



Improving Washington's Response to Abuse & Neglect

Analysis & Recommendations



DISABILITY RIGHTS
WASHINGTON

Formerly known as Washington Protection & Advocacy System

A report by Disability Rights Washington
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Authorship

This report has been prepared by Disability Rights Washington (DRW) Staff Attorney Susan Kas, DRW Advocate Craig Awmiller, DRW Director of Systems Advocacy Betty Schwieterman, and DRW Director of Public Policy David Lord.

DRW is a non-profit, federally-mandated organization designated by the Governor as the Protection and Advocacy System for the State of Washington. In this capacity, DRW advocates on behalf of individuals with disabilities by providing information and referral services and legal representation, by monitoring facilities that serve these individuals, by conducting investigations into alleged incidents of abuse or neglect, and by participating in various public policy and educational initiatives.¹ Through these activities, DRW is in a unique position to observe how state agencies respond to abuse and neglect allegations and to hear directly from our constituents who rely on state agencies for protection from abuse and neglect.

The Washington Long Term Care Ombudsman (LTCO) Louise Ryan also contributed to the Appendix of this report. DRW acknowledges and thanks Ms. Ryan for providing feedback and valuable case examples illustrating many of the issues discussed in this report.

¹ Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e; Protection and Advocacy of Individuals with Mental Illnesses (PAIMI) Act, 42 U.S.C. § 10801 *et. seq.*; Developmental Disabilities Bill of Rights (DD) Act, 42 U.S.C. § 15041 *et. seq.*

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FOREWORD

Washington's system for responding to abuse and neglect of adults is currently failing to provide the protection that adults with disabilities need in order to live safely and with dignity. Therefore, it is the recommendation of this report that the State of Washington engage in a rigorous evaluation of its system for responding to allegations of abuse and neglect of adults with disabilities in order to propose concrete steps to improve this system.

This report describes how the effectiveness of investigations is compromised by poorly conducted investigations, low substantiation rates, and lack of adequate policies and resources. This report also discusses other related issues including assessment of allegations, enforcement of mandatory reporting statutes, and the protection of alleged victims of abuse during ongoing investigations.

The failure of Washington to protect adults with disabilities is due to multiple problems within Washington's abuse and neglect response system, which includes the divisions housed in the Department of Social and Health Services (DSHS) and Health Professions Quality Assurance (HPQA) of the Department of Health (DOH). To address these cross-agency issues, we specifically recommend that a task force of leaders and professionals from DSHS and DOH investigation and enforcement units be convened along with consumers of state protection services, DRW, and the Long Term Care Ombudsman (LTCO) to develop a system-wide self-assessment tool. We recommend that this tool be used in order to propose research-based recommendations for specific reforms, further study, and additional resources.

DRW is sharing this information with the Washington State Attorney General's Office (AGO), HPQA, and DSHS with the understanding that we all share a common interest and commitment to stop abuse and neglect of adults with disabilities. Therefore, the purpose of this report is not to assign blame or allege liability, but to identify the barriers to a successful abuse and neglect response system so that these barriers can be addressed collaboratively between advocates and state agencies. While we do discuss individual instances and cases that demonstrate serious failures on the part of investigators and state agencies, these examples are used to illustrate broader problems which are symptomatic of the system's lack of coordination and lack of adequate resources.

DRW believes this report is timely. Washington's Attorney General and state agencies, for example, are already taking multi-disciplinary initiatives to propose new solutions to problems identified through the Vulnerable Adult Summit and Workgroups. We believe this state-wide project demonstrates commitment to improve our current system as well as recognition that abuse and neglect of vulnerable adults is a serious problem in our state. Likewise, the Government Management Accountability and Performance (GMAP) initiative, recently implemented at the instruction of the Governor, is an indicator of efforts at the highest levels of state government to regularly measure results, improve performance, and identify barriers which prevent state agencies from performing the

functions appropriately expected of them by the citizens of the state. It is the hope of DRW that this report can serve to support these steps now being taken by the Attorney General and the Governor.

Ensuring high performance on the part of the state's abuse and neglect response system is also of heightened importance given the recent Washington Supreme Court decision, *Ongom v. State*, 159 Wn.2d 132 (2006). In this case, the Court decided that state investigators and enforcement officials must now establish through "clear and convincing evidence" that misconduct, including abuse or neglect, occurred before the state can take enforcement actions against healthcare professionals under RCW 18.130.160. This is a marked departure from the more expansive burden of proof which was previously required in order to take these same disciplinary actions. Accordingly, in order to meet this more rigorous evidentiary standard, state investigators and enforcement officials who wish to sanction healthcare providers must be all the more vigilant in their efforts so to ensure that this heightened standard of proof does not serve to further jeopardize the safety of Washington citizens.

Finally, DRW is submitting this report in the context of growing nationwide interest in improving abuse and neglect response. Other states have initiated comprehensive reforms of their abuse and neglect response systems,² and there is proposed federal legislation (the Elder Justice Act).³ Our state would be well-placed to take advantage of federal grant funding or programs, should they become available, provided it immediately evaluates and reforms its systems for responding to abuse and neglect.

DRW appreciates the assistance and cooperation by DSHS and DOH in responding to our requests for data, specific case information, and the policies and protocols that are currently in effect. The responsiveness by both these agencies has enabled us to conduct this review, and all of this information was essential to understanding the issues from a systemic perspective.

² For examples, see South Carolina S.B. 1116 and Wisconsin A.B. 785.

³ See S. 1070 and H.R. 1783.

EXECUTIVE SUMMARY

I. EFFECTIVENESS OF INVESTIGATIONS

A. Quality of Investigations

Problem: Investigations of abuse and neglect are not thoroughly conducted and are compromised by staffing shortages and inadequate training for investigators.

Recommendation: DSHS and DOH should work together in consultation with an investigations consultant to compare and evaluate whether their investigator trainings and quality assurance mechanisms ensure each investigation properly identifies issues to be resolved and thoroughly exhausts all sources of information.

B. Substantiation Rates

Problem: Washington's Adult Protective Services (APS) substantiation rates for its investigations fall far below national substantiation rates. This raises concern that investigations are ineffective, resulting in continuing risk to victims of abuse and neglect.

Recommendation: DOH and DSHS should work collaboratively with an independent consultant to determine the reasons why Washington's substantiation rates fall so far below the national averages and develop strategies to improve the effectiveness of these investigations.

C. Individual Accountability

Problem: No State agency is holding non-licensed individuals civilly accountable for abusing or neglecting vulnerable adults receiving services from DSHS licensed providers.

Recommendation: Residential Care Services (RCS), APS, and HPQA should meet with the Division of Developmental Disabilities (DDD) as well as Home and Community Services (HCS) to clarify the role and limitations of RCS investigations. These agencies should determine how Washington is going to start ensuring the safety of facility residents by holding individual perpetrators of abuse and neglect civilly responsible when the perpetrators are not licensed health care professionals but work in DSHS licensed facilities.

II. PROTECTION OF VICTIMS

A. Quality of Intake Services

Problem: Due to vague or inconsistent intake assessment standards, serious allegations of abuse and neglect may receive little or no response, leaving victims in danger of additional and more severe abuse or neglect.

Recommendation: DSHS and DOH should review their intake and screening policies with the assistance of an independent consultant, to determine whether there is a reasonable basis for their screening policies to differ; whether the policies adequately set forth objective standards that will result in consistent results; and whether these agencies need to request additional authority or a more definite mandate from the legislature to determine when investigations are appropriate.

B. Enforcing Mandatory Reporting

Problem: Washington does not hold mandatory reporters accountable for failure to report incidents of abuse and neglect as required under state law. Where abuse is witnessed but unreported by others, a climate of acceptance – and continuing abuse – is fostered.

Recommendation: DSHS and DOH should work with an independent consultant to carefully consider whether they need additional tools, such as the ability to sanction license holders, to ensure mandatory reporters comply with their obligations. DRW also recommends that DSHS and DOH evaluate whether there may be other strategies to ensure incidents are reported, other than relying on mandatory reporters.

C. Availability of Protective Services

Problem: Protective measures and resources do not sufficiently reduce the risk of further harm to alleged victims during and after investigations.

Recommendation: DSHS and DOH should identify the current mechanisms each agency utilizes to ensure immediate victim safety during investigations; evaluate whether these mechanisms need further coordination; and determine whether new resources, authority, or mandates are necessary to provide for victims, especially where victims rely on the alleged perpetrators as their caregivers.

III. RECOMMENDED PROCESS

A. Create a Commission

To address the system's overall lack of coordination among the various state agencies mandated to respond to allegations of abuse and neglect, we recommend an inter-agency, multi-disciplinary commission which includes HPQA and DSHS consumers, administrators, investigators, an independent expert, the LTCO, DRW, and other stakeholders.

B. Assess the System

We recommend that this commission create and apply a multi-agency assessment tool to evaluate each agency's performance and policies in the areas discussed in this report.

C. Create a Coordinated Plan

Based on the information the team gathers using this tool, we recommend that the commission craft a list of planned internal actions, legislative recommendations, and proposed funding requests calculated to efficiently coordinate the resources, functions, and expertise of each state agency.

ABOUT THE REPORT

Scope of Review

Responding to abuse and neglect of adults with disabilities is a social responsibility shared by all members of society, and a truly adequate response system includes individual citizens and private entities, as well as public entities and law enforcement. For the purposes of this report, however, DRW has focused its review upon cases, data, laws, regulations, and policies specifically relating to how the Department of Social and Health Services (DSHS) and the Health Professions Quality Assurance (HPQA) unit of the Department of Health (DOH) respond to allegations of abuse or neglect of adults with mental illnesses or a physical or developmental disability. DRW has not reviewed, nor does this report discuss the Medicaid Fraud Unit of the Attorney General's Office or the State Long Term Care Ombudsman, both of which also play roles in investigating allegations of abuse and neglect.

In addition, while this report discusses general issues relating to the Residential Care Services (RCS) unit of DSHS, it does not discuss the RCS's investigations or enforcement actions against the Residential Habilitation Centers (RHC). DRW is investigating separate concerns about this issue, and DRW will raise any findings or conclusions about these concerns relating to RHC regulation in a separate forum.

The scope of this report relies on a broad definition of the terms "abuse" and "neglect" to include "financial exploitation" and "abandonment," pursuant to state law, as well as any other action that would fall under the federal or state definitions of abuse or neglect. A list of definitions for "abuse" and "neglect" is attached to this report as Appendix B.

We have defined the scope broadly in order to review how well these state entities work together, to identify gaps in services, and to compare strategies that appear to be working or could be shared. We also chose not to limit our scope to any particular kind of setting or facility, because all adults with disabilities and mental illnesses are entitled to comparable protection from abuse and neglect, regardless of whether they live independently, in institutions, or in the community with provider support.

The chief issues explored in this report relate to the adequacy and quality of investigations and the services provided while investigations are pending. This report does not discuss State post-investigation practices and policies against entities and individuals found to have failed in a facility practice, or engaged in abuse or neglect. DRW, however, has additional concerns about the way these enforcement actions are implemented, and we hope to further explore this issue with DSHS and HPQA at a later time. See Case Examples 3, 5, and 6, Appendix C.

Other important adult abuse and neglect issues such as initial credentialing requirements, criminal prosecution, public education, and availability of quality long-term care resources are beyond the scope of this report; but we are pleased to note that

many of these issues are being addressed in other forums, particularly the Vulnerable Adult Workgroups. We have chosen to focus instead on the initial response by the system to allegations of abuse and neglect. We believe this is a cornerstone of any abuse and neglect response system. While we hope conversations and concrete action continue to occur regarding these other abuse and neglect issues, such issues are not discussed in this report.

Purpose of Report

The purpose of this report is to demonstrate that Washington's system for responding to allegations of abuse and neglect of vulnerable adults is inadequate, and to advocate for HPQA and DSHS to work together, with input from their consumers, other stakeholders, and professionals, to create a coordinated plan to improve Washington's civil abuse and neglect response system.

Methodology of Review

We have compiled this report based on our review of four main sources of information: 1) DRW secondary reviews of individual APS and RCS cases; 2) State and Federal statutes and regulations; 3) agency policies and protocols, 3) national and state reports and surveys; and 4) data reported by each agency in response to our requests for public disclosure. For each area of concern, we reviewed information from at least two of these main sources of information.

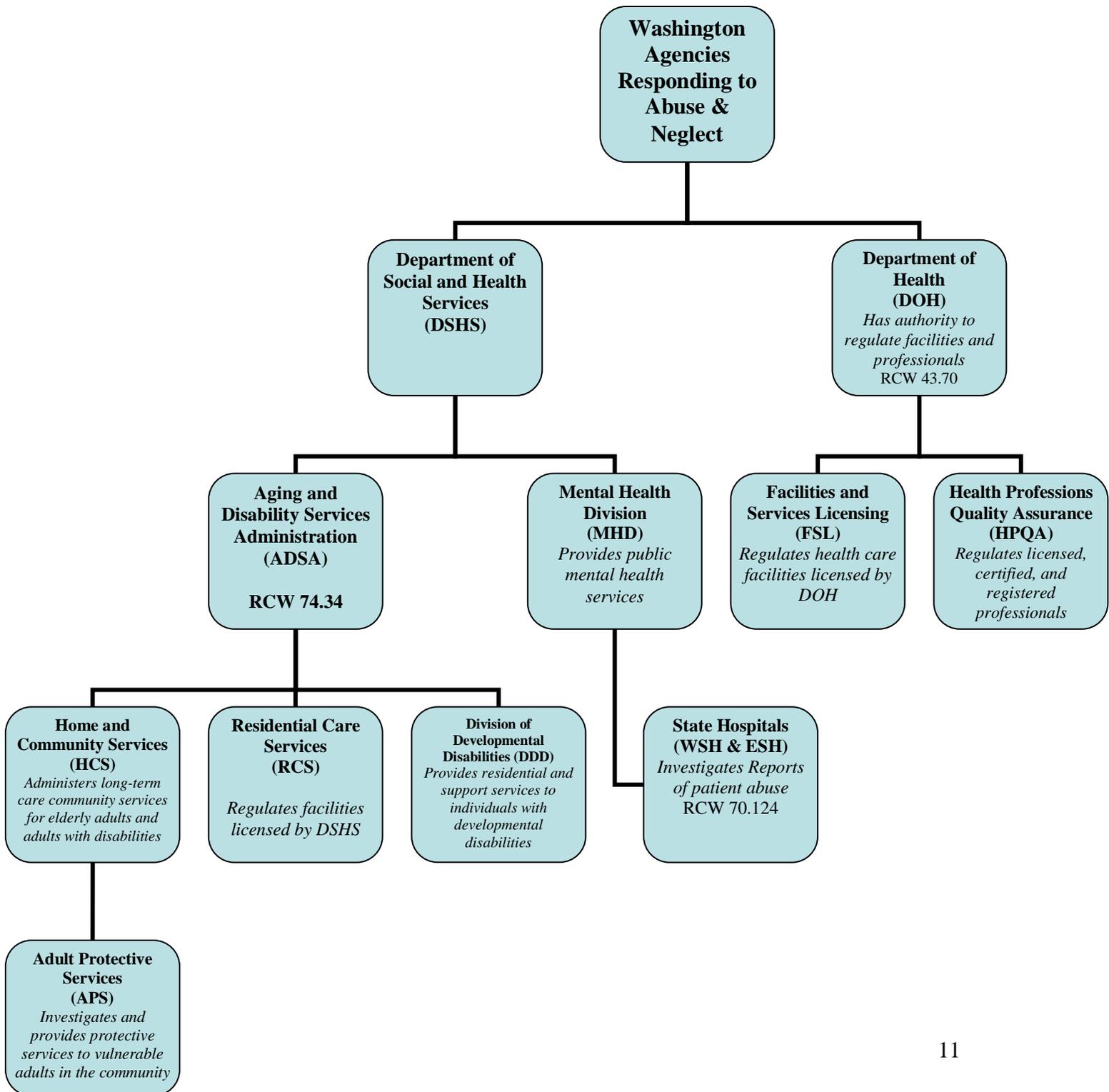
For the secondary reviews of individual investigations, we reviewed the state's findings as well as the complete investigation record, including all the interview and observation notes, evidence, and records relied upon by the investigator. In some cases, we also interviewed the primary investigator. All of these representative examples have been exhaustively documented by DRW staff. For the purposes of confidentiality, much of the identifying information has been purposely left out of the report.

The state and federal statutes and regulations that we reviewed are listed in the Table of Authorities, (Appendix B). The policies we reviewed include the APS manual and the intake, referral, and investigation protocols for RCS, included as Appendices C and D. In addition, we reviewed summaries of HPQA policies that were reported in the HPQA Performance Audit Report.⁴ Finally, the data cited in this report is taken directly from information available online or from information provided to DRW in response to public disclosure requests.

⁴ Report No. 1000002; Performance Audit Report: Department of Health, Office of Health Professions Quality Assurance, August 2007 (cited hereinafter as "HPQA Performance Audit Report"); available at http://www.sao.wa.gov/PerformanceAudit/audit_reports.htm or by request to Washington State Auditor's Office.

OVERVIEW OF WASHINGTON'S ABUSE AND NEGLECT RESPONSE SYSTEM

In Washington, DSHS and DOH are the two state agencies that have primary responsibility for responding to abuse and neglect of vulnerable adults. Under these large, umbrella agencies there are smaller system components which each play a part in the abuse and neglect response system. To provide background on the state entities discussed in this report, this section describes how these two agencies are organized and their primary functions.



DSHS Role in Responding to Allegations of Abuse and Neglect

DSHS houses two main investigatory units that respond to abuse and neglect allegations involving “vulnerable adults.”⁵

Adult Protective Services (APS), which is housed in the Home and Community Services (HCS) unit of the Aging and Disability Services Administration (ADSA), investigates and makes findings about abuse and neglect allegations against private individuals. These individuals usually include, but are not limited to, family members, neighbors, friends, or other acquaintances. APS can also provide protective services if allegations are substantiated.

Residential Care Services (RCS) is another unit of ADSA, which investigates allegations against employees or volunteers of long term care facilities including nursing homes, adult family homes, boarding homes, veteran’s homes, Residential Habilitation Centers, and supported living providers, all of which are licensed by DSHS. RCS has authority to issue citations against the facilities if abuse or neglect allegations are substantiated. However, RCS does not make findings against individual perpetrators.⁶ DSHS also houses the Mental Health Division (MHD), which has responsibility for investigating and taking action where there are incidents of abuse or neglect involving patients of a state psychiatric hospital.⁷

In addition, DSHS provides an array of social and health services to people with disabilities, including residential support and care. Services for people with developmental disabilities are provided by the Division of Developmental Disabilities (DDD) directly and through contracts with private providers. Similarly, HCS also provides case management services to individuals needing long term care to assist in accessing services and resources necessary to continue living safely in the community. HCS case managers are responsible under state law to take action to protect clients from abuse and neglect.⁸

DSHS is also responsible, under a variety of federal laws and regulations which have been promulgated, to ensure the safety and dignity of individuals who are receiving federally funded services. For example, nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are required by federal regulations to ensure that

⁵ The term “vulnerable adults” is defined by RCW 74.34.020(15) to include any person who is “(a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or (b) Found incapacitated under chapter [11.88](#) RCW; or (c) Who has a developmental disability as defined under RCW [71A.10.020](#); or (d) Admitted to any facility; or (e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter [70.127](#) RCW; or (f) Receiving services from an individual provider.”

⁶ Below, this report will discuss why DRW finds the limited scope of RCS investigations and enforcement actions to be problematic.

⁷ There is some discussion of examples relating to abuse and neglect in the state hospitals, but this report does not focus much discussion on this part of the abuse and neglect response system.

⁸ HCS contracted case manager was held liable for negligence when client on COPES waiver was abused and neglected by care provider. *Caulfield v. Kitsap Co.*, 108 Wn. App. 242 (2001).

their residents are free from abuse and neglect.⁹ RCS, as the state survey agency for the Centers for Medicare and Medicaid Services (CMS), is responsible for certifying compliance with these regulations.¹⁰ Similarly, the Social Security Act requires that states take necessary safeguards to protect the health and welfare of individuals receiving home and community based services (known as “waiver” services). DDD and HCS, two subdivisions of DSHS, administer these “waivers” and are the state entities responsible for implementing safeguards to protect their clients’ health and welfare.

Thus, while RCS and APS are DSHS’s primary investigatory units, multiple subdivisions of DSHS share responsibility under state and federal law to ensure the safety of individuals receiving both care and support services.¹¹

HPQA Role in Responding to Allegations of Abuse and Neglect

Housed in the Department of Health, HPQA is charged with responding to allegations of professional misconduct against health care professionals credentialed by DOH. Such misconduct includes, but is not limited to “abuse of a client or patient” as well as acts “involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession” and “Incompetence, negligence, or malpractice which results in injury to a patient or which creates an unreasonable risk that a patient may be harmed.”¹²

HPQA investigations are used to discipline 23 categories of health care professions that it also credentials. Twelve Boards and four commissions also rely on HPQA investigations in order to discipline 34 categories of health care professionals that they credential.¹³ Facilities and Services Licensing (FSL) is another agency with an investigatory role housed in DOH, and it regulates health care facilities such as hospitals, home health care and hospice agencies, laboratories, and surgical centers. Although FSL may regulate facilities that serve individuals with disabilities, this report does not evaluate FSL’s response to abuse and neglect as HPQA is generally the unit that has responded to individual incidents.

⁹ 42 C.F.R. § 483.420(a)(5); § 483.13

¹⁰ 42 C.F.R. Parts 442 and 488; RCS is also responsible for investigating abuse and neglect allegations against nursing home employees under 42 U.S.C. § 1396r(c).

¹¹ 42 U.S.C. 1396n

¹² RCW 18.130.180

¹³ HPQA Performance Audit Report

I. EFFECTIVENESS OF INVESTIGATIONS

In order to hold facilities and individuals responsible for acts of abuse and neglect, state investigations must gather and analyze appropriate evidence in a timely fashion. Any enforcement action ultimately taken against either a facility or individual will inevitably be based upon the quality of the evidence assembled. As such, the importance of conducting effective initial investigations cannot be overstated.

This section discusses how the investigatory capacity of the state of Washington is gravely compromised. Our state substantiates allegations of abuse at a much lower rate than the national average. Most investigations do not result in outcomes benefiting individuals. Without appropriate investigations, it is impossible to justify actions against perpetrators, to know the extent to which abuse and neglect is a problem in our state and in specific facilities, and - in many cases - to protect vulnerable adults from further harm.

We recommend that DSHS and DOH work together to evaluate their training strategies and quality assurance mechanisms, determine the reasons why Washington substantiation rates are so low, and develop strategies to make Washington investigations more effective.

A. Individual allegations of abuse and neglect are insufficiently investigated and are compromised by staffing shortages and inadequate training.

Having conducted multiple primary investigations of abuse and neglect, DRW is aware that there are often significant challenges when investigating allegations of abuse and neglect of adults with disabilities. The alleged victim, for example, may be unable to articulate statements against the perpetrators or otherwise assist in providing necessary information to the investigator. Perpetrators sometimes have great influence over the victims, as many perpetrators may be family or caregivers upon whom the victims rely for physical or financial assistance. These challenges make it absolutely necessary for investigators to exhaust all potential sources of information, including other eyewitnesses, records, photographs, and the investigators' first-hand observations of physical evidence in order to effectively determine whether the incident in question occurred. DRW is aware of several instances in which investigations by DSHS agencies ignored such potential sources of evidence. In other cases, as DRW has observed, state investigators have assumed an even higher standard of proof than is already required by law—and such assumptions may in turn have prevented or delayed remedies that would have appropriately protected the reported victims.

Examples of problematic investigations include the following:

- Family members of a ninety-three year old nursing home resident reported to RCS that they had found injuries on her body which the facility could not explain. When an RCS surveyor conducted an

unannounced onsite survey the day after receiving these allegations, the surveyor made no record of examining the resident to assess the alleged marks on her body. In spite of RCS's knowledge that photographs of these marks were taken on the day they were discovered, RCS never reviewed these photos. Instead, the surveyor relied on the administrator's description of the injuries, which she described as "minor." RCS did not document any independent interviews with potential witnesses to any incident that could have caused the marks found on the resident's body. RCS found the nursing home in compliance with all state and federal regulations and did not issue any citations for failed facility practices. Within a few weeks, the resident died unexpectedly, and as discussed below in Section II.A., RCS did not investigate whether her death was the result of abuse or neglect.

- APS received a report that a non-relative acquaintance of an elderly man had been coercive and verbally abusive. APS made one attempt to interview the elderly man. At the time of this interview, the alleged perpetrator was also present. The APS investigator introduced herself as an APS investigator and then requested that the alleged perpetrator leave the room. He did so. The alleged victim then declined to be interviewed. DRW found no record of any subsequent efforts to address the potential fear of retaliation that may have inhibited the alleged victim from talking with the investigator, particularly as he knew that the alleged perpetrator had been made aware of APS involvement. The investigation did not include any interviews with the staff of the facility where the alleged coercion and abuse occurred. Nor did the investigator interview the alleged victim's long-term partner who witnessed daily interactions with between the alleged victim and perpetrator. Based on this limited investigation, the APS investigator made an "inconclusive" finding and refused to assist in filing for a protection order against the acquaintance, who allegedly continued to harass and verbally abuse the elderly man until he died a few weeks later.
- DRW received information that an individual with a developmental disability and a mental illness had been abused and neglected at a community psychiatric hospital. DRW conducted an investigation into these allegations and found that a number of individuals had witnessed this person being subjected to verbal abuse and being secluded in a single room for unnecessarily lengthy periods of time. DRW also found in the course of its investigation that a second individual with a developmental disability and a mental illness had been abused and neglected at this same community psychiatric hospital. This second individual had been denied food and water to the point that the individual required treatment at a local hospital for dehydration. DRW

informed DSHS of its findings. In response, the Division of Developmental Disabilities (DDD) and the Mental Health Division (MHD) conducted their own investigations. The investigators, however, did not seek information about whether the any of the alleged acts of abuse or neglect had taken place. Instead, the investigations were limited to determining what general steps the facility was taking in order to provide treatment to individuals with developmental disabilities. The investigators did not speak with any of the witnesses DRW identified. The investigators found that the community psychiatric hospital was indeed meeting its obligations, in part because no incidents of abuse and neglect were “self-evident” in the written medical record.

- In the course of conducting its own investigation, DRW notified APS that a vulnerable adult receiving residential services through DDD was living in unhealthy conditions with fecal matter scattered and smeared in the bathtub, in the bathroom sink, on the bathroom floor, in the bathroom waste basket, on the hallway floor, on the living room floor, on the bedroom floor, and on the vulnerable adult’s bed linen. DRW also reported that this individual—who had a history of making suicidal statements and gestures—had unfettered access to a filing cabinet containing multiple weeks worth of psychotropic medication, including Depakote, Zyprexa, and Ativan. DRW provided verbal descriptions to APS as well as photographs that DRW had taken with the individual’s permission to document these conditions. However, the APS investigator concluded the allegations were unsubstantiated because when he, the APS investigator, visited the individual he did not witness the unlocked medications or filthy living conditions. Thus, the investigator found the allegations unsubstantiated based on his own observations and failed to weigh evidence of two eyewitness statements and multiple photographs to determine whether there was a “preponderance of evidence” to support allegations of neglect.
- In regard to this same individual from the example above, when the vulnerable adult was interviewed by the APS investigator, the APS investigator reported that the vulnerable adult acknowledged that one of the co-owners of the agency had yelled at and had been mentally abusive to him. The APS investigator, however, determined that the allegations of verbal abuse were “inconclusive” based on his finding that the mental abuse had occurred “only once” and that this abuse had occurred “over the phone.” Thus, even though the investigator found that “abuse” had occurred according to the definition of abuse in RCW 74.34.020, the investigator unilaterally added elements to this definition by requiring a showing that the “abuse” occurred more than once and in person.

- APS¹⁴ received allegations that an employee of a residential services provider for people with developmental disabilities had been verbally and physically abusive to three residents. This same employee allegedly had taken pornographic photos of another resident. In response, the only investigative step taken by the APS investigator assigned to the case was to interview a single supervisor at the residential services provider on one occasion. The APS investigator did not interview the employee who had made the allegations or any other employees who were said to have first hand knowledge about the allegations and who would possibly have been able to corroborate the statements made by the reporting employee. The investigator also did not interview the alleged perpetrator. Most significantly, the investigator never viewed the allegedly pornographic photographs herself. Based solely on the supervisor's denial of the allegations and the supervisor's statement that she did not personally believe the pictures were pornographic, the case was closed without any further investigation.

Please see Appendix C for additional case examples from other sources.

DRW also has concerns about the quality of investigations conducted by HPQA, based on the HPQA Performance Audit recently performed by the Washington State Auditor's Office.¹⁵ According to the Auditor's report, HPQA investigations of complaints are "compromised by staffing shortages and internal control deficiencies." The report noted that HPQA does not provide formal training to new investigators and that "one investigator noted the process of becoming a new investigator is 'sink or swim.'" The audit also found that due to high caseloads, "investigations may not be as thorough as warranted" and that "given consistent annual increases in the number of complaints received over the past decade, the problem is likely to worsen."

The findings of the HPQA Performance Audit Report are particularly alarming given that HPQA has a higher burden of proof than APS or RCS. HPQA has to prove misconduct by "clear and convincing evidence," rather than a "preponderance of evidence." Thus, for HPQA, it is even more crucial for investigators to find as much evidence as possible to substantiate allegations of abuse or neglect. HPQA must have the evidence to lay a foundation for further actions to protect patients and clients of credentialed health care professionals.¹⁶

Based on these cases and the HPQA Performance Audit, we recommend that DSHS and DOH work together in consultation with an investigations expert to compare and

¹⁴ At the time this incident occurred, APS was responsible for investigating this incident.

¹⁵ HPQA Performance Audit Report.

¹⁶ The HPQA Performance Audit Report also noted that as a result of this Supreme Court decision, "HPQA investigators will have a greater difficulty finding sufficient evidence to sustain disciplinary action, particularly in cases that involve individuals who are unable to speak for themselves, such as minors or those who are incapacitated." p. viii.

evaluate the way in which they train investigators, as well as their quality assurance mechanisms to ensure that each investigation properly identifies issues to be resolved and thoroughly exhausts all sources of information.

B. *The vast majority of state investigations result in no benefit to individuals with disabilities who are at risk of being abused or neglected. This raises concerns about the effectiveness of these investigations, suggesting that victims of abuse and neglect remain at an unacceptable level of risk.*

Washington's Vulnerable Adult Statute provides authority for APS and RCS investigators to conduct interviews and gather evidence by reviewing records and taking photographs.¹⁷ Similarly, HPQA has the authority to conduct investigations of professional misconduct by health care professionals, which includes several categories of actions that also constitute abuse and neglect.¹⁸ If there is sufficient evidence to substantiate the allegations¹⁹, APS, RCS, and HPQA can take various actions to ensure the future safety of individuals with disabilities and to hold providers and perpetrators accountable for their misconduct.

In the vast majority of cases, however, APS, RCS, and HPQA do not succeed in substantiating the initial allegation of abuse or neglect which prompted the investigation. The mere fact that such a small fraction of the incidents reported to RCS, APS, and HPQA are substantiated raises concerns about the effectiveness of investigations by all three agencies.

- For APS, only 10% (1381) of the reports received in 2006 (13,136) were substantiated, and of the reports APS investigated (10,640), only 13% were substantiated.²⁰
- For RCS, 5.8% (estimated 1332) of the complaints received in 2006 (22,970) were substantiated,²¹ and of the reports assigned for an on-site investigation (8,927), DRW estimates about 15% were substantiated;²²

¹⁷ RCW 74.34.067; Residential Care Services Complaint/Incident Investigation Guidance; APS Manual

¹⁸ RCW 18.130.080; RCW 18.130.180.

¹⁹ For APS and RCS, the burden of proof required is "preponderance of evidence" and for HCPA, the burden of proof required is "clear and convincing evidence."

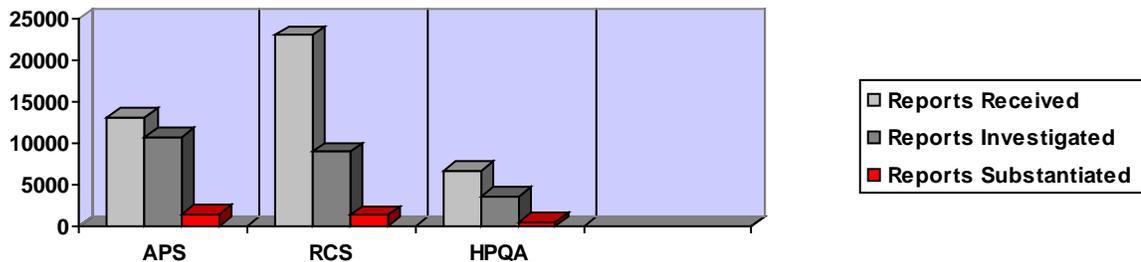
²⁰ When these statistics were gathered, a total of 1,827 cases (14%) were still under investigation. However, if we were to subtract all the pending cases from the total number of cases assigned for investigation, APS's substantiation rate still would only be about 16% (1,381 out of 8,813) of investigated cases.

²¹ RCS defines "substantiated" to mean whether there was a "failed facility practice" in relation to the complaint being investigated and not whether a specific event happened. As discussed below, this practice is in the process of changing, so there is no current data about RCS's rate of substantiating whether specific incidents occurred.

²² This estimate is based on data RCS provided to DRW that 14,043 reports were assigned a "Quality Review" priority, which does not involve an on-site investigation. 5.8% of 22,970 is approximately 1332 cases, which is about 15% of the remaining 8,927 cases that were assigned for an on-site investigation.

- For HPQA, about 10% (594) of the reports received in 2006 (6581) resulted in disciplinary action, and of the reports HPQA investigated (3576), 17% resulted in disciplinary action.

Figure 1 – Washington Substantiation Rates



Based on these statistics, a large majority of cases that go through investigation do not result in protective services, a change in facility practice, or disciplinary action against a professional. Regardless of the cause for the low substantiation rates, this data illustrates a significant problem with efficiency, as it is evident that a large amount of resources are being devoted to cases for which there is no outcome benefiting Washington citizens.

Washington’s APS rates of substantiation do not compare favorably to national statistics for adult protective services. In a 2004 national survey of Adult Protective Services,²³ APS agencies for 50 states plus the District of Columbia and Puerto Rico responded to a survey question regarding the number of reports of abuse each state received regarding vulnerable adults of all ages. According to the survey, the total number of reports received by these 52 APS agencies was 565,747. Out of these reports, 49 states reported a total of 461,135 investigations, and 46 states reported that they had substantiated a total of 191,908 cases. In other words, about 34% of the total number of reports received by the 52 APS agencies that responded to the survey question about the number of reports received was substantiated.²⁴ The survey report also found, “[o]f the 42 states that could provide both the number of reports investigated and substantiated, the substantiation rate was 46.2%” and “the median substantiation rate of individual states was 35.1%.”²⁵

As discussed above, Washington’s substantiation rate for investigated cases is about 13%, or about 16% if all pending cases are subtracted from the total number of

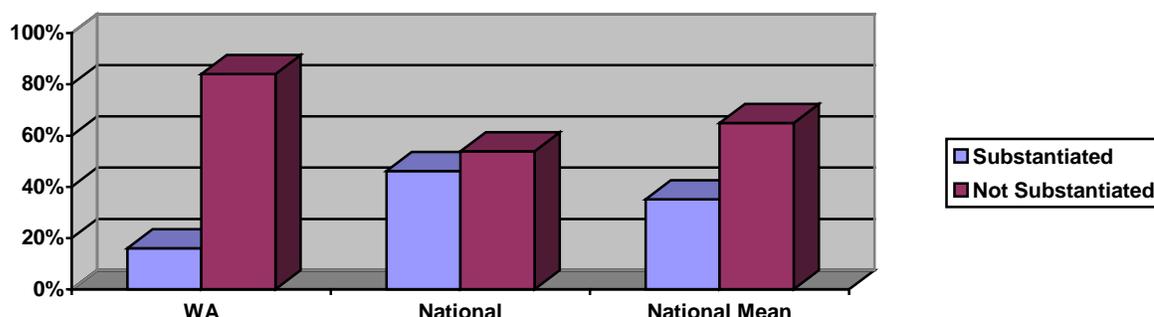
²³ “The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older.” Available online at http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf

²⁴ Because the number of reports substantiated only includes 46 out of the 52 respondents who gave numbers for total reports received, (50 states plus Guam and D.C.), this calculated rate is probably lower than it would be if all 50 states plus Guam and the District of Columbia who reported the number of reports received had reported how many cases are substantiated. With this consideration, the comparison between Washington and national statistics would be even worse for Washington.

²⁵ “The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older,” page 13.

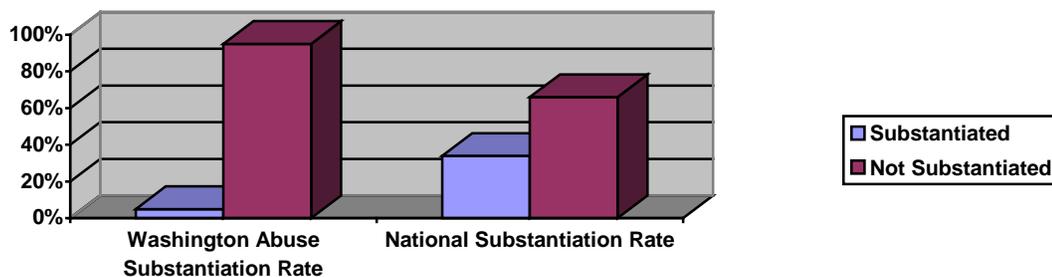
investigations. Thus, these national rates are well over twice as high as the substantiation rates for all cases investigated by Washington’s APS.

Figure 2 – Washington and National Substantiation Rates



Furthermore, these national statistics are only for reports of “abuse” resulting in physical or psychological harm, while the Washington data reflects reports to APS for abuse, neglect, financial exploitation, and abandonment. However, if we were to compare Washington’s APS rates of substantiating “abuse” allegations, the comparison looks astonishingly worse for Washington. For APS, the total number of abuse reports received, including physical abuse, sexual abuse, and mental abuse, was 3,395, but only 177, or just over 5%, were substantiated, which is over *six times lower* than the national substantiation rate for all reports received.²⁶

Figure 3 – Washington and National Abuse Substantiation Rates



This comparison raises a serious question about why Washington’s substantiation rates are so low. There are most likely a number of factors that contribute to this statistic. Some of the possible factors could include poor investigations, poor enforcement processes, or inadequately defined standards for substantiation. These possibilities are grave, and therefore the question of why Washington’s substantiation rate is so low demands careful attention and rigorous analysis.

²⁶ If this calculation were to factor in the consideration that 14% of the cases were pending and subtracted 14% (475) of the total abuse reports received (3395), the substantiation rate would still be as low as 6% (177 out of 2920).

Moreover, while we have not found national statistics to compare RCS's rate of finding "failed facility practices" with national rates,²⁷ national studies find that many state survey agencies struggle to adequately identify violations of federal regulations by nursing homes. In December of 2005, a report by the U.S. Government Accountability Office (GAO) found "ongoing understatement of deficiencies" in which state survey agencies overlooked and failed to cite nursing home facilities for violations of federal regulations.²⁸ In May of 2007, the GAO testified to Congress that although the problem of understating deficiencies has improved since 2005, this problem continues at various levels for different states.²⁹

Also, due to delayed investigations, lack of other eyewitnesses, burdens of proof, and inability to identify perpetrators, researchers have found that in general for nursing home surveys, "the actual number of abuse and neglect cases reported by the nurse aide registries as substantiated is quite small relative to the number of allegations received."³⁰ Given DRW's secondary investigations of RCS cases and the fact that the vast majority of complaints submitted to RCS are unsubstantiated or do not require any plan of correction, DRW is concerned that like other states, Washington also has a significant problem of understating deficiencies for its nursing homes as well as other residential facilities.

We recommend that DOH and DSHS collaborate with an independent consultant to determine the reasons why Washington's substantiation rates fall so far below the national averages and develop strategies to improve the effectiveness of these investigations.

C. *No State agency is holding non-licensed individuals civilly accountable for abusing or neglecting vulnerable adults receiving services from DSHS licensed providers.*

In Washington, RCS is charged with the responsibility for investigating complaints involving employees and volunteers of DSHS-licensed facilities and of supported living providers for clients of the Division of Developmental Disabilities (DDD). APS specifically declines to investigate these cases, and HPQA only has authority to

²⁷ In a 2001 study regarding nursing home surveys, 47% of states reported substantiation rates of 20 to 39 percent, while 35% had rates between zero and 19 percent, but these rates only apply to nursing home surveys and not complaint investigations for all long-term or residential care settings, which is reflected in the Washington data DRW acquired. See Hawes, C., D. Blevins, and L. Shanley 2001 *Preventing Abuse and Neglect in Nursing Homes: The Role of the Nurse Aide Registries*. Report to the Centers for Medicare and Medicaid Services (formerly HCFA) from the School of Rural Public Health. College Station, TX: Texas A&M University System Health Science Center.

²⁸ "Nursing Homes: Despite Increased Oversight, Challenges Remain in Ensuring High Quality Care and Resident Safety," GAO Report to Congressional Requesters, December 2005; Available online at: <http://www.gao.gov/new.items/d06117.pdf>

²⁹ "Nursing Home Reform: Continued Attention is Needed to Improve Quality of Care in Small but Significant Share of Homes," GAO Testimony Before the Special Committee on Aging, U.S. Senate, May 2, 2007; Available online at: <http://www.gao.gov/new.items/d07794t.pdf>

³⁰ Richard J. Bonnie and Robert B. Wallace, Editors; "Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America" (2002).

investigate allegations against individuals who are registered, certified, or licensed through the Department of Health.

RCS, however, is not equipped to conduct investigations calculated to substantiate whether the incident of abuse or neglect actually occurred. According to RCS's current policies, the purpose of RCS investigations is limited to identifying a "failed facility practice," which by RCS's policy definition is "more than one occurrence" of "inadequately providing services or the provision of poor quality of services to one or more residents," although "one severe incident" may constitute a practice as an exception to the rule.³¹ Thus, these investigations do not seek evidence to substantiate whether single incidents of abuse or neglect occurred. RCS, instead, relies heavily on the facilities' own investigations, and unless it finds a flaw in the facility's investigative process, defers to the facility conclusions. The focus is thus on whether the facility followed policies and conducted an investigation, but does not usually involve a primary "de novo" investigation of its own to determine whether its conclusions match with those of the facilities.

Reliance on facilities to reach accurate conclusions about their own employees and practices places residents at risk. This is because facility self-investigations have inherent biases and conflicts of interest. For instance, facilities could be held civilly liable for actions by employees, and findings of abuse or neglect could be an admission of liability. Facilities also have an interest in protecting their reputation, and finding their own employees guilty of abuse or neglect would conflict with this interest. Therefore, as one investigation expert has noted, investigations are insufficient if they only amount to "administrative" reviews that look to whether policies were followed as opposed to what actually occurred and who was responsible.³²

DRW understands RCS is in the process of changing its operational procedures to conduct investigations calculated to determine whether alleged incidents of abuse or neglect occurred. However, these policies have yet to be adopted or implemented. Furthermore, DRW understands that RCS has acquired funding for a total of seven full-time employees for all licensed residential care facilities in the State of Washington. These employees must investigate any evidence to hold individuals responsible for one-time instances of abuse or neglect. Given the fact that there are over 3,000 licensed facilities in Washington, for over 64,000 residents,³³ the addition of seven full-time employee positions is grossly insufficient for RCS to be able to conduct these investigations.

Like APS, RCS has the authority to conduct investigations of individual allegations under RCW 74.34. It also has a responsibility to do so. For nursing homes, RCS is required under federal law as the state survey agency to "make a finding as to the

³¹ Residential Care Services Complaint/Incident Investigation Guidance, available online at <http://www.aasa.dshs.wa.gov/professional/RCS/QSURE/C-I%20Guidance.pdf>

³² Randolph W. Thomas, et al, "Unequal Justice for South Carolinians with Disabilities" (2005); available online at www.protectionandadvocacy-sc.org.

³³ <http://www.aasa.dshs.wa.gov/Professional/RCS/charts/html/afhbhnhfacilitydata07.htm>,

accuracy of the allegations” and if it finds abuse or neglect, to report this to the appropriate authorities. 42 U.S.C. § 1396g(1)(C). The federal regulations require the state survey agency to “establish procedures and maintain adequate staff to investigate complaints of violations of participation requirements,” and if, based on its investigation, the State “has reason to believe that an identifiable individual neglected or abused a resident,” the State is required to act in accordance with § 488.335, which provides specific notice, hearing, and reporting obligations. 42 C.F.R. § 488.332.

In addition, the Division of Developmental Disabilities has represented to the Centers for Medicare and Medicaid Services (CMS) that Washington ensures the safety of Medicaid waiver participants with developmental disabilities through investigations by RCS. These investigations cannot be the basis for ensuring the participants’ health and welfare if they are not even calculated to determine whether there is evidence to substantiate allegations of abuse and neglect and rely primarily on the representations by the facility administrators.

By relying on RCS as it is currently configured to investigate abuse and neglect by providers, the state of Washington has allowed for the creation of a dangerous gap in its abuse and neglect response system. This gap must be immediately addressed by leaders from all parts of the system.

Consequently, Washington does not have the capability to collect enough evidence to support state civil action against the individual perpetrators, and will only take action against the facility if there is a “practice” of noncompliance with a specific regulation. A gap is therefore created because no other investigatory unit reviews these incidents, that is no State agency investigating single incidents of abuse and neglect of residents living in nursing homes, boarding homes, adult family homes, institutions, and with supported living services.

Individuals who live in facilities deserve the same protection from abuse and neglect as individuals who live in the community. The difference in the way RCS and APS responds to allegations of abuse and neglect results in unequal protection by the state for adults who do not live independently.

DRW thus recommends that RCS, APS, and HPQA immediately meet with DDD as well as HCS to clarify the role of RCS and determine how Washington can begin to better protect facility residents.

II. PROTECTION OF VICTIMS

Other aspects of Washington's civil investigation system do not adequately ensure a proper initial response to alleged incidents of abuse and neglect. Although Washington's system has mechanisms in place for incident reporting, case assignment, and protecting victims while investigations are pending, these mechanisms require improved coordination and must be applied with more concrete and consistent standards in order to fulfill their proper function. DRW recommends that DOH and DSHS evaluate these mechanisms to identify gaps in services and propose new strategies to ensure that incidents are reported, cases are appropriately assigned, and that victims are kept safe.

A. *Washington does not hold mandatory reporters accountable for failure to report incidents of abuse and neglect as required under state law. Where abuse is witnessed but unreported by others, a climate of acceptance – and continuing abuse – is fostered.*

Almost every state in the U.S., including Washington, has a mandatory reporting statute requiring certain groups of professionals and direct care staff to make reports to the state where there is reason to believe a vulnerable adult has been abused or neglected.³⁴ Adults with disabilities sometimes lack the ability to report problems on their own. As one writer notes, “For many elderly victims of abuse, the hospital is the only potential site for outside contact and support.”³⁵ Others point out that “victims with cognitive disabilities often lack the vocabulary to report the abuse,” and “[e]ven if it is reported, the victim is often not believed or is thought to be fantasizing, or to have merely misinterpreted what occurred.”³⁶ Moreover, identified “victim factors” that make elderly adults and adults with disabilities more vulnerable to abuse and neglect include “cognitive deficits which may make it difficult for the victim to recognize unlawful activity and/or their rights to safety and protection” as well as “presence of communication or physical impairments which limit their ability to...disclose abuse” and “fear of retribution from the perpetrator if they do report.”³⁷ Thus, due to the fact that many victims are not able to recognize and report abuse or neglect themselves, mandatory reporting laws can be extremely useful, if not essential, to ensure state systems are able to detect and respond to abuse and neglect.

Washington's mandatory reporting laws require many different kinds of professionals to immediately report to DSHS when there is reasonable cause to believe a vulnerable adult has been abused, neglected, exploited, or abandoned. Reports must also be made to law enforcement if there is reason to suspect that the abuse constituted a

³⁴ Richard J. Bonnie and Robert B. Wallace, Editors; Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America (2002), page 122.

³⁵ Kahan FS, Paris BE, Mt. Sinai J Med. 2003 Jan; 70(1): 62-8.

³⁶ Joan Petersilia, “Invisible Victims: Violence Against Persons with Developmental Disabilities”; American Bar Association Section of Individual Rights and Responsibilities, Winter 2000 Human Rights. Available online at: <http://www.abanet.org/irr/hr/winter00humanrights/petersilia.html>.

³⁷ Abuse and Neglect of Adults with Developmental Disabilities: A Public Health Priority for the State of California. Available online at: <http://www.pai-ca.org/PUBS/701901.htm>.

sexual or physical assault.³⁸ The list of mandatory reporters includes 11 different professional categories, including law enforcement officers, school personnel, social workers, health care providers, and facility employees. Failure to report could result in a criminal conviction with a penalty of up to one year in jail and \$5,000 in fines.³⁹ Reporters are also immune from liability based on reports made in good faith, can choose to remain anonymous, and can seek damages against employers who retaliate for reporting.⁴⁰

These mandatory reporting laws are, however, rarely—if ever—enforced. DRW has repeatedly encountered cases in which mandatory reporters fail to report incidents of possible abuse or neglect with no consequent civil or criminal liability. These reporting lapses are not limited to group homes, Residential Habilitation Centers (RHC) or nursing facilities, but appear in multiple service delivery systems as a state-wide issue requiring a multi-agency strategy.

Examples illustrating this problem include:

- At a state-run RHC for people with developmental disabilities, DRW found widespread failure on the part of staff to report incidents of abuse and neglect. While the facility in question responded with a plan of correction and staff training, DRW conducted an investigation a year later and found that the facility continued to fail to appropriately report incidents. According to its own records, the facility acknowledges that a “culture” of failing to appropriately report incidents continues to exist at the facility.
- In another case, DRW was advocating for an individual receiving services from a home care agency. In spite of repeated reports by the individual and DRW to the individual's case manager that the home care agency workers were not coming to work as scheduled, the case manager did not make a report to APS until DRW brought it to his attention by letter that he is a mandatory reporter.
- DRW also has noted numerous other examples at both State Psychiatric Hospitals⁴¹ in which staff have failed to report allegations of abuse or neglect of patients.

The sole remedy under Washington's Vulnerable Adult statute for enforcing a mandatory reporter's obligation is to pursue criminal sanctions. However, DRW is unaware of *a single case* in which the criminal penalties provided in the mandatory reporting statutes were applied. DRW is unaware of any policy requiring referrals to law enforcement in the event that the mandatory reporter knowingly failed to make a

³⁸ RCW 74.34.035

³⁹ RCS 74.34.053

⁴⁰ RCW 74.34.050

⁴¹ State Hospital employees are mandatory reporters under RCW 70.124.030.

report.⁴² Furthermore, facilities are not required by law to terminate employees who fail to report, and none of the examples discussed above resulted in an employee being terminated on the basis of the employee's failure to make a mandatory report.

Other states have statutes that provide state agencies with authority to impose other non-criminal penalties that could also encourage mandatory reporters to comply with their obligations. At least five other states make the failure to file "any report" required by law grounds for disciplinary action by the state or license revocation, and the District of Columbia allows state discipline for failing to report suspected elder abuse or neglect.⁴³ However, Washington's Uniform Disciplinary Act, which applies to healthcare professionals who are credentialed through DOH and includes a list of 25 items that constitute "unprofessional conduct" for which a credentialed practitioner may be disciplined, does not include failing to make a mandatory report to DSHS.⁴⁴

Vulnerable adults often depend on mandatory reporters to identify abuse or neglect they are suffering, but it appears that mandatory reporters routinely fail to fulfill their duties under the law, which renders the tool of mandatory reporters useless. The sole remedy to enforce mandatory reporting, while severe, appears to be seldom or never used. In order to protect vulnerable adults who do not have the ability to report abuse or neglect themselves, Washington must either find a way to enforce its mandatory reporting statute, or find another mechanism to ensure incidents are discovered and investigated.

Thus, DRW recommends that DSHS and DOH work with an independent expert to carefully consider whether they need additional tools, such as the ability to sanction license holders, to ensure mandatory reporters comply with their obligations. DRW also recommends that DSHS and DOH evaluate other strategies to supplement the mandatory reporting process in order to ensure that incidents are appropriately reported.

B. Due to vague or inconsistent intake assessment standards, serious allegations of abuse and neglect may receive little or no response, leaving victims in danger of further abuse or neglect.

In Washington, state investigations of all complaints, including complaints of abuse and neglect, are discretionary. APS has discretion to determine whether or not to

⁴² RCW 74.34 requires referrals to law enforcement if the alleged abuse or neglect constitutes a criminal act. This language does not appear to require law enforcement referrals where there is evidence of other crimes, such as failure to make a mandatory report. The APS manual instructs APS workers to consult with Regional Administrators or designees to determine whether to make a law enforcement referral when mandatory reporters fail to make mandatory reports, but APS policies do not require these referrals. DRW found no RCS policy requiring law enforcement referrals for instances where failures to report were identified.

⁴³ Seymour H. Moskowitz, Reflecting Reality: Adding Elder Abuse and Neglect to Legal Education, 47 Loy. L. Rev. 191 (2001): "Because health care and other professionals are usually in the best position to discover and treat elder abuse, the threat of licensure sanctions may provide the best means to encourage reporting...Some states require licensure boards to be notified of professionals convicted of failure to report elder abuse." (219-20).

⁴⁴ RCW 18.130.180

investigate the complaints of abuse or neglect it receives.⁴⁵ RCS, likewise, has discretion to determine whether to assign a complaint against a long-term care facility employee or volunteer for investigation. HPQA only investigates complaints of unprofessional conduct by credentialed professionals if the disciplining authority determines the allegation merits investigation.

The decision to initiate an investigation of an allegation of abuse is especially critical particularly because, as has been noted by experts in the field, “mistreatment is likely to escalate in frequency and severity over time” and “if intervention is not initiated when abuse is first observed,” the abuse will be likely to continue.⁴⁶ Moreover, as explained above in the introduction to this report, the state is responsible for ensuring the health and welfare of residents living in community long-term care settings⁴⁷ and for enforcing rules requiring facilities to ensure residents are not abused or neglected.⁴⁸

Based on our review of case examples, data, and policies, DRW has growing concerns that Washington’s entire system for responding to abuse and neglect allegations is not equipped with adequate standards or resources to thoroughly assess the thousands of allegations received by DSHS and DOH each year.

DRW’s concerns are partly based on examples of problematic intakes, some of which are summarized below:

- APS received a report that medical evidence had been found to strongly suggest that a young woman with a developmental disability had been raped. According to the report, the woman, who was functionally non-verbal and lacked the capacity to consent to a sexual relationship, was found to have a sexually-transmitted disease which her doctor stated was most likely contracted through sexual contact with an infected individual. APS declined, however, to investigate on the basis that “there is no time frame given when the sexual contact took place and also no named perpetrator” even though her doctor had noted that she had tested negative for this disease during her previous exam and two care providers who had direct contact with the individual during this time had been the subject of prior APS investigations involving allegations of physical abuse, sexual abuse, and neglect.
- In the nursing home case discussed above, within weeks of RCS determining that the nursing home was in compliance with state and federal regulations, the nursing home made a self-report to RCS that the woman whom the facility had been accused of abusing and neglecting had unexpectedly died. The facility’s own report stated that her death was “unexpected,” but based on the facility’s

⁴⁵ WAC 388-71-0115

⁴⁶ Moskowitz, (citing Lorin A. Baumhover & S. Colleen Beall, Prognosis: Elder Mistreatment in Health Care Setting, in Abuse, Neglect, And Exploitation Of Older Persons; Strategies For Assessment And Intervention, 241, 248 (1996)); See *also*, Example 10, Appendix C.

⁴⁷ 42 U.S.C. 1396n(c)(2) (requiring states to have necessary safeguards to protect the health and welfare of the individuals);

⁴⁸ 42 C.F.R. § 483.420(a)(5); § 483.13

self-report that her death was “probably a natural death.” RCS declined to investigate whether the resident’s death was related to abuse or neglect, or any other failure by the facility to provide adequate care. RCS made this decision in spite of the recent complaints RCS had received about her care and in spite of RCS’s own observations that she recently had been fed when there was a “do not feed” order in place to reduce her risk of aspiration. RCS also made the decision not to investigate whether her death was related to abuse or neglect in spite of medical records from the night before her unexpected death documenting that the nursing home refused her family’s request for her to be taken to the emergency room. The nursing home made this refusal even though no nursing home doctor or nurse assessed her condition to determine whether she needed hospital care.

- DRW received a complaint from an individual that he had been physically and verbally abused by one of the supervisors at a sheltered workshop where he was employed. DRW referred the reporter to the 1-866-END-HARM hotline to make a complaint, but the reporter stated that the intake worker informed him that DSHS would not investigate. The reporter, who self-identified himself to DRW as having cognitive disabilities, reported to DRW that he was never able to fully explain that he worked at a sheltered workshop for people with disabilities, and he stated he was unable to explain that he had a mental disability. Frustrated with this process, and having second thoughts based on his fear of retaliation, he did not wish to further pursue an investigation himself. A few weeks later, he moved out of state to be closer to his family. DRW alerted DDD about the report, and DDD responded in writing that APS “could not follow up without names and addresses” of alleged victims.
- HPQA investigated a complaint by a facility against one of its former employees for lacking professionalism when she had an argument with one of her superiors. The Respondent sent a statement to the investigator alleging that she had spoken up against the facility for engaging in medical malpractice and had made multiple specific cross-allegations against the facility for patient abandonment and neglect. These incidents of abandonment and neglect, according to the Respondent, had resulted in patient injuries and had placed patients with serious mental health conditions at risk. HPQA is authorized to open investigations based on information received from any source⁴⁹ and is not limited to investigating “complaints” received through its formal complaint process, and therefore could have investigated these allegations. However, the investigator for the original complaint against the respondent informed DRW that no further investigation had been conducted for the allegations made by the respondent in her letter.

See also, Example 1, Appendix C.

⁴⁹ RCW 18.130.080

These examples demonstrate problems with the amount of discretion agencies have to determine whether to initiate an investigation. Washington does not have consistent statutory standards upon which intake staff for APS and RCS can rely to determine whether or not a complaint merits investigation. The governing statutes provide little or no guidance for RCS and APS. Under the Vulnerable Adult Act, DSHS, which houses both APS and RCS, is required to respond within 24 hours of receiving a report of abuse or neglect,⁵⁰ but this statute does not have any language to guide the decision as to whether or not to investigate the allegations.

While there is some additional guidance for whether to initiate facility investigations, which are conducted by RCS, these statutes do not establish a uniform standard for all RCS regulated facilities and include highly subjective factors that are poorly defined. For instance, statutes governing Nursing Homes and Boarding Homes specify that investigations are required for complaints of abuse and neglect unless DSHS determines (a) the complaint is intended to willfully harass a licensee or employee of the licensee; or (b) there is no reasonable basis for the investigation; or (c) corrective action has been taken. No further language defines the basis for determining when an investigation need not occur.⁵¹ The state statute for Adult Family Homes specifies that an investigation must be conducted when it has been alleged that an Adult Family Home is operating without a license, but statutes do not require investigations in response to any other allegation.⁵² Additionally, state statutes offer no guidelines as to when an investigation is required into allegations of abuse or neglect occurring at other facilities such as the Residential Habilitation Centers (RHCs) and supported living facilities for people with developmental disabilities.⁵³

HPQA also has a statutory mandate to review complaints and initiate an investigation “if the disciplining authority determines that the complaint merits investigation, or if the disciplining authority has reason to believe, without a formal complaint, that a license holder or applicant may have engaged in unprofessional conduct.”⁵⁴ By contrast to statutes applying to RCS and APS, the statute for HPQA provides guidance to the disciplining authority to consider historical factors such as prior complaints, actions, findings of fact, or stipulations, and investigations are mandated where the disciplining authority receives information that a health care provider has been disqualified from participating in the federal Medicare program.⁵⁵

Nevertheless, the findings of the HPQA Performance Audit showed significant practical problems with HPQA’s intake process, including findings that “intake and assessment staff do not consistently use and apply written assessment guidelines” and “the

⁵⁰ RCW 74.34.063

⁵¹ RCW 18.20.185(3); RCW 18.51.200

⁵² RCW 70.128.110;

⁵³ Also note that WAC 388-97-077(2) requires review of abuse and neglect allegations against nursing home staff and an investigation if based on the review, there is reason to believe a nursing home resident has been abused or neglected, but these regulatory requirements do not exist for other long-term care facilities such as boarding homes and adult family homes.

⁵⁴ RCW 18.130.080(1)

⁵⁵ RCW 18.130.080

database does not include specific information about complaints so staff can meet this requirement [to determine if other complaints have been filed]” and are “unable to identify patterns of behavior that might escalate to unprofessional conduct or that consistently fall below a standard of care.”⁵⁶

APS, RCS, and HPQA have developed policies to guide their intake processes. These policies differ dramatically from one another.

- According to APS’s written policies,⁵⁷ APS investigates all allegations against perpetrators who are not facility employees or volunteers *except* if 1) the alleged victim does not meet the definition of “vulnerable adult” 2) the allegations do not constitute abuse, neglect, abandonment, or financial exploitation; 3) the allegations were of a single incident resulting in no or superficial injuries; 4) the report does not contain sufficient information to locate the alleged victim and APS cannot obtain clarification; or 5) the alleged victim was deceased 14 days before the report was made.
- HPQA may not investigate unless the boards and commissions determine whether a complaint merits investigation.⁵⁸ The boards and commissions, however, do not have standardized guidelines to determine if a complaint does or does not meet the requirements for initiating an investigation.⁵⁹
- RCS screens out reports of noncompliance by long term care facility staff if the facility “appears to have taken appropriate action in response to the situation, and measures have been instituted by the home to prevent reoccurrences.”⁶⁰ Such cases are assigned a priority of “Quality Review,” which means that RCS does not conduct an on-site investigation of the allegations.

The data regarding the number of complaints actually investigated reflects these differences in policies and demonstrates considerable variation in the rates of investigation among the three agencies. Based on the data DRW received from DSHS and DOH:

- APS, the DSHS subdivision responsible for investigating abuse by non-staff in community settings, investigated 9,986 (80%) out of 12,518 reports received of abuse or neglect.
- HPQA, which is responsible for investigation allegations against professional holding a license, initiated investigations for 3576 (54%) out of 6581 complaints received.

⁵⁶ HPQA Performance Audit Report, p. 19

⁵⁷ HCS Management Bulletin H07-025

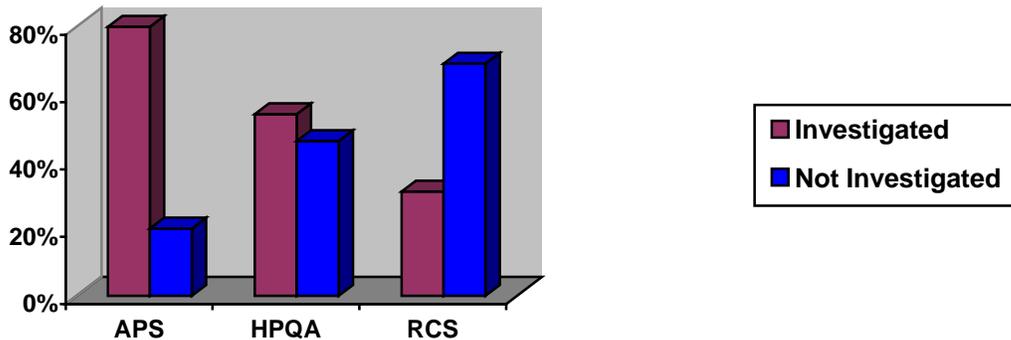
⁵⁸ *Client A. v. Yoshinaka*, 128 Wn. App. 133 (2005)

⁵⁹ HPQA Performance Audit Report, p. 22.

⁶⁰ “RCS Complaint Priorities” attached hereto as Appendix D.

- RCS, which is responsible for investigating allegations of complaints regarding facilities, including complaints of abuse and neglect, assigned 8,927 (31%) of 28,492 allegations received for an onsite investigation.⁶¹

Figure 4 – Investigation Rates



RCS only investigates allegations which, in the opinion of RCS, are considered to be indicative of likely *future* harm. As such, this standard does not address—and is not apparently intended to address—the issue of whether the alleged incident of abuse or neglect actually occurred. It is therefore not surprising that RCS, among the agencies discussed, has the lowest rate of investigation.

This policy is alarming for a number of reasons and appears to be in violation of federal and state regulations. Specifically, relevant regulations regarding nursing homes require that DSHS investigate if there is “reason to believe” that a nursing home resident has been abused or neglected by an individual.⁶² These regulations do not allow DSHS to make an exception that it need only investigate those allegations of abused or neglected nursing home residents which may result in future harm. Furthermore, the intake unit for RCS, called the Complaint Resolution Unit, relies on the individual judgments of the intake staff to determine whether the complaint should be investigated. Aside from this rather vague standard, RCS does not have a written policy with a more specific criteria to determine assignment of investigation.⁶³

Because investigations are necessary to find evidence that will enable state action to protect vulnerable adults, it is crucial for the intake process to appropriately identify cases requiring investigation. Given the discrepancy between the rates at which complaints are assigned for investigation, coupled with the lack of concretely defined

⁶¹ 14,093 of these complaints were assigned a priority of “quality review” in which no investigation is assigned and 5,522 were not assigned any priority at all.

⁶² 42 C.F.R § 488.335; WAC 388-97-077

⁶³ The federal guidance found in the State Operations Manual (SOM) for CMS only states that intakes may be assigned an offsite administrative review as opposed to an onsite investigation “if an onsite investigation is not necessary,” and that this category should not be used for deemed providers for allegations of substantial noncompliance. See SOM § 5075.5.

standards for determining whether to investigate, DRW has serious concerns that these examples represent broader systemic problems with the intake mechanisms for RCS, APS, and HPQA. If these mechanisms are not reformed, the issues depicted above suggest that many cases warranting investigation will receive no or very limited response, further jeopardizing the safety of many individuals.

We recommend that DSHS and DOH review their intake and screening policies with the assistance of an independent expert to determine whether there is a reasonable basis for their screening policies to differ, to evaluate whether the policies adequately set forth objective standards that will result in consistent results, and whether these agencies need to request additional authority or a more definite mandate from the legislature to determine when investigations are appropriate.

C. *Washington's protective services are limited and do not sufficiently reduce the risk of further harm to alleged victims during and after investigations.*

In addition to investigating allegations of abuse and neglect, an adequate abuse and neglect response system protects victims during and after investigations. Based upon our review of Washington's system and experiences, DRW has concluded that Washington's civil response system is poorly equipped to provide protections to vulnerable adult victims who are willing and capable, either on their own or through an existing guardianship, of giving consent for protective services.

For example, in the case discussed above wherein a young woman with a developmental disability had been raped, the woman was left in the same facility for *five months* while a subsequent investigation by RCS was pending. This was particularly concerning given that the alleged rapist may have been one of the caregivers employed by the facility and, as such, may have had continued access to the young woman. DDD informed the young woman's mother that DDD would not take any additional or emergency steps to facilitate her moving because APS had not made a positive finding of abuse or neglect and because the RCS investigation was still open. In spite of DRW's efforts to convince DDD to remove the client from the facility where the rape most likely occurred, and where the client could be raped again, DDD continued to instruct the client's mother to seek out other contracted providers on her own. The mother and DRW were informed that the client would only be moved once the mother found an acceptable alternative placement, once the new placement agreed to accept the client as a new resident, and once the "bid" submitted to DDD by the new service provider for the proposed cost of care was approved by DDD. Both the mother and DRW were informed that this was the standard method by which DDD procured new placements for clients and that no additional or emergency steps would be taken.

This example highlights the importance in accessing protective services in a timely fashion. This is an issue that challenges Washington, as well as other states. In a 2003 national survey of APS administrators, 24% of the 42 respondents stated that they believed the lack of emergency alternative placement options was one of the most

significant problems they faced. DRW is not aware of any emergency facilities specifically for vulnerable adults who may be displaced from their homes after occurrences of abuse or neglect. Although facilities may be able to remove the alleged perpetrators in some instances, this remedy is limited where the perpetrator cannot be immediately identified, or where the alleged perpetrator is the only caregiver immediately available.

We have noted that the Vulnerable Adult Statute provides DSHS with the ability to provide protective services after receiving an initial report of abuse or neglect that may be criminal.⁶⁴ In regard to non-criminal allegations, however, DSHS is only required to ensure the victim's access to protective services "when the investigation is completed and the department determines that an incident of abandonment, abuse, financial exploitation, neglect, or self-neglect has occurred."⁶⁵ During the investigation, DSHS may conduct ongoing case planning with mandatory reporters, designated consultants, and tribal representatives, but it is presently unclear as to whether DSHS has statutory authority to provide protective services prior to substantiating a complaint when there is no suspicion of a criminal act. It is the finding of the present report that such statutory authority should be made explicit.

Moreover, an "inconclusive" or even "unsubstantiated" finding does not necessarily mean that the incident did not occur or that the alleged victim is safe without further protection. In the 90% of reported cases which are either not investigated or result in an "inconclusive" or "unsubstantiated" finding by APS, victims have very limited remedies they can pursue without state assistance. Although they may still seek a protection order against the alleged perpetrator, this remedy has significant practical limitations for individuals with cognitive disabilities or significant health issues as these individuals may be unable to file on their own behalf.

The remedies for individuals who allege abuse by facility staff are even more limited due to the fact that it can take multiple agencies to remove abusive or neglectful staff from the facilities or to provide alternate placements for the residents. In many cases, the only third party investigations conducted are by RCS, which does not provide protective services like APS. As illustrated in the example described above, RCS must also rely on DDD to find alternative placements to ensure the safety of victims during and after investigations, and on HPQA to take action against the perpetrator's credentials.⁶⁶ HPQA investigates allegations against individual professionals, but these do not include many caregivers who work in community residential homes or RHC's. Furthermore, there is no mandatory reporting law to DOH, so HPQA has to rely on permissive reporters and referrals from DSHS to conduct these investigations. These investigations also can take over a year to complete, and no safeguards for residents

⁶⁴ RCW 74.34.063(2)

⁶⁵ RCW 74.34.067(6)

⁶⁶ The regulations for the Nursing Home Resident Protection Program require nursing homes to investigate allegations and ensure the safety of alleged victims during investigations, but there are not regulations for DSHS to ensure safety in the interim, and these regulations do not necessarily apply to other licensed long-term care facilities.

are provided by HPQA while these investigations are pending. Thus, because of this fragmentation of responsibility among multiple state agencies, facility residents have very few immediate options for accessing services that will ensure their safety, even after allegations of abuse or neglect have been submitted to the state.

All individuals, whether they live in their own homes or in a facility, have a right to be safe from abuse and neglect. Unfortunately, based on the resources and organization of state agencies in Washington, DRW fears that many vulnerable adults may not be able to access protections they need to ensure their safety while investigations are pending and even after investigations are complete.

Ensuring the safety of victims will take coordination between divisions within DSHS as well as coordination between DSHS and DOH. Therefore, DRW recommends that DSHS and DOH identify the current mechanisms each agency has to immediately ensure victim safety before investigations are complete, evaluate whether these mechanisms need to be further coordinated, and whether new resources, authority, or mandates are necessary to provide for victims, especially where victims rely on the alleged perpetrators as their caregivers.

III. **CONCLUSION: Convene Abuse and Neglect Response Reform Commission**

The policies, data and examples discussed for this report demonstrate reasons why DRW believes much improvement is needed in order for Washington to ensure the protection of individuals with disabilities. These areas of needed improvement affect multiple systems and agencies. We conclude that comprehensive and coordinated reforms are necessary in order to improve how each agency responds to abuse and neglect, as well as how the agencies work together as a system.

In order to achieve reforms that will work in Washington, DRW recommends that DSHS and HPQA jointly convene an inter-disciplinary commission to systemically evaluate the state's response to abuse and neglect. We recommend that the commission use the areas of concern we have raised in this report as a starting point. We anticipate that the commission will propose legislative, regulatory, and policy changes, and request the resources that will be necessary to make these improvements a reality.

To ensure an adequate base of knowledge and expertise as well as a balance of perspectives, we recommend that this commission include state agency administrators with decision-making authority and at least one investigator with a current caseload from RCS, APS, and HPQA. We also recommend that HPQA and DSHS invite at least three individuals with disabilities and three seniors who have received or requested services from one or more investigatory units. In addition, we recommend including representatives from major non-state stakeholder organizations, including the Long-Term Care Ombudsman, Disability Rights Washington, and the Arc of Washington.

Specifically, we request that this commission first develop an evaluation tool with the assistance of an independent expert in order to conduct a system-wide review. This review must, at minimum, address the following:

- Quality Assurance - Evaluation of the overall quality of their investigations and mechanisms to ensure all APS, RCS, and HPQA investigations are thoroughly conducted. This evaluation should analyze: quality assurance mechanisms, staff trainings on abuse response investigation, amount of time given to each investigation, investigation protocols, staffing, and caseloads to determine what each agency needs in order to improve the general quality of investigations.
- Intake and Investigation - An interagency review by APS, RCS, and HPQA of their intake procedures and policies to determine if the standards for deciding whether to investigate provide a sufficient level of guidance for intake staff. This review should assess whether there is a basis for standards to differ among the agencies, whether the differences in standards reasonably reflect differences in function, or whether the policies and standards are the result of resource limitations that would justify legislative or executive action.
- Protection of Victims -Further study and evaluation to determine the extent to which DSHS and DOH are able to provide reasonable protections for alleged

victims who are willing to receive such services, to determine what resources or legislative amendments may be necessary, and to evaluate whether current policies and trainings could be changed to enhance the tools and resources already available.

- Mandatory Reporting - Assessment of DSHS and DOH administrative policies, actions to improve compliance with mandatory reporting requirements, and quality of reports received. This assessment should include consideration of legislative changes to broaden the range of options that DSHS and DOH may use to encourage reporting and hold mandatory reporters accountable when they fall short of their obligation.

Such an interdisciplinary approach would have several benefits. One of Washington's challenges in responding to abuse and neglect is coordinating services of multiple agencies. Recently, at the Washington Attorney General's Vulnerable Adult Summit held last summer, one of the issues identified by group sessions included "complexity caused by multiple systems/agencies involved in providing justice." This concern appears to be shared by other states as well. In a 2003 national survey of APS administrators asking what they considered "the most significant problems facing the field of Adult Protective Services," 14% of the 42 states that responded echoed this concern about lack of communication and collaboration among multiple state agencies, and at least one state specifically expressed concerns that there was no single agency that "had authority to investigate allegations of adult abuse, neglect, and exploitation and that coordination among agencies was problematic."⁶⁷

Some states have begun to address this problem through legislation to encourage coordination between agencies and referrals. For example, California passed a bill in 2005 creating "a new section governing cross-reporting between APS, the Long Term Care Ombudsman Program (LTCOP), law enforcement agencies, and other state agencies in cases involving suspected financial or other types of abuse" and requiring APS, the LTCOP, and law enforcement agencies to inform the referring agency about the results of its investigation.⁶⁸ South Carolina passed legislation in 2006 to create a "State Law Enforcement Division" to "receive and coordinate referrals of abuse, neglect, and exploitation of vulnerable adults in facilities" operated by or contracted with the State.⁶⁹ Massachusetts also has a relatively new program that involves multiple state agencies, including the state law enforcement agency.⁷⁰ While the approach proposed

⁶⁷ Joanne Otto and Joan Cass Bell, "Report on Problems Facing State Adult Protective Services Programs and the Resources Needed to Resolve Them" (2003); Available online at http://www.ncea.aoa.gov/NCEARoot/Main_Site/pdf/publication/NAAPSA7.pdf.

⁶⁸ Lori Stiegel, J.D. and Ellen M. VanCleave Klem, J.D., "Analysis of 2005 State Legislation Amending Adult Protective Services Laws" (2006); Available online at http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/APS/Analysis_State_Laws.aspx.

⁶⁹ Lori Stiegel, J.D., and Ellen M. VanCleave Klem, J.D., "Analysis of 2006 State Legislation Amending Adult Protective Services Laws" (2007); available at http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/APS/Analysis_State_Laws.aspx.

⁷⁰ See <http://www.mass.gov/dppc/dppc.html> and <http://www.ganconference.com/napsa.html> for more information.

here is not identical to the changes that occurred in these states, we believe examples such as these illustrate a growing trend towards interdisciplinary teams working collaboratively to achieve improved results for victims of abuse and neglect.

We also make this recommendation for an interagency, multi-disciplinary created evaluation tool based on the fact that experts have argued that more research is necessary to identify effective interventions to respond to abuse and neglect and to evaluate interventions being implemented.⁷¹ Creating an evaluation tool would present an opportunity to credibly assess Washington's interventions, find creative new approaches, and evaluate the effectiveness of these new intervention strategies that may result from this process.

Finally, we make this recommendation based on our belief that the team we recommend is best situated to creatively propose solutions, assess the likelihood of success, and determine the resources needed to implement changes. Given their experience and detailed knowledge of the current system, administrators and investigators have the expertise necessary to effectively evaluate and compare the current strategies, policies, and statutory authority. Moreover, the individuals who will be ultimately responsible for implementing any changes proposed should have a significant voice in deciding what changes should occur. Stakeholders and clients should also be involved in this process to advise policy makers of the challenges people with disabilities face during the course of an abuse and neglect investigation. These perspectives must be included to ensure the service delivery system and policies accurately reflect the lived realities as well as desires of the people the system is seeking to protect and serve.

Many of the individuals who rely on Washington's abuse and neglect system are extremely vulnerable, and lack the ability and resources to advocate for themselves without assistance.⁷² For these reasons, it is essential that the state system for responding to abuse and neglect work as efficiently and thoroughly as possible to ensure the safety of people who are at highest risk of being victimized.

⁷¹ Richard J. Bonnie and Robert B. Wallace, Editors. Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. National Academies Press, Washington D.C. (2002), page 122.

⁷² Peleo M. Iarocci G, Connolly DA "Eyewitness Testimony and Perceived Credibility of Youth With Mild Intellectual Disability" *J. Intellect. Disabl. Res.* 2004 Oct; 48 (Pt 7): 699-703. Studies also show that people with disabilities are more likely to experience more severe abuse, experience abuse for a longer duration, be victims of multiple episodes, and be victims of a larger number of perpetrators (Schaller, J. & Fieberg, J.L. (1998) Issues of abuse for women with disabilities and implications for rehabilitation counseling. *Journal of Applied Rehabilitation Counseling* 29 (2), 9-17; Sobsey, D. & Doe, T. (1991) "Patterns of Sexual Abuse and Assault" *Journal of Sexuality and Disability*, 9(3), 243-259; Young, M., Nosek, M., Howland, C., Chanpong, G., & Rintala, D. (1997) Prevalence of abuse of women with physical disabilities. *Archives of Physical Medicine and Rehabilitation*. Special Issue 78 (December): S34-S38).

APPENDIX A – ABBREVIATIONS AND GLOSSARY

APS	Adult Protective Services	DSHS unit responsible for investigating abuse and neglect of vulnerable adults where the alleged perpetrator is not a facility employee or volunteer, but a private individual or in-home care provider
CMS	Centers for Medicare and Medicaid Services	Federal agency responsible for administering Federal Medicare and Medicaid funds and ensuring that States comply with Medicare and Medicaid rules
DDD	Division of Developmental Disabilities	DSHS unit which provides several different kinds of federally and state funded support services to clients with developmental disabilities
DOH	Department of Health	State agency with authority to regulate health care facilities and professionals
DRW	Disability Rights Washington	Protection and Advocacy System for the State of Washington, which is a federally mandated and funded program to investigate abuse and neglect of individuals with disabilities and mental illnesses and advocate for the protection of their federal and state rights
DSHS	Department of Social and Health Services	State agency that administers a host of services and public benefits to children, and adults who are low-income and/or disabled
HCS	Home and Community Services	DSHS unit that administers federally and state funded long-term care community services for adults with disabilities
HPQA	Health Professions Quality Assurance	DOH unit responsible for credentialing, investigating, and disciplining health professionals
ICF	Intermediate Care Facility	Federal term for institutions receiving Medicaid funding to provide residential support and habilitation services to people with developmental disabilities
LTCO	Long-Term Care Ombudsman	Federally mandated program to assist residents of long-term care facilities in resolving complaints about their care, educate residents about their rights, and advocate for public policies that will benefit long-term care residents
RCS	Residential Care Services	DSHS unit responsible for licensing, investigating, and disciplining long-term care facilities
RHC	Residential Habilitation Center	State term for institutions for residents with developmental disabilities

APPENDIX B – DEFINITIONS OF ABUSE AND NEGLECT

ABUSE

1. **Washington Vulnerable Adult Statute, RCW 74.34.020:** “the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter [71A.12](#) RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter [71A.12](#) RCW, whether or not it is consensual.

(b) "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) "Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) "Exploitation" means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.”

2. **Federal CMS Regulations for Long-Term Care Facility Surveys, 42 CFR § 488.301:** “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.”

3. Federal Protection and Advocacy Mandates

- A. **Protection and Advocacy of Individuals with Mental Illnesses Regulations, 42 C.F.R. § 51.2:** “any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault, striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.”
- B. **Developmental Disabilities Bill of Rights Regulations, 45 C.F.R. § 1386.19:** any act or failure to act which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with developmental disabilities, and includes such acts as: Verbal, nonverbal, mental and emotional harassment; rape or sexual assault; striking; the use of excessive force when placing such an individual in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal or State laws and regulations or any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.

NEGLECT

1. **Washington Vulnerable Adult Statute, RCW 74.34.020:** (a) a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or (b) an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW [9A.42.100](#).
2. **Federal CMS Regulations for Long-term Care Facility Surveys, 42 CFR § 488.301:** failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

3. Federal Protection and Advocacy Mandates

- A. **Protection and Advocacy of Individuals with Mental Illnesses Regulations, 42 C.F.R. § 51.2:** a negligent act or omission by an individual responsible for providing services in a facility rendering care and treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes but is not limited to acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff.
- B. **Developmental Disabilities Bill of Rights Act, 45 C.F.R. § 1386.19:** a negligent act or omission by an individual responsible for providing treatment or habilitation services which caused or may have caused injury or death to an individual with developmental disabilities or which placed an individual with developmental disabilities at risk of injury or death, and includes acts or omissions such as failure to: establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; provide a safe environment which also includes failure to maintain adequate numbers of trained staff.

APPENDIX C – ADDITIONAL CASE EXAMPLES

Case Examples from Long-Term Care Ombudsman (LTCO)

Washington's Long-Term Care Ombudsman (LTCO) provided the following case examples to DRW to append to our report, "Improving Washington's Response to Abuse and Neglect: Analysis and Recommendations." DRW has not independently investigated any of these examples. These summaries, therefore, are based exclusively on the LTCO's report to DRW.

Case Example 1

A county LTCO was involved with a complaint regarding a Boarding Home resident whose mental and physical functioning continued to deteriorate. She was refusing care and medications. The LTCO had to insist that the staff call 911 because she was in bed lying in her own vomit and feces. Three days later, the resident died. This death was reported to RCS, but RCS did not cite the facility for lack of reporting to APS, or for neglect.

Case Example 2

In early 2007, a county LTCO observed an unlicensed staff dispensing medications to boarding home residents. The LTCO learned that RCS has issued numerous and repeated citations to this facility for medication mismanagement. However, in spite of these repeated findings of noncompliance, RCS did not place any conditions related to medication mismanagement on this facility or issue any fines for this ongoing problem.

Case Example 3

In the fall of 2007, at this same boarding home where RCS had not taken any enforcement actions relating to medication mismanagement, a middle-aged resident with a mental illness stopped taking his medications for two weeks. Due to his untreated mental condition, he slashed his wrists and leapt to his death from his upper story bedroom. Moreover, although he had been making suicidal statements to the staff during the week prior to his suicide, the staff did not act to prevent his death. The day before he died, the resident broke his bedroom window, but the facility left the glass shards on the floor and sticking out of the window frame. On the day of his death, the facility's caregiver left the resident alone in his 3rd floor room with the glass shards. RCS found that Boarding Home C: (1) had no protocol to handle possible suicide cases or to evaluate and correct dangerous conditions in the building; (2) had no adequate system to dispense and monitor critical medications needed by the residents; (3) failed to monitor residents' medical well-being, including failing to check the blood sugar levels

of residents with diabetes; (4) failed to adequately train its staff, some of whom had not even completed CPR training; and (5) was understaffed, having only one caregiver for 57 residents on most shifts. DSHS issued a stop placement order and placed a condition on the license but did not send a follow-up report to local law enforcement to request an investigation of criminal mistreatment. A criminal investigation has now occurred at the request of the State LTCO. The Administrator, however, is still working for the mental health agency. See "State Stops Admissions at Home for Mentally Ill After Man's Suicide," Seattle Post-Intelligencer, November 2, 2007; "Ill Man's Suicide Raises Questions For Capitol Hill Boarding Home," Seattle Times, November 1, 2007.

Case Example 4

The LTCO was involved with RCS investigations of two boarding homes for not providing basic boarding home services, including basic housekeeping and laundry. The LTCO noted that one boarding home reeked of urine, and another had a rampant cockroach infestation that the county LTCO observed on numerous occasions. Neither of these boarding homes provided adequate support and/or facilities for laundry. The LTCO also observed beds without sheets on the mattresses, rooms filled with dirty laundry, and residents dressed in dirty clothes. One resident who was physically unable to do her own laundry did not receive any staff assistance and panhandled money to pay another resident to wash her clothes. Although RCS observed and cited these problems, RCS did not take any enforcement action.

Case Example 5

The LTCO complained to RCS that four boarding homes were depending on residents to "volunteer" to complete chores in exchange for play money. At one boarding home, the chore sign up board is prominently displayed in the dining room. Although the chores are "voluntary," it is obvious that if residents didn't volunteer the buildings would be in more of a mess. Typical staffing at this boarding home, which has 58 residents, includes one care giving staff, one housekeeper and one cook. Due to lack of staff, the residents were expected to provide help for clean up after meals. The LTCO has pointed out that this "volunteerism" appears to be exploitation of the residents because they are not paid real money for providing real work. The volunteer work, or "life skills" training, is not incorporated into their negotiated service agreement or in any way supervised. The LTCO also pointed out to one Administrator that if the chores are training rather than an actual job, then the activity needs to be reviewed and discussed privately with each resident. The Administrator was flabbergasted at the idea that staff should be expected to have private care planning conversations with residents. According to the Administrator, "that would take hours." In March 2007, the LTCO notified RCS of this issue in writing, but RCS still has not cited the facility for exploitation or taken any enforcement actions to correct the problem.

Case Example 6

A boarding home resident died of natural causes while asleep and staff did not identify that the resident was missing or dead for at least 36 hours. Only when his roommate expressed concern about the resident did the staff take action. There was no enforcement action given by RCS despite numerous identified failed practices.

Case Example 7

RCS received a complaint that “staff treated residents disrespectfully.” RCS investigated by interviewing five residents, two current employees, and one former employee. The interviewees reported that the two identified staff yell at residents, that these two identified staff handle residents roughly, and that one of these identified staff told a resident to “shut up.” In spite of this evidence, RCS did not find a failed facility practice and no action was taken.

Case Example 8

The LTCO program discovered that a nursing home cook, who was also cross-trained as a certified nursing assistant, had struck a nursing home resident who was very cognitively impaired. The resident was newly admitted and in an emotionally volatile state. The cook attempted to direct the resident (who was already under the supervision of a nurse) and the resident spit at the cook. In response, the cook then slapped the resident in the face. The police were called, but it was the resident who was taken away in handcuffs. In spite of eyewitnesses and an admission by the cook that he had assaulted the nursing home resident, RCS did not find any failed facility practice. The perpetrator continues to work at the nursing facility with vulnerable adults.

Case Examples from the Media

The following case example summaries highlight cases in the media where the State responded to allegations of abuse and neglect. DRW has not investigated these cases and these summaries are based on the media sources cited at the end of each example.

Case Example 9

The Seattle Post-Intelligencer reported a story about APS's involvement in a series of incidents where a young woman with a developmental disability was repeatedly injured by her staff. In the first incident, a staff person dragged her across a rug four or five times in response to her behaviors, and she suffered rug burns and bruises as a result. APS investigated, but the employee continued to work at this facility where the woman continued to reside. Six weeks later, the woman's mother reported to APS that she had two fractured ribs, but "APS could not determine what happened, saying there was 'insufficient evidence' to substantiate abuse," even though APS noted staff had "repeatedly restrained the woman in previous weeks, sometimes for up to 25 minutes." The woman's mother removed her from the facility to move back home after the woman's vocational day program said she came to work with a broken wrist and a day later, the provider had still not taken her to the doctor. The staff told APS that she had landed on her arm when he was trying to restrain her, but her roommate reported that the man had shoved her into a wall in a rolling chair. APS cited the house manager for medical neglect, but the article did not state that APS substantiated whether the man had abused the woman. See "Two fractured ribs...and a broken wrist for Jessica," Seattle Post-Intelligencer, November 16, 2005, available online at http://seattlepi.nwsourc.com/local/248446_jessica16.html.

Case Example 10

In another article published by the Seattle Post-Intelligencer, the newspaper reported that a provider notified APS that a resident had sexually assaulted another resident two days after the provider learned of the incident. The victim's mother advocated for him to be removed from this program, which provided services to clients with histories of violence or sexual aggression. The mother's request was based on a letter from his psychologist that he did not need to be in this program. It was also documented that his current living situation was "NOT a safe environment...due to his vulnerability." Nevertheless, the state refused to move the man out of the program, despite his victimization and the fact professionals were opining that he was at risk of future victimization if he continued to live in that environment. The state did not begin an exit plan until a year later, after another evaluator wrote, "Although (he) has no sex offender history or proclivity, he is housed with convicted sex offenders," and "His cognitive limitations and wish to be liked make him vulnerable to being manipulated and exploited again." See "Molested and Trapped in the System," Seattle Post-Intelligencer, November 16, 2005, available online at http://seattlepi.nwsourc.com/local/248447_trapped16.html.

Case Example 11

The Spokesman Review reported a story in which it took DSHS two years to close down an adult family home that had been reported several times to DSHS for abusing and neglecting residents with physical and developmental disabilities. Within months of the home's opening, DSHS was told that a resident had been left alone at the home, but DSHS failed to substantiate the complaint. The allegations escalated when it was reported that the owner/chief caregiver screamed, yelled, and shouted in front of residents, but DSHS failed to verify this report as well. As months went by, the allegations grew worse – the owner was alleged to have called one resident “psycho” and “disgusting,” had taken a resident's favorite toy, and neglected to obtain medical treatment for a resident who was bitten by a fellow housemate. The state took moderate actions in response to these complaints and ordered the owner to replace the toy she had taken and to hire an additional staff person. Eventually the State received reports of serious physical abuse that the owner pushed two residents up against a wall while yelling and cursing at them, taped another resident to a chair with her mouth also taped shut, and forced a resident to drink a glass of water to the point that the resident was coughing and choking. It was not until these serious allegations of physical abuse and humiliation were reported and investigated that the State finally terminated her adult family home license. See “Adult Home Owner Barred,” Spokesman Review, August 20, 2007, online at <http://www.spokesmanreview.com/breaking/story.asp?ID=11076>.

Case Example 12

Recently, the Kitsap Sun reported a story in which the Kitsap County Sherriff's Department found a man with a developmental disability in his own home bound in chains. The Sherriff's deputy found evidence that the man had been chained and pepper-sprayed several times by his housemate, who asserted that she sprayed him in self-defense and bound him in chains with his consent. APS stated that the perpetrator “had a history of taking advantage of mentally disabled adults and that they can't do anything because [the perpetrator] isn't a state provider.” APS also stated that the man does not meet the agency's criteria, although he was reported to have a developmental disability. As of the date the article was published, two days after the man had been found, the woman had not been charged with any crime. See “Bremerton Man Said Woman Chained, Pepper-Sprayed Him as Punishment,” Kitsap Sun, February 21, 2008, available online at <http://www.kitsapsun.com/news/2008/feb/21/bremerton-man-said-woman-chained-pepper-sprayed/>.

Improving Washington's Response to Abuse & Neglect Analysis & Recommendations

A Report by Disability Rights Washington



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This booklet is available in alternative formats upon request.

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