This will encourage thoughtful discussion of these issues, allow people in the community to get involved in identifying these issues, and encourage more training on elder abuse issues.

Closing

Again, thank you for allowing us the opportunity to contribute to your review. We hope that this report and the recommendations for improving the system are helpful.

Attachment A
Headlines from Office of the Attorney General

<http://migration.kentucky.gov/Newsroom/ag/cakyabuse.htm>
<http://migration.kentucky.gov/Newsroom/ag/salleesentenced.htm>
<http://migration.kentucky.gov/Newsroom/ag/mediousscharged.htm>
<http://migration.kentucky.gov/Newsroom/ag/hazardnursinghome.htm>
<http://migration.kentucky.gov/Newsroom/ag/tackettpriceindicted.htm>
<http://migration.kentucky.gov/Newsroom/ag/starostkarevoked.htm>
<http://migration.kentucky.gov/Newsroom/ag/royseindicted.htm>
<http://migration.kentucky.gov/Newsroom/ag/Communitypresencesentencing.htm>
<http://migration.kentucky.gov/Newsroom/ag/lambplea.htm>
<http://migration.kentucky.gov/Newsroom/ag/communitypresencepleas.htm>
<http://migration.kentucky.gov/Newsroom/ag/logancaretakersindicted.htm>
<http://migration.kentucky.gov/Newsroom/ag/wallingfordpleads.htm>
<http://migration.kentucky.gov/Newsroom/ag/harrisonsentenced.htm>
<http://migration.kentucky.gov/Newsroom/ag/harrisonsentenced.htm>
<http://migration.kentucky.gov/Newsroom/ag/elderabuseawareness.htm>
<http://migration.kentucky.gov/Newsroom/ag/salleelandlambindictments.htm>
<http://migration.kentucky.gov/Newsroom/ag/Communitypresencesentencing.htm>
<http://migration.kentucky.gov/Newsroom/ag/vanwinkleguiltyplea.htm>
<http://migration.kentucky.gov/Newsroom/ag/presenceinc.htm>
<http://migration.kentucky.gov/Newsroom/ag/vanwinklearrest.htm>
<http://migration.kentucky.gov/Newsroom/ag/stacyharrisonindicted.htm>
<http://migration.kentucky.gov/Newsroom/ag/communitypresenceindictments.htm>
<http://migration.kentucky.gov/Newsroom/ag/campbellfarrischarged.htm>
<http://migration.kentucky.gov/Newsroom/ag/vanwinklejailed.htm>
<http://migration.kentucky.gov/Newsroom/ag/salleeplea.htm>

<http://migration.kentucky.gov/Newsroom/ag/bellbauercharged.htm>

<http://www.whas11.com/news/local/64104597.html>

<http://www.courier-journal.com/article/20100816/NEWS01/308160101/Former+state+inspectors+plead+guilty+to+lying+to+federal+agent++submitting+false+documents>

Elder Abuse Trainings by the Office of the Attorney General

Various Senior Programs by the Office of Consumer Protection - 179 since January 2008

DOCJT – Elder Abuse Issues and Investigations – 4 separate in-service trainings

Coroner’s Association Conference, Land between the Lakes – MFCU and Elder Abuse

Coroner’s Association Annual Conference, Louisville – MFCU and Elder Abuse

Protecting Vulnerable Adults Seminar, Frankfort – Elder Abuse Issues

Louisville Gerontology Fair – Increasing Awareness of Elder Abuse & Neglect

NAMFCU Annual Conference, Louisville

West Virginia Elder Abuse Conference, Morgantown WV – Elder Abuse

Publications Issued by the Office of the Attorney General

How to Protect Nursing Home Resident’s Booklet.

<http://ag.ky.gov/NR/rdonlyres/EBFBC5C7-1DAC-42F4-96C0-133037D31521/0/protectnursinghomeresidents.pdf>

Living Will Packet. <http://ag.ky.gov/NR/rdonlyres/2DA643B3-B474-44B6-8A7E-9EDC7B88FD1C/0/livingwillpacket.pdf>

Protecting Seniors Booklet. <http://ag.ky.gov/NR/rdonlyres/189370CF-DB33-4EE4-928A-F7B0FC702C1E/0/helpingseniors.pdf>

Patient Abuse Pamphlet. <http://ag.ky.gov/NR/rdonlyres/6AA5C2C2-45F8-4E83-A5C1-5EE4035AAF86/0/PatientAbusebrochure.pdf>

OAG Prosecutions Manual for Crimes Against the Elderly – Distributed to all Commonwealth and County Attorneys.

**APPENDIX 2: DOCUMENTS SUBMITTED BY KENTUCKIANS
FOR NURSING HOME REFORM**

KENTUCKIANS FOR NURSING HOME REFORM

1530 Nicholasville Road
Lexington, KY 40503

Tel: (859) 312-5617

<http://www.KyNursingHomeReform.org>

MEETING WITH SECRETARY MILLER

LONG-TERM CARE REVIEW AND SUGGESTIONS

MADAME SECRETARY:

Kentuckians for Nursing Home Reform appreciates being included in your meeting to review the current state of long-term care regulatory enforcement in Kentucky and the opportunity to offer our proactive suggestions for improvement.

Our organization has been at the forefront for a number of years proposing changes in and outside state government that would improve the care of some 23,000 Kentuckians. We have been calling this segment of our population the "Forgotten Kentuckians," and until the Lexington newspaper began reporting its investigations, they were indeed forgotten. We are here today to do something about that.

The problems we face right now in Kentucky are mirrored by similar situations in other states across the nation. Just recently, the Government Accountability Office said, "State agencies charged with assessing nursing homes' compliance with quality standards continue to miss serious care deficiencies"

Wanda and I would like to address what we see as both deficiencies and opportunities in the field of elder care.

In response to Gov. Beshear's order of an internal review, we would first offer these proactive suggestions:

1. MANDATORY STAFFING STANDARDS.

If we sound like a broken record on this, it is because continuing research and study shows over and over that the main problem – not the only problem, mind you – is the lack of mandatory staffing ratios in nursing homes. Kentucky is still among the only 13 states nationally that do not have some kind of staffing standards. How can

enforcement people judge adequate care when they know staffing is key but have no regulatory standards to support this judgment? Our organization plans to have legislation introduced once again the 2011 session and we would hope that the cabinet and the governor will work with us to get it passed.

2. BACKGROUND CHECKS AND RANDOM DRUG TESTING.

It is important to have sufficient staff in nursing homes, but it also is important to have quality staff. We compliment the cabinet for its recent application for a federal grant to help strengthen the system of criminal background checks in Kentucky. As you move forward with the federal support, we also ask you to:

- (1) Modify the current Kentucky law on background checks by making it applicable to all employees of nursing homes; and
- (2) Work with us to get a law on random drug testing passed in the 2011 session.

3. TRAINING FOR DEMENTIA PATIENTS CAREGIVERS.

It is important to have sufficient staff with quality backgrounds, but it also is important they be trained well. This is particularly applicable to the large number of dementia patients in most nursing homes. Many nursing homes have up to 2/3rds or more of their residents suffering from dementia problems or Alzheimer's Disease. We feel the training of nursing home staff to provide quality care for residents with dementia is lacking, and we will work to have introduced in the 2011 session a bill to fund dementia training for all nursing home caregivers. We would hope that the governor and cabinet will support this legislation.

4. STRENGTHEN THE OMBUDSMAN PROGRAM.

We think the nursing home ombudsman program needs reorganizing and strengthening. We support the efforts and interest within the cabinet to make the program better and we suggest that you use CMP funds to pay for the improvements, just as you are using CMP funds now to support full-time district nursing home ombudsmen statewide.

5. PROGRAM TRANSPARENCY.

The programs of the cabinet need to be more transparent to the public. In this regard, we suggest:

- (1) Immediate notification of the news media on any Type A Citation; and
- (2) Quarterly reports to the news media on deficiencies issued, and
- (3) In conjunction with CMS, release on a quarterly basis all CMPs.

6. GOVERNOR'S COMMISSION ON LONG-TERM CARE.

We urge you to continue this exercise of examining long-term care and offering improvements. We suggest the formation of a commission on long-term care that would be headed by the governor and meet quarterly to gauge progress and to offer suggestions for improvement just like we are doing today. We would charge such a commission with oversight of all state agencies involved in long-term care. And we think it would be particularly important for the commission to consider reorganizing and

overseeing the enforcement process and also instituting training programs on the local levels for prosecutors and coroners.

CONCLUSION.

In his letter to you, ordering this investigation, Gov. Beshear said: "...Our administration must be satisfied that state government's efforts in this important area are the best they can be."

We are here today because we agree with Gov. Beshear, and we want to work with him, and you, and your staff to make long-term care in Kentucky the best it can be.

And please, please, as you consider our suggestions don't whisper that oft' heard comment in Frankfort: "... But we have no money to do that." The situation we find ourselves in today is a crisis, an emergency. It's been here for sometime, ignored by governor after governor, legislature after legislature. The easy out is that there is no money. But this is not about money.... It's about lives.... Can't you find another way to cut corners, save money without putting it on the backs of these 23,000 forgotten Kentuckians?

We were struck by a *Courier-Journal* article last week about another elder care issue, in which Louisville lawyer David Tachau said it all: "It's almost as if the most vulnerable people are being walled off or hidden away from any meaningful oversight," he said. Let's tear those walls down and begin treating our respected elders with respect, dignity, and support.

And we say in conclusion that we offer the highest of praise to the *Lexington Herald-Leader*, its reporters and editors for the emphasis they are putting on long-term care and the expert way in which they have gone about reporting problems. To them we say simply, "Bravo!"

Bernie Vonderheide
KENTUCKIANS FOR NURSING HOME REFORM
August 26, 2010

I respectfully make the following suggestions for immediate steps to improve care for residents and families of the resident of long term care:

1. Insure that the Cabinet is neutral in its relationship with the industry , and
2. Provide greater transparency of the citation process including public attendance at the Dispute Resolution Hearings and
3. Educate families as to the process of filing a claim and the citation process, and
4. Increase penalties for repeat offenses by the same facility, and
5. Begin citing facilities for staff insufficient to meet the needs of the patients.

For longer term solutions, I feel there is a strong need for more criminal actions on the abuse and neglect cases. For that end, a task force composed of law enforcement, public policy makers, researchers, industry representatives, and resident advocates would be recommended.

I appreciate the efforts of the Cabinet to improve the process and procedures for safe guarding this vulnerable population. If there is any way in which I could be of assistance, I would be pleased to do so.

Wanda R Delaplane


August 26, 2010

**APPENDIX 3: DOCUMENTS SUBMITTED BY KENTUCKY
INITIATIVE FOR QUALITY NURSING HOME
STANDARDS**

Woods, Telitha (CHFS Office of the Secretary)

From: Lois Pemble [lpemble.kyiq@gmail.com]
nt: Monday, August 30, 2010 1:14 PM
Miller, Janie (CHFS Office of the Secretary)
subject: KYIQ Recommendations for Report
Attachments: Janie Miller response 8.30.10.doc

Secretary Miller,

Thank for meeting with us Thursday. I have pasted below the recommendations we hope will be included in your report to Governor Beshear. I have also attached the file. We are engaged in a challenging effort and the KYIQ Group is committed to seeking collaborattive solutions.

Please feel free to contact me if there are any questions about the intent or substance of our suggestions.

Respectfully,

Lois

KENTUCKY INITIATIVE FOR QUALITY NURSING HOME STANDARDS

RECOMMENDATIONS OF THE KYIQ GROUP FOR THE REPORT TO GOVERNOR BESHEAR

We wish to take this opportunity to again thank you for inviting us to participate in the Meeting this past Thursday, and for extending the further opportunity to provide our suggestions for inclusion in the Report to be submitted to Governor Beshear. To that end, the attached recommendations are provided for your consideration. Significantly, since they are focused on nursing home care, most, if not all, of the expenses associated with implementing the recommendations should be able to come from the CMP Funds, which would eliminate the need to compete for austere budget resources

IMMEDIATE ACTIONS

1. **Optimize the existing infrastructure of the State Ombudsman Program** by increasing its existing staff so that a Representative from that Office has the time to contact the appropriate family members of each resident, and inform them as to the role of the Ombudsperson.
2. **Encourage all nursing homes to submit to the Cabinet the "best practices"** that they have implemented. Consolidate those "best practices" and distribute them to all nursing homes.
3. **Establish a dedicated staff within the Cabinet that will create a simplified complaint procedure** to guide family members, as well as a checklist for this dedicated staff to follow when complaints are received. (Allow family members to use the internet to file complaints.)
4. **Establish a "NO NOTICE" requirement for all nursing home inspections.** The military and OSHA use "NO NOTICE" inspections to verify and validate the actual operational readiness of the military and the safety conditions in the workplace.
5. **Require that all inspections of nursing homes begin no earlier than 2:30 pm,** and that at least one member of the inspection team is continuously present for the first 24 hours of the inspection for the purpose of chronicling what occurs during each shift change and overnight.

ACTIONS THAT REQUIRE MORE PLANNING AND WORK

1. **Explore the feasibility of the use of Video Cameras in the rooms of residents**, and how best to ensure that family members may use this potential option.
2. **Establish and facilitate a series of Mentoring Teams** that will mentor and train the respective staffs in those nursing homes that are identified through the inspection and complaint programs to be in need of general improvement in the quality of care provided to nursing home residents.

LONG-TERM ACTIONS AND GOALS

1. **Review and examine the existing Dispute Resolution Process** to ensure that it is not used to “muffle” and mask systemic and correctible problems that may exist in some nursing homes.
2. **Establish within the Cabinet a Board of Review** that conducts a Quarterly and Annual Review of actions implemented to improve the quality of care for nursing home residents, and that makes further recommendations on what more can and should be done.

--

Lois Pemble
Kentucky Initiative for Quality Nursing Home Standards
Web: www.kyiqnursinghome.org

"Never whisper in the presence of wrong"
Bernard Lown, 1993



5249 Skyline Drive
Cold Spring, KY 41076
859 803 5293

August 26, 2010

The advocacy group known as **Kentucky Initiative for Quality Nursing Home Standards (KYIQ Group)** was founded over two years ago, to creatively work with all stakeholders to improve the quality of care for Kentucky nursing home residents. To that end, we have established credibility with family members of residents; representatives from the Kentucky Department of Aging and the Ombudsman Office; and with the Kentucky nursing home industry leadership, which represents both the for-profit and not-for-profit nursing homes. Significantly, the for-profit sector of the industry featured the “KYIQ Best Practices Award” Program in its industry magazine.

The KYIQ Group applauds Governor Beshear’s decision to ensure that the Commonwealth of Kentucky addresses the complex problems associated with nursing home care. The KYIQ Group respectfully offers the following suggestions to ensure the creation of a “Task Force” that will produce constructive and desired results.

RECOMMENDED COMPOSITION OF TASK FORCE MEMBERSHIP

The Task Force should be “quad-partisan” and include representatives from the four major stakeholders:

1. **The Kentucky Government Departments** that have oversight responsibilities over Kentucky nursing home operations.
2. **The Attorney General’s Office.**
3. **The Nursing Home Industry:** this should include a representative from both the for-profit and the not-for-profit sectors.
4. **Residents and Family Members:** this should include a representative from both Kentuckians for Nursing Home Reform and from the KYIQ Group, to ensure that a balanced and comprehensive perspective will be presented on behalf of residents and family members. AARP and other appropriate groups should be represented.

RECOMMENDED TASK FORCE OBJECTIVES

1. Identify and list the respective concerns of each of the four stakeholders.
2. Identify and list the suggested actions that could improve nursing home residents’ quality of care.
3. Identify and list the “pros” and “cons” of each suggested action, including economic feasibility and realistic practicality of each suggested action.
4. Identify and list the actions that need to be undertaken to ensure compliance with existing Federal and State Laws and Regulations.
5. Identify and list the reasons why some nursing homes generally provide a higher quality of care than other nursing homes, even though all nursing homes must comply with the same Federal and State Laws and Regulations.
6. Identify the highest priority actions that need to be undertaken, and further identify which are mandatory and which are worthy of adoption, notwithstanding the fact that there is no mandatory statutory or regulatory requirement.
7. Identify which recommended actions require legislation, and which require other types of response.
8. Identify and list the actions that each stakeholder should commit to undertake.

Our Initiative is focused on broadening public awareness of the need to preserve the dignity, physical care, and mental well being of all loved ones in nursing homes.

**APPENDIX 4: DOCUMENTS SUBMITTED BY ALZHEIMER'S
ASSOCIATION-GREATER KENTUCKY AND
SOUTHERN INDIANA CHAPTER**

Woods, Telitha (CHFS Office of the Secretary)

From: Ellen Kershaw [Ellen.Kershaw@alz.org]
Sent: Thursday, August 26, 2010 3:07 PM
Miller, Janie (CHFS Office of the Secretary)
Subject: Elder abuse and neglect input

Dear Secretary Miller,

Thank you for all your work to comprehensively address the systemic issues involved with nursing home elder abuse and neglect and for including a representative from the Alzheimer's Association in your meeting today with advocates. With the focus both on ways to assure better responses to incidents of abuse and neglect in nursing homes, and on ways to prevent the abuse from occurring in the first place, this is a most important and vital undertaking.

As discussed at the meeting this morning, I wanted to outline the following points that I hope can be addressed in your report and recommendations:

Finding: 69% of residents in Kentucky nursing homes have mild – severe cognitive impairment. These individuals pose special challenges for care. Nursing home staff need to have dementia care skills in care areas including communication, food and fluid intake, pain management, social engagement, care planning, behavior, fall prevention, proper use of restraints, wandering, end-of-life care and communication with families. Front-line and administrative and support staff all need dementia care education and training.

Finding: Of the cases reported in the media, a great number involved persons with dementia, Alzheimer's or related cognitive impairment. These are among the most vulnerable of nursing home residents as the disease affects their ability to perform activities of daily living, to communicate pain, express hunger, or even to call for help. Wandering is a common symptom of Alzheimer's, and the nursing home staff's training in how to handle — and other Alzheimer's symptoms is important to assuring a safe and secure residential environment.

Recommendation: Providing quality, person-centered care involves sufficient trained staff. Dementia care training will help both in preventing abuse and in investigating and resolving cases. This should include at least the following: nursing home staff as described above, adult protection workers, state surveyors, state guardianship staff, long-term care ombudspersons, law enforcement, emergency responders, and everyone involved in investigating and prosecuting cases.

Recommendation: Contact the elder abuse councils, who grapple with these issues and have direct experience that can help suggest practical ways to improve the system. Here is a contact for the Louisville Elder Abuse Council: Jennifer Leibson, the Council Chair, email: Jennifer.leibson@louisvilleky.gov and her phone number is 502-574-7389. The co-chair is Claudia Smith: Claudia.smith@louisvilleky.gov and her phone number is 502 574-6251.

Recommendation: Use the Civil Monetary Penalty Fund to help with the costs of training and other quality care improvements in the nursing homes.

Again, thank you for your consideration. We are hopeful that changes can be implemented to avert such tragic incidents from occurring in the future.

Ellen Kershaw, Public Policy
Alzheimer's Association - Greater Kentucky and Southern Indiana Chapter
ellen.kershaw@alz.org
24/7 Helpline: 1-800-272-3900

**APPENDIX 5: DOCUMENTS SUBMITTED BY KENTUCKY
STATE POLICE**

Materials included may assist in deciding how to implement a plan to develop a multidisciplinary team to assist the Cabinet with elder neglect and abuse issues. Also attached are portions of the Kentucky State Police policy addressing juvenile issues and missing persons investigations.

605.140 Juvenile Court Advisory Board.

- (1) The Chief District Judge may appoint a board of not less than six (6) nor more than ten (10) reputable inhabitants of the county to be called the Advisory Board of the Juvenile Court. The members of the board shall hold office during the pleasure of the judge and shall serve without compensation.
- (2) The board shall visit at least once a year all facilities in the county receiving children under KRS Chapters 600 to 645. At least two (2) of the members of the board shall go together on the visits and shall make a report to the board. The board shall report to the court from time to time the condition of the children in the facilities and shall make an annual report to the court.
- (3) The board shall advise and cooperate with the Chief District Judge upon all matters affecting the workings of KRS Chapters 600 to 645 and shall recommend to the court any needful measures for the purpose of carrying out the provisions of KRS Chapters 600 to 645. The appointment and utilization of such advisory boards by each District Judge is recommended by the General Assembly as a matter of policy.

Effective: April 10, 1988

History: Amended 1988 Ky. Acts ch. 350, sec. 12, effective April 10, 1988. -- Created 1986 Ky. Acts ch. 423, sec. 17, effective July 1, 1987.

620.040 Duties of prosecutor, police, and cabinet -- Prohibition as to school personnel -- Multidisciplinary teams.

- (1)
 - (a) Upon receipt of a report alleging abuse or neglect by a parent, guardian, or person exercising custodial control or supervision, pursuant to KRS 620.030(1) or (2), the recipient of the report shall immediately notify the cabinet or its designated representative, the local law enforcement agency or the Department of Kentucky State Police, and the Commonwealth's or county attorney of the receipt of the report unless they are the reporting source.
 - (b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk determined, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.
 - (c) The cabinet shall, within seventy-two (72) hours, exclusive of weekends and holidays, make a written report to the Commonwealth's or county attorney and the local enforcement agency or the Department of Kentucky State Police concerning the action that has been taken on the investigation.
 - (d) If the report alleges abuse or neglect by someone other than a parent, guardian, or person exercising custodial control or supervision, the cabinet shall immediately notify the Commonwealth's or county attorney and the local law enforcement agency or the Department of Kentucky State Police.
- (2)
 - (a) Upon receipt of a report alleging dependency pursuant to KRS 620.030(1) and (2), the recipient shall immediately notify the cabinet or its designated representative.
 - (b) Based upon the allegation in the report, the cabinet shall immediately make an initial determination as to the risk of harm and immediate safety of the child. Based upon the level of risk, the cabinet shall investigate the allegation or accept the report for an assessment of family needs and, if appropriate, may provide or make referral to any community-based services necessary to reduce risk to the child and to provide family support. A report of sexual abuse shall be considered high risk and shall not be referred to any other community agency.
 - (c) The cabinet need not notify the local law enforcement agency or the Department of Kentucky State Police or county attorney or Commonwealth's attorney of reports made under this subsection.
- (3) If the cabinet or its designated representative receives a report of abuse by a person other than a parent, guardian, or other person exercising custodial control or supervision of a child, it shall immediately notify the local law enforcement agency or the Department of Kentucky State Police and the Commonwealth's or county attorney of the receipt of the report and its contents, and they shall investigate the

matter. The cabinet or its designated representative shall participate in an investigation of noncustodial physical abuse or neglect at the request of the local law enforcement agency or the Department of Kentucky State Police. The cabinet shall participate in all investigations of reported or suspected sexual abuse of a child.

- (4) School personnel or other persons listed in KRS 620.030(2) do not have the authority to conduct internal investigations in lieu of the official investigations outlined in this section.
- (5)
 - (a) If, after receiving the report, the law enforcement officer, the cabinet, or its designated representative cannot gain admission to the location of the child, a search warrant shall be requested from, and may be issued by, the judge to the appropriate law enforcement official upon probable cause that the child is dependent, neglected, or abused. If, pursuant to a search under a warrant, a child is discovered and appears to be in imminent danger, the child may be removed by the law enforcement officer.
 - (b) If a child who is in a hospital or under the immediate care of a physician appears to be in imminent danger if he or she is returned to the persons having custody of him or her, the physician or hospital administrator may hold the child without court order, provided that a request is made to the court for an emergency custody order at the earliest practicable time, not to exceed seventy-two (72) hours.
 - (c) Any appropriate law enforcement officer may take a child into protective custody and may hold that child in protective custody without the consent of the parent or other person exercising custodial control or supervision if there exist reasonable grounds for the officer to believe that the child is in danger of imminent death or serious physical injury or is being sexually abused and that the parents or other person exercising custodial control or supervision are unable or unwilling to protect the child. The officer or the person to whom the officer entrusts the child shall, within twelve (12) hours of taking the child into protective custody, request the court to issue an emergency custody order.
 - (d) When a law enforcement officer, hospital administrator, or physician takes a child into custody without the consent of the parent or other person exercising custodial control or supervision, he or she shall provide written notice to the parent or other person stating the reasons for removal of the child. Failure of the parent or other person to receive notice shall not, by itself, be cause for civil or criminal liability.
- (6) To the extent practicable and when in the best interest of a child alleged to have been abused, interviews with the child shall be conducted at a children's advocacy center.
- (7)
 - (a) One (1) or more multidisciplinary teams may be established in every county or group of contiguous counties.
 - (b) Membership of the multidisciplinary team shall include but shall not be limited to social service workers employed by the Cabinet for Health and Family Services and law enforcement officers. Additional team members may

include Commonwealth's and county attorneys, children's advocacy center staff, mental health professionals, medical professionals, victim advocates, educators, and other related professionals, as deemed appropriate.

- (c) The multidisciplinary team may review child sexual abuse cases referred by participating professionals, including those in which the alleged perpetrator does not have custodial control or supervision of the child or is not responsible for the child's welfare. The purpose of the multidisciplinary team shall be to review investigations, assess service delivery, and to facilitate efficient and appropriate disposition of cases through the criminal justice system.
- (d) The team shall hold regularly scheduled meetings if new reports of sexual abuse are received or if active cases exist. At each meeting, each active case shall be presented and the agencies' responses assessed.
- (e) The multidisciplinary team shall provide an annual report to the public of nonidentifying case information to allow assessment of the processing and disposition of child sexual abuse cases.
- (f) Multidisciplinary team members and anyone invited by the multidisciplinary team to participate in a meeting shall not divulge case information, including information regarding the identity of the victim or source of the report. Team members and others attending meetings shall sign a confidentiality statement that is consistent with statutory prohibitions on disclosure of this information.
- (g) The multidisciplinary team shall, pursuant to KRS 431.600 and 431.660, develop a local protocol consistent with the model protocol issued by the Kentucky Multidisciplinary Commission on Child Sexual Abuse. The local team shall submit the protocol to the commission for review and approval.
- (h) The multidisciplinary team review of a case may include information from reports generated by agencies, organizations, or individuals that are responsible for investigation, prosecution, or treatment in the case, KRS 610.320 to KRS 610.340 notwithstanding.
- (i) To the extent practicable, multidisciplinary teams shall be staffed by the local children's advocacy center.

Effective: June 26, 2007

History: Amended 2007 Ky. Acts ch. 85, sec. 331, effective June 26, 2007. -- Amended 2005 Ky. Acts ch. 99, sec. 665, effective June 20, 2005. -- Amended 2000 Ky. Acts ch. 14, sec. 63, effective July 14, 2000; ch. 144, sec. 6, effective July 14, 2000; and ch. 164, sec. 1, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 426, sec. 617, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 18, sec. 5, effective July 15, 1996. -- Amended 1994 Ky. Acts ch. 217, sec. 1, effective July 15, 1994. -- Amended 1992 Ky. Acts ch. 434, sec. 2, effective July 14, 1992. -- Amended 1990 Ky. Acts ch. 39, sec. 1, effective July 13, 1990. -- Amended 1988 Ky. Acts ch. 258, sec. 3, effective July 15, 1988; and ch. 350, sec. 44, effective April 10, 1988. -- Created 1986 Ky. Acts ch. 423, sec. 65, effective July 1, 1987.

620.050 Immunity for good faith actions or reports -- Investigations -- Confidentiality of reports -- Exceptions -- Parent's access to records -- Sharing of information by children's advocacy centers -- Confidentiality of interview with child -- Exceptions -- Confidentiality of identifying information regarding reporting individual -- Internal review and report.

- (1) Anyone acting upon reasonable cause in the making of a report or acting under KRS 620.030 to 620.050 in good faith shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed. Any such participant shall have the same immunity with respect to participation in any judicial proceeding resulting from such report or action. However, any person who knowingly makes a false report and does so with malice shall be guilty of a Class A misdemeanor.
- (2) Any employee or designated agent of a children's advocacy center shall be immune from any civil liability arising from performance within the scope of the person's duties as provided in KRS 620.030 to 620.050. Any such person shall have the same immunity with respect to participation in any judicial proceeding. Nothing in this subsection shall limit liability for negligence. Upon the request of an employee or designated agent of a children's advocacy center, the Attorney General shall provide for the defense of any civil action brought against the employee or designated agent as provided under KRS 12.211 to 12.215.
- (3) Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report under this section or for excluding evidence regarding a dependent, neglected, or abused child or the cause thereof, in any judicial proceedings resulting from a report pursuant to this section. This subsection shall also apply in any criminal proceeding in District or Circuit Court regarding a dependent, neglected, or abused child.
- (4) Upon receipt of a report of an abused, neglected, or dependent child pursuant to this chapter, the cabinet as the designated agency or its delegated representative shall initiate a prompt investigation or assessment of family needs, take necessary action, and shall offer protective services toward safeguarding the welfare of the child. The cabinet shall work toward preventing further dependency, neglect, or abuse of the child or any other child under the same care, and preserve and strengthen family life, where possible, by enhancing parental capacity for adequate child care.
- (5) The report of suspected child abuse, neglect, or dependency and all information obtained by the cabinet or its delegated representative, as a result of an investigation or assessment made pursuant to this chapter, except for those records provided for in subsection (6) of this section, shall not be divulged to anyone except:
 - (a) Persons suspected of causing dependency, neglect, or abuse;
 - (b) The custodial parent or legal guardian of the child alleged to be dependent, neglected, or abused;
 - (c) Persons within the cabinet with a legitimate interest or responsibility related to the case;
 - (d) Other medical, psychological, educational, or social service agencies, child care administrators, corrections personnel, or law enforcement agencies,

including the county attorney's office, the coroner, and the local child fatality response team, that have a legitimate interest in the case;

- (e) A noncustodial parent when the dependency, neglect, or abuse is substantiated;
 - (f) Members of multidisciplinary teams as defined by KRS 620.020 and which operate pursuant to KRS 431.600;
 - (g) Employees or designated agents of a children's advocacy center; or
 - (h) Those persons so authorized by court order.
- (6) (a) Files, reports, notes, photographs, records, electronic and other communications, and working papers used or developed by a children's advocacy center in providing services under this chapter are confidential and shall not be disclosed except to the following persons:
- 1. Staff employed by the cabinet, law enforcement officers, and Commonwealth's and county attorneys who are directly involved in the investigation or prosecution of the case;
 - 2. Medical and mental health professionals listed by name in a release of information signed by the guardian of the child, provided that the information shared is limited to that necessary to promote the physical or psychological health of the child or to treat the child for abuse-related symptoms; and
 - 3. The court and those persons so authorized by a court order.
- (b) The provisions of this subsection shall not be construed as to contravene the Rules of Criminal Procedure relating to discovery.
- (7) Nothing in this section shall prohibit a parent or guardian from accessing records for his or her child providing that the parent or guardian is not currently under investigation by a law enforcement agency or the cabinet relating to the abuse of a child.
- (8) Nothing in this section shall prohibit employees or designated agents of a children's advocacy center from disclosing information during a multidisciplinary team review of a child sexual abuse case as set forth under KRS 620.040. Persons receiving this information shall sign a confidentiality statement consistent with statutory prohibitions on disclosure of this information.
- (9) Employees or designated agents of a children's advocacy center may confirm to another children's advocacy center that a child has been seen for services. If an information release has been signed by the guardian of the child, a children's advocacy center may disclose relevant information to another children's advocacy center.
- (10) (a) An interview of a child recorded at a children's advocacy center shall not be duplicated, except that the Commonwealth's or county attorney prosecuting the case may:
- 1. Make and retain one (1) copy of the interview; and

2. Make one (1) copy for the defendant's counsel that the defendant's counsel shall not duplicate.
 - (b) The defendant's counsel shall file the copy with the court clerk at the close of the case.
 - (c) Unless objected to by the victim or victims, the court, on its own motion, or on motion of the attorney for the Commonwealth shall order all recorded interviews that are introduced into evidence or are in the possession of the children's advocacy center, law enforcement, the prosecution, or the court to be sealed.
 - (d) The provisions of this subsection shall not be construed as to contravene the Rules of Criminal Procedure relating to discovery.
- (11) Identifying information concerning the individual initiating the report under KRS 620.030 shall not be disclosed except:
 - (a) To law enforcement officials that have a legitimate interest in the case;
 - (b) To the agency designated by the cabinet to investigate or assess the report;
 - (c) To members of multidisciplinary teams as defined by KRS 620.020 that operated under KRS 431.600; or
 - (d) Under a court order, after the court has conducted an in camera review of the record of the state related to the report and has found reasonable cause to believe that the reporter knowingly made a false report.
- (12)
 - (a) Information may be publicly disclosed by the cabinet in a case where child abuse or neglect has resulted in a child fatality or near fatality.
 - (b) The cabinet shall conduct an internal review of any case where child abuse or neglect has resulted in a child fatality or near fatality and the cabinet had prior involvement with the child or family. The cabinet shall prepare a summary that includes an account of:
 1. The cabinet's actions and any policy or personnel changes taken or to be taken, including the results of appeals, as a result of the findings from the internal review; and
 2. Any cooperation, assistance, or information from any agency of the state or any other agency, institution, or facility providing services to the child or family that were requested and received by the cabinet during the investigation of a child fatality or near fatality.
 - (c) The cabinet shall submit a report by September 1 of each year containing an analysis of all summaries of internal reviews occurring during the previous year and an analysis of historical trends to the Governor, the General Assembly, and the state child fatality review team created under KRS 211.684.
- (13) When an adult who is the subject of information made confidential by subsection (5) of this section publicly reveals or causes to be revealed any significant part of the confidential matter or information, the confidentiality afforded by subsection (5) of this section is presumed voluntarily waived, and confidential information and

records about the person making or causing the public disclosure, not already disclosed but related to the information made public, may be disclosed if disclosure is in the best interest of the child or is necessary for the administration of the cabinet's duties under this chapter.

- (14) As a result of any report of suspected child abuse or neglect, photographs and X-rays or other appropriate medical diagnostic procedures may be taken or caused to be taken, without the consent of the parent or other person exercising custodial control or supervision of the child, as a part of the medical evaluation or investigation of these reports. These photographs and X-rays or results of other medical diagnostic procedures may be introduced into evidence in any subsequent judicial proceedings. The person performing the diagnostic procedures or taking photographs or X-rays shall be immune from criminal or civil liability for having performed the act. Nothing herein shall limit liability for negligence.

Effective: July 13, 2004

History: Amended 2004 Ky. Acts ch. 169, sec. 1, effective July 13, 2004. -- Amended 2002 Ky. Acts ch. 87, sec. 2, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 144, sec. 7, effective July 14, 2000; and ch. 164, sec. 2, effective July 14, 2000. -- Amended 1998 Ky. Acts ch. 57, sec. 19, effective March 17, 1998; and ch. 303, sec. 2, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 18, sec. 6, effective July 15, 1996; and ch. 347, sec. 7, effective July 15, 1996. -- Amended 1988 Ky. Acts ch. 350, sec. 45, effective April 10, 1988. -- Created 1986 Ky. Acts ch. 423, sec. 66, effective July 1, 1987.

**605.170 Reporting of assaults, threats, and menacing conduct against client or staff
-- Information system to track threats and violent incidents against staff --
Safety liaisons.**

- (1) Each staff member of the department shall report to his or her supervisor any physical or verbal conduct of a client or an individual associated with a client that appears to be threatening or menacing, and any incident of assault, attempted assault, or physical contact that appears to be threatening to any staff member. Any use or threat of use of any type of weapon shall be reported. The supervisor shall report threat or incident information to the commissioner of the department or his or her designee. An employee who reports under this subsection shall be protected from reprisals pursuant to KRS 61.102.
- (2) The department shall establish and maintain an information system and track all reports of threats or incidents involving violence against department staff as required by subsection (1) of this section. The department shall provide, upon request, the number and type of reports received and any information available regarding civil or criminal action or changes to policies and procedures resulting from threats or incidents of violence upon staff.
- (3) The department shall designate or establish a safety liaison position within its central office and in each regional office. The regional administrator may designate or establish a safety liaison position in each county office. The duties of the central office safety liaison shall include but not be limited to:
 - (a) Development and implementation of policies and procedures related to the prevention of violence in the office and in community settings;
 - (b) Screening and assessment of the level of threat for professional-client interactions;
 - (c) Facilitation of safety training and safety and first alert protocols with all law enforcement agencies that work with each county office. Existing multidisciplinary teams may be utilized in the development of local safety protocols; and
 - (d) Administration of a Web-based social worker safety site and a threat and violence incident database.

Effective: April 5, 2007

History: Created 2007 Ky. Acts ch. 140, sec. 3, effective April 5, 2007.



GENERAL ORDER OM-B-11

Title / Subject AGENCY RESPONSE TO INCIDENTS INVOLVING MENTALLY ILL PERSONS		EFFECTIVE DATE 1/1/90	REVISION DATE 12/31/05
REFERENCES		CALEA STANDARDS	DISTRIBUTION
KRS 202A.041 KRS 202A.119 OM-B-4	KRS 645.020 KRS 645.120	41.2.8	All Sworn and Telecommunications Personnel <i>REPORT:</i> <input type="checkbox"/>

POLICY

This general order establishes the policy and procedures for recognizing and handling both adults and juveniles with known or suspected mental illness.

The rights of mentally ill or suspected mentally ill persons shall be observed consistent with those granted other members of the general public. Officers should at all times remain attentive to legitimate personal and public safety concerns when dealing with known or suspected mentally ill persons. Mental illness is not a crime, and officers should take no enforcement action simply because a person is mentally ill. Law enforcement intervention should not occur unless a law is violated, the person's actions pose a threat to themselves, to another person, or to another's property.

DEFINITIONS

- A. **Mentally Ill Person (KRS 202A.119(9))** – A person with substantially impaired capacity to use self control, judgement or discretion in the conduct of the person's affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior or emotional symptoms can be related to physiological, psychological or social factors.
- B. **Mentally Ill Juvenile (KRS 645.020(8))** – A person less than 18 years of age who, considering the juvenile's age and development:
 - 1. Has a substantially impaired capacity to use self control, judgement or discretion in the conduct of the juvenile's affairs and social relations; or
 - 2. Displays maladaptive behavior; or
 - 3. Exhibits recognized emotional symptoms that can be related to physiological, psychological or social factors.

RECOGNITION OF MENTAL ILLNESS/DISORDERS

Upon initial contact with persons suspected of mental illness or disorder the following indicators may be present and observed:

A. Appearance – visual frisk

1. Strange clothing
2. Dirty, disheveled
3. Weapons
4. Eyes and face

B. Behavior

1. Speech
 - a. Illogical
 - b. Very rapid
 - c. Slurred
 - d. Very loud or very quiet
 - e. Irritated, angry, belligerent or soft and flat
2. Body Movement
 - a. Agitated, pacing, abrupt, forceful, furtive
 - b. Repetitive
 - c. Slowed
 - d. Poor eye contact
3. Body Language
 - a. Threatening
 - b. Open
 - c. Guarded
 - d. Defensive

C. Characteristics of Mental Illness or Disorder

1. Psychosis – out of touch with reality: relatives, friends or neighbors may provide information to determine normal mode of behavior
2. Loss of memory – symptoms include disorientation and decreased attention span
3. Paranoia – Suspiciousness, watchfulness, believe everything has to do with them, guardedness, delusions of persecution, constant state of preparedness, unable to trust anyone
4. Grandiose ideas – believe they are exalted religious leaders or esteemed people from the past, rapidly changing ideas, constant talking, exaggerated gaiety, physical over-activity
5. Delusions/Hallucinations – false beliefs in spite of invalidating evidence, false sensations
6. Visions, strange odors or peculiar tastes
7. Exaggerated or bizarre physical ailments
8. Extreme fright or anxiety – decreased ability to focus on a single subject, but may be hyper alert. Accompanying responses are easily startled, decreased concentration, and hyper-alertness.
9. Phobic – persistent irrational fear of a specific object, activity or situation. May display panic attacks, trembling, uncontrollable anxiety

10. Antisocial Behavior – inflexible personality traits, absence of guilt and tension, impulsive and irresponsible nature, adept at manipulating others.

These lists are not all-inclusive and are provided for illustrative purposes only.

GUIDELINES FOR GENERAL CONDUCT

As all employees, sworn and civilian, have the potential to come into contact with persons suffering from some form of mental illness, the following points should be taken into consideration in order to provide the most beneficial results for all involved:

- A. Be patient and understanding, provide reassurance and utilize active listening.
- B. Maintain a position of safety and move slowly.
- C. Time and circumstances permitting, the presence of family and/or friends may be helpful.
- D. Anticipate provocation.
- E. Firm authority and control reduces anxiety and establishes control.
- F. Repeat what you say and say it slowly if possible. Use simple and short sentences.
- G. Consistent with personal and public safety, avoid physical contact.
- H. Watch for clues of increased anxiety, aggression and/or danger.
- I. Call for assistance and back up support if the situation appears to be escalating.
- J. If employee is a civilian, call a sworn officer.

These guidelines are not meant to limit an employee's or officer's on-scene discretion in determining how best to address or resolve a situation involving mentally ill persons who pose a risk of harm to self or others. Nothing contained in this policy should be construed to limit the use of force consistent with the requirements of the Fourth Amendment, KRS Chapter 503 and the provisions of General Order **OM-B-4**.

GUIDELINES FOR WITNESS/VICTIM CUSTODIAL INTERVIEWS AND OTHER CONTACTS

These guidelines are instructive in nature and do not limit an officer's discretion in conducting interviews, custodial and otherwise, in a manner other than suggested in this policy when the circumstances dictate such a course of action.

- A. Take into consideration the time and location of the interview. Try not to interview in an enclosed space. Allow the subject to stand and/or pace during an interview.
- B. Officers may consider interviewing family members prior to any interview in order to gather useful information on how to effectively communicate with the individual.

- C. The officer shall control the interview.

Nothing contained in this policy with respect to custodial interviews or other contacts with mentally ill subjects should be construed as a grant of greater substantive or procedural rights than otherwise permitted by the United States Constitution, Constitution of the Commonwealth of Kentucky or Kentucky statutes.

EMERGENCY DETENTION OF MENTALLY ILL ADULTS/WARRANTLESS ARREST (KRS 202A.041)

- A. Officers who have reasonable grounds to believe that an individual is mentally ill and presents a danger or threat to self, family or others if not restrained shall take the individual into custody and transport the individual without unnecessary delay to a hospital or psychiatric facility designated by the Kentucky Cabinet for Health and Family Services for the purpose of evaluation to be conducted by a qualified mental health professional.
- B. Upon transport of the person to the hospital or psychiatric facility, the officer shall provide written documentation that describes the behavior of the person that precipitated the officer to take the person into custody.
- C. If, after evaluation, the qualified mental health professional finds that the person does not meet the criteria for involuntary hospitalization, the person shall be released and transported back to the person's home by an appropriate means of transportation as provided by KRS 202A.101.
- D. If, after evaluation, the qualified mental health professional finds that the person meets the criteria for involuntary hospitalization, appropriate proceedings under KRS Chapter 202A shall be initiated.

DETENTION OF MENTALLY ILL JUVENILES

The statutory requirements for involuntary hospitalization of a juvenile are set forth in KRS 645.120.

TRAINING

- A. The Kentucky State Police Academy will ensure that all sworn, and telecommunications personnel and other agency personnel who may come in contact with the public receive documented entry level training on the recognition and handling of persons with known or suspected mental illness.
- B. The Academy shall coordinate and document refresher training on mental illness at least every 3 years for all sworn and telecommunications personnel and other agency personnel who may come in contact with the public.



GENERAL ORDER OM-C-9

Title / Subject

MISSING PERSONS AND CHILD ABDUCTIONS

EFFECTIVE
DATE
1/01/02

REVISION
DATE
12/31/05

REFERENCES

42 USC Sec 5772
KRS 17.450
KRS 16.175

42 USC Sec 5870(2)
KRS 17.460

CALEA STANDARDS

41.2.6 41.2.7

DISTRIBUTION

All Personnel

REPORT:

POLICY

The Kentucky State Police will respond to reports of missing persons--including children believed to have been abducted--in a timely, coordinated and reasonable manner. It is important to remember that police actions within the first 48 hours towards identifying the abductor, determining the motivation behind the abduction, and discovering the likely whereabouts of the missing person are critical to a successful outcome. Many missing person reports involve individuals who voluntarily leave their residences for personal reasons, while other reports are often unfounded or resolved within a matter of hours. Unfortunately, it is difficult to determine with certainty the reason for a disappearance without making an investigation into the circumstances. Therefore, it is the policy of the Kentucky State Police to thoroughly investigate all reports of missing persons.

OBJECTIVES

- A. The formulation of a standardized response plan that includes procedures likely to result in the safe and timely return of a missing person.
- B. Identification of practices and procedures likely to result in identifying, apprehending, and successfully prosecuting offenders in cases involving harm to a victim or other violation of law.
- C. Establishment of a framework for the workflow associated with the gathering, processing, dissemination and quality control of information associated with all types of missing person investigations.

STATUTORY PROVISIONS

Federal law requires the immediate entry of all missing children into the National Crime Information Center's (NCIC) Missing Person File.

- A. **42 U.S.C. Section 5780(2):** The National Child Search Assistance Act of 1990 states that law enforcement agencies may not observe a waiting period before accepting a missing child report and that each missing child reported to law enforcement must be entered immediately into the state law enforcement computer system (in Kentucky, the Law Information Network of Kentucky -- LINK) and NCIC.

- B. **28 U.S.C. Section 534:** The Missing Children Act clarifies that "any information that would assist in the location of any missing person" should be entered into NCIC, and that the abductor need not be charged with a crime to enter a missing person's report into the NCIC Missing Person File. Each child taken from a legal custodian should be entered into NCIC--even if they are with a parent. A child is still considered "missing" when his or her general location is unknown. The child should remain in NCIC as "missing" until the exact address where the child can be found is determined.
- C. **KRS 16.175:** Specifies procedure to activate the Kentucky Amber alert system when a child has been abducted and Kentucky State Police determines the circumstances exist to activate the Amber alert system. No law enforcement agency, other than the Kentucky State Police, shall activate the notification system without the authority of the Kentucky State Police.
- D. **KRS 17.460:** Specifies procedure by law enforcement agencies upon receipt of report of missing child. Mandates that a copy of the completed "Kentucky Missing Persons Report" (KSP-261) be received by the Missing Person/Child Information Center within 24 hours after completion. Directs the law enforcement agency locating the child to return the child to the appropriate parent, guardian or person exercising custodial control or supervision caretaker.
- E. **KRS 17.470:** Upon receipt of a report of a missing child born in Kentucky, the Missing Person/Child Information Center shall notify--within 48 hours--the state registrar of vital statistics that the child is missing, and provide the state registrar identifying information about the missing child. If the Missing Person/Child Information Center believes that a missing child has been enrolled in a specific Kentucky elementary or secondary school, it shall notify the chief state school officer who shall notify the last such known school as to the child's disappearance.
- E. **502 KAR 35:010-050:** Defines terms; locates the Kentucky Missing Child Information Center (KMCIC) within the Kentucky State Police; specifies duties and operation of KMCIC; requires Missing Person Report to be completed in its entirety and submitted to the KMCIC within 24-hours; provides for completion and submission of "Affidavit Certifying Noncompliance with KRS 17.450 by a Law Enforcement Agency" for reporting an officer who fails to provide service to the parent or guardian of a child reported as missing, and requires the state police to conduct a missing person investigation. **Also requires an agency receiving a missing person report to immediately make an entry of the missing person in to LINK/NCIC.**
- F. **KRS 39F.180:** Requires the reporting of all reports of persons missing, lost or overdue, if a search for the lost person has lasted for more than two (2) hours to the local emergency management director and the local search and rescue coordinator for the jurisdiction in which the person is reported missing. Any search and rescue

mission which has lasted four (4) hours without the subject being located, shall be immediately reported to the duty officer of the Division of Emergency Management by telephone or radio.

DEFINITIONS

- A. **Child:** Any person under 18 years of age, or any person certified or known to be mentally incompetent or disabled, as defined by KRS 17.450.
- B. **Kentucky Missing Child Information Center:** A unit that was established per KRS 17.450 and placed within the Intelligence Branch of the Kentucky State Police to act as the central repository of, and clearinghouse for, information about Kentucky children believed to be missing, and children from other states believed to be missing in Kentucky. Its responsibilities include the review of information submitted on the Kentucky Missing Persons Report (KSP-261) for completeness and accuracy, and the maintenance of this information in a computer database. In its capacity as the state's clearinghouse for missing persons, it also acts as the state's primary liasion with the National Center for Missing and Exploited Children (NCMEC) in Alexandria, Virginia.
- C. **Missing Child:** 42 U.S.C. Section 5772 defines a missing child as an individual under 18 years of age whose whereabouts are unknown to the individual's legal custodian, and who was either taken from the control of the legal custodian without the custodian's consent, or the circumstances of the case indicate the child is likely to be abused or sexually exploited.
- D. **Missing Person:** A person may be declared "missing" when his/her whereabouts are unknown and unexplainable for a period of time that is regarded by knowledgeable parties as highly unusual or suspicious in consideration of the subjects behavior patterns, plans or routines. A missing person is also any person who has been reported to a law enforcement agency as missing by a responsible party, and for whom a Kentucky Missing Persons Report has been completed. However, in cases involving suspected child abductions, where the health and safety of a child is reasonably at risk, the completion of this form is not a prerequisite to the immediate entry of known information into the LINK and NCIC Missing Persons database.
- E. **Amber Alert:** A system to notify the public when a child has been abducted. It is only activated by, or with the authority of, the Kentucky State Police for serious child abduction cases where the abducted child is determined to be in danger of serious bodily harm or death and there is sufficient descriptive information about the child, the abductor and/or the suspect's vehicle.

RESPONSIBILITIES

- A. The Kentucky State Police, upon request, shall fingerprint children without charge on forms provided by the Justice Cabinet. The completed fingerprint forms shall be delivered to the child's parent or guardian and no copy of the fingerprint form shall be retained by the Kentucky State Police.
- B. The Missing Person/Child Information Center shall use a computer "capable of immediately retrieving the name, and complete description" of any child reported as missing in Kentucky. Information within this computer system shall be retrievable by the child's name, date of birth, social security number, fingerprint classification, and number of physical descriptions including hair and eye color, body marks, known associates and locations. The unit also shall regularly issue flyers containing physical and situational descriptions of missing children when requested by a law enforcement agency or when determined by the cabinet.

INITIAL REPORT TAKING

- A. All reports of missing persons will be given full consideration and attention by all members of the Kentucky State Police. Particular care must be exercised in instances involving missing children and those who may be mentally or physically impaired, or others who are insufficiently prepared to care for themselves.
- B. There shall be **NO** waiting period for receiving and entering a report for a missing person.
- C. The initial call taker must gather as much pertinent information as possible in order to properly classify a report [of a missing person] and initiate a proper response. This includes the following information:
 - 1. Name, age, physical and clothing description of the subject, and the relationship of the reporting party to the missing person;
 - 2. Time and place of last known location and the identity of anyone accompanying the subject;
 - 3. The extent of any search for the subject prior to the filing of the report;
 - 4. Whether the subject has been missing on prior occasions and the degree to which the absence departs from established behavior patterns, habits or plans;
 - 5. Whether the individual has been recently involved in domestic incidents, suffered emotional trauma or life crises, demonstrated unusual, uncharacteristic or bizarre behavior, is dependant on drugs, alcohol or prescription medication, and/or has a history of mental illness; and
 - 6. The current physical condition of the subject and whether the person is presently on, or has recently had a change in prescription medication.
- D. If the missing person is a child, the call taker or initial responding officer shall inquire to determine if the child:

1. Is, or may be, with any adult who could cause him or her harm;
 2. May have been the subject of a parental abduction; and
 3. Has previously run away from home, has threatened to do so or has a history of explainable or unexplainable absences for extended periods of time.
- E. An individual may be considered "**missing-critical**" when he or she meets the criteria (as listed above in "D") and who, among other possible circumstances:
1. Appears to be missing under circumstances that suggest they may be the subject of foul play;
 2. Because of his/her age (young or old), may be unable to properly safeguard or care for himself/herself;
 3. Suffers from diminished mental capacity or medical conditions that are potentially life threatening if left untreated/unattended;
 4. Is a patient of a mental institution and is considered potentially dangerous to himself/herself or others; and
 5. Has demonstrated the potential for suicide or may have been involved in a boating, swimming or other sporting accident or natural disaster.
- F. The post commander, on-duty supervisor, and public affairs officer should be notified immediately upon classification of a report as "**missing critical**."
- G. If warranted, the initial call taker may initiate a regional broadcast to surrounding LINK terminal agencies containing preliminary information obtained from the telephone interview with the person making the missing person report. These messages will be sent as "administrative messages." Care must be exercised by the call taker to obtain as accurate information as is possible for inclusion in these messages. The investigating officer, prior to his/her arrival at the scene, may request a regional broadcast of the preliminary information obtained by the call taker. If the missing person is found within hours, another regional administrative broadcast cancelling the first message will be sent.
- H. Reports of juveniles who have voluntarily left home (i.e., "runaways") should be classified as such only after thorough investigation. Juveniles who have voluntarily left home shall not be the subject of Amber alert activation.
- I. Based on the outcome of initial inquiries, a decision may be made concerning the potential danger posed to the missing person.

PRELIMINARY INVESTIGATION

- A. An investigating officer shall be dispatched to the location of the person making the missing person report. As soon as it appears that a person is "missing," a Missing Person Report (KSP-261) shall be completed by the officer assigned to the incident. Since this form is used as the source document for information required for entry of

the person into LINK/NCIC, the completed KSP-261 shall be submitted to post as soon as is practical using the fastest means possible.

- B. Communications personnel will use information available from the reporting officer and make the appropriate computer database entries (i.e., LINK, NCIC, etc.) as soon as the minimum information is available, regardless of whether the reporting person signs the KSP-261. If an investigating officer believes a missing child has been abducted and/or is missing under circumstances suggesting foul play or a threat to life, this information must be conveyed clearly to communications personnel at post making the entry so the code "CA" can be entered into the "MNP" field of the NCIC entry. Entry of the "CA" code in the "MNP" field ensures that the FBI's Child Abduction and Serial Killer Unit (CASKU) and the National Center for Missing and Exploited Children (NCMEC) are notified immediately.
- C. It is the responsibility of the investigating officer to ensure that a legible copy of the Missing Person Report (KSP-261) is submitted to the KSP Missing Person/Child Information Center (Intelligence Branch) within 24-hours of its completion. Submission may be accomplished electronically, by use of either e-mail or a fax. In the event access to a high resolution scanner is available to the officer, the accompanying photograph of the missing person should also be submitted electronically. The date, time, means of submission, and all documents or photographs accompanying the KSP-261 shall be noted in the case report.
- D. In the case of a person being designated as "**missing critical**," the on-duty supervisor may:
 - 1. Direct that the on-call investigator be summoned;
 - 2. Make notification to all other units within the post area and other surrounding posts;
 - 3. Direct available information regarding the subject be broadcast to all officers on-duty, and via LINK and NLETS messages to other jurisdictions, including law enforcement agencies in other states if the post area borders on another state, or if there is reason to believe the missing person may be enroute to another state.
 - 4. Notify and request assistance from the Aircraft Branch and Civil Air Patrol if an air search is indicated.
 - 5. Summon the canine officer if ground searches are indicated.
 - 6. Request the special response team when it is apparent that the preliminary investigation information suggests the need for additional assistance and that time is critical.
 - 7. Request and coordinate assistance from other agencies and volunteer groups. Refer to KRS 39F.180.
- E. If the missing person is a child, especially a young child missing from the home or near the home, every effort should be made by initial responding units to make a thorough search of the child's home, garage, shed, or any other structure on the

premises. (Refer to the Amber alert system sections elsewhere in this general order for criteria for possible Amber alert system activation.)

- F. The preliminary and ongoing investigation involving missing persons shall follow the procedures and guidelines outlined in **OM-C-1**.

AMBER ALERT SYSTEM CRITERIA

Once law enforcement has conducted the initial investigation, certain criteria must be met to activate the Kentucky Amber alert system. At a minimum:

- A. Law enforcement confirms a child has been abducted. Parental abductions where the other qualifying criteria are absent shall not warrant activation of the Amber alert system.
- B. Law enforcement believes and confirms the circumstances surrounding the abduction.
- C. There are indications the child is in danger of serious bodily harm or death.
- D. There is sufficient descriptive information about the child, the abductor and/or the suspect's vehicle.

AMBER ALERT ACTIVATION/DEACTIVATION

The Kentucky State Police has the primary responsibility for activation of the Kentucky Amber alert system. In the event a local, city, county, or state law enforcement agency makes a request for Amber alert system activation, the following procedure shall apply.

- A. The request for Amber alert activation shall be made through the nearest state police post.
- B. The post commander or his designee shall forward this request by the quickest means available to the Amber alert coordinator at headquarters during normal business hours or to the Command Officer in Charge otherwise.
- C. If the criteria for Amber alert system activation are met, the Kentucky State Police command officer in charge shall direct the headquarters telecommunicator to obtain all pertinent data from the investigating agency.
- D. The headquarters telecommunicator shall then contact the Division of Emergency Management, Emergency Operations Center (24 hour access) via phone and fax to inform them of an Amber alert system activation. The telecommunicator shall then enter the applicable data into the Kentucky Amber Alert Web Portal thus activating the alert. The Kentucky Amber Alert Web Portal will disseminate the alert to all Amber Alert Web Portal partners.
- E. The headquarters telecommunicator shall also notify the National Center for Missing and Exploited Children via telephone that the Kentucky Amber alert system has been activated and shall provide brief circumstances surrounding the disappearance.

Upon location of the missing child, the following procedure shall apply:

- A. The request for Amber alert deactivation shall be made through the nearest state police post.
- B. The post commander or his designee shall forward this request by the quickest means available to the Amber alert coordinator at headquarters during normal business hours or to the Command Officer in Charge otherwise.
- C. The Kentucky State Police command officer in charge shall direct the headquarters telecommunicator to deactivate the Amber alert system.
- D. The headquarters telecommunicator shall then contact the Division of Emergency Management, Emergency Operations Center (24 hour access) via phone and fax to inform them of deactivation of the Amber alert system. The telecommunicator shall then enter the applicable data into the Kentucky Amber Alert Web Portal thus deactivating the alert. The Kentucky Amber Alert Web Portal will disseminate the alert to all Amber Alert Web Portal partners.
- E. The headquarters telecommunicator shall also notify the National Center for Missing and Exploited Children via telephone that the Kentucky Amber alert system has been deactivated.

RECOVERY OF MISSING PERSON AND CASE CLOSURE

- A. All missing persons, once found, shall be questioned to establish the circumstances surrounding their disappearance and whether criminal activity was involved. Where indicated, criminal charges shall be filed.
- B. Upon locating a missing person, all agencies previously contacted for assistance shall be notified. Specific information pertaining to the location and circumstances of the missing person's whereabouts shall be submitted to the Kentucky Missing Person/Child Information Center (Intelligence Branch) by a LINK "administrative message." This information will be used to update the database entry and can provide a basis for future investigative leads and statistical analysis.
- C. In cases where an adult missing person has been located in response to a NCIC entry--and the adult is reasonably safe and in no immediate danger--the missing person may request that the person initiating the missing person report not be notified of his/her location. In cases where the missing adult is not wanted as a suspect in a crime, or for the commission of a criminal offense, the person should not be detained solely on the basis of a missing person entry made by another agency. Officers locating such missing adults shall:
 - 1. Advise them that they are the subject of a missing person investigation;
 - 2. Ask if they desire the reporting party or next-of-kin to be notified of their whereabouts; and,
 - 3. Make provisions to transmit this information to the reporting party or next-of-kin if permitted by the missing person.

4. In all cases, reporting parties shall be informed of the well-being of located missing persons. Unless criminal matters necessitate other action, desires of missing persons not to reveal their whereabouts shall be honored.

D. In cases involving juveniles, officers shall ensure that:

1. The initial questioning of the youth identifies the circumstances surrounding the child's disappearance, any individuals who may be criminally responsible, and whether an abusive or negligent home environment was a contributory factor; and,
2. Parents, guardians, and the person reporting the missing youth are notified in a timely manner.

E. Where indicated, follow-up action shall include filing of an abuse and neglect report with the Social Services Department.

F. The missing person case report shall include a complete report on the whereabouts, actions, and activities of children while missing.



GENERAL ORDER OM-B-10

Title / Subject		EFFECTIVE DATE	REVISION DATE
JUVENILE OPERATIONS		04/15/99	12/1/05
REFERENCES	CALEA STANDARDS	DISTRIBUTION	
OM-B-6 OM-C-1 OM-C-3	44.1.1 44.1.2 44.1.3 44.2.1 44.2.2 44.2.3 82.1.1	All Personnel	
KRS 600-645		REPORT: <input checked="" type="checkbox"/>	

POLICY

As part of the agency's efforts to serve the citizens of the Commonwealth, the Kentucky State Police is committed to actively reducing juvenile offenses and protecting the public from juvenile offenders through discretionary enforcement efforts, school liaison, and community-based outreach programs. Therefore, it shall be the policy of this agency that all juveniles be treated in strict accordance with the Unified Juvenile Code, Chapters 600-645 of the Kentucky Revised Statutes and be subject to the preventive efforts employed by the Kentucky State Police. To successfully address juvenile-related offenses, agency employees and organizational components shall understand established procedures for handling juveniles in criminal and non-criminal incidents and shall support the agency's overall juvenile operations function.

OBJECTIVES

- A. To inform agency employees of the statutory authority and proper procedures for responding to calls involving juveniles possibly violating public offenses and/or status offenses.
- B. To encourage all agency employees to actively support the role of the Kentucky State Police when responding to, and attempting to prevent, juvenile offenses.

STATUTORY AUTHORITY

Kentucky Revised Statutes: Chapters 600 – 645 (Referenced herein).

DEFINITIONS

- A. **Court-Designated Worker:** Individual delegated by the Administrative Office of the Courts for the purposes of placing juveniles in alternative placements prior to arraignment, conducting preliminary investigations, and formulating, entering into, and supervising diversion agreements and performing such other functions as authorized by law or court order.
- B. **Juvenile:** Any person who has not reached his eighteenth (18th) birthday.
- C. **Public offense:** An action, excluding contempt, brought in the interest of a juvenile who is accused of committing an offense under KRS Chapter 527 (Offenses Relating to Firearms and Weapons) or a public offense which, if committed by an adult, would be a crime, whether the same is a felony, misdemeanor, or violation, other than an action

alleging that a child sixteen (16) years of age or older has committed a motor vehicle offense.

- D. **Status Offense:** Any action brought in the interest of a juvenile who is accused of committing acts, which if committed by an adult, would not be a crime. Such behavior shall not be considered criminal or delinquent and such juveniles committing such offenses shall be termed status offenders. Status offenses shall not include violations of state or local ordinances, which may apply to juveniles such as a violation of curfew or possession of alcoholic beverages.

GENERAL GUIDELINES

- A. Whenever reasonable and justified under this policy, officers are encouraged to take those measures necessary to effect positive changes in juvenile offenders' behavior that are consistent with state law and the safety and security interests of the community. This may include but not limited to the following:
1. Collaboration with other components of the juvenile justice system in the specific response to complaints against juvenile offenders;
 2. Collaboration with other components of the juvenile justice system in an overall review of this agency's policies and procedures regarding response to, control and prevention of juvenile offenses.
 3. Participation in the agency's D.A.R.E program as provided by General Order **AM-H-3**;
 4. Participation in the Kentucky State Police Trooper Island camp targeting less fortunate youth throughout the state;
 5. Development, implementation and/or support of any other outreach efforts for purposes of decreasing juvenile offenses and increasing school and community safety, which may be facilitated by individual Posts/Branches and/or the Media Relations Branch.
- B. Agency officers shall use reasonable discretion in deciding on the least coercive action that is necessary and appropriate for responding to juvenile offenses. Alternatives that may be considered include:
1. Release without further action;
 2. Informal counseling;
 3. Direct or Transport home;
 4. Issuance of citation and summons;
 5. Custody; Release/referral to parents or responsible adult; or
 6. Custody; Release/referral to Court-Designated Worker and/or Department of Juvenile Justice.
- C. Juveniles share the same constitutional protection as adults, and as a result, the restrictions and obligations upon the police actions of stops, frisks, searches and seizures, questioning and identification must be followed in the case of juveniles.

REPORTING AND PROCEDURES

- A. Juveniles alleged to have committed a **traffic** violation shall be issued a citation, which shall serve as a summons, and a copy of the citation shall be attached to the petition. Also, the following reporting procedures shall apply:
1. All juvenile personal data (i.e., Name, DOB, Social Security Number, Address and any other identifying information) shall be included on all citations, UOR-1, UOR-2, and any supplements. It shall not be necessary to block out this information.
 2. A **traffic** offense citation that is given to a juvenile who is fifteen (15) years of age or younger shall not be submitted to the Court Clerk's Office and shall not be subject to open records. In these circumstances, the **traffic** offense must be processed through the Court-Designated Worker's Office.
 3. A juvenile that is sixteen (16) years of age or older cited for a **traffic** offense is to be treated as an adult offender, and all related documentation shall be subject to open records. In these circumstances, the citation shall be submitted to the Court Clerk's Office.
- B. Juveniles alleged to have committed a **misdemeanor or felony** shall be issued a citation, which shall serve as a summons, and, if applicable, a copy of the citation shall be attached to the petition. Also, the following reporting procedures shall apply:
1. All juvenile personal data (i.e., Name, DOB, Social Security Number, Address and any other identifying information) shall be included on all citations, UOR-1, UOR-2, and any supplements. It shall not be necessary to block out this information, **however, officers shall clearly write in the upper left-hand corner on all citations issued to juveniles the word "JUVENILE." A case investigation that contains juvenile victim, suspect, accused and/or witness data must have clearly written in the upper left-hand corner of the UOR-1, UOR-2 and/or any supplements the word "JUVENILE."**
 2. When a juvenile is issued a criminal citation, or taken into custody, a copy of the citation shall be provided to the Court-designated worker.
 3. Additional copies of the criminal citation may be provided to the guardian, prosecutor, and/or a Department of Juvenile Justice employee upon request. All other individuals requesting copies of such citations shall do so through the Kentucky State Police Official Custodian of Records pursuant to KRS 61.870 and General Order **AM-C-3**.
- C. Officers may take into custody juvenile offenders charged with public offenses for which adult offenders may be subject to arrest according to state law; however, the taking of a juvenile into custody under such law shall be termed as such and shall not be defined as an arrest. Officers may divert juveniles from the formal court process and, without filing formal charges, release him or her to a court-approved juvenile center offering voluntary services if specific circumstances exist, as defined by KRS 610.255.

- D. Officers taking or receiving a juvenile into custody on a charge of committing an offense shall ensure that the parent or relative, or guardian or custodian if parent is not available and any other appropriate persons are notified. The officer must state to that person the charges against the juvenile, the specific violation, and the time and place of the juvenile hearing. Also, officers shall ensure that the juvenile is provided any necessary medical attention, is apprised of his or her constitutional rights, and is released if appropriate, according to KRS 610.200.
- E. As provided by KRS 610.200, the release of a juvenile to a parent or responsible adult, or the referral of a juvenile to appropriate officials, shall not preclude an agency officer from proceeding with a complaint against the juvenile.
- F. The juvenile session of the district court has exclusive jurisdiction if the juvenile is under eighteen and has committed a public offense; therefore, no such juvenile shall be placed in any detention facility except at the direction of the district judge or other person whom the judge may designate. Officers shall deliver physical custody of such youth, along with the appropriate paperwork, to the intake officer of the detention facility.
- G. Juvenile offenders of domestic violence shall be handled in the same manner as adult offenders with the added provisions as listed below:
1. If a juvenile is taken into custody, officers shall process the juvenile under the provisions of the Juvenile Code (KRS Chapters 600-645).
 2. Officers shall not release juvenile offenders at the scene, but contact the Court-Designated Worker for alternative placement.
- H. As provided by KRS 630.030, agency officers shall only take into custody juveniles **committing status offenses** if the following provisions exist:
1. Pursuant to an order of the court for failure to appear before the court for a previous status offense; or
 2. If there are reasonable grounds to believe that the juvenile has been a habitual runaway from his parent or person exercising custodial control or supervision of the juvenile.
 3. Agency officers shall refer to KRS 630.040 for additional requirements when taking status offenders into custody.
 4. Agency officers shall have a court order in cases where the juvenile is being transported to a detention facility.
- I. Agency Officers shall take into custody any person for whom a Commissioner's Warrant has been issued, by the Department of Juvenile Justice, pursuant to KRS 635.100, and deliver that person directly to a state juvenile detention facility. Youth taken into custody by virtue of a Commissioner's Warrant have no involvement with the Court Designated Worker process.

PROTECTIVE CUSTODY

- A. Officers shall take into protective custody juveniles alleged to be subject of abuse, neglect, abandonment, or where there is imminent danger to the juvenile's life or health. In these circumstances, officers shall refer to KRS 620.040 for additional procedures. Officers who accept physical custody of a newborn infant in accordance with KRS 405.075 shall immediately arrange for the infant to be taken to the nearest hospital emergency room and shall have implied consent to any and all appropriate medical treatment.
- B. Officers shall take into custody juveniles that have been declared missing upon location of such juveniles and upon verification of the National Crime Information Center (NCIC) entry. In these circumstances, officers shall further adhere to requirements as defined in General Order **OM-C-9** and KRS 17.640. This includes, but is not limited to:
1. Transporting these juveniles to the parent, guardian, other person exercising custodial control or supervision, or to the authorized representative of Cabinet for Families and Children (CFC) or Department for Community Based Services (DCBS); and
 2. Contacting a court-designated worker with jurisdiction for placement determination if the officer is unable to return the juvenile to the appropriate caretaker.
- C. If an officer has reason to believe that a juvenile is lost, he may take that juvenile into custody and contact the parents or guardians of the juvenile for his safe return as soon as possible. If the parents or guardians of the juvenile cannot be contacted or refuse to accept custody, the officer shall contact the Department for Community Based Services.
- D. Officers taking into custody juveniles who are mentally ill shall refer to KRS 645.120 and General Order **OM-B-11** for proper guidelines and processing procedures.

PROCESSING A JUVENILE IN CUSTODY

- A. Officers taking juvenile offenders into custody shall be held responsible for the proper processing and treatment accorded these individuals, and shall abide the following guidelines:
1. The officer shall fill out any and all forms or petitions that the court has prescribed for juveniles.
 2. The officer may handcuff juveniles in custody if he feels it is necessary for the same reasons that would justify handcuffing an adult offender.
 3. Juvenile offenders shall be transported and searched as in any arrest of an adult offender, in accordance with General Order **OM-B-6**.
 4. Juvenile offenders shall only be fingerprinted and photographed in accordance with General Order **OM-C-1** and/or under one of the following circumstances:

- a. When taken into custody and charged with commission of a public offense;
 - b. Under an order of the court for the purpose of comparison or elimination in a particular investigation; or
 - c. After a juvenile court has certified a juvenile offender to the circuit court and the individual has been tried and convicted in the circuit court as an adult.
5. In any of the above circumstances in which a juvenile is fingerprinted, the citation number for the juvenile in custody shall be indicated on the fingerprint card in the same manner as it would be for an adult. In cases involving Livescanning of the juvenile, officers shall provide the Livescan technician with the citation number.
6. Juveniles may waive their constitutional protections and rights the same as an adult. However, if circumstances warrant the questioning of a juvenile, officers shall adhere to the following guidelines:
- a. During the interview, the officer shall explain the agency and juvenile justice system procedures as prescribed by this general order and applicable KRS;
 - b. During the interview, the juvenile may confer with a parent, guardian, legal custodian, or legal counsel, if present;
 - c. The number of officers present during the interview should be limited to no more than two (2); and the interview session should not continue more than one (1) hour without a ten (10) minute break.
- B. When it is necessary to take a juvenile into custody at school, the officer shall first notify the principal or other school authority, and shall have the juvenile brought or sent to a school office out of sight of the rest of the school body.

JUVENILE RECORDS AND INFORMATION

- A. All juvenile records shall be secured separately from adult records and remain confidential in accordance with statutory requirements of KRS 600-645 and General Order **AM-C-3**. The Kentucky State Police Criminal Identification & Records Branch shall take the necessary precautions to ensure that Uniform Offense Reports or citations containing juvenile criminal information will be used only for statistical information. No part of this general order precludes the sharing of agency juvenile records in accordance with General Order **AM-C-3**, KRS 17.125 and/or KRS 17.151.
- B. The Kentucky State Police D.A.R.E Office, Trooper Island, and if appropriate, the Media Relations Branch and individual Post/Branches shall compile information throughout the Calendar Year that represents their achievements, significant events, and overall activities of programs directed at preventing juvenile offenses. This information may be included as part of the annual report for the appropriate organization component or as part of the reporting requirements for the agency's overall Strategic Plan. This report shall be subject to an annual review. This review should consider both the quantitative and qualitative elements of each prevention program, lending itself to decisions regarding whether a specific program or project should function as is, be modified, or be discontinued.

**APPENDIX 6: APPENDICES - DEPARTMENT FOR
COMMUNITY BASED SERVICES REVIEW**

Statewide APS Calls FACT Sheet

APS Calls Completed from 07/01/2009 to 06/30/2010A

	State	
Total # APS Calls ^B	49,109	
Total # APS Individuals ^B	60,089	
# Individuals Investigated or Assessed	34,740	58%
# Individuals Resource Linkage	25,349	42%

Investigated or Assessed APS Individuals ^C						
	Domestic Violence ^D		Vulnerable Adult ^E		General Adult ^F	
	(State)		(State)		(State)	
	#	%	#	%	#	%
Total Inv. or Assessed	20,538	59.1	11,097	31.9	3,104	8.9
Findings						
Substantiated	4,063	19.3	2,932	26.4	N/A	N/A
Unsubstantiated	4,472	21.3	7,755	69.9	N/A	N/A
No Findings / KRS 209.020*	11,212	54.6	N/A	N/A	N/A	N/A
Unable to Locate	791	3.9	409	3.7	289	9.3
Accepts Services	N/A	N/A	N/A	N/A	1,623	52.3
Refuses Services	N/A	N/A	N/A	N/A	1,190	38.3
Gender of Victim						
Male	3,834	18.7	4,472	40.3	1,370	44.1
Female	16,285	79.3	6,327	57.0	1,660	53.5
Missing Data	419	2.0	298	2.7	74	2.4
Age of Victim						
18 or 19 years	770	3.7	210	1.9	240	7.7
20 to 29 years	7,559	36.8	760	6.8	245	7.9
30 to 39 years	6,306	30.7	657	5.9	172	5.5
40 to 49 years	3,758	18.3	988	8.9	266	8.6
50 to 59 years	1,353	6.6	1,475	13.3	355	11.4
60 to 69 years	354	1.7	1,754	15.8	391	12.6
70+ years	217	1.1	5,041	45.4	1,322	42.6
Missing Data	221	1.1	212	1.9	113	3.6
Race of Victim						
Caucasian	14,613	71.2	7,036	63.4	1,592	51.3
African American	2,430	11.8	984	8.9	200	6.4
Hispanic	147	0.7	21	0.2	6	0.2
Other	675	3.3	623	5.6	322	10.4
Missing Data	2,673	13.0	2,433	21.9	984	31.7
Victim's # Referrals						
First Referral	6,501	31.7	4,243	38.2	1,434	46.2
Has Two or More Referrals	14,037	68.3	6,854	61.8	1,669	53.8

A. These data may include facility investigations as one individual.

B. Includes duplicate individuals with more than one APS referral in the reporting period.

C. Source: Data from a special TWIST pull (272).

D. Domestic Violence includes spouse and partner abuse.

E. Vulnerable Adult includes adult abuse, caretaker neglect, self neglect, and exploitation.

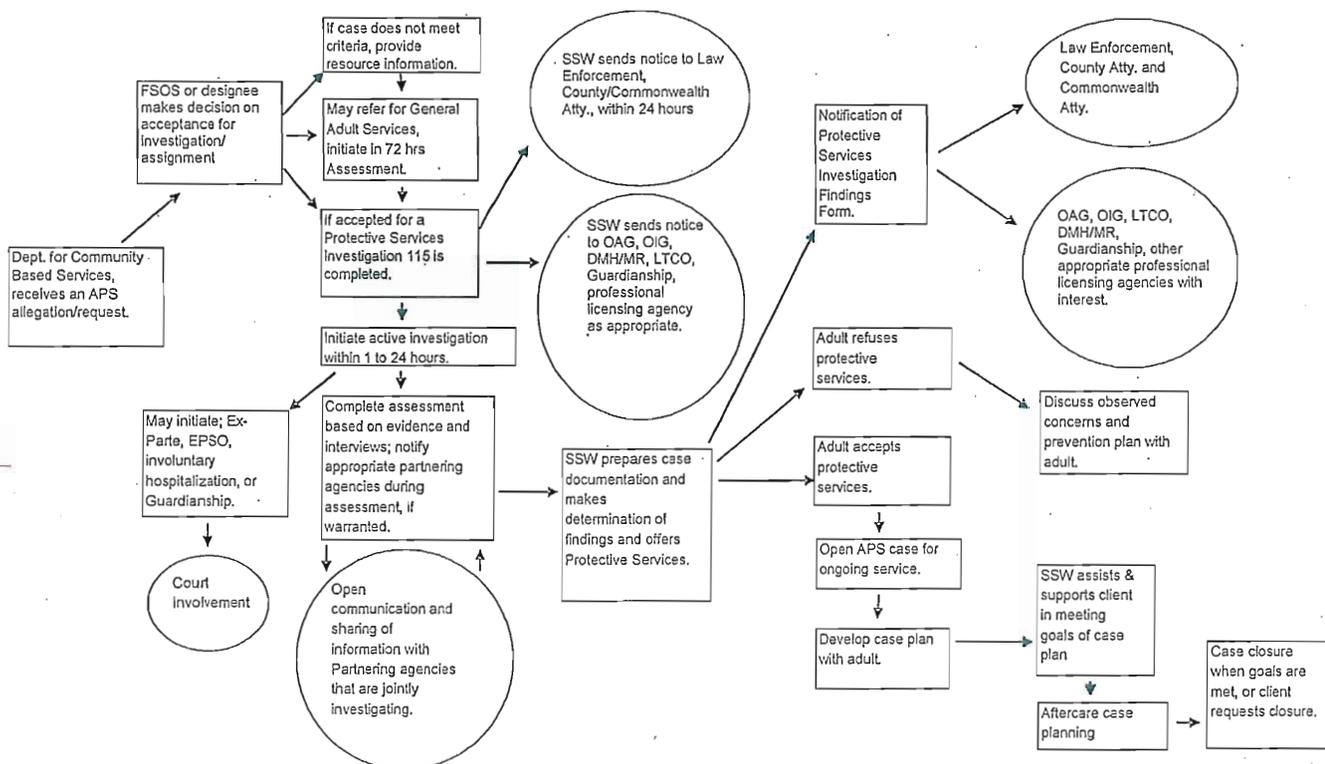
F. General Adult includes cases needing services without the presence of abuse or neglect.

* Investigation initiated, alleged victim declined.

Data Run Date: 07/16/2010

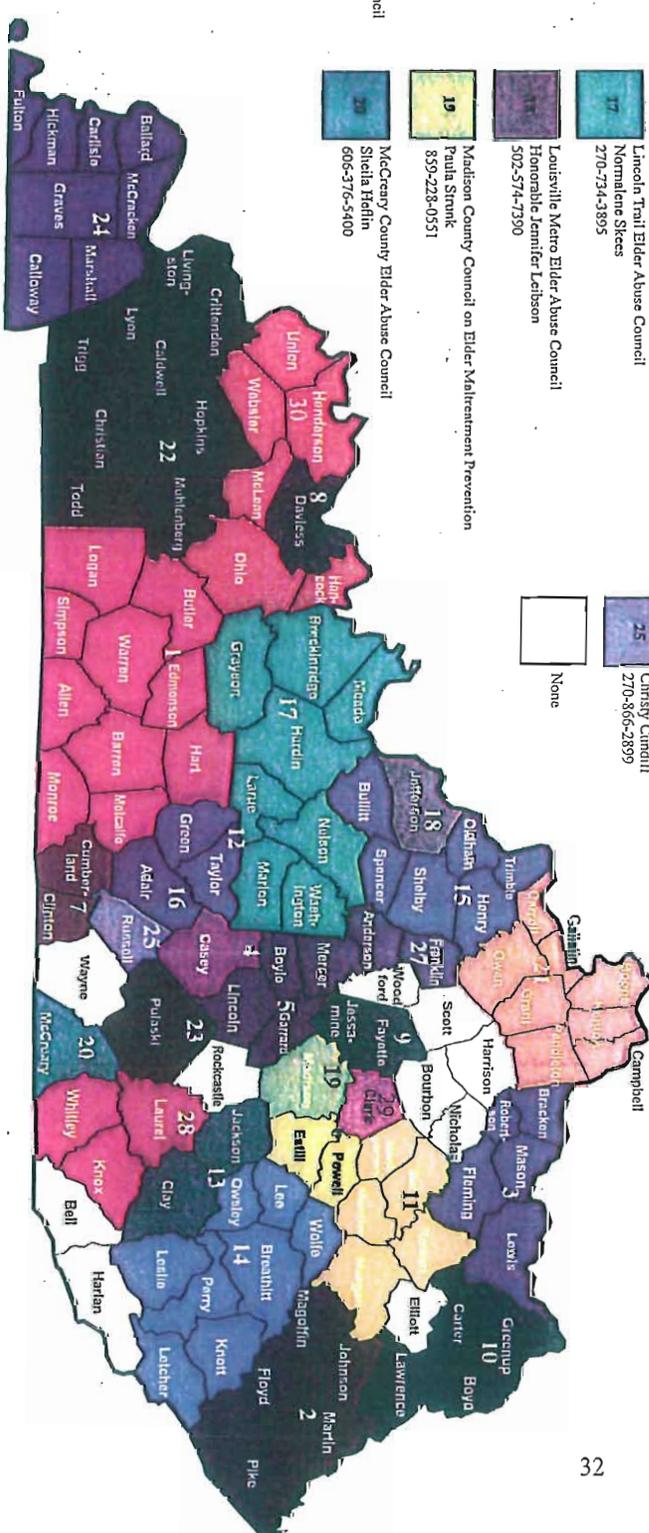
DCBS Adult Protective Services Process Map

The Department for Community Based Services is statutorily charged (KRS 209.010) with the provision of protective services for dysfunctioning adults. This process is accomplished through a multidisciplinary approach outlined in the following diagram.



2010 Local Coordinating Councils on Elder Abuse

- | | |
|----|---|
| 1 | Barren River Elder Abuse Council
Daniel Curry
1-800-782-1924 |
| 2 | Big Sandy Elder Abuse Council
Steve Jones
606-886-2374 |
| 3 | Buffalo Trace Elder Abuse Council
L.A. Justin Horchi
606-564-9411 |
| 4 | Casey County Elder Abuse Council
Norma McQuary
606-787-8066 |
| 5 | Central Kentucky Elder Abuse Council
(Boyle, Garrard, Lincoln, Mercer, Anderson)
Jackie Sims
859-236-2070 |
| 6 | Estill and Powell LCC
Mary Crawley-Schmidt
859-269-8021 |
| 7 | Cumberland/Clinton Elder Abuse Council
Cindy Branscum
270-866-4200 |
| 8 | Daviess County
Debra Jacob
270-687-7491 |
| 9 | Fayette and Jessamine County Elder Abuse Council
Amanda Soka
859-269-8021 |
| 10 | Fresno Elder Abuse Council
Shanna Carter
606-836-3187 |
| 11 | Gateway Elder Abuse Council
Regina Back
606-780-0090 |
| 12 | Green/Taylor Elder Abuse Council
Chief John Brady
270-932-4202 |
| 13 | Jackson and Clay County Elder Abuse Council
Melissa Davidson
606-598-2027 |
| 14 | Kentucky River Council against Maltreatment of Elders
Shee Noble
606-496-5158 |
| 15 | KIPDA Rural Elder Abuse Council
Ben Kennedy
502-647-9245 |
| 16 | Lake Cumberland Elder Abuse Council
Patricia Harper
270-384-6411 |
| 17 | Lincoln Trail Elder Abuse Council
Norma Sue Sikes
270-734-3895 |
| 18 | Louisville Metro Elder Abuse Council
Honorable Jennifer Leibson
502-574-7390 |
| 19 | Madison County Council on Elder Maltreatment Prevention
Paula Strank
859-228-0551 |
| 20 | McCreary County Elder Abuse Council
Sheila Hoffin
606-376-5400 |
| 21 | Northern Kentucky
Elder Maltreatment Alliance
Pam Pangburn 859-491-0522 |
| 22 | Pennyrite Elder Abuse Council (Hopkins,
Muhlenberg, Trigg, Christian, Todd, Livingston,
Crittenden, Lyon and Caldwell counties)
Randa Ramsey
270-886-9184 |
| 23 | Putnack County Elder Abuse Council
Virginia Dick
606-505-1137 |
| 24 | Purchase Elder Abuse Council
Susan Hall
270-653-4314 |
| 25 | Russell County Elder Abuse Council
Christy Cundiff
270-866-2899 |
| 26 | Tri County Council on Elder Abuse
Debbie Bowker
606-528-8738 |
| 27 | Franklin County Council on Family Abuse
Kay Triplett
502-223-5794 |
| 28 | Green River Triad Elder Abuse Coalition
Vivian Craig and Brenda Kennedy
270-926-4433 |
| 29 | Clark County Elder Abuse Council
Sabrina Puckett
859-271-3765 |



Procedure for Transition of Medicare/Medicaid residents from Nursing Facilities Due to Loss of Funding or Closure

A. Prior to going on site:

- CO -Identify point for partner agencies and develop contact sheet with numbers where contact may be made on 24 hour basis (OIG, Medicaid, OLS, LTCO, AG, Communications)
- CO- Partner meeting to identify issues specific to this facility (number of residents, de-certification, loss of license, resources in community)
- Identify CO (APS, nurses, guardianship, facilities management) and regional staff (APS, guardianship, support staff, family support contact)
- CO and Regional point-Assign staff roles and establish information flow
- CO and Regional point- Identify and secure needed equipment and supplies (fax machine, copiers, phone lines, cell phones, laptop computer and printer, copier paper, case file folders, file folder labels, masking tape, surgical gloves, permanent markers, pens, notepads, scissors, Kentucky Road Map, telephone message book)
- CO point- Meet with region to inform of expectations (Point for region is SRAA or a supervisor for an APS team. Need consistent staff in 5 day blocks of time, consistent support staff, arrangement for equipment and supplies to be on site by when, time code for activity related to closure, provide written copy of OIG termination letter and related citations)
- CO will contact Fleet Management and arrange for transportation of at least one (1) cargo van for the length of the closure.
- CO support staff- Arrange for direct billing for DCBS staff that will have to be housed in the area

B. On Site

- CO and Regional point- Meeting with facility administration (explain roles of agencies; request facility census with level of care, type of transport required, payor source; identify other involved agencies/special circumstances such as Hospice/VA/renal clinics/etc.; listing of facility contacts for Administrator/DON/Social Services/Housekeeping);
- CO and Regional point-Develop projected work schedule for staff
- Meetings with residents and families (CO and Regional point-large family/resident meeting, assigned staff-1:1 resident/family meetings)
- CO point or designee-Information flow between facility and Cabinet
- Regional point and support staff- Set-up of work area (families and non-DCBS staff should not be in areas where daily placement log is recorded and files are maintained due to confidentiality)
- Regional point and staff-Set-up of spread sheet and assignment of residents
- Regional point and support staff- Provide each SSW copy of face sheet for each resident, listing for assigned cases which includes responsible party/payment source, and copy of names/phone numbers/vacancies for facilities within 50 mile radius
- Medical support team tag all residents records
- Regional Support staff runs 2 copies of resident records and set-up in files. Mark outside of folder to indicate DCBS file or file to go to facility, assigned worker team, and private pay/Hospice/VA residents
- Regional point and support staff- Team member assignments (inform residents of worker assigned to assist them, face to face contact with each resident within first 2 working days)

- Moving Coordinator is responsible for inventorying all residents belongings (Particularly electronic supplies and equipment.
 - Packer will ensure that at least one change of clothing will be unpacked and will accompany resident when they leave facility (Ditty bag).
- C. Completing transition and leaving site
- CO and Regional point- Plan debriefing
 - Moving Coordinator- Verify that all resident's belongings have been forwarded to them
 - Regional point- Close worksite area (equipment picked up)
 - Regional point- Secure and archive records
 - Regional point- Follow-up on each resident placed
 - CO point- Recognize all staff and partners for their assistance

Tasks for Transition Team (TT)

- A. Before going on site: Identify in-house staff and partners for TT
- Local APS and Leadership team
 - SW, support staff, Temps
 - SW from other teams
 - Other regions APS SW
 - Medicaid
 - State person
 - Local support staff
 - Guardianship
 - OIG
 - Facility monitors/nurses
 - Quality Central
 - APS nurses/support staff
 - Leadership team
 - Media team
 - Ombudsman
 - Hospice
 - Nursing facility staff
 - Administrator
 - DON
 - Social worker
 - City or County Adult Service
 - Social Workers
 - Support staff
 - VA
 - Others

Identify TT and Determine responsibilities of each team member

- A. Secure adequate staff, (SW, Nurses, Medicaid and support staff)
- Identify
 - i. Point person
 - ii. Team leader for securing staff (Cabinet/ temps)
 - iii. Team leader for caseloads

- iv. Team leader for Medicaid
- v. Team leader for information flow
- vi. Team leader for MR retrieval
- vii. Team leader for moving team
- viii. Team leader for interaction with family/residents
- ix. Supply coordinator

If possible key people need to be able to work on Transition Team until last resident has been moved out

- B. Time frames need to be identified:
 - Number of days projected for completing move, include weekends/nights
 - Schedule staff
 - Codes for time and travel
- C. Determine supplies/equipment needed
- D. Develop written statement of TT role, purpose and function
- E. Secure copy of OIG finding and reasons for action taken

Information flow

- A. Prior to going to site
 - Based on current resident roster:
 - Set up spread sheet for tracking logs
 - Assign caseloads to SW teams
- B. Folders
 - Two sets of folders are needed
 - Social Worker (SW)
 - To be used by any one "working" the case for documentation
 - SW to have contact sheets, actions requested sheets, face sheets, payment source, responsible party.
 - Mark outside of folder if private pay, Hospice or VA
 - On outside of folder identify SW team assigned the case
 - Medical Record (MR)
 - To be used to keep Medical information needed for placement and services
 - List of information to be copied stapled to inside of folder
 - Label in red "MR Folder Do Not Remove"
 - On outside of folder identify SW team assigned the case
- C. Identify
 - One or more "flaggers"
 - Review list of information to be copied
- D. Identify
 - Copy team
 - Records clerk
 - Runners

Prior to going on site:

- A. Identify
 - Team leader
 - Faxers
- B. Determine how fax needs will be handled:
 - Taken out of facility

- Access to phone line for fax machines at NF (Cabinet would be responsible for all cost on sending out faxes)
- C. Set up FAX cover sheets (include section for verification of fax received)
- D. Set up list of fax and telephone numbers for facilities receiving fax
- E. Determine fax number for TT incoming fax needs
- F. Set up log for faxing: time/date taken to be faxed, verification that fax was received and time/date fax was returned to site or worker
- G. If local facility needs the information
 - Hand carry
 - Log who requested information to be given to local NF; time/date information taken to facility and who received the information

On Site

- A. Securing medical records for copying or review
- Only staff assigned as “runners” can retrieve/return MR from NS
 - Sign out sheets for each Nurses station (NS)
 - Log for time MR taken from NS
 - Follow list of information to be copied, make an “original” copy of MR
 - All pages to be copied are to be flagged
 - All pages copied must be one sided

This folder is to be marked in red MR and a copy of the “original” maintained in it at all times

- B. Set up system for securing and maintaining information after copying
- All MR files must be signed out and in with records clerk
 - One “original” copy must be kept in MR folder
 - If information is needed for fax or hand delivered use “action needed sheet” and request copy

All Nursing Facility Medical Charts must remain with either copy team or if being reviewed by providers in the provider room.

Partner meeting

Before going on site meet with partners to discuss or arrange the following:

A. OIG

- Provide written information on why action is being taken
- Define time frames for actions needed (include nights/weekends)
- Provide information on how families/residents are to be notified of actions being taken
- Outline agenda/times for resident family meeting
- Determine if private pay residents will be required to moved by same date as Medicaid/Medicare/VA residents
- Provide schedule for monitoring care and safety of all residents until transition is completed.

B. Medicaid

- Frankfort
 - Provide on site technical assistance on all Medicaid issues
 - Provide nurse for assistance as needed by TT
- Local
 - Identify contact in Frankfort for transportation issues
 - Determine process for arranging transportation of residents
 - Notify ambulance services, Wheels and Cab companies
 - Determine method of payment

- Set up forms for who requested transportation
- Set up tracking log for residents move out
- Notify facility of move out date
- Set up system for moving SW folders to “out date file”

C. Nursing Facility

Meet with Nursing Facility staff to negotiate the following:

- Date and time of TT coming into facility to start transition (may be night or weekend for MR coping/setting up work site).
- Space for transition team:
 - At least one room needs to be locked and rooms need to be close together.
 - Information central:
 - Copiers/MR records
 - Fax machines
 - Transportation team
 - Tracking team
 - Staff calling other providers for beds
 - Posted list of all available beds
 - SW and Ombudsman
 - Space to interview residents/families
 - Make telephone calls
 - Provider Space
 - Space to review MR and talk with families/residents
- Identify NF staff to work with TT
 - Lead person
 - SW
 - DON

D. Daily tasks for transition

- Set time each day to brief SW and providers about the residents, special needs, problems with care/behaviors etc.
- Staff responsible for daily census of residents
- Staff to be notified of new placement and date to be transported
- Staff responsible in house to notify NF staff to prepare discharge summary
- Billing clerk
 - Medicaid/Medicare, VA cards, amount in patient accounts
 - Staff to assist resident and moving team with their personal possessions and any medical equipment bought for them with Medicaid/Medicare funds.
- Discuss procedure for access to MR
 - Sign in/out sheets at each NS
 - Numbers taken from each station each day
 - Location of Nurses notes/special orders
 - Discharge summaries
- Discuss how to secure information need by ambulance service
 - Which staff has responsibility to provide information needed TT or NF
- Roles and responsibilities when dealing with “private pay” residents and families.
- Lead for conflict resolution between NF staff and TT.

E. Ombudsman

- Assist SW with meeting residents/families
- Identifying residents with no family, special needs
- Assist with residents/families concerns/issues over actions being taken
- Assist with resident rights
- Assist with packing/moving resident's personal possession's

F. VA

- Assist with residents that are eligible for VA placement/services
- Identify placement options with VA facilities
- Assist with applications for VA placements

G. Central Office (DCBS)

- APS
 - Assist with forming the TT
 - Provide nursing assistance
 - Secure van, boxes for helping residents/families move
 - Provide telephone list of agency names and numbers for TA or media questions
 -
- Leadership
 - Assist with media
 - Assist with securing staff
 - Assist with securing equipment
- Providers

Before going on site TT:

- Secure listing of all NF in Kentucky.
- Request OIG give listing of any that are not acceptable for placement
- Make list of NF telephone and fax numbers
- Start calling all local and within 50 miles NF for beds available
- Set up schedule for providers to come to NF
 - Date/times for each day

On site - TT discuss the following with providers:

- Location of provider room
- Time of daily "overview" of current residents
- Guidelines for provider interviewing residents assisted by Ombudsman or SW
- Guidelines for review of MR
- Guidelines for requesting MR information on residents
 - Information request sheets
 - Copy request sheets
- Concept of "cream of the crop" vs. accepting "hard to place residents" (TT request that NF bring their "waiting list" to determine if any residents are already on that list)
- How to notify TT of acceptance of resident for admission and complete the following tasks:
 - Verification of residents and or families acceptance of placement
 - Date and time of transfer
 - Written request for transportation to be arranged
 - Notification of NF or transfer date/time
 - Request for discharge summary

On Site Tasks:

Set up work areas for TT

- See equipment/supply list
- Adequate space is needed for
 - TT members
 - Families/residents
 - NF staff
 - Providers
- Copiers, fax machines, records (DCBS and Provider) staff sign in logs, lists of beds available, incoming call and message center

At least one area needs to be secured. If needed, TT purchase door locks and request NF staff install the locks.

Team member's responsibilities:

A. Point person

- Determine daily staffing plan
- Determine daily "start/close" times
- Notify NF that TT is on site and what information will be needed daily from NF staff
- Participate in resident/family information meeting
 - Give out TT roles/responsibilities
- Determine method for scheduling appointments with residents/families
 - Schedule appointment times 10am to 7pm and during weekend hours if needed

B. "Greeter"

- Assists families/residents in meeting with SW/TT
- Assist with scheduling appointment times with the SW.

C. SW

- Working with Ombudsman, family, residents and new providers to determine best placement as close to local area as possible at the appropriate level of care and payment source.
- Help residents with loss of security in current placement, loss in relationships with family and NF staff, answer questions about new facility.
- Requesting MR packet for new providers or ambulance services
- Documentation of all contacts with resident or others via: SW folder

D. Duties of the Information Team

- Responsible to handling MR for copying/review
- Works with providers on information needs
- Responsible for flagging MR for copying
- Responsible for copying MR or other documents as needed
- Responsible for maintaining MR folders
- Tracks what information has been given to whom
- Responsible for daily calls to other NF to determine bed availability
- Calls and checks on residents adjustment to new placement

E. Transportation team

- Responsible for determining method of transportation needed arranging transportation
- Maintaining log of moving out date/time
- Maintaining SW folders after placement has been arranged
- Maintaining written verification of who requested transportation
- Maintaining resident tracking list

F. Moving team

- Secure van from Motor Pool (plan for estimated time to complete closure)
- Secure boxes/tape/stickers
- Coordinate with TT residents/family needing assistance with moving
- Work with Ombudsman/TT to pack personal belongings
- Work with SW/new Providers on whether or not family or new Provider can assist with move
- Set schedule for moving residents belonging

G. OIG

- Monitor care and safety of residents until transition is complete

Tasks for TT for completing transition and leaving site:

- Plan debriefing with all TT partners to discuss strengths and weakness of transition process used
- Complete moving resident's possession
- Return all equipment/supplies
- Follow up on any resident not already contacted before last day at NF
- Determine if any correspondence needs to be sent to residents/families as another type of follow-up.
- Determine how files/documents will be stored/archived and for how long
- Determine ways to thank all partners/TT members and anyone else that helped in the process

Supplies/Equipment needed:

- Lap top/disks
- Copiers (2 or more)
 - Number needs to be determined by number of residents and time frames for transition
- 3-4 boxes of paper
 - number needs to be determined by number of residents and time frames for transition
- Fax machines
- Cell phones/chargers
- Tables
- Chairs
- Flip charts/paper
- Markers (different colors)
- File folders (enough for SW and MR files)
- Paper clips (large, small)
- Clamps (med/large)
- Paper
- Pens
- Staplers
- Staplers
- Staple pull
- Post its
- Flags
- Metal folder holders (15 to 20)
- Boxes with lids
- Storage boxes for residents belongings

APS Federal Funding

Grant	Projected
Community Services Block Grant	12,207,407
American Recovery and Reinvestment Act	6,355,200
Family Violence	1,412,525
Medicaid	2,500
Social Services Block Grant	716,055
Preventive Service Block Grant	98,975
Rape Prevention and Education	544,515
Empower II	99,123
Child Abuse and Domestic Violence	742,613
Total	21,436,300

**APPENDIX 7: DEPARTMENT FOR AGING AND INDEPENDENT
LIVING – APPENDICES FOR KENTUCKY
LONG TERM CARE OMBUDSMAN PROGRAM
AND KENTUCKY STATE GUARDIANSHIP
PROGRAM**

**Not provided – voluminous; contains statutes and
regulations.**