COMMONWEALTH OF PENNSYLVANIA **DEPARTMENT OF AGING** **Harrisburg, Pa. 17101**	**PENNSYLVANIA DEPARTMENT OF AGING**	
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AGING PROGRAM DIRECTIVE

SUBJECT: PROTECTIVE SERVICES INVESTIGATIONS

TO: COUNTY COMMISSIONERS
CHAIRPERSONS, NON-PROFIT AAA GOVERNING BOARDS

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COMPTROLLER

FROM:
LINDA M. RHODES
SECRETARY
DEPARTMENT OF AGING

PURPOSE: This Aging Program Directive (APD) was designed to provide a document that identifies standards in the Protective Service process:

- Relevant Information on the Report of Need
- Relevant Collateral Resources in the Investigation Process
- Relevant Questions to Elicit Pertinent Information
- Appropriate Use of the Investigation Report Form
- Clarification on Substantiation
- Case Narration

These standards are to be followed wherever a Report of Need indicates the need for a protective service investigation. This document will further provide a vehicle for the Field Consultants to address clinical standards in the report of findings to the Area Agencies on Aging.

The Report of Need

The purpose of this section is not to give a line by line training on the completion of the Report of Need form. The goal is to establish quality standards for each AAA to model its performance after. It is assumed that the agency is aware of the time restrictions imposed by Act 79 and will adhere to them and that the staff will have received appropriate training.

The Report of Need is an intake form completed by a trained individual. It is designed to include enough information so that the intake worker, and subsequently the protective service worker, can identify and support the referral category assigned to each case:

- Emergency
- Priority
- Non-Priority
- Another PSA
- No Need for Protective Services

Completion of the Form

The following requirements must be satisfied by the intake worker when completing the Report of Need form:

- All sections in the Report of Need form must be completed.

- All sections must be completed in a manner that, as a whole, will identify and support the assigned category.

The intake worker should not expect the reporter to have an understanding of Act 79 or casework for the elderly. The intake worker must, therefore, ask probing questions to identify what the reporter is alleging, the presence or absence of risk, the client's environment, and any other pertinent information that may help determine the appropriate referral category. The "Problem" and "Nature and Extent of Need for Protective Services" sections of the form should clearly indicate the type and extent of risk associated with the need for protective service intervention. The information obtained from the reporter must be accurately recorded on the Report of Need form so that the protective service worker will be able to accurately change or confirm the referral category. The intake worker may make some additional follow-up calls to complete the form (re: to obtain addresses or phone numbers), but must not make additional calls to evaluate risk; doing so constitutes the initiation of an

investigation that the worker may not be qualified to conduct.

The following terminology should be avoided as it does not clearly identify risk:

Problem	Nature and Extent of Need for P.S.
Client lives alone and is at risk.	Investigate for self neglect
Client lives in poor conditions.	Investigate for self neglect
Client doesn't take medications and does not eat well.	Investigate for self neglect

The following terminology would be more appropriate:

Problem	Nature and Extent of Need for P.S.
Client lives alone, has no heat, his lips are turning blue, breathing is labored, and it is very cold in the house. Client refuses to leave home.	Client may be experiencing hypothermia and requires medical treatment as well as emergency energy assistance.
Client lives in deplorable conditions and there are signs of rodent and insect infestation. Client has numerous bite marks and appears extremely confused. The only food available is rotten and moldy. He has lost a lot of weight in past few months. He is lying in his own bodily waste.	Investigate for self neglect to determine the extent of medical and environmental needs and ability to obtain required services.
Client is a brittle diabetic and is refusing to take insulin as well as seek medical care. Client is not following her diet; her last blood sugar was 532 and is exhibiting signs of diabetic shock.	Investigate for self neglect to determine the possibility of a medical crisis and need for intervention.

The second set of examples clearly identify the risk to the client and support the need for a protective service investigation.

The protective service worker, upon receipt of the Report of Need, must review the document and decide if the referral category should be changed or confirmed. This decision must be made immediately. The decision must be based solely on the Report of Need. Any additional phone contacts or field visits would constitute the initiation of an investigation that must be completed in its entirety within the guidelines of Act 79.

Under no circumstances should a protective service worker receive the Report of Need, make additional calls or home visits, and classify the case as no need by changing the category on the report to "No Need for Protective Services." It is required that the case be fully investigated and then classified as unsubstantiated if it is found the client does not fit the criteria of an older adult in need of protective services.

Protective Service Investigation

This section will focus on investigating Reports of Need for protective services. This section was not designed to address services (emergency) initiated to reduce or eliminate risks identified during the investigation process. All personnel addressed in this section are assumed to have the appropriate credentials and received the appropriate training as mandated by Act 79.

It is very important to note that this process is not an assessment or any other type of casework; it is an investigation. The protective service worker is responsible for determining if the allegations in the Report of Need are accurate or if there is any other reason why that client fit(s) the criteria of an older adult in need of protective services. If the protective services worker's investigation does confirm the details of a report or determines that the subject of the report is an older adult in need of protective services, the report shall be classified as a substantiated report. It is also important to note that confirming the allegation(s) does not by itself require the case to be classified as substantiated. Confirming the allegations would warrant substantiation only if the client fit the criteria for an older adult in need of protective services when the "abusive action" took place.

Act 79 requires an investigation be initiated:

- "Immediately" for a Report of Need classified as EMERGENCY.
- "As soon as possible" for a Report of Need classified as PRIORITY.
- "In a timely manner but never later than 72 hours" for a Report of Need classified as NONPRIORITY.

Again, this is a discussion on the actual investigation process. It is assumed that all time frames addressed in Act 79 will be followed as they are very specific and non-negotiable.

There are three very important issues that must be clarified before any discussion on the investigation can begin:

- Although the client has the right to refuse to participate in an investigation, the investigation must be completed in a manner that will satisfy the intent of Act 79 and provide sufficient information to determine the classification. The Department of Aging advocates the client's right to self determination and recognizes that there are rare

occasions where the protective service worker will find a client who presents as a reliable reporter, requests a termination of the investigation, or claims the allegations are not true and there is nothing to support that the client may fit the criteria of an older adult in need of protective services. On the rare occasions that this occurs, the protective service worker may terminate the investigation after obtaining written confirmation by a supervisor trained in protective services and written acknowledgement by the AAA Director.

- The protective service worker is not required to obtain written or any other form of permission to interview friends, relatives, neighbors, and anyone else pertinent to the investigation. (These people also have the right to refuse to speak to the protective service worker.)

- In most cases, investigations restricted to interviews with only the client or the client and alleged perpetrator will not be considered sufficient within the guidelines of Act 79. Protective service workers have a limited caseload that affords them sufficient time to conduct a thorough investigation. It is understood, however, that there are clients that are so isolated that it is impossible to locate significant others to interview. In these circumstances, the Protective Service worker should clearly document his/her effort to conduct an indepth investigation and clearly outline the rationale of his/her conclusion.

There are several reasons why a client and the alleged perpetrator(s) are considered to be poor reporters:

1. The client may have difficulties with cognitive functioning.

2. The client may not want to implicate the perpetrator/relative out of fear, dependence, etc.

3. The perpetrator may be threatening the client.

4. Perpetrators rarely implicate themselves.

The Investigation Process

It is acknowledged that every case is different and it is not possible to outline a specific process for conducting a protective service investigation. The intent of this paper is to establish a minimum standard by which every AAA to model its performance after.

Time Frames

Act 79 identifies specific time frames for the initiation of the investigation, the initial face-to-face interview with the client, and the conclusion of the investigation. The protective services worker is responsible for the timing of each interview. The protective services worker must comply with the time frames specified in Act 79 in order to assure that the investigation is conducted expediently.

Interviews

Alleged Abuse or Neglect

Investigations of alleged abuse or neglect must include the accumulation of information on the client's medical condition, at least as it relates to the allegation(s). The client's physician is an excellent resource and should be interviewed early in the investigation. (Even if medical issues are not alleged, the client's physician is an excellent source of information about the client.)

When interviewing the client's physician, the protective service worker must also ask questions that will solicit information about potential abuse or neglect, for example:

- Dr. Smith, have you every observed any suspicious bruising or other symptoms that may be associated with abuse?
- Dr. Smith, have you observed any symptoms of malnourishment, dehydration or other symptoms associated with neglect?
- Dr. Smith, is your patient's condition such that you may question how reliable he/she has been in appropriately medicating himself/herself?
- Dr. Smith, what is your opinion on your patient's ability to make an informed decision? In your

opinion is your patient capable of making an informed decision?

These questions should be a routine part of a protective service investigation. The last question is important because it gives the protective service worker a handle on the client's cognitive functioning ability. The client's cognitive functioning ability is important when developing the care plan.

Unfortunately, many elderly clients fail to see a physician on a regular basis and pertinent information from a physician may not be available. Therefore, other resources that should be interviewed include, but are not limited to, the following:

- Home Health Agency
  - Nurse Supervisor
  - Home Health Aide
  - Personal Care Worker
- AAA Consultant
  - Physician
  - Registered Nurse
- Mental Health/Mental Retardation Agencies
- Significant Others
  - Relatives
  - Friends
  - Neighbors

The protective service worker should carefully document all interviews and efforts, especially if, after a thorough investigation, he/she is unable to detect any pertinent medical information.

Alleged Financial Exploitation

Investigations of alleged financial exploitation must include the accumulation of information on the client's financial status. In all cases, the protective service worker must review bank records or whatever else may be available that would indicate or support mismanagement or actual exploitation. The following additional items are examples of documents that the protective services worker should consider when investigating allegations of financial exploitation:

- Deed(s)
- Mortgage(s)
- Certificates of Deposit
- Stocks, Bonds, Mutual Funds
- Power of Attorney, Guardianship Records for Review

It is advisable that if the financial standing of a client is extremely complicated, the protective services worker should attempt to utilize the agency or county accountant (the agency or county accountant must first sign a confidentiality agreement) to assist in the protective services worker's evaluation.

Aside from professionals, the protective service worker can gain an important perspective by interviewing relatives, friends, or neighbors. To do so objectively, however, requires that several of the significant others be interviewed. The protective services worker has the discretion to determine when it is necessary to interview such collateral resources and who to interview. These interviews should occur when the protective service worker has been unsuccessful in gathering other pertinent information from professionals. It is important to note that it is not the quantity of information obtained from collateral resources, but the quality, that is important.

Many protective service workers have voiced a concern about breaching the client's rights or confidentiality by interviewing friends, neighbors or relatives. These people can be effectively interviewed without breaching rights/confidentiality by using appropriate questions. The following is an example of how to initiate an interview:

- My name is Sally Social Worker and I work for the local office on aging. We received a referral for your [friend/neighbor/relative], Mrs. Client. I am visiting you today to see if you have any concerns about Mrs. Client or if there is any information that you could provide me so I can determine if there are any services our agency can offer to her.

Such an opening, with additional probing questions to the response (without providing details of the Report or other confidential issues), should generate usable information.

Keep in mind that the investigation is occurring to protect a vulnerable person where there is evidence of a risk. It would further the risk to the client to limit the scope of the investigation and close the case without evaluating any corroborating "evidence." It would also be damaging to the alleged perpetrator if a case with a limited investigation implicates the perpetrator without the benefit of evaluating corroborating "evidence."

Once again, the protective service worker should carefully document all contacts and/or attempts, especially if after a thorough investigation he/she is unable to identify many (or any) significant others who can offer corroborating information. It is advised that the worker list all collateral resources with a brief description of his/her impressions and the worker's findings. This should be

included on the back of the Investigation Report form or summarized in the case narratives.

Summary

A Protective Service Investigation is just that; an investigation. The goal of this investigation is to gather sufficient information to permit the protective service worker to evaluate and conclude whether or not the case should be substantiated. Substantiation does not have to be "beyond a shadow of a doubt." It must, however, come as the result of a thorough investigation. Medical professionals must be included in investigations of abuse and neglect. Various financial documents must be examined in cases of financial exploitation. In most cases, the protective service worker also must interview significant others to obtain a balanced perspective in the allegation. This is especially important if the case is ultimately classified as unsubstantiated, since the client will not be provided with additional services for protection.

The Investigation Report Form

The purpose of this section is not to give a detailed line by line training on the Investigation Report Form. The purpose is to establish quality standards for completing the investigation form.

The Investigation Report Form is the document by which the protective service worker records his/her findings during the investigation of a protective services case. The information documented on the Investigation Report Form will be used by the protective services worker to identify the problem(s) and support his/her conclusion of whether to substantiate the case.

The following requirements must be satisfied by the protective service worker when completing the Investigation Report Form:

- Complete every section of the form.
- Complete each section in a manner that, as a whole, will give a clear picture of the client, type of abuse, the alleged perpetrator, and his/her environment.
- Include additional written narrative under "OBSERVATIONS."
- The form should reflect the number of days required to complete the investigation.
- Include documentation of all his/her interviews and observations. If space is not available on the actual Investigation Report Form, it is suggested that, on a separate piece of paper or on the back of the form, the Protective Service Worker list all contacts with a description of the worker's observations and contact's impressions. An investigation is an involved process that must be carefully documented on this form and any addendums.
- Document under the "Action Taken" section of the form the immediate steps taken by the protective services worker to reduce the risk prior to the assessment and implementation of the care plan. For example:

  "Placed the client in a Personal Care Home until the heat can be restored."

  There is no need to give an extended summary of all the steps of the investigation in the "Action Taken" section of the form. All the steps of the investigation will be documented in the actual report.

Results of the Investigation

An investigation is conducted to determine if:

- the allegations in the Report of Need are true and as result, the client fit(s) the criteria for an older adult in need of protective services; or
- there is any other reason why the client fits the criteria of an older adult in need of protective services.

If the protective services worker determines, during the course of the investigation, that the allegations in the Report of Need are accurate or the client fits the criteria of an older adult in need of protective services, then the protective service worker must classify the case as SUBSTANTIATED.

Example:

The Report of Need implies that a client is being physically and verbally abused by her son. Through the course of the investigation, the protective service worker accumulates enough information to indicate that the son has repeatedly hit his mother, has been verbally abusive, and there is reason to believe that this behavior will continue. The worker obtained this information by interviewing the client's physician, personal care aide, relatives and a few neighbors. The case would be classified as substantiated.

If the protective services worker determines, during the course of the investigation, that the allegations in the report were unfounded, but there are other reasons why the client fits the criteria of an older adult in need of protective services, the protective service worker must classify the case as SUBSTANTIATED.

Example:

The Report of Need implies that a client is being physically abused by her son. Through the course of the investigation, the protective service worker cannot find any evidence of physical abuse occurring, but does find sufficient information to support financial exploitation by another relative. The worker obtained this information by interviewing the client's physician, personal care aide, relatives, neighbors and reviewing financial papers. The case would be classified as substantiated.

There has been some confusion as to how to classify a case where the protective service worker identified a risk to the client but did not require or provide protective services. The following examples provide further clarification:

If the protective service worker determines, during the course of the investigation, that the client fit the criteria of an older adult in need of protective services **at the time of the incident** but the protective service worker has discovered that, for some reason, the client has no <u>further</u> need for protective services, then the protective service worker must classify the case as SUBSTANTIATED.

Example:

The Report of Need implies that a client is being physically abused by her son. Through the course of the investigation, the protective service worker accumulates enough information to indicate that the son had repeatedly hit his mother. The protective service worker also discovers that the son has suffered a severe stroke and is no longer a risk to his mother. The worker is also unable to uncover any other reason why the client would fit the criteria of an older adult in need of protective services. Despite the fact that there is no <u>further</u> need for protective services, the case would be classified as <u>substantiated</u> because the client fit the criteria at the time of the report.

Example:

The Report of Need implies that a client is being physically abused by her son. Through the course of the investigation, the protective service worker obtains sufficient information to substantiate the allegation, and determines that the client fits the criteria for the need for protective services. The protective service worker, however, discovers that the client has made an informed decision to refuse protective services. The case would be classified as <u>substantiated</u>, and the case would be closed.

In conclusion, when determining if a protective service case should be classified as substantiated the protective services workers should refer to the criteria as defined in Act 79, 6 Pa. Code §15.2. A case is to be classified as <u>substantiated</u> whenever the client fits the criteria of an older adult in need of protective services (at the point of the incident as discovered through the investigation) even if they refuse services or there is no <u>further</u> need for protective services. A case is classified as <u>unsubstantiated</u> when the client DOES NOT fit the criteria.

The following pages include the investigation report forms and case narratives from two different protective service investigations:

Mrs. Benson
Mrs. Quigley

These cases are examples of how the scope of an investigation is expanded and documented.

These are actual cases. The names and other identifying information have been changed to assure confidentiality. There are important documents, not included in this packet, that are necessary to arrive at the conclusion, but the following documents will sufficiently illustrate the process for proceeding with an investigation.

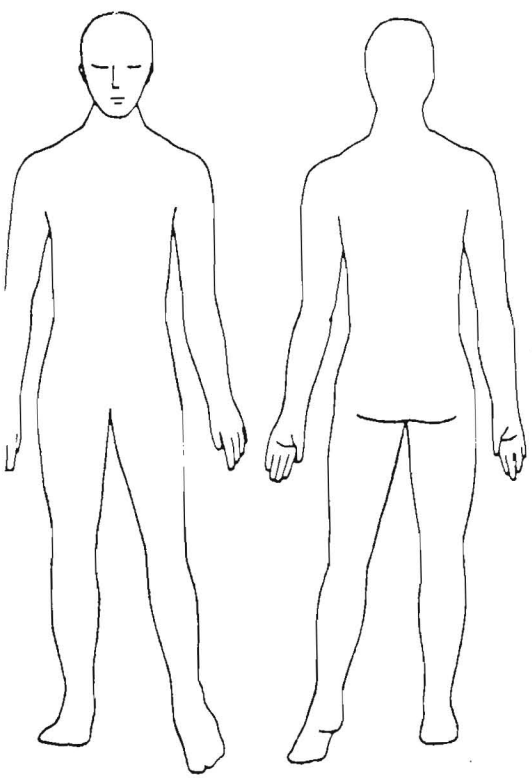
OLDER ADULTS PROTECTIVE SERVICES INVESTIGATION REPORT

PART I INVESTIGATION OF ABUSE, NEGLECT, EXPLOITATION OR ABANDONMENT

CLIENT NAME Cora Benson SEX Female AGE 88
ADDRESS Pleasant View Nursing Home SOCIAL SECURITY NO. _____
PHONE (___) _____

CONFIRMED = C POSSIBLE = P UNKNOWN = U NO = N

A. EVIDENCE OF SERIOUS PHYSICAL ABUSE	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Bruises, Welts				✓	9/11/92 Hosp. S.W. - "no overt signs of physical abuse noted." Client was admitted to the hospital because of an inability to ambulate.
2. Sprains, Dislocations				✓	
3. Burns, Scalding				✓	
4. Abrasions, Lacerations				✓	
5. Wounds, Cuts, Punctures				✓	
6. Broken Bones				✓	9/17/92 Daughter-in-law had many complaints about the Pleasant View nursing home but stated she never witnessed abuse, observed signs of abuse, or had any concern that the client was physically abused.
7. Internal Injuries				✓	
8. Sexual Assault				✓	
9. Other				✓	



9/14/92 Observation - no overt signs of abuse noted. Client, however, has not been at the nursing facility for about three (3) months.

9/15/92 An involved friend learns that she has not observed any overt signs of abuse.

B. EVIDENCE OF SERIOUS EMOTIONAL ABUSE	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Sleep Disturbance				✓	9/14/92 Chart describes client as "pleasant and talkative" "confused and wanders"
2. Worried, Anxious				✓	
3. Irritable, Easily Upset				✓	
4. Changed Eating Habits				✓	
5. Loss of Interest				✓	9/14/92 Observed - client was bed bound quiet with occasional rambling and inappropriate statements.
6. Threatened, Intimidated, Fearful				✓	
7. Suicidal Talk, Wishes				✓	
8. Frequent Shaking, Trembling or Crying				✓	9/14/92 Daughter-in-law states that the client's mental condition has deteriorated with the progression of the illness.
9. Disoriented (Person, Place, Time)	✓				
10. Appears Confused	✓				
11. Unable to Communicate	✓				
12. Unable to Comprehend	✓				
13. Hallucinations				✓	
14. Other				✓	

C. ABUSIVE ACTIONS (EMOTIONAL AND PHYSICAL)	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Insulted, Swore or Yelled at Victim				✓	9/14/92 Daughter-in-law claims that the nursing home staff were not verbally abusive but demeaning in their treatment of the client. She was concerned that they lost all her good clothes and allowed her to dress herself in a less than dignified manner.
2. Threatened, Coerced				✓	
3. Confined/Isolated				✓	
4. Attempted to Harm				✓	
5. Threw Objects at Victim				✓	
6. Pushed, Grabbed Victim				✓	
7. Struck or Kicked Victim				✓	
8. Threatened Victim With Weapon				✓	
9. Injured Victim With Weapon				✓	
10. Other				✓	

D. EVIDENCE OF SERIOUS NEGLECT (BY SELF OR CAREGIVER) -	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
Dirt, Fleas or Lice on Person				✓	9/14/92 DiL claims the facility ignored her dental and foot care needs.
2. Skin Rash				✓	
3. Sores				✓	
4. Malnourished				✓	9/16/92 Reviewed reports from dentist and podiatrist that indicate neglect of care in these areas (see included report).
5. Dehydrated				✓	
6. Inappropriate Clothing				✓	
7. Fecal/Urine Smell				✓	
8. Untreated Medical Problem				✓	Note from dentist indicates advanced periodontal disease as well as advanced decay in more teeth.
9. Other, Dental, Foot Care	✓				Note from DPM indicates "paronychia aspect and lateral aspect bilateral hallux" . "She has grossly extended mycotic nails."

E. NEGLECT FOR ACTIONS (FAILURE OF CAREGIVER TO PROVIDE)	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Adequate Food				✓	9/14/92 DiL claims that client lost a great deal of weight while at Pleasant View
2. Adequate Heat				✓	
3. Adequate Personal Care				✓	
4. Adequate Supervision				✓	9/15/92 An involved friend feels that the client weighted about 90 lbs. upon discharge and now weighs about 120-25.
5. a. Prescribed Medication				✓	
b. Medical Equip or Aids				✓	
c. Other Medical Service				✓	
6. Other				✓	

9/17/92 Chart indicates that client weighed 100 upon admission. The chart indicates that Mrs. Benson actually gained a little weight during her stay.

F. FINANCIAL EXPLOITATION	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Stolen Money/Assets Of Victim				✓	9/14/92 Client owes the nursing facility $366.00 but the DiL will not pay because of the shabby treatment.
2. Misused Money/Assets of Victim				✓	
3. Missing Money/Assets				✓	DiL also claims that the facility took the client's personal allowance.
4. Recent Change in Bank Accounts				✓	
5. Unexpected Change in Accounts				✓	9/15/92 Pleasant View provided sufficient documentation that showed the personal allowance was properly utilized.
6. Unusual Financial Arrangments				✓	
7. Access to Accounts (e.g., joint, etc.)				✓	
8. Fiduciary Relationships				✓	

(e.g., Guardian, Power of Attorney, Rep. Payee)
(List)

	Court	Date(s)
a.		
b.		

G. PHYSICAL ENVIRONMENT PROBLEMS	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Repair				✓	Client is currently a patient at the General
Cleanliness				✓	hospital and is awaiting transfer to a nursing
3. Architectural Barriers				✓	facility where all her needs will be met in
4. Kitchen/Bath Facilities				✓	a safer and healthy environment.
5. Living/Sleeping Area				✓	
6. Utilities				✓	
7. Fire Safety				✓	
8. Pest Problems				✓	
9. Pet/Animal Problems				✓	
10. Garbage/Trash Accum.				✓	
11. Other				✓	

PART II MEDICAL INFORMATION

A. CURRENT MEDICAL CONDITIONS: ( ) if Diagnosed

1. (✓) Lacunar Infarcts with Ambulatory Dysfunction
2. (✓) Severe Dementia
3. (✓) Permanent Pacemaker Secondary to Sick Sinus Syndrome
4. ( ) with a VVI Pacemaker
5. ( )

P RECENT HOSPITALIZATIONS: DATES

1.	Inability to Ambulate - General Hospital	Presently in-patient
2.		
3.		
4.		

C. CURRENT MEDICAL TREATMENT/THERAPIES (BY SELF OR OTHERS):

1. Extended care unit awaiting nursing home placement
2.
3.
4.

D. CURRENT MEDICATIONS:

	DATE	NAME	DOSAGE/FREQUENCY	PURPOSE	DOCTOR	PHARMACY
1.	9/12/92	Tylenol	10 gr q 6h prn			
2.		MOM	30 cc prn			
3.		Dulcolox	Supp. ÷ prn for constipation			
4.		Haldol	1.0 mg bid			
5.		K-Dur	10 mg TID			
6.						

PART III CHARACTERISTICS OF SUSPECTED ABUSER

	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Lives With Victim	_	_	_	✓	Mrs. Benson only implicates the nursing
2. Alcohol User or Abuser	_	_	✓	_	home staff and not any particular person(s).
3. Drug User or Abuser	_	_	✓	_	
4. Emotional Problems	_	_	✓	_	
5. Behavioral Problems	_	_	✓	_	
6. Previous Pysch. Hospitalization	_	_	✓	_	
7. Mentally Retarded	_	_	✓	_	
8. History of Assaults on Others	_	_	✓	_	
9. Confused/Disoriented	_	_	_	✓	
10. Unemployed	_	_	_	✓	
11. Dependency on Victim	_	_	_	✓	
a. Income/Finances	_	_	_	✓	
b. Housing	_	_	_	✓	
c. Transportation	_	_	_	✓	
12. Criminal Arrest Record	_	_	_	✓	

PART IV FINDINGS

A. NEED FOR PROT. SERV. SUBSTANTIATED _____

NEED FOR PROT SERV. UNSUBSTANTIATED X

B. ACTION TAKEN (DESCRIBE AND GIVE BRIEF RATIONALE)

Case classified as unsubstantiated. Refer to summary in case narrative.

PART V SIGNATURES

PROTECTIVE SERVICES WORKER Dennis J Odaard DATE 9/28/92

SUPERVISOR _____ DATE _____

9/11/92 Investigation Initiated -
1:15 PM Phone Call to General Hospital - Spoke with Ms. Ruth Brown, SW for Mrs. Benson during her hospitalization. Mrs. Brown explained that the family does not want Mrs. Benson returned to Pleasant View but is having some difficulty with an alternative placement because they are $1,000 in arrears at that facility.

Mrs. Brown explained that she made the referral to protective services on behalf of Mrs. Benson's daughter-in-law, Mary Ann Benson. Cora Benson (client) was at Pleasant View when the daughter in law took her home about three (3) months ago because of suspected abuse or neglect. For example, the daughter-in-law reports that the client weighed 80 lbs. at that time. Mrs. Brown reports that the client is now a thin 120 lbs.

4:05 PM Attempted to contact the Department of Health as per regulations but no one was available. Will call on Monday morning (9/14/92).

9/14/92 Phone call to the Department of Health. Spoke with Mrs.
8:30 AM Smith who was involved in the other two (2) active cases. Notified her that I would be conducting an investigation at the Pleasant View Nursing Home regarding Mrs. Benson. Requested a copy of the individual reports of previous cases. She will check with the central office.

9/14/92 Reviewed chart from when Mrs. Benson was a resident of
11:00 AM Pleasant View.

Chart Reviewed:

Admitting Diagnosis (5/3/92) Room M-423-A

- Sick sinus syndrome with pacemaker
- Dementia (Alzheimer's type)
- ASVD
- DJD
- Irritable Bowel Syndrome

Client described at the time as "very pleasant, alert, oriented to person, place and time but a little forgetful."

Nursing notes characterize Mrs. Benson as:
- Regular diet with supplement 3 x day
- Ambulates by self
- Confused and wanders
- Pleasant and talkative

- o Must be encouraged to take a bath
- o Clothes must be laid out for her
- o Control of Bowel and Bladder

Chart indicates that Mary Ann Benson (daughter-in-law) chose to sign out Mrs. Benson (client) because of poor care. The chart further documents Mrs. Benson's concern about her mother-in-law's appearance and how poorly her clothes were cleaned. It mentions that Mary Ann Benson had a list of other complaints but were not noted on the chart. Mrs. Benson was discharged to the family (AMA) on 7/1/92. The Social Worker documented her concern over the family's ability to care for the client.

NOTE: It was documented that Mrs. Cora Benson's weight, as measured on June 23, 1992, was 103 lbs. It was also documented that Mrs. Cora Benson was a picky eater but usually consumed 50 - 60% of her meals. On 4/26/92 Mrs. Cora Benson complained of a tooth ache and was seeing a dentist on 5/5/92 for a tooth extraction. It was documented that there were no complications from the extractions.

Medications (7/1/92)	Modane Tabs	1 x day
	Multivit-Best	1 x day
	Lactose	250 mg.T/D
	Acetaminophen	325 mg. PRN
	MOM	at bed time PRN
	Bacitracin ont.	PRN

9/14/92 Face-to-face visit with client and daughter-in-law at General Hospital.

Mrs. Cora Benson (client) was bed bound and unable to provide appropriate answers to questions.

Mrs. Mary Ann Benson signed a release of information and the hospital social worker will forward pertinent medical information from the file.

Mrs. Mary Ann Benson provided a statement from Mrs. Cora Benson's (client) podiatrist (see enclosed).

Mrs. Mary Ann Benson will provide an "affidavit" from her Mother-in-Law's dentist.
Plan to receive report and interview dentist.

Mrs. Mary Ann Benson states that Dr. Foote attended to her Mother-in-law shortly after the discharge from Pleasant View.

Mrs. Mary Ann Benson claims that her Mother-in-law was treated very poorly at the nursing home. She complained that all her good clothes were either lost or ruined by the laundry. She also stated that her dental and foot care was poor.

She denied any physical or verbal abuse or noticing any suspicious bruising or lacerations. Along with the aforementioned physicians, Mrs. Mary Ann Benson claims that her neighbor could attest to the poor condition upon leaving the facility.

Special Note: Mrs. Mary Ann Benson reported that her Mother-in-law weighed as little as 103 lbs. while at Pleasent View.

9/15/92 **Investigation at Pleasant View Nursing Home.**
10:00 AM-
12:30 AM On this date ten (10) employees from Pleasant View were interviewed for their impression of the care and treatment of residents and potential knowledge of specific incidents in their facility. Staff included RNs, LPNs, Aides and support staff.

- No one witnessed any acts of physical abuse or violence toward any residents in the facility.
- Several had heard rumors of physical abuse but could not or would not elaborate.
- Several felt that many of the "attitudes", "tempers" or "problems" are a result of serious understaffing of aides.
- One person witnessed a client falling and requiring stitches because an aide left her alone in a compromising position. She would give no further information.
- Several feel that residents are spoken to in a hard and harsh manner on a fairly large scale.
- On a much smaller scale, it was reported that some clients (mostly those that are combative) are handled roughly.
- There were complaints about "short cuts", "things (care) missed" (i.e: oral hygiene, care of ears) because of different levels of commitment.

- Four (4) of the interviewees felt the care and treatment of the residents was good and witnessed no acts of abuse or neglect.

These interviews did not shed any light on the specific case(s) being investigated.

Plan to interview 3 to 11 shift staff.

9/15/92 12:30 PM — Circulated around Pleasant View and visited with clients. The majority of clients have severe dementia and are unable to communicate. Those who were able to communicate proved to be unreliable reporters because of various states of dementia. This is the SNF and ICF wards.

9/15/92 1:45 PM — Met with the Director of Social Service. She claimed that it was quite a surprise that the client was removed from the facility. She further elaborated on the daughter-in-law being very upset about missing clothes. The Social Worker will FAX additional information.

9/15/92 2:00 PM — Reviewed and was provided copy of patient's assets and reports that provide a complete accounting of the $30/month personal allowance (see enclosed material). This rules out the allegations of misuse of these funds.

9/16/92 10:15 PM — Phone call to Sally White (friend of the Benson's) who was involved with the client upon discharge from the nursing facility. She complained of the condition they found Mrs. Cora Benson:

- "Stuff on her feet" and they had to take her to the doctor
- "Dirty"
- "Skin was dry and cracking"
- Poor oral hygiene
- "Lost a lot of weight"

Mrs. White estimated the client weighed about 95 lbs. on the day she was discharged and after 2 to 3 months with her daughter-in-law increased to 120 to 125 lbs. Mrs. White was also concerned about the client's complaint of shoulder pain. Mrs. White claims the client stated that a nurse pulled her arm. She did not observe any bruising or other indications of overt physical abuse.

16/92 10:30 AM Daughter-in-law called to inform the Department she has an affidavit from the client's dentist (Dr. Johnson). **Arrangements were made to have it picked up at 11:45 AM today.**

9/16/92 11:30 AM Visited daughter-in-law at her home to pick up an "affidavit"from the client's dentist. Also, Mrs. Benson is concerned about where her mother-in-law will reside. She did mention that if they had help she would take her home. We briefly discussed the possibility of home care. She will discuss this possibility with her husband.

9/17/92 9:15 AM Phone call to Dr. Carson's office. He is not in but will call Friday. The office will mail a release form to the daughter-in-law so they can send medical records.

9/17/92 11:00 AM Phone call to Mr. O'Leary to inform the administrator that Area Agency on Aging personnel will be out at 1:30 PM to continue the investigation. This will include chart review and interviews with staff.

9/17/92 11:30 AM Phone call to General Hospital. Spoke with Mrs. Brown, Social Worker. Medical information has been mailed and Mrs. Cora Benson has been transferred to their extended care unit until a permanent placement can be arranged.

9/17/92 3:00 PM Continuation of Investigation accompanied by RN.
3 to 11 Shift

Interviewed with three relatives (of one resident). They were the only visitors on the floor at the time. The resident has been at Pleasant View for about two (2) years. Everyone agreed that the care and treatment was good. No complaints.

Able to interview residents that appeared to have good cognitive functioning. There were no complaints about the treatment or care.

OBSERVATION: This is a 46 resident wing, there were five (5) staff available for the shift:

- Two (2) nurses;
- Three (3) aides.

The rooms and residents appeared to be clean with a minimal amount of odor detected as one resident was being changed for bowel incontinency. Many of the residents were dressed and

out of bed (either in a chair in their room, congregating in the halls, or in the day room). Staff were active in their intervention with the residents.

Interview with staff (3):

- All three aides claim that there is no abuse occurring on their shift.
- They differed in their opinions of the other shifts. One aide stated she would be surprised if there were any abuses on other shifts. The other aide said there were abuses but refused to elaborate.
- The nurse was much more vocal in her concerns but clearly indicated that she has not witnessed or heard about any abuses of residents. She was concerned about understaffing and the poor quality of aides. She claims that there is "verbal abuse" (negative slanderous remarks) and some "rough handling" of residents. Because of the shortness of staff, she stated that "people don't get changed" and "turned.
- The nurse did not observe or hear about a fracture with one specific resident. Another resident, however, was dropped about three years ago and suffered a fracture and being "emotional" is often "pushed when they want her to move."

NOTE: Was provided additional information for the Director of Social Services (included in the PS file).

9/17/92 3:30 PM Further review of chart by Area Agency on Aging staff and RN. There is sufficient documentation in the file that indicates that the facility was concerned about a weight loss ("unknown etiology"). Weight on admission listed as 100 lbs. The physician has ordered the patients to be weighed every 3 months. Mrs. Cora Benson, however, was weighed monthly and it is documented that her weight decreased slightly. Her intake and output was observed, she was placed on a diet supplement and her weight increased to 103 lbs. by June 7, 1992. Mrs. Cora Benson is 5 feet. 2 inches.

9/23/92 9:00 AM Phone call to Dr. O'Leary's office requesting an interview about a potential protective services case. I was informed that Dr. O'Leary will call back.

'/23/92 30 AM Call from daughter-in-law. She is going to sign a release of information so Dr. O'Leary can forward written reports.

7/23/92 2:00 PM — Phone call with Dr. Johnson, DMD.

Dr. Johnson reported that the client has significant infection in her mouth due to poor oral hygiene. This can be a serious concern for heart patients, such as Mrs. Cora Benson. Dr Johnson did add that she saw the client 29 days after discharge from the facility. The condition at the time of appointment could have been the result of neglect within the last 29 days. It cannot be concluded that the nursing facility's neglect of Mrs. Cora Benson's oral hygiene was the cause of her present condition.

9/24/92 9:00 AM — Spoke with Dr. Foote, DPM. He stated that Mrs. Allen's foot condition was such that he should have seen her sooner. He further stated that the condition is common among nursing home residents as well as those at home. The "fungus" condition is common and places the client in no danger. He did not feel that the foot condition placed Mrs. Cora Benson at any risk.

9/24/92 — Several attempts to speak with Dr. O'Leary were unsuccessful. There is no further need to pursue his testimony as there is sufficient evidence to support the findings.

SUMMARY

- Client was a resident of Pleasant View from May, 1991 through June of 1992.
- Mrs. Mary Ann Benson, daughter-in-law, signed her out of the facility, against medical advice on 7/1/92.
- Client is presently at an extended care unit at General Hospital awaiting placement in another nursing facility. The daughter-in-law claims to be unable to care for her. The hospital social worker and Pleasant View social worker also question the family's ability to care for the client as she requires a great deal of care.
- The nursing home chart indicates that the client was removed from the facility because of "poor care." It further documents the daughter-in-law's concern about the client's appearance and how poorly her clothes were maintained. It mentioned that the daughter-in-law had a list of other complaints but they were not noted on the chart.
- The daughter-in-law states the following complaints during the PS interview.
  - The facility lost or ruined all of the client's good clothes.
  - The client's foot care and oral hygiene were poor.
  - The client has lost a great deal of weight (25 lbs) during her 14 month stay at the facility.
  - The facility misappropriated her $30 per month personal care allowance.
- Daughter-in-law denies observing any signs of physical abuse.
- A friend to the family supports the claims of the daughter-in-law. She also did not witness any evidence of physical abuse.
- The daughter-in-law submitted a written statement from the client's dentist that indicates "loose teeth" "advanced periodontal disease" and "advanced decay in some teeth."
- The nursing home chart indicates that the client was sent to a dental clinic on 5/5/92 for a tooth extraction.

- The daughter-in-law submitted a written statement from the client's podiatrist which states that the client had "grossly extended mycotic nails" and "severe HD on the fifth toe, bilaterally" and was treated on July 8, 1992.

- The nursing home chart indicates a concern for a weight loss of unknown etiology. This was noted upon admission. Weight upon admission was listed as 100 lbs. The client was weighed regularly and placed on a diet supplement when a slight weight loss was noted. The client's weight on June 23, 1992 was documented as 103 lbs. The client is 5 feet' 2 inches.

- The facility provided sufficient information to disapprove the daughter-in-law's accusation that the facility misused the client's $30/month care allowance.

- Hospital records show the client's weight at 116 lbs as of 8/17/92.

- Dr. Johnson, dentist, was unable to conclusively link poor oral hygiene with the care provided by the nursing facility.

- Dr. Foote, DPM, indicated that the foot condition is a common occurrence and did not place the client at risk.

Although there are quality of care issues; there is no evidence to support that this client meets the criteria of an older adult in need of protective services. Therefore, this case is classified as UNSUBSTANTIATED.

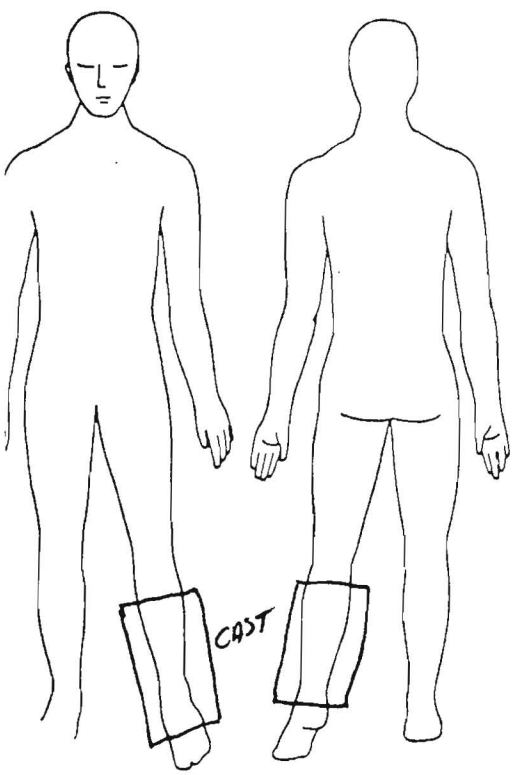
OLDER ADULTS PROTECTIVE SERVICES INVESTIGATION REPORT

T I INVESTIGATION OF ABUSE, NEGLECT, EXPLOITATION OR ABANDONMENT

CLIENT NAME Alma Quigley SEX Female AGE 77
ADDRESS Pleasant View Nursing Home SOCIAL SECURITY NO. _____
PHONE (___) _____

CONFIRMED = C POSSIBLE = P UNKNOWN = U NO = N

A. EVIDENCE OF SERIOUS PHYSICAL ABUSE	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Bruises, Welts				✓	9/11/92 Dr. Black - "No signs or symptoms
2. Sprains, Dislocations				✓	of physical abuse" i.e. bruises or lacerations.
3. Burns, Scalding				✓	
4. Abrasions, Lacerations				✓	
5. Wounds, Cuts, Punctures				✓	9/14/92 Observation - no overt signs of physical
6. Broken Bones				✓	abuse - no bruises or other injuries observed.
7. Internal Injuries	✓				
8. Sexual Assault				✓	
9. Other				✓	9/14/92 No documentation of any type of injury in the client's chart.



Client has a cast on her left leg as result of recent surgery (9/15/92) to repair a failed knee prostheses that had been deteriorating over a period of time.

Client claims (and appears) to be in pain and discomfort.

Client complained that a nursing assistant bumped her "bad knee" on the side rail. This was a documented incident that occurred on 6/8/92 as an accident with no additional consequences.

Client denied any physical abuse by nursing home staff.

9/18/92 Received a written report from Dr. Black that challenges the credibility of Mrs. Quigley's allegations of abuse.

B. EVIDENCE OF SERIOUS EMOTIONAL ABUSE	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
. Sleep Disturbance	_	_	_	✓	9/11/92 Dr. Black - "substantial cognitive
2. Worried, Anxious	✓	_	_	_	deficit"
3. Irritable, Easily Upset	✓	_	_	_	"poor judgement"
4. Changed Eating Habits	_	_	_	✓	"subjective depression/agitation"
5. Loss of Interest	_	_	✓	_	"elaborate system of persecution/paranoia"
6. Threatened, Intimidated, Fearful	✓	_	_	_	scored 16 on the Folstien Mini Mental
7. Suicidal Talk, Wishes	_	_	_	✓	9/14/92 Chart Review
8. Frequent Shaking, Trembling or Crying	✓	_	_	_	"Demanding - complaining to weepy"
9. Disoriented (Person, Place, Time)	✓	_	_	_	9/14/92 Observation
10. Appears Confused	_	_	_	✓	Client was crying during the interview and
11. Unable to Communicate	_	_	_	✓	gave conflicting testimony as to her treatment
12. Unable to Comprehend	_	_	_	✓	ranging from good to bad.
13. Hallucinations	_	_	_	✓	
14. Other	_	_	_	✓	Client voices a concern over the manner in which she is treated but can only pinpoint "everyone yells around here"-"can they be arrested".
					9/18/92 Refer to written evaluation by Dr. Black that is part of this file.

C. ABUSIVE ACTIONS (EMOTIONAL AND PHYSICAL)	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Insulted, Swore or Yelled at Victim	_	_	✓	_	9/11/92 Dr. Black - Reports that client
2. Threatened, Coerced	_	_	✓	_	claims various types of emotional abuse. He
3. Confined/Isolated	_	_	_	✓	feels, however, that it is part of her elaborate
4. Attempted to Harm	_	_	_	✓	paranoid state. He feels she has suffered
5. Threw Objects at Victim	_	_	_	✓	psychiatric episode and has recommended
6. Pushed, Grabbed Victim	_	_	_	✓	psychiatric intervention.
7. Struck or Kicked Victim	_	_	_	✓	
8. Threatened Victim With Weapon	_	_	_	✓	9/14/92 Client claims "everyone yells here"...
9. Injured Victim With Weapon	_	_	_	✓	has also given conflicting testimony that makes
10. Other	_	_	_	✓	her credibility suspect.
					No observed emotional abuse - none documented in the client's chart.

D. EVIDENCE OF SERIOUS NEGLECT (BY SELF OR CAREGIVER) -	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
Dirt, Fleas or Lice on Person	_	_	_	✓	9/11/92 Dr. Black - "no evidence of neglect" "proper hydration and nutrition". Hospitalization was due to failed knee prostheses that could not be connected to neglect.
2. Skin Rash	_	_	_	✓	
3. Sores	_	_	_	✓	
4. Malnourished	_	_	_	✓	
5. Dehydrated	_	_	_	✓	
6. Inappropriate Clothing	_	_	_	✓	
7. Fecal/Urine Smell	_	_	_	✓	9/14/92 Observation - Client was neat and clean in appearance. No offensive odor detected. No other signs of neglect.
8. Untreated Medical Problem	_	_	_	✓	
9. Other	_	_	_	✓	

E. NEGLECT FOR ACTIONS (FAILURE OF CAREGIVER TO PROVIDE)	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Adequate Food	_	_	_	✓	9/14/92 Observation - Client was provided lunch during the interview. It was a bowl of soup and ice cream. Although she c/o the amount she later stated she had enough to eat. Client is in what appears to be a well maintained room in a nursing facility.
2. Adequate Heat	_	_	_	✓	
3. Adequate Personal Care	_	_	_	✓	
4. Adequate Supervision	_	_	_	✓	
5. a. Prescribed Medication	_	_	_	✓	
b. Medical Equip or Aids	_	_	_	✓	
c. Other Medical Service	_	_	_	✓	
Other	_	_	_	✓	

F. FINANCIAL EXPLOITATION	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Stolen Money/Assets Of Victim	_	_	_	✓	No evidence or concern of financial exploitation.
2. Misused Money/Assets of Victim	_	_	_	✓	
3. Missing Money/Assets	_	_	_	✓	
4. Recent Change in Bank Accounts	_	_	_	✓	
5. Unexpected Change in Accounts	_	_	_	✓	
6. Unusual Financial Arrangments	_	_	_	✓	
7. Access to Accounts (e.g., joint, etc.)	_	_	_	✓	
8. Fiduciary Relationships	_	_	_	✓	

(e.g., Guardian, Power of Attorney, Rep. Payee)
(List)

	Court	Date(s)
a.		
b.		

G. PHYSICAL ENVIRONMENT PROBLEMS	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
Repair				✓	Client resides in what appears to be a well
Cleanliness				✓	maintained nursing facility.
3. Architectural Barriers				✓	
4. Kitchen/Bath Facilities				✓	
5. Living/Sleeping Area				✓	
6. Utilities				✓	
7. Fire Safety				✓	
8. Pest Problems				✓	
9. Pet/Animal Problems				✓	
10. Garbage/Trash Accum.				✓	
11. Other				✓	

PART II MEDICAL INFORMATION

A. CURRENT MEDICAL CONDITIONS: ( ) if Diagnosed

1. (✓) DJD
2. (✓) S/P removal of left knee protheses
3. (✓) ASHD
4. (✓) Absent right numeral head
5. (✓) History of Hiatal Hernia

RECENT HOSPITALIZATIONS:	DATES
1. Repair of failed knee protheses	9/5/92
2.	
3.	
4.	

C. CURRENT MEDICAL TREATMENT/THERAPIES (BY SELF OR OTHERS):

1. Client is wearing a cast on left knee
2.
3.
4.

D. CURRENT MEDICATIONS:

DATE	NAME	DOSAGE/FREQUENCY	PURPOSE	DOCTOR	PHARMACY
1.	Perrus Glucose	325 mg	1 x daily		
2.	Lanoxin	.25 mg	1 x daily		
3.	Diphenhydranine	25 mg	BID		
4.	Placebo Cap		QID when awake		
5.	Metoclopiomide	10 mg	1 Tab. before meals and at bed time		
6.					

PART III CHARACTERISTICS OF SUSPECTED ABUSER

* No one person implicated Staff	C	P	U	N	OBSERVATIONS (NOTE SOURCES AND NATURE OF CONFIRM. OR OTHER EVIDENCE)
1. Lives With Victim	_	_	_	✓	*Staff that work at the facility.
2. Alcohol User or Abuser	_	_	✓	_	
3. Drug User or Abuser	_	_	✓	_	
4. Emotional Problems	_	_	✓	_	Unknown as there has not been a specific
5. Behavioral Problems	_	_	✓	_	perpetrator implicated by the client.
6. Previous Pysch. Hospitalization	_	_	✓	_	
7. Mentally Retarded	_	_	_	✓	
8. History of Assaults on Others	_	_	✓	_	
9. Confused/Disoriented	_	_	✓	_	
10. Unemployed	_	_	_	✓	
11. Dependency on Victim	_	_	_	✓	
a. Income/Finances	_	_	_	✓	
b. Housing	_	_	_	✓	
c. Transportation	_	_	_	✓	
12. Criminal Arrest Record	_	_	✓	_	

PART IV FINDINGS

A. NEED FOR PROT. SERV. SUBSTANTIATED _____

NEED FOR PROT SERV. UNSUBSTANTIATED X

B. ACTION TAKEN (DESCRIBE AND GIVE BRIEF RATIONALE)

~~9/18/92~~

This case has been classified as ~~unsubstantiated~~. Please refer to Summary outlined in case narrative.

PART V SIGNATURES

PROTECTIVE SERVICES WORKER Denny Delantes DATE 9/28/92

SUPERVISOR _____ DATE _____

Investigation Initiated -

15 PM 9/11/92 — Phone call to General Hospital - Spoke with Mrs. Brown (SW) as Mrs. Quigley's social worker was not available. Mrs. Brown explained that Mrs. Quigley was due for discharge on either 9/12 or 9/14/92. She further explained that her discharge was postponed until Dr. Black (geriatric specialist) had the opportunity to examine her.

3:40 PM — Phone Call to Dr. Black. Dr. Black was very cooperative in his discussion about Mrs. Quigley.

Physical Health - Mrs. Quigley was admitted to the hospital for a failed knee prostheses. Dr. Black explained that the protheses has been deteriorating over a period of years and increasingly so over the past few months. He stated that Mrs. Quigley's medical records will indicate hospitalizations for this reason. He does recognize that this is a conflict with Mrs. Quigley's assertion that this protheses was damaged by constant (and recent) abuse through poor transfer techniques and other assistance from nursing home staff. Dr. Black stated there were no signs or symptoms of injuries or any other indication of intentional abuse or neglect.

Mental Health - Dr. Black stated that he had administered a series of tests including the Folstien Mini - Mental exam (of which she scored a 16). Dr. Black describes Mrs. Quigley's mental health as:

- "substantial cognitive deficit"
- "poor judgement"
- "subjective depression/agitation

He further described an elaborate system of persecution and paranoia. Among others, Mrs. Quigley claims that the nursing home is trying to poison her.

Dr. Black further stated that following the review of her records, his exam, and interviewing with hospital staff, he holds no credence to her claims of abuse and feels it is appropriate to readmit her to the facility.

4:00 PM — Attempted to contact the Department of Health as per regulations but no one was available. Will call on Monday morning (9/14/92).

9/14/92 8:30 AM — Phone call to the Department of Health. Spoke with Mrs. Smith who was involved in the other two (2) active cases. Notified her that I would be conducting an investigation at the Pleasant View Nursing Home regarding Alma Quigley. Requested a copy of individual report of previous cases. She will check with the Central Office.

.4/92 Visit to Pleasant View, Room 42.12:00 AM Chart reviewed:

Meds:	Perrsus Gluc	325 mg. 1 x daily
	Lanoxin	.25mg 1 x daily
	Diphern Hydrance	25 mg. twice a day
	Placebo Cap.	every day while awake
	Metoclopromide	10 mg. 1 tablet before meals and bed time

Nursing Notes Categorize Client:
- o "Oriented x 3. Demanding, complaining to weepy"
- o "Totally dependent on staff for all ADLs"
- o "Meds must be administered"

Further Notation:

- o Surgery at General Hospital (9/5/92) to regain failed knee prostheses. Failure occurred over a lengthy period of time as per Dr. Black.
- o On 6/8/92 nurses notes document that the client complained that a nursing assistant bumped her bad knee against the bedrail.

,,14/92 12:30 PM Visit with client who was in bed and just finished eating lunch (soup and ice-cream). Client complained that she is being treated poorly and wants staff arrested and the home closed.

The client's only report of any type of abuse was the Nurse Aide bumping her bad knee against the bed rail. She denied that she was ever struck by any staff. She also said that "everyone here yells."

Mrs. Quigley gave contradictory statements such as:

- o "They never let me out of bed" and "they leave me to sit on geri chair for as long as four hours".
- o "They do not give me enough to eat" and complained about the small lunch but later said she had enough to eat.

As stated, Mrs. Quigley was lying in her bed during the interview. She had a cast on her left leg as a result of recent surgery. She made several complaints including nervousness and pain. There were no overt signs of mistreatment. The "bedrail" incident was documented in the chart as having occurred on 6/8/92. It was described as an accident and there was no evidence to indicate otherwise. Mrs. Quigley denied any type of physical abuse.

Will obtain phone numbers of relatives.

9/14/92 Spoke with Dr. Pepper who is the facility physician. He will review the chart and be available tomorrow (9/15/92).

9/15/92
10:00 -
12:30 PM Investigation at Pleasant View Nursing Home.
On this date ten (10) employees from Pleaseant View were interviewed for their impression of the care and treatment of residents and potential knowledge of specific incidents in their facility. Staff included RNs, LPNs, Aides and support staff.

To Summarize:

- o No one witnessed any acts of physical abuse or violence toward any residents in the facility.
- o Several had heard rumors of physical abuse but could not or would not elaborate.
- o Several felt that many of the "attitudes", "tempers" or "problems" are a result of serious understaffing of Aides.
- o One person witnessed a client falling and requiring stitches because an aide left her alone in a compromising position. She would give no further information.
- o Several feel that residents are spoken to in a hard or harsh manner on a fairly large scale.
- o On a much smaller scale, it was reported that some clients (mostly those who are combative) are handled roughly.
- o There were complaints about "short cuts", "things" (care) missed (i.e. oral hygiene, care of ears) because of different levels of commitment.
- o Four of those interviewed felt the care and treatment of the residents was good and witnessed no acts of abuse or neglect.

These interviewees did not shed any light on the specific cases(s) being investigated.

Plan to interview 3 to 11 shift.

9/15/92 Circulated around Pleasant View and visited with clients.

12:30 PM — The majority of the clients have severe dementia and are unable to communicate. Those who are able to communicate proved to be unreliable reporters because of various stages of dementia. This is the SNF and ICF Ward.

9/15/92 — Met with the Director of Medical Services, Dr. Pepper, who has been the physician on record for Mrs. Quigley for some time. He claims that his observations and discussions with family show a person who has been dissatisfied with life, and a complainer for a long time. He personally examined her knee after a nurse aide bumped it on the bed rail and found no evidence of trauma. He attributed her difficulties with the knee prostheses to a lack of cooperation with physical therapy. He does not believe there is any foundation to her accusations.

9/15/92
1:45 PM — Met with the Director of Social Services. She will forward me additional information for the investigation.

9/17/92
3:00 PM — Continuation of Investigation accompanied by R.N. 3 - 11 **shift**. Interview with three relatives (of one resident). They were the only visitors on the floor at the time. The resident has been at Pleasant View for about two (2) years. Everyone agreed that the care and treatment was good. No complaints.

Able to interview three residents with what appeared to be fair to good cognitive functioning. There were no complaints about the treatment or care.

OBSERVATION: This is a 46 resident wing. There were five (5) staff available for the shift.

- Two Nurses
- Three Aides

The rooms and residents appeared clean with a minimal amount of odor detected as one resident was being changed for bowel incontinency. Many of the residents were dressed and out of bed (either in a chair in their room or in the day room). Staff were active in their interaction with the residents.

Interview with staff (3):

- The two aides both claimed that there is no abuse occurring on their shift.
- They differed in their opinion of other shifts . One aide stated she would be surprised if there were any abuses on other shifts. The other aide said there were abuses but refused to elaborate.

- The nurse was much more vocal about her concerns but clearly indicated that she has not witnessed or heard about any abuses of residents. She was concerned about understaffing and the poor quality of aides. She claims that there is "verbal abuse" (negative slanderous remarks) and some "rough handling" of residents. Because of the shortness of staff, she stated that "people don't get changed" or "turned."

- This nurse did not observe or hear about a fracture with one specific resident. Another resident, however, was dropped about three years ago and suffered a fracture and being "emotional" is often "pushed when they want her to move."

9/18/92 Received a written evaluation by Dr. Black.

Summary

- Dr. Black, Geriatric Specialist, examined Mrs. Quigley and found her to have cognitive and psychiatric difficulties including paranoia, persecution complex, agitation, depression and disorientation. He observed no overt signs of abuse or neglect and felt that Mrs. Quigley was an unreliable reporter.

- Interview with Mrs. Quigley showed no overt signs of abuse or neglect. Mrs. Quigley denies any overt acts of abuse but stated a nurses aide bumped her knee on a bed rail. She contradicts herself in her allegations of neglect and is vague about verbal abuse ("Everyone here yells.")

- A review of her chart showed documentation of the incident where the knee was bumped. It was characterized as an accident. There were no other entries describing any type of injury or abuse.

- Dr. Pepper, Director of Medical Services, examined the knee after the incident and documented no overt signs of trauma. He attributes the prosthesis failure to Mrs. Quigley's lack of cooperation with physical therapy. He held no weight to Mrs. Quigley's allegations.

- Interviews with staff and visitors were inconclusive.

- An evaluation by Dr. Black -- there has been no evidence of intentional traumatic injury; the failed left knee prostheses is the result of a process occurring over the last three or four years, not just two months. The patient's allegations of mistreatment appear to be symptoms of a paranoid thought disorder, which is coexisting with moderately severe dementia and possible depression.

- Hospital records indicate the son reported that his mother has been "a constant complainer and has habitually accused caregiving staff of mistreatment over the years."

- Dr. Black's report was based on his examination and interviews with other medical staff.

- Observation of the facility (two separate visits):

  During both visits; patients were observed and interviewed. In general, the clients and rooms were clean. Despite it being a skilled/heavy ICF wing; several patients were dressed and out of bed. Those patients who were alert, stated they were receiving good care and had no complaints. Staff were observed

interacting with residents. No overt acts of abuse or neglect were witnessed during these two visits.

Staff claim to have observed or witnessed no acts of abuse or neglect (either intentional of unintentional). Several staff complain about understaffing and as a result there are patients who do not receive appropriate care. There was also discussion about "harsh" tone of voice and "rough" handling of residents (primarily combative residents).

- Although there are serious quality of care issues at this facility, the only logical conclusion for this case is to classify it as **unsubstantiated** as the allegations could not be confirmed and the client does not fit the criteria of an older adult in need of protective services as defined in the ACT.