SB

211

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/10/96 FURTHER: Judiciary

Date of 5-Day Notice: 2/29/96
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 3/8/96

The State Affairs Committee considered SB 211

"An Act relating to sexual assault; and relating to endangering the welfare of vulnerable adults and neglect of vulnerable adults."

and recommends:

[X] be **replaced** with ____ CS SB 211 (STA)

[ ] adopt **previous** ____ CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to the _____ Committee

Senate Bill:
[X] same title
[ ] new title

House Bill:
[ ] same title
[ ] technical title
[ ] new: SCR _____

SIGNING DO PASS	*DP*	*OTHER RECOMMENDATIONS*	*NR*	*DNP*	*AM*
	✓				
	✓				
	✓				
	✓				
CHAIR:	✓				

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Administration	3/7	0	
Corrections	3/1	0	
Law	3/6	0	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal

COMMITTEE REPORTS

[ ] APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

N 3

FISCAL NOTE

Bill Version: CS SB 211 CSTA

(S) Publish Date: 3/11/96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:
Dept. Affected: Department of Law
Title: "...relating to endangering the welfare of vulnerable adults and neglect of vulnerable adults."
BRU: Criminal Division
Component: Criminal Division
Sponsor: Senator Ellis
Requester: Senate State Affairs Committee
COMPONENT SERIAL NO. 2085

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $ 0.0

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

In addition to clarifying language in the state's sexual assault statutes, AS 11.41.410 and AS 11.41.420, this bill establishes two new crimes, endangering the welfare of a vulnerable adult and criminal neglect of a vulnerable adult. The bill provides that a person commits the crime of endangering the welfare of a vulnerable adult if the person intentionally deserts the vulnerable adult in any place under circumstances creating a substantial risk of physical injury to the vulnerable adult and the vulnerable adult is entrusted to the person's care by law. This crime would be punishable as a class C felony.

The bill further provides that a person commits the crime of criminal neglect of a vulnerable adult if the person fails without lawful excuse to provide support for the vulnerable adult and the vulnerable adult is entrusted to the person's care by law. This crime would be punishable as a class A misdemeanor.

Richard I. Peques

Prepared by: Richard I. Peques, Director
Phone: 465-3672
Division: Administrative Services Division
Date: 3/6/96

Richard I. Peques /FOR/

Approved by Commissioner: Bruce M. Botelho, Attorney General
Date: 3/6/96
Agency: Department of Law

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FISCAL NOTE

STATE OF ALASKA
1996 LEGISLATIVE SESSION

BILL NO. SB 211

ANALYSIS CONTINUATION:

Instances of this conduct are somewhat infrequent, occurring every year or two. However, when they do occur they are of great public concern. Due to the infrequency of this conduct ,there will not be a fiscal impact for the Department of Law.

No. 2

FISCAL NOTE

Bill Version: CS SB 211 (STA)

(S) Publish Date: 3/11/96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:
Dept. Affected: Corrections
Title: An Act relating to sexual assault; and relating to endangering the welfare of vulnerable adults and neglect .....
BRU: ALL
Component:
Sponsor: Senator Ellis
Requester: House State Affairs
COMPONENT SERIAL NO. #0694

Expenditures/Revenues

(Thousands of Dollars)

OPERATING EXPENDITURES	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY96) cost: $ 0.0

POSITIONS

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

This bill amends AS 11.41.410 (3) (B)(ii) and AS 11.41.420 (a)(2)(B)(ii) by including 1st Degree and 2nd Degree Sexual Assualt language to include care providers who are licensed by the State , and by adding new language to AS 11.51.200 ; specifically (b) Endangering the welfare of a vulnerable adult is a class C felony; and by adding new language to AS 11/51.210; specifically (c) Criminal nonsupport of a vulverable adult is a class A misdemeanor.

The number of arrests, convictions by the Department of Law, and the lenghth of any jail sentence that a court might impose for either of these types of offenses is unknown at this time. For this reason no costs have been shown in the fiscal note.

Prepared by: Joe Reeves
Phone: 465-4652
Division: Office of the Commissioner
Date: 3/1/96

Approved by Commissioner: Margaret de Pinedo
Date: 3/1/96
Agency: Department of Corrections

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No. 1

FISCAL NOTE

Bill Version: CS SB 211 (STA)

(S) Publish Date: 3/11/96

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Revision Date:
Title: An Act relating to sexual assault; and relating to endangering the welfare of vulnerable adults...
Sponsor: Ellis
Requestor:

Dept. Affected: Administration
BRU: Senior Services
Component: Protection, Community Services & Administration
COMPONENT SERIAL NO. 2083

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITUR	FY 97	FY 98	FY 99	FY 00	FY 01	FY 02
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SCURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other						
Total	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year (FY 96) cost: $

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)
This bill will have no fiscal impact on this division.

Prepared by: Connie J. Sipe, Director — Phone: 563-5654
Division: Senior Services — Date:

Approved by Commissioner: Mark Boyer — Date: 3/7/96
Agency: Department of Administration

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(Rev 1/95)

AARP

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ALASKA STATE LEGISLATIVE COMMITTEE

CHAIR
Richard Gay
[illegible] Second Street
P O Box [illegible]
Hope, AK 99605
(907) 782-3651

VICE CHAIR
Merrit Olson
1037 W 11th Avenue
Anchorage AK 99501
(907) 272-9156

SECRETARY
Barbara Bush
P O Box 80462
Fairbanks AK 99708
(907) 479-2569

COORDINATOR
Capital City Task Force
Rupert Andrews
9415 Long Run Drive
Juneau AK 99801
(907) 789-7422

March 20, 1996

Senator Robin Taylor
Chair, Senate Judiciary Committee
Alaska State Legislature
Nineteenth Legislature- Second Session

Dear Senator Taylor:

The American Association of Retired Persons (AARP) in Alaska support Senate Bill 211, an act that if adopted by the Legislature, would increase the protection of vulnerable adults in Alaska. AARP has a long record of research into the problem of abuse of vulnerable adults. I am attaching a copy of AARP findings and model legislation to assist your committee and individual legislators in understanding this problem and what might be accomplished legislatively in Alaska to bring it under control.

If there are any questions or further information that the Judiciary Committee might require I can be contacted at (907) 789-7422 or FAX (907) 789-1846.

We hope the attached material proves helpful in your deliberations.

Sincerely,

Rupe Andrews, CCTF Cordinator, AARP

Elder Abuse

- AARP Policy
- South Carolina Omnibus Adult Protection Act
- *Elder Abuse and Neglect*
- Elder Abuse: The National Perspective
- "Elder Abuse: A Family Tragedy"
- "Fighting against Financial Exploiters"
- The Elder Abuse and Dependent Adult Civil Protection Act

AARP Policy on Elder Abuse

Federal

Elder abuse, like many other forms of domestic violence, is a hidden phenomenon affecting hundreds of thousands of older Americans. Elder abuse occurs everywhere, regardless of race, religion, income, education, place of residence, or living arrangement. Because abuse is not always reported, information on who is likely to suffer a particular type of abuse is not available. We do know that physical abuse is more likely from a spouse, adult child, or other family member.

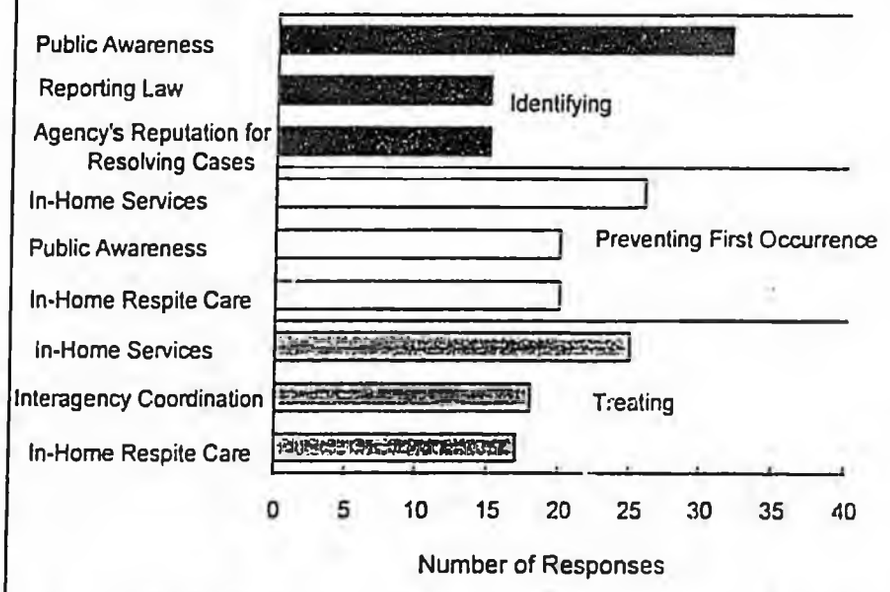
Experts on elder abuse generally believe that increasing the level of awareness among the general public and among professionals is the most effective means of encouraging people to recognize and report cases of elder abuse (see Figure 11-1). A 1991 report prepared by the Government Accounting Office showed that the 40 state agency officials interviewed believed that the most effective factor in preventing and treating abuse of the frail elderly is in-home services such as meals-on-wheels or home health care. Many jurisdictions have services to assist victims of domestic violence, especially female victims. Such services can provide victims with valuable information about legal and other strategies for preventing further abuse.

The American Medical Association estimates that one out of every four elderly persons experiences abuse or neglect. Elder abuse can be physical, financial, or psychological and may take place in a home or institutional setting. Elder abuse can also be systemic, when guardianship procedures intended to protect the infirm, ill, or incompetent are used to deprive older persons of their rights or resources. Guardianship infringes on the right of the individual to make his or her own decisions on where and how to live, and when to seek medical attention, among other decisions affecting self-determination. Differing state laws may also result in a person being deemed competent in one state, but unable to gain control of his or her assets in another state where the guardianship laws may be more restrictive.

Figure 11-1

Factors Rated Most Effective in Identifying, Preventing & Treating Elder Abuse

Top 3 in Each Area, as Rated by 40 State Agency Officials



Source: GAO, 1990 (multiple answers permitted)
Prepared by AARP Public Policy Institute

*Includes professional as well as general public awareness

The rapid increase in the number of older persons needing care will require the development and improvement of a variety of protective services, ranging from simple household chore services to money management, conservatorships, and guardianships. Community-based programs provide services for both intervention and prevention, such as counseling, information and referral, and personal money management. However, the percentage of total state adult protective services budgets allocated to elderly protective services remains disproportionately low.

More federal support, through commitment of financial resources, better coordination of existing services, and the strengthening of safeguards, will be necessary to establish a comprehensive response and delivery system.

ASSOCIATION POSITION:

AARP supports federal legislation that would encourage the states to make a criminal offense the abuse, exploitation, or intentional neglect by any person, who by law, contract, court order, or voluntary action is charged with or has assumed responsibility for the food, clothing, or shelter needs of an elderly individual. In addition, states should make institutions liable for criminal and civil penalties for victimization of those in their care. The Department of Health and Human Services should work toward uniform definitions of abuse and neglect among the states.

The Association supports a strong federal effort to assist state and local agencies in preventing, treating and prosecuting all forms of elder abuse, including spousal abuse. This effort should include research on the causes and frequency of abuse, demonstration projects on treatment and intervention to assist both abuser and abused, and financial and technical assistance to states. Funding for Social Services Block Grant and Older Americans Act programs that deal with abuse must continue and increase as the number of extremely elderly persons increases.

The federal government must encourage the expansion of programs that provide alternative protective arrangements that are less restrictive than guardianship, and educational and support programs to assist guardians, particularly those who are family members, in carrying out their responsibilities. It can accomplish this by coordinating programs funded under Social Services Block grants and the Older Americans Act and state and local programs, both public and private, such as Legal Assistance to the Elderly, representative payees, and volunteer monitoring, visitor, and auditor programs.

State

In the area of elder abuse, states should:

1. **Enact laws that make it a criminal offense with enhanced penalties to abuse, neglect and/or exploit a vulnerable older person.**

2. **Enact laws that provide victims and their legal representatives adequate civil remedies (including the award of attorney fees and**

costs, expedited hearings, and post-mortem recoveries for pain and suffering) against alleged perpetrators of abuse, neglect, and exploitation. In civil cases brought under elder abuse laws, if the victims are able to prove that they meet the statutory definition of a vulnerable adult, then the burden of proof shall shift to the alleged perpetrators to show they did not commit the abuse, neglect and/or exploitation.

3. Establish programs to help family members and caregivers who are abusers correct their abusive behavior.

4. Enact and enforce adult protective services laws that provide for investigation, access, and intervention in emergency and non-emergency situations of abuse, neglect, and exploitation of vulnerable individuals in the community and long-term care facilities. These laws must balance the individual's autonomy and self-determination with the need for the state to protect those people who cannot protect themselves. Any protective action that is taken shall be the least restrictive while meeting the specific needs of the vulnerable individual.

5. Develop public awareness programs, promote interagency coordination, and expand in-home services, including respite care, as a means of identifying cases of elder abuse and preventing or treating its occurrence.

6. Establish mechanisms for assessing the incidence of spouse/partner abuse among older couples, and work to assure that domestic violence and adult protective services agencies within the state make their programs more responsive to the needs of older abused spouses.

A BILL

TO AMEND TITLE 43, CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING CHAPTER 35 SO AS TO ENACT THE OMNIBUS ADULT PROTECTION ACT; TO DEFINE TERMS; TO PROVIDE FOR THE DUTIES OF THE STATE DEPARTMENT OF SOCIAL SERVICES AND THE DIVISION OF OMBUDSMAN AND CITIZEN SERVICES, OFFICE OF THE GOVERNOR, RELATIVE TO ADULT ABUSE, NEGLECT, AND EXPLOITATION; TO DESIGNATE THOSE REQUIRED TO REPORT; TO ESTABLISH REPORTING AND INVESTIGATING PROCEDURES; TO PROVIDE FAMILY COURT PROCEDURES; TO ABROGATE THE HUSBAND-WIFE AND DOCTOR-PATIENT PRIVILEGE IN ADULT ABUSE CASES; TO PROVIDE FOR EMERGENCY REMOVAL OF AN ADULT; TO PROVIDE IMMUNITY FOR GOOD FAITH REPORTING; TO PROVIDE CIVIL AND CRIMINAL PENALTIES; TO CREATE THE ADULT PROTECTION COORDINATING COUNCIL AND TO PROVIDE FOR ITS MEMBERSHIP AND DUTIES; TO AMEND SECTION 8-17-340, RELATING TO THE STATE EMPLOYEE GRIEVANCE COMMITTEE, SO AS TO REVISE THE STANDARD FOR REVIEWING A CASE INVOLVING ABUSE, NEGLECT, OR EXPLOITATION; TO AMEND SECTION 16-1-10, AS AMENDED, RELATING TO CRIMES CLASSIFIED AS FELONIES, SO AS TO INCLUDE THE OFFENSES ADDED BY THIS ACT; AND TO REPEAL SECTION 23-1-220 AND CHAPTERS 29 AND 30 OF TITLE 43.

Whereas, the General Assembly finds it necessary:

(1) to provide a system of adult protection in South Carolina;

(2) to clarify the roles and responsibilities of agencies involved in the system;

(3) to provide a mechanism for problem resolution and interagency coordination;

(4) to address continuing needs of vulnerable adults;

(5) to uniformly define abuse, neglect, and exploitation for vulnerable adults in all settings;

(6) to clarify reporting procedures for allegations of abuse, neglect, and exploitation;

(7) to provide procedures for emergency protective custody;

(8) to define the role of the court in the adult protection system;

(9) to provide civil and criminal penalties for abuse, neglect, and exploitation;

(10) to provide services in the least restrictive setting possible. Now, therefore,

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. The 1976 Code is amended by adding:

"CHAPTER 35

Adult Protection

Article 1

Duties and Procedures
of
Investigative Entities

Section 43-35-5. This chapter may be cited as the Omnibus Adult Protection Act.

Section 43-35-10. As used in this chapter:

(1) 'Abuse' means physical abuse or psychological abuse.

(2) 'Caregiver' means a person who provides care to a vulnerable adult, with or without compensation, on a temporary or permanent or full or part-time basis and includes, but is not limited to, a relative, household member, day care personnel, adult foster home sponsor, and personnel of a public or private institution or facility.

(3) 'Exploitation' means:

(a) causing or requiring a vulnerable adult to engage in activity or labor which is improper,

illegal, or against the wishes of the vulnerable adult. Exploitation does not include requiring a vulnerable adult to participate in an activity or labor which is a part of a written plan of care; or

(b) an improper, illegal, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a vulnerable adult by a person for the profit or advantage of that person or another person.

(4) 'Facility' means a nursing care facility, community residential care facility, a psychiatric hospital, or a facility operated or contracted for operation by the State Department of Mental Health or the South Carolina Department of Mental Retardation.

(5) 'Investigative entity' means the Division of Ombudsman and Citizens Services, Office of the Governor, or the State Department of Social Services.

(6) 'Neglect' means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident which has produced or is likely to result in serious physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect. Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death.

(7) 'Occupational licensing board' means a health professional licensing board which is a state agency that licenses and regulates health care providers and includes, but is not limited to, the State Board of Examiners for Nursing Home Administrators and Community Residential Care Facility Administrators, State Board of Nursing for South Carolina, State Board of Medical Examiners, State Board of Social Work Examiners, and the State

Board of Dentistry.

(8) 'Physical abuse' means intentionally inflicting or allowing to be inflicted physical injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery as defined in Section 16-3-651, overmedication for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other qualified professional is not considered physical abuse if it is part of a written plan of care. Physical abuse does not include altercations or acts of assault between vulnerable adults.

(9) 'Protective services' means those services whose objective is to protect a vulnerable adult from harm caused by the vulnerable adult or another. These services include, but are not limited to, evaluating the need for protective services, securing and coordinating existing services, arranging for living quarters, obtaining financial benefits to which a vulnerable adult is entitled, and securing medical services, supplies, and legal services.

(10) 'Psychological abuse' means deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress.

(11) 'Vulnerable adult' means a person eighteen years of age or older who has a physical or mental condition which substantially impairs the person from adequately providing for his or her own care or protection. This includes a person who is impaired in the ability to adequately provide for the person's own care or protection because of the infirmities of aging, including, but not limited to, organic brain damage, advanced age, and

physical, mental, or emotional dysfunction.

Section 43-35-15. (A) The Division of Ombudsman and Citizen Services, Office of the Governor, shall investigate or cause to be investigated reports of alleged abuse, neglect, and exploitation of vulnerable adults occurring in facilities. The Ombudsman may develop policies, procedures, and memoranda of agreement to be used in reporting these incidents and in furthering its investigations.

(B) The State Department of Social Services shall investigate or cause to be investigated reports of alleged abuse, neglect, and exploitation of vulnerable adults occurring in all settings other than facilities and where appropriate, provide protective services. The department may promulgate regulations and develop policies, procedures, and memoranda of agreement to be used in reporting these incidents, in furthering its investigations, and in providing protective services.

Section 43-35-20. In addition to all other powers and duties that an investigative entity is given in this article, the investigative entity may:

(1) have access to facilities for the purpose of conducting investigations;

(2) request and receive written statements, documents, exhibits, and other items pertinent to an investigation, including, but not limited to, hospital records of a vulnerable adult which the hospital is authorized to release upon written request of the investigative entity without obtaining patient authorization;

(3) issue administrative subpoenas for the purpose of gathering information and documents;

(4) institute proceedings in a court of competent jurisdiction to seek relief necessary to carry out the provisions of this chapter;

(5) require all persons, including family members of a vulnerable adult and facility staff members, to cooperate with the investigative entity

in carrying out its duties under this chapter, including, but not limited to, conducting investigations and providing protective services;

(6) require all officials, agencies, departments, and political subdivisions of the State to assist and cooperate within their jurisdictional power with the court and the investigative entity in furthering the purposes of this chapter;

(7) conduct studies and compile data regarding abuse, neglect, and exploitation;

(8) issue reports and recommendations.

Section 43-35-25. (A) A physician, nurse, dentist, optometrist, medical examiner, coroner, other medical, mental health or allied health professional, Christian Science practitioner, religious healer, school teacher, counselor, psychologist, mental health or mental retardation specialist, social or public assistance worker, caregiver, staff or volunteer of an adult day care center or of a facility, or law enforcement officer having reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited shall report the incident in accordance with this section. Any other person who has actual knowledge that a vulnerable adult has been abused, neglected, or exploited shall report the incident in accordance with this section.

(B) Except as provided in subsection (A), any other person who has reason to believe that a vulnerable adult has been or may be abused, neglected, or exploited may report the incident.

(C) A person required to report pursuant to this section is personally responsible for making the report; however, a state agency may make a report on behalf of an agency employee if the procedure the agency uses for reporting has been approved by the investigative entity to which the report is to be made.

(D) A person required to report under this section must report the incident within twenty-four hours or the next business day. A report must be made in writing or orally by telephone or otherwise

to the Ombudsman of the Office of the Governor for incidents occurring in facilities and to the State Department of Social Services for incidents occurring in all other settings. In the event an investigative entity receives a report which is not within its investigative jurisdiction, it shall forward the report to the appropriate entity not later than the next business day.

(E) No facility may develop policies or procedures that interfere with the reporting requirements of this section.

(F) Provided the mandatory reporting requirements of this section are met, nothing in this section precludes a person from also reporting directly to law enforcement, and in cases of an emergency, law enforcement must also be contacted.

Section 43-35-30. A person required to report pursuant to this article or a person investigating a report may take or cause to be taken color photographs of the trauma visible on the vulnerable adult who is the subject of a report. A person required to report under this chapter as a member of the staff of a medical facility, public or private institution, school, facility, or agency immediately shall notify the person in charge or the designated agent of the person in charge who shall take or cause to be taken color photographs of visible trauma. The investigative entity or law enforcement, if indicated, may cause to be performed a radiological examination or medical examination of the vulnerable adult without consent. All photographs, x-rays, and results of medical examinations and tests must be provided to law enforcement or to the investigative entity upon request.

Section 43-35-35. A person required to report or investigate cases under this chapter who has probable cause to believe that a vulnerable adult died as a result of abuse or neglect shall report the death and suspected cause of death to the coroner or medical examiner. The coroner or

medical examiner shall conduct an investigation and may conduct or order an autopsy. The coroner or medical examiner must report the investigative findings to law enforcement and the circuit solicitor in the appropriate jurisdiction.

Section 43-35-40. Upon receiving a report the investigative entity promptly shall initiate an investigation and within two business days of receiving the report must review the report for the purpose of reporting to law enforcement those cases requiring involvement of law enforcement. A report to law enforcement must be made within one business day of completing the review. The law enforcement agency shall initiate an incident report and provide upon request a copy to an entity conducting an investigation pursuant to this chapter or any other provision of state or federal law.

Section 43-35-45. (A) In investigating a report if consent cannot be obtained for access to the vulnerable adult or the premises, the investigative entity may seek a warrant from the family court to enter and inspect and photograph the premises and the condition of the vulnerable adult. The court shall issue a warrant upon a showing of probable cause that the vulnerable adult has been abused, neglected, or exploited or is at risk of abuse, neglect, or exploitation.

(B) At any time during or subsequent to an investigation where a vulnerable adult is at substantial risk to be or has been abused, neglected, or exploited and consent to provide services cannot be obtained, the Department of Social Services may petition the family court for an order to provide protective services. In those cases requiring emergency protective services or emergency removal of the vulnerable adult from the place the adult is located or residing, the department may seek ex parte relief. The court may expedite the ex parte proceeding to any extent necessary to protect the vulnerable adult. The family court may order ex parte that the vulnerable adult be taken into emergency protective custody

without the consent of the vulnerable adult or the guardian or others exercising temporary or permanent control over the vulnerable adult, if the court determines there is probable cause to believe that by reason of abuse or neglect there exists an imminent danger to the vulnerable adult's life or physical safety. The court also may order emergency services or other relief as necessary to protect the vulnerable adult.

(C) Within ten days following the filing of a petition pursuant to this section the court must appoint a guardian ad litem and an attorney for the vulnerable adult; and within forty days of the petition being filed the court shall hold a hearing on the merits.

(D) Before the hearing on the merits the Department of Social Services must conduct a comprehensive evaluation of the vulnerable adult. The evaluation must include, but is not limited to:

(1) the vulnerable adult's current address and with whom the vulnerable adult is residing;

(2) a list of all persons or agencies currently providing services to the vulnerable adult and the nature of these services;

(3) a summary of services, if any, provided to the vulnerable adult by the Department of Social Services;

(4) if needed, a medical, psychological, social, vocational, or educational evaluation;

(5) recommendations for protective services which would serve the best interests of the vulnerable adult; however, when these services are to be provided by another state agency, these recommendations must be developed in consultation with the other agency.

A copy of the evaluation must be provided to the court, the guardian ad litem, and the attorney at least five working days before the hearing on the merits. Reasonable expenses incurred for evaluations required by this subsection must be paid by the Department of Social Services which must seek reimbursement for these evaluations, where possible.

(E) At the hearing on the merits, the court may

order the department to provide protective services if it finds that:

(1) the vulnerable adult is at substantial risk of being or has been abused, neglected, or exploited and the vulnerable adult is unable to protect herself or himself; and

(2) protective services are necessary to protect the vulnerable adult from the substantial risk of or from abuse, neglect, or exploitation.

(F) Protective services ordered pursuant to this section must be provided in the least restrictive setting available and appropriate for the vulnerable adult and noninstitutional placement must be used whenever possible. Subsequently, if commitment to a treatment facility is required, the Department of Social Services may initiate commitment proceedings.

(G) Any interested person, on behalf of the vulnerable adult, may file a motion for review of the court order issued pursuant to this section.

(H) Following a court order from the merits hearing to provide protective services to a vulnerable adult, the Department of Social Services, at least every six months, must evaluate the vulnerable adult and submit a written report to the court, and any other parties required by the court, regarding the vulnerable adult's need for continued protective services as defined in this chapter.

(I) If the court determines that the vulnerable adult is financially capable of paying for services ordered pursuant to this section, then payment by or from the financial resources of the vulnerable adult may be ordered.

(J) In an action for exploitation or in which payment for protective services is in issue, upon its own motion or a motion of any party, the court may order that the vulnerable adult's financial records be made available on a certain day and time for inspection by the parties.

(K) Expenses incurred by the Department of Social Services on behalf of a vulnerable adult that have not been reimbursed at the time of the vulnerable adult's death become a claim against the

estate of the vulnerable adult.

(L) Payments for which a vulnerable adult is responsible or for which the Department of Social Services is to be reimbursed only include payments to third parties and do not include personnel or operating expenses of the Department of Social Services.

Section 43-35-50. The privileged quality of communication between husband and wife or between a professional person and the person's patient or client, except that between attorney and client or priest and penitent, are abrogated and do not constitute grounds for failing to report or for the exclusion of evidence in any civil or criminal proceeding resulting from a report made pursuant to this chapter.

Section 43-35-55. (A) A law enforcement officer may take a vulnerable adult in a life-threatening situation into protective custody if:

(1) there is probable cause to believe that by reason of abuse, neglect, or exploitation there exists an imminent danger to the vulnerable adult's life or physical safety;

(2) the vulnerable adult or caregiver does not consent to protective custody; and

(3) there is not time to apply for a court order.

(B) When a law enforcement officer takes protective custody of a vulnerable adult, the officer must transport the vulnerable adult to a place of safety which must not be a facility for the detention of criminal offenders or of persons accused of crimes. The Department of Social Services has custody of the vulnerable adult pending the family court hearing to determine if there is probable cause for protective custody.

(C) A vulnerable adult who is taken into protective custody by a law enforcement officer, may not be considered to have been arrested.

(D) When a law enforcement officer takes protective custody of a vulnerable adult under this

section, the law enforcement officer must immediately notify the county Department of Social Services and the circuit solicitor of the county where the vulnerable adult was situated at the time of being taken into protective custody. This notification must be made in writing or orally by telephone or otherwise and must include the following information:

(1) the name of the vulnerable adult, if known, or a physical description of the adult, if the name is unknown;

(2) the address of the place from which the vulnerable adult was removed by the officer;

(3) the name and the address, if known, of any person who was exercising temporary or permanent custody of or control over or who was the caregiver of the vulnerable adult at the time the adult was taken into protective custody;

(4) the address of the place to which the vulnerable adult was transported by the officer;

(5) a description of the facts and circumstances resulting in the officer taking the vulnerable adult into protective custody.

(E) The solicitor is responsible for filing a petition for protective custody within one business day of receiving the notification required by subsection (D).

(F) The family court shall hold a hearing to determine whether there is probable cause for the protective custody within seventy-two hours of the solicitor filing the petition, excluding Saturdays, Sundays, and legal holidays.

(G) Upon receiving notification that a vulnerable adult has been taken into protective custody the Department of Social Services shall commence an investigation. After the hearing required by subsection (F), the department may initiate or cause to be initiated a petition for services pursuant to Section 43-35-45.

Section 43-35-60. Unless otherwise prohibited by law, a state agency, an investigative entity, and law enforcement may share information related to an investigation conducted as a result of a

report made under this chapter. Information in these investigative records must not be disclosed publicly.

Section 43-35-65. A facility as defined in Section 43-35-10 shall prominently display notices stating the duties of its personnel under this chapter, the text of which must be provided by the Division of Ombudsman and Citizens Services, Office of the Governor. The notices must also include the addresses and telephone numbers of the Ombudsman and local law enforcement.

Section 43-35-70. The investigative entity may report an incident of abuse, neglect, or exploitation alleged against a health care professional to the occupational licensing board by whom that person is licensed.

Section 43-35-75. (A) A person who, acting in good faith, reports pursuant to this chapter or who participates in an investigation or judicial proceeding resulting from a report is immune from civil and criminal liability which may otherwise result by reason of this action. In a civil or criminal proceeding good faith is a rebuttable presumption.

(B) A person who, acting in good faith, makes a report or who cooperates with an investigation conducted pursuant to this chapter has a cause of action for compensatory damages against a person who caused a detrimental change in the employment status of the reporting or cooperating person.

Section 43-35-80. (A) Notwithstanding any regulatory or administrative penalty that may be assessed and in addition to a private civil cause of action that may be brought against a person or facility based on an action or failure to act that otherwise constitutes abuse, neglect, or exploitation under this chapter, the Attorney General, upon referral from the Division of Ombudsman and Citizens Services, Office of the Governor, may bring an action against a person who

fails through pattern or practice to exercise reasonable care in hiring, training, or supervising facility personnel or in staffing or operating a facility and this failure results in the commission of abuse, neglect, exploitation, or any other crime against a vulnerable adult in a facility.

(B) In granting relief under this section, the court may assess a civil fine of not less than ten thousand dollars or order injunctive relief, or both, and may order other relief as the court considers appropriate.

(C) Nothing in this section may be construed to create a private cause of action against one who fails through pattern or practice to exercise reasonable care as provided for in subsection (A).

(D) For the purposes of this section 'person' means any natural person, corporation, joint venture, partnership, unincorporated association, governmental entity, or other business entity.

(E) To the extent fines collected pursuant to this section exceed the cost of litigation, these fines must be credited to the South Carolina Department of Social Services Adult Protective Services Emergency Fund and may be carried forward from one fiscal year to the next.

Section 43-35-85. (A) A person required to report under this chapter and who knowingly and wilfully fails to do so is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than five years.

(B) A person who knowingly and wilfully abuses a vulnerable adult is guilty of a felony and, upon conviction, must be imprisoned not more than ten years.

(C) A person who knowingly and wilfully neglects a vulnerable adult is guilty of a felony and, upon conviction, must be imprisoned not more than ten years.

(D) A person who knowingly and wilfully exploits a vulnerable adult is guilty of a felony and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than ten

years, or both, and may be required by the court to make restitution.

(E) A person who threatens, intimidates, or attempts to intimidate a vulnerable adult subject of a report, a witness, or any other person cooperating with an investigation conducted pursuant to this chapter is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned for not more than five years.

(F) A person who wilfully and knowingly obstructs or in any way impedes an investigation conducted pursuant to this chapter, upon conviction, is guilty of a misdemeanor and must be fined not more than five thousand dollars or imprisoned for not more than five years.

Section 43-35-90. This article is not intended to affect in any way the authority of any agency to act under state or federal law.

Article 3

Adult Protection Coordinating Council

Section 43-35-310. (A) There is created the Adult Protection Coordinating Council under the auspices of the State Health and Human Services Finance Commission and is comprised of:

(1) one member from the institutional care service provision system or a family member of a consumer of that system and one member from the home and community-based service provision system or a family member of a consumer of that system, both of whom must be appointed by the Governor for terms of two years; and

(2) these members who shall serve ex officio:

(a) Attorney General or a designee;

(b) Board of Examiners for Nursing Home Administrators and Community Residential Care Facility Administrators, Executive Director or a designee;

(c) State Board of Nursing for South

Carolina, Executive Director or a designee;

(d) Commission on Aging, Executive Director or a designee;

(e) Criminal Justice Academy, Executive Director or a designee;

(f) South Carolina Department of Health and Environmental Control, Commissioner or a designee;

(g) State Department of Mental Health, Commissioner or a designee;

(h) South Carolina Department of Mental Retardation, Commissioner or a designee;

(i) State Department of Social Services, Commissioner or a designee;

(j) Health and Human Services Finance Commission, Executive Director or a designee;

(k) Joint Legislative Committee on Aging, Chair or a designee;

(l) Police Chiefs' Association, President or a designee;

(m) Prosecution Coordination Commission, Executive Director or a designee;

(n) South Carolina Protection and Advocacy System for the Handicapped, Inc., Executive Director or a designee;

(o) South Carolina Sheriff's Association, Executive Director or a designee;

(p) South Carolina Law Enforcement Division, Chief or a designee;

(q) State Ombudsman of the Office of the Governor or a designee.

(B) Vacancies on the council must be filled in the same manner as the initial appointment.

Section 44-35-320. The Adult Protection Coordinating Council shall coordinate the planning and implementation efforts of the entities involved in the adult protection system. Members shall facilitate problem resolution and develop action plans to overcome problems identified within the system. The council shall develop methods of addressing the ongoing needs of vulnerable adults, including increasing public awareness of adult abuse, neglect, and exploitation. The council shall remain abreast of new trends in adult

protection from national clearinghouses and other appropriate entities. The Adult Protection Coordinating Council has no authority to direct or require implementing action from any member or entity.

Section 44-35-330. (A) Duties of the council are to:

(1) provide oversight in adult protection and to recommend changes in the system;

(2) identify and promote training on critical issues in adult protection;

(3) facilitate arrangements for continuing education seminars and credits, when appropriate;

(4) coordinate agency training when possible to avoid duplication;

(5) coordinate data collection and conduct analyses including periodic monitoring and evaluation of the incidence and prevalence of adult abuse, neglect, and exploitation;

(6) determine and target problem areas for training based on the analysis of the data;

(7) promote resource development;

(8) assist with problem resolution and facilitate interagency coordination of efforts;

(9) promote and enhance public awareness;

(10) promote prevention and intervention activities to ensure quality of care for vulnerable adults and their families;

(11) provide technical assistance for developing memoranda of agreement among involved entities;

(12) promote coordination and communication among groups and associations which may be affected by the Adult Protection Coordinating Council's actions through the use of memoranda of agreement.

(B) Duties of the council are subject to the appropriation of funding and allocation of personnel sufficient to carry out the functions of the council.

Section 44-35-340. The chair of the council must be elected by a majority of the council membership for one two-year term. Other officers may be

elected as needed in the same manner as the chair. A majority of the membership of the council constitutes a quorum for official business to be conducted.

Section 44-35-350. Meetings of the council must be held at least quarterly at the call of the chair or may be called by a petition of two-thirds of the council membership."

SECTION 2. Paragraph 8 of Section 8-17-340 of the 1976 Code is amended to read:

"The committee may sustain, reject, or modify a grievance hearing decision of an agency. ~~except that~~ However, in cases involving actual or threatened ~~mental or physical~~ abuse, neglect, or exploitation as defined in Section 43-35-10 of a patient, client, or inmate by an employee, the agency's decision ~~shall~~ must be given greater deference and may not be altered or overruled by the committee, unless the grievant establishes that:

(1) the agency's ~~findings of facts are not sustained by the committee~~ finding that the grievant abused, neglected, or exploited or threatened to abuse, neglect, or exploit a patient, client, or inmate is clearly erroneous in view of reliable, probative, and substantial evidence~~, or~~;

(2) ~~the committee finds that~~ the agency's disciplinary action was not within its established personnel policies, procedures, and regulations~~, or~~;

3 (3) ~~the committee finds that~~ the agency's action was arbitrary ~~or~~ and capricious."

SECTION 3. The felonies added by Section 1 of this act must be added to the list of felonies in Section 16-1-10 of the 1976 Code.

SECTION 4. Section 23-1-220 and Chapters 29 and 30, Title 43, Code of Laws of South Carolina, 1976, are repealed.

SECTION 5. This act takes effect three months after approval by the Governor.

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PUBLIC POLICY INSTITUTE

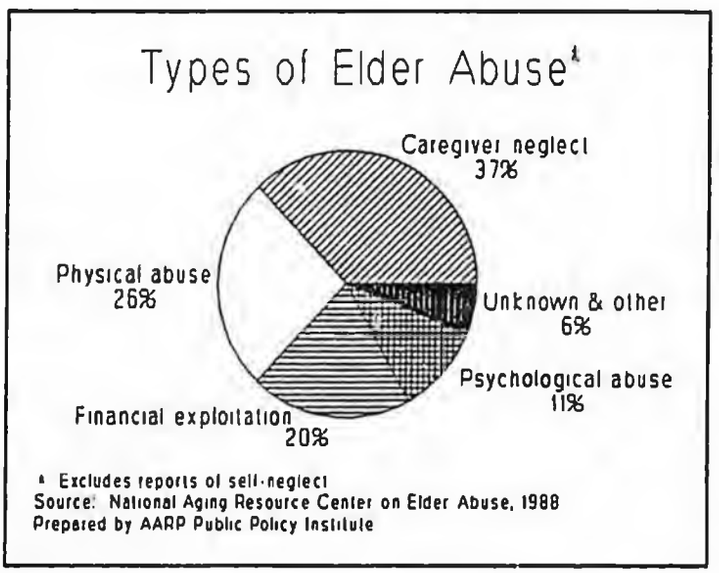
FACT SHEET

ELDER ABUSE AND NEGLECT

Types of Elder Abuse

Although the term "elder abuse" is commonly thought to mean acts of physical violence against older persons, it encompasses many different forms of dangerous behavior. Common forms of elder abuse and neglect are:

- Physical abuse - the intentional use of physical force causing pain or bodily harm.
- Psychological abuse - the intentional infliction of mental anguish by threat, intimidation, humiliation, or other abusive conduct.
- Financial exploitation - the conversion or unauthorized use of an elderly person's money, property, or other resources.
- Caregiver neglect - a caregiver's intentional or unintentional failure to fulfill a caregiving obligation needed to maintain an elderly person's well-being.
- Self-neglect - an older person's failure to provide himself or herself with the necessities of life, such as food, clothing, shelter, adequate medication, and reasonable financial management.



Prevalence of Elder Abuse

Each year, an estimated 1 to 2 million Americans are victims of elder abuse or neglect in domestic settings. Self-neglect comprises an estimated 40 to 50 percent of the cases reported to states' adult protective services (APS) units. Repeat elder abuse cases constitute nearly 20 percent of the reported instances of elder abuse and neglect.

A 1988 survey of nearly 600 nursing home staff suggests that elder abuse is a fact of institutional life: 40 percent of those surveyed admitted to personally committing at least one psychologically abusive act in the preceding year; 10 percent admitted to physically abusing patients.

Insufficient data, due in part to variations in the definition of elder abuse and neglect by states, may underestimate the prevalence of the problem.

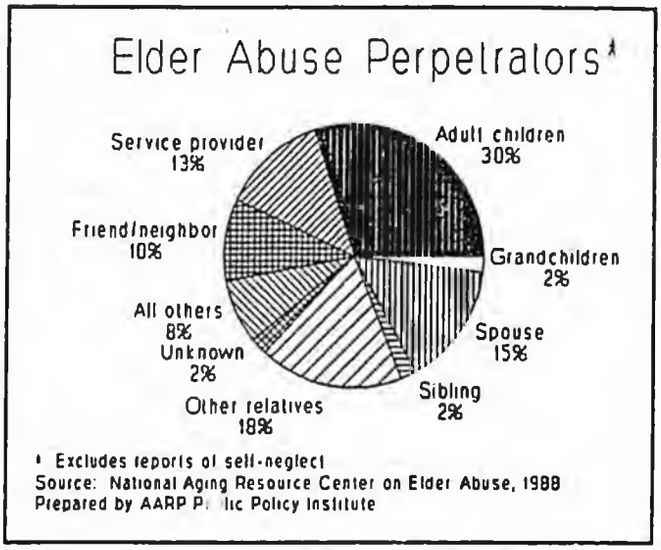
AARP

601 E Street, N.W., Washington, DC 20049

Characteristics of Victims and Abusers

- The U.S. House of Representatives Select Committee on Aging reports that the most likely victims of elder abuse include: women; persons age 75 or older; and individuals who are isolated and dependent on others for care and protection.

- More than two-thirds of elder abuse perpetrators are family members, most often an adult child or spouse.



Addressing the Problem of Elder Abuse

A variety of federal and state laws and programs seek to detect, prevent, or remedy elder abuse:

- The criminal justice system enables victims to press criminal charges against their abusers. Domestic violence laws enable victims to obtain from the court protection orders compelling the abuser to leave the home.

- State long-term care ombudsman programs investigate and resolve complaints made by or on behalf of long-term care facilities' residents. Federal nursing home law guarantees residents' rights, including freedom from physical and mental abuse, right to privacy, freedom from discrimination based on source of payment, prohibition against involuntary transfer or discharge, freedom from chemical or physical restraints imposed for discipline or for convenience, and control of and protection for personal funds. In 38 states, Medicaid Fraud Control Units investigate and prosecute cases of patient abuse and neglect in long-term care facilities that receive Medicaid funds.

- State adult protective services programs receive and investigate reports of elder abuse and provide social and health services. The Older Americans Act provides eligible individuals with in-home supportive services and legal assistance, and earmarks funds for state programs to prevent abuse, neglect, and exploitation of the vulnerable elderly.

In spite of these laws and programs, elder abuse continues to increase. The Department of Health and Human Services' Task Force on Elder Abuse found these existing programs to have many limitations:

- insufficient data and research about and lack of uniform definition of elder abuse;

- lack of coordination and follow-through among agencies responsible for reporting, investigating, and developing policy to address elder abuse;

- little public knowledge about the extent and causes of elder abuse;

- inadequate resources to enforce statutes and to carry out services.

For more information, contact Elizabeth Clemmer at AARP's Public Policy Institute. FS22-4/93.

Source: An Exploratory Study of Adult Protective Services Programs' Repeat Elder Abuse Clients, by Marsha Simon, October 1992.

ELDER ABUSE: THE NATIONAL PERSPECTIVE

WHAT IS ELDER ABUSE?

Multiple definitions of abuse exist and vary from state to state. Below are some definitions from the federal level found in the Older Americans Act of 1992.

Elder Abuse - defined as abuse of an older individual. 42 U.S.C.A. § 3002(24) (Supp. 1993).

Abuse - means the willful:

a) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish;

OR b) deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. 42 U.S.C.A. § 3002(13) (Supp. 1993).

Older individual - defined as a person who is 60 years of age or older. 42 U.S.C.A. § 3002(38) (Supp. 1993).

Neglect - defined as:

a) the failure to provide for ones self the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness (self-neglect);

OR b) the failure of a caregiver to provide goods or services. 42 U.S.C.A. § 3002(37) (Supp. 1993).

Exploitation - means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain. 42 U.S.C.A. § 3002(26) (Supp. 1993).

ELDER ABUSE STATISTICS

Who are the abused? Abused elders are spouses, parents, aunts/uncles, brothers/sisters, or any other relative, residents/clients, employers - from any and all walks of life. Some studies have shown white females are the most at risk, although such studies really are inconclusive.

Several studies estimate that as many as five percent of the nation's elderly may be victims of moderate to severe abuse. Nearly one out of every twenty or 1.5 million elders are victims of domestic and institutional abuse every year. [Source: House Select Committee on Aging, *Elder Abuse: A Decade of Shame and Inaction*. 1990.]

The National Aging Resource Center on Elder Abuse estimates that in 1988. there were 2 million reportable cases of domestic elder abuse. [Source: Tatara. Toshio *Elder Abuse in the United States: An Issue Paper*. NARCEA. 1990.] Researches estimate that only one out of fourteen cases is actually reported. [Source: The National Eldercare INstitute on Elder Abuse and State Long-Term Care Ombudsman.]

Who are the abusers? Although abusers come from as varied backgrounds as the abused, perpetrators were most likely to be adult children, with other relatives and spouses coming in close behind. Despite efforts to portray the victim as the dependent person in the relationship, it is often the abuser who is the most dependent. especially in domestic abuse situations.

It is apparent that both the incidence and prevalence of abuse is increasing. Studies show the rise in the occurrence of abuse but are unable to adequately portray the numbers. The abused and the abusers can not be ascertained by set difinitions. Elder abuse remains a hidden phenomenon.

Theoretical Causes of Abuse

A. ***Caregiver Stress***: The increased frustration and stress of caring for a parent, relative or resident may lead to abuse. This is particularly true when the caregiver is not prepared or lacking the needed resources to care for the elder.

B. ***Impairment of the Elder***: Studies have shown a correlation between the type of impairment and extent of dependency upon the incidence of abuse. The more dependent and impaired an individual is, the more likely s/he is a victim of abuse.

C. ***Pattern of Family Violence***: In some families, violence is a learned behavior and is transmitted from one family member to the next. When violence is learned, it becomes the normal and inherent response to any conflict, tension or stress.

D. ***Personal Problems of the Caregiver***: Studies show abusers tend to have more personal problems than non-abusers. Problems include: mental and physical disorders, alcohol and/or drug addiction, and financial difficulty.

ISSUES SURROUNDING ELDER ABUSE LAWS

When elder abuse entered the public eye in the late 1970's, public outcry demanded that states react quickly to the problem. States responded by creating legislation modeled after the other "big" abuse problems - child and spousal abuse. After more than a decade of this "copycat" legal response, critics raise several questions as to whether legislation has been a positive response to the elder abuse phenomenon. What follows is a list of some of these critics concerns, and why they might be important to advocates dealing with elder abuse situations.

CONCERNS ABOUT THE CONNECTION WITH CHILD ABUSE LAWS

- Unlike child abuse, incidence of elder abuse are difficult to investigate. Many times, the older adult has limited social interaction. In the worst cases of abuse, the only contact the abused might have with the outside world is the abuser.

- Elder abuse is also much more difficult to detect than child abuse. The same injury that would cause suspicion in a child might be attributable to infirmities of age in an adult.

- Each state has a different definition of elder abuse. Some states may recognize self-neglect as a form as abuse, while another state does not.

- The legal response to child abuse is oriented to a situation that involves clear cut victims, accusers, offender behavior, and usually willing and cooperative witnesses. Unfortunately, with unclear definitions of abuse and abusers, elder abuse cannot fit into the "clear cut" case scenarios. [Source: Formby, W.A., "Should Elder Abuse Be Decriminalized? A Justice System Perspective," 4(4) Journal of Elder Abuse and Neglect 121 (1992).]

- Who does the advocate represent? Suppose an aunt and nephew enter your office and the nephew states he is seeking durable power of attorney over his aunt's substantial estate. **Who is your client?** This question is perhaps the most complicating of all issues, especially when the older adult is potentially incompetent.

- The intention of elder abuse laws, especially mandatory reporting laws, has been to assure assistance to defenseless victims. The assumption is that all elderly are not able to choose for themselves or are incompetent. On the contrary, most elders are independent and financially secure. [Source: Shapiro, J., "The Elderly Are Not Children: So How Come Abuse Laws Treat Them That Way," U.S. News and World Report, p. 26, January 13, 1992.]

- The assumption that elders (like children) are dependent upon their abusers is often wrong. In fact, usually the abuser is most dependent on the abused. Similarly, the elder may be both a victim of abuse, and an abuser. Some of the violence and abuse between elders and caretakers is mutual, especially when there has been an history of family violence. [Source: Utech, M. & Garrett, R. "Elder and Child Abuse: Conceptual and Perceptual Parallels", 7 Journal of Interpersonal Violence 418, (1992).]

- Most elder abuse laws that are based on child abuse focus on the physical aspects of abuse. Studies show, however, that the elderly are more prone to be victims of financial abuse. [Source: Shapiro, J., "The Elderly Are Not Children: So How Come Abuse Laws Treat Them That Way," U.S. News and World Report, p. 26, January 13, 1992.]

MANDATORY REPORTING CONCERNS

- Will reporting suspected abuse or neglect really promote the older adult's welfare if the only realistic remedy is placement in a nursing home - when the adult wished to avoid this from the start?

- Mandatory reporting laws require abuse to be reported by certain professionals and others close to older adults. But should abuse be reported over the objection of a competent older adult?

- At what point is suspicion reasonable such that mandatory reporting requirements and accompanying provisions providing immunity against defamation claims come into operation?

- When a state requires mandatory reporting, at what time does a professional (doctor, dentist, etc.) violate the doctor-patient confidentiality and report suspected abuse.

- Studies show that agencies that work most with elder abuse feel the most important thing for maximizing reports of elder abuse would be to increase public and professional awareness. Reporting laws were not considered particularly effective in preventing or treating abuse. (In-home services were noted by those surveyed a the most effective factor in preventing and treating elder abuse.) [Source: General Accounting Office Report, "Elder Abuse: Effectiveness of Reporting Laws and Other Factors," April 1991.]

- Physicians have a lower reporting rate for elder abuse than for child abuse. Reasons for the lower rate include:

    - physicians are uninformed about the existence of the state's mandatory reporting laws;

- physicians and other health care professionals are skeptical about the effectiveness of existing reporting laws to ensure the anonymity of the report and the reporter's legal immunity form prosecution for reporting;

- a belief in patient - client confidentiality;

- a fear of lengthy court appearances; and

- a belief that the victim will deny the charges anyway. [Source: Tatara, T. National Aging Resource Center on Elder Abuse (NARCEA), "Elder Abuse in the United States: An Issue Paper, " 1990.]

- Punishments/penalties for not reporting abuse are rarely enforced.

CONCERNS ABOUT THE CONNECTION TO DOMESTIC/SPOUSAL ABUSE LAWS

- Some state laws require that the abused file a separation order or divorce decree before any action is taken against the abuser. In most instances the abused spouse is unwilling to take such a drastic measure.

- Services for spousal abuse victims are not usually geared to the elderly (i.e. battered women shelters are targeted to younger women with children).

- Definitions of domestic abuse tend to be limited to incidence of direct physical and psychological abuse, whereas elder abuse encompasses a variety of types and definitions of abuse.

GENERAL IMPLEMENTATION CONCERNS

- States are reluctant to strengthen reporting systems or outreach because of a fear that APS agencies may be flooded with probable cases. [Source: Thobaben, "State Elder/Adult Abuse and Protection Laws," in Filinson and Ingman (eds.) , Elder Abuse: Practice and Policy, P. 148.]

- States lack elder abuse prevention programs. Many times this is because states lack any funding to prepare such preventative measures.

- There is a lack of coordination between state agencies that deal with elder abuse. Given that agencies each play diverse roles in the detection, prevention, and protection of elder abuse victims, without agency coordination the victims of abuse are not getting the services that they need.

THE LEGAL RESPONSE TO ELDER ABUSE

Since the late 1970's there has been little coordinated Federal response to elder abuse. States have been left to their own devices to deal with the various aspects of the problem. Check with authorities in your state to receive appropriate response alternatives.

I. LEGAL METHODS TO *PROTECT* ABUSED OR AT-RISK ELDERS

A. *Adult Protective Services (APS)*

1. Most states have Adult Protective Services laws which:

   a) receive reports of abuse and/or neglect.

   b) investigate suspected abuse and/or neglect.

   c) provide protective services to the *consenting* older adult, and

   d) intervene on behalf of incompetent persons (without consent) who are being abuseed, neglected or exploited.

NOTE: Although APS allows advocates to protect those who are unwilling to receive assistance, it is important to remember that every competent individual has the right to make their own decisions, even if it is a bad decision.

B. *Mandatory Reporting Laws*

1. As of November of 1990, 42 states and the District of Columbia had mandatory reporting laws in which doctors, nurses, social workers, and other persons designated by the state are legally required to report suspected abuse cases. [Source: GAO Report, *Elder Abuse: Effectiveness of Reporting Laws and Other Factors*, April, 1991.]

2. The remaining states (Colorado, Illinois, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin) have voluntary reporting laws.

C. *Guardianship and Conservatorship* (Check state law for the difference between the two)

1. A highly intrusive measure in which another is given the right to make decisions for, and act on behalf of the elder adult.

2. Procedural considerations:

   a) usually, a petition is filed with probate court in the county where the individual resides or has property.

   b) usually, there are very few limitations on who can file the petition for guardianship/conservatorship.

   c) proposed ward's rights:
   - notice must be given to the proposed ward in all states
   - some states require the ward's presence at the hearing
   - all states recognize the ward's right to counsel, but few provide counsel
   - most states require appointment of a disinterested person to investigate alleged facts and to report to the court

   d) guardians are supposed to be monitored by the court to protect from further abuse, etc.

3. Substantive considerations:

   a) Most states have a two prong test for incompetency:

      1) the individual has an underlying physical or mental conditions, and

      2) as a result, the individual can no longer care for self.

   b) Some states have adopted functional tests of incapacity in which an individual is impaired if s/he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her person, or property will be dissipated or wasted unless proper management is provided.

NOTE: Guardianship/conservatorship is an extremely inhibiting method of protection. It is always wise to consider the least restrictive alternative of assisting the older adult.

ADVOCACY TIP: A good question for advocates to ask when considering guardianship as an alternative for older adults is: "Would guardianship be the alternative of choice if this person were 30 years old instead of 90 years old?"

II. LEGAL METHODS FOR *PREVENTING* THE ABUSE OF ELDERS

A. *Pre-incapacity Planning*

1. *Joint Property Arrangements*: When two or more persons have co-ownership over an asset. This is beneficial when the elder adult is capable but unable to go to the bank. etc.

NOTE: Drawbacks include a potential for misappropriation of funds by a dishonest co-owner.

2. *Power of Attorney*:

a) **General Power of Attorney**: An older adult appoints a person (agent) to act on his/her behalf. A regular Power of Attorney terminates if the older adult becomes incapacitated.

b) **Durable Power of Attorney**: The agent is authorized to act in the older adult's behalf before and after incapacity.

c) **Springing Durable Power of Attorney**: The authority to act as agent or attorney-in-fact is not activated until the older adult becomes incapacitated.

d) **Health Care Durable Power of Attorney**: Allows the agent to make only health care decisions for the older adult before and after the elder is incapacitated.

e) **Disadvantages of Powers of Attorney**:

1) Potential of abuse by the agent. As a fiduciary, however, the agent can be sued for mismanagement (see Section III: Prosecution).

2) Agents are not under court supervision.

3) Some banks may not recognize Durable Powers of Attorney, even with proper forms and identification, unless the principal had signed the form the bank uses to designate an agent or attorney-in-fact.

3. *Trusts*

a) Defined: Property is transferred by one person for the benefit of him/herself or another party and is administered or managed by a third party.

b) A revocable inter vivos trust becomes operative during the grantor's

lifetime and can be fixed to "spring" at grantor's incapacity.

c) One disadvantage with traditional trusts is the large legal fee required to establish the trust. The recent Uniform Custodial Trust Act, however, allows low and middle-income individuals to set up trusts through a simple statement noting the trust was established under the provisions of the act.

4. *Money Management Devices*
Designed to assist those who have difficulty handling routine financial matters. These methods have several advantages including: low risk of financial abuse: allowing the older adult as much control and autonomy over finances: and the establishment of these methods is easy and inexpensive.

a) **Direct Deposit:** benefit payments and other money is deposited directly into the older adult's bank account.

b) **Automatic Banking/Bill paying services:** some banks or professional bill paying services will pay a customer's bills automatically.

c) **Utility late payment backup reporting:** some utility companies will notify a designated third party when an older adult's services are in danger of being cut off due to past due bills.

5. *Representative Fayeeship*

a) Individuals are appointed by the agency to receive Federal benefit checks on behalf of recipients who are unable to manage their benefits. The authority given to the representative payee extends only to the benefit.

1) A payee can be a friend, relative or stranger.

2) Recent legislation now requires the Social Security Administration (and only the Social Security Administration) to investigate payees, but only after their appointment. 42 U.S.C. § 405(j)(2) (Supp. 1990).

b) Disadvantages of a representative payee:

1) The payee is not monitored by the agency or the courts.

2) Agencies have no remedies for persons financially abused by a payee.

B. *Community Based Services*

1. The outside assistance provided by Community Based Service: home health, volunteer programs, meals-on-wheels, etc.) can be helpful tool in preventing abuse.

2. Funds for such services may be provided through Medicare, Medicaid, SSI, etc. (Check eligibility requirements for all). States are also required to provide in-home services with a portion of allotted money form the Older Americans Act (Title III) funds. 42 U.S.C. 3026(a)(2)(B).

Social Service Block Grants (SSBG) may also provide some support for in-home care. States allocate these funds at their discretion, and usually little money is available for community based care programs.

III. LEGAL METHODS FOR THE *PROSECUTION* OF ALLEGED ABUSERS

A. *Possible Civil Actions*

1. **Assault and Battery** - for cases of physical abuse.

2. **False Imprisonment** - an alternative for use of excessive restraints.

3. **Negligence/Malpractice Action** - mismanagement of funds, care, etc.

4. **Injunction/Temporary or Permanent Restraining Order**

5. **Restitution**

B. *Advantages of Civil Actions*

1. Removal of the abuser from the victim's presence creates a safer environment.

2. It may assist the abuser in getting counseling or assistance.

C. *Disadvantages of Civil Actions*

1. In some states, these remedies are available to abused spouses only. Furthermore, other states limit protective orders to those who have filed separation agreements or divorce petitions.

2. In many states, only the victim may file for protective-type orders. If the older adult fears provoking more abuse, alienating the family, or isolation, s/he will not file for protection.

3. Any award of damages affects benefit payments. Some states, however, have adopted laws which disallow counting damage awards as income or resources.

4. The victim may die before the civil case comes to court. In some states then the tort action would die too. Even if the case did not terminate at the death of the victim, many juries are unwilling to award damages to family members.

5. Statute of limitations - if the appropriate time limit has passed, the civil case now becomes a contract dispute between the abused and the caregiver, and any abuse is considered merely a breach of contract.

6. An abusive caregiver is better than no caregiver. This is especially true when supportive services are difficult to identify. For many older adults, they see the only alternative to abuse as institutionalization.

C. *Possible Criminal Actions*

1. **Assault/Battery/Reckless Endangerment** - for cases of physical abuse.

2. **Burglary/Extortion** - for cases of financial abuse

3. **Special provisions for crimes against elders** - Some states have passed provisions which enhance the penalty for crimes committed against the elderly, or impose penalties for abusive actions taken by caregivers and institutions.

D. *Advantages to Criminal Prosecution*

1. Pressing charges may assist the abuser to get court mandated counseling or assistance.

2. Removal of the abuser from the victim's presence creates a safer environment.

3. It may serve as a deterrent to future abuse if the abuser realizes s/he may be criminally liable for his/her actions.

E. *Disadvantages to Criminal Prosecution*

1. The elder refuses to press charges because s/he fears retaliation.

2. Even after initially pressing charges, the older adult may change his/her mind and drop all charges.

3. The elder does not wish to "cause trouble" for the abuser, especially when the abuser is family.

4. The older adult may be too ashamed or embarrassed to admit his/her family member is abusive.

5. The physical and emotional strain of filing a complaint may be too intimidating to the older adult.

6. In some cases, the older adults wants only rehabilitation for the abuser and when it becomes apparent that the abuser may spend some time in jail, the victim will drop the charges.

IV. INSTITUTIONAL ABUSE

A. *State Long-Term Care Ombudsman Programs:*

a) In cases of elder abuse, a state ombudsman might investigate and resolves any complaints made by or on behalf of residents of long-term care facilities, including complaints of abuse.

b) Ombudsman programs vary from state to state, but usually the State Unit on Aging or the Department on Aging houses the state-wide ombudsman program.

B. *Nursing Home Laws:*

a) Omnibus Budget Reconciliation Act (OBRA)

1) Implemented a resident bill of rights which protects those adults in institutions. Among one of the rights is the right to be free of physical, psychological, or sexual abuse or punishment. 42 C.F.R. 483.10(e) (1992).

2) Developed stricter nursing aide training and evaluation requirements. States are required to establish a registry of adies who have satisfacorily finished the training and information abot

aides involved in incidences of resident abuse, neglect, or misappropriation of resident funds. 42 U.S.C. § 1395i-3(b)(5); 42 U.S.C. § 1396r(b)(5),

3) Required more professional nursing staff.

4) Made significant changes in the survey and certification process. 42 U.S.C. 1395i-3(g); 42 U.S.C. 1396r(g). The law now requires a multidisciplinary team to survey, in depth private interviews with residents, private discussions with the resident council, and interviews with family members.

5) The facility must furnish a written description of legal rights which includes a statement that the resident may file a complaint with the state survey and certificationagency concerning resident abuse, neglect, and misappropriation of resident property in the facility. 42 C.F.R. 483.10.

6) Facilities are required :

a) to implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents;

b) to not employ persons concivted of abusing, neglecting or mistreating individuals;

c) to ensure that violations are reported to the administrator or other officials in accordanve with state law through established procedures;

d) to have evidence that alleged violations are investigated; and

e) to report the results of investigations to the administrator or other officials. 42 C.F.R. 483.13.

C. *Medicaid Fraud Control Units (MFCU)*

a) MFCU's are law enforcement units authorized by federal law to investigate and prosecute cases of neglect and abuse of individuals in facilities that receive Medicaid funds. 42 US.C. 1396b(q)(4).

b) The state MFCU is composed of attorneys, auditors and investigators managed by a unit director, typically an Assistant Attorney General.

c) Any person or entity convicted of program-related abuse or neglect are excluded from a number of government health programs, including

Medicaid. Medicare. and Block Grant Programs. See Summit Health Ltd.. dba Marina Convalescent Hospital v. The Inspector General. HHS Departmental Appeals Board. Appellate Dev.: June 29. 1990.

Elder Abuse
A Family Tragedy

by Rosalie S. Wolf

The *International Year of the Family* provides a fitting context in which to discuss one of the darker sides of family life: the phenomenon that has come to be known as elder abuse. First described in British scientific journals as "granny bashing" and introduced in the U.S. as "parent battering," it has moved into the political arena alongside child and spouse abuse. The 1993 launching of *Action on Elder Abuse* in the United Kingdom, the publication of a position paper on elder abuse by the Canadian parliament, and the establishment of a National Center on Elder Abuse in Washington, D.C. attest to its legitimacy as a pervasive social problem.

Disclosures that older persons are being abused, neglected and exploited by family members and others in whom they have placed their trust have prompted scientific and governmental activity throughout the world. The revelations from Britain and the U.S. in the 1970s were followed in the 1980s by studies from Canada, Norway, Sweden, Hong Kong, and Australia, and in the 1990s by a report of the Council of Europe's Study Group on Violence Against Elderly People in which 22 European countries participated. Although the existence of the problem is now well documented, data on its incidence and prevalence have not been easily obtainable, nor its causes fully understood or interventions evaluated.

Scope of the Problem

In 1985 and 1986, a research team in the U.S., using a method validated in two national family-violence surveys, interviewed over 2,000 elders living in the metropolitan Boston area by telephone or in person.[1] They found that 3.2% had experienced physical abuse, verbal aggression, and/or neglect since reaching age 65. Spouse abuse was twice as prevalent as abuse by adult children, the proportion of victims was roughly equally divided between males and females, and economic status and age were not related to the risk of abuse.

The Boston survey questionnaire with financial abuse added was repeated on a national representative sample of non institutionalized Canadian elders.[2] Four percent of those able to respond to a telephone call had experienced one or more forms of mistreatment. Again, the rates for men and women were about equal, but financial abuse was more prevalent than physical or verbal aggression, or neglect. Another variation of the Boston and Canadian studies was utilized by a British group.[3] Recognizing some of the difficulties in carrying out the investigation in their particular part of London (few telephones, multi-ethnic population), re-

searcher had several of the Boston survey questions added to the national annual Omnibus Survey. Based on a representative sample of 2,000 adults, of whom 593 were 65-plus, the findings showed that nationally 5% of the elders reported having been recently verbally abused by a close family member of relative; 2% physically abused; and 2% financially exploited.

In a small, semi-industrialized town in Finland, researchers used postal questionnaires, interviews, and clinical examinations to determine the rate of physical, psychological, and sexual abuse; neglect; and economic exploitation experienced by the elderly population after the age of retirement.[4] They found 5.4% prevalence rate of abuse in family settings by relatives: 2.5% for men and 7% for women.

If financial exploitation is added to the prevalence rate for elder abuse in the Boston area, it is estimated that the percentage in the U.S. would be closer to the 5% reported in the other countries. Still, these numbers must be considered minimum figures given the secrecy, denial, and guilt associated with this problem and the omission of cognitively impaired elders from those surveyed.

How Commmon Is Violence Against the Elderly?

Abuse involving violence and theft rather than neglect is reportedly more common among older Canadians than previously assumed. The *Maison Jeanne Simard,* Canada's first shelter for abused elderly, reports that cracked ribs, cigarette burns, forced starvation and stolen pension checks are often the experience of those it serves. Since its founding in 1992 by Johanne Cotnoir, a Montréal gerontologist, the shelter has accepted 55 elderly people.

Further evidence about the frequency of abuse in Canada includes a survey taken in 1990, which revealed that of the 90,000 seniors living in private dwellings who are victims of abuse, 12,000 suffered from physical abuse. Other studies show that 4% to 12% of older Canadians can be considered abused. (*International Federation on Ageing Newsletter,* 2/94.)

Risk Factors and Characteristics

Even with evidence to the contrary, the tendency in the early years was to regard the stress of caring for dependent family members as the leading cause of elder abuse and neglect. This view was particularly attractive to politicians, the media and the public. It was easier to blame the victim than to challenge societal and family customs that allowed the mistreatment to occur. Besides, this interpretation of elder abuse could be accommodated within the traditional child abuse framework. It assumed the victim to be vulnerable and dependent upon family caregivers for physical, emotional and financial support. In fact, reports of elder abuse cases collected by health and welfare agencies did show that, on average, victims were over 75 years of age, female, with physical and mental impairments and dependent on the perpetrator.

The desire to move beyond the relatively simplistic and incomplete early depiction of the problem led researchers to examine how individual, familial, and cultural factors were related to family conflict.[5] Comparative studies of cases by type of abuse disclo... distinct profiles for abuse, neglect, and financial ploitation. Physical and psychological abuse were mo... closely associated with the problems of the perpetrator than the victim. Poor emotional health but relative independence in carrying out the activities of daily living were characteristic of the victims whereas perpetrators were more likely to have a history of psychopathology and to depend on the victim for financial resources. Since these forms of abuse involved family members who were most intimately related and emotionally connected, it is likely that this type of mistreatment has its underpinnings in long-standing, pathological family dynamics and interpersonal processes that become more highly charged when the dependent relationship is altered either because of illness or financial needs.

In marked contrast to the cases of physical and psychological abuse, those involving neglect seemed to be very much related to the dependency needs of the victims who were often widowed, very old, with cognitive and functional impairments. For the perpetrators in these situations, caring for these victims was a source of stress. In financial abuse cases, the motivating factor appeared to be greed rather than individual pathology or victim dependency. These perpetrators often had nancial problems and histories of substance abuse. T. victims were likely to be widowed, with few social contacts.

Victim-perpetrator dependency, perpetrator psychopathology, and caregiver stress emerge from the comparative studies as major risk factors for elder mistreatment with substance abuse and social isolation as serious contributing elements. Other factors that have been associated with child and spouse abuse such as the intergenerational transmission of violence and stressful life events have not yet been supported by elder abuse data.

Solutions

United States. Although the U.S. Congress played a prominent role in drawing the attention of the nation to the problem of elder abuse beginning in the late 1970s, finding solutions was left to the 50 states. Following a national protective services demonstration project in the mid-70s, grants were awarded to the states for the provision of services to protect all adults, 18 years or older, who were incapable of caring for themselves or in danger of abuse, neglect or exploitation. Some states adopted specific legislation, establishing an adult protective service system; a few added "adults" to their existing child protection laws that had been passed almost a decade earlier.

Once elder abuse became linked with family violence, state legislators reacted by pressing for special elder abuse laws. Within a few years, most states had passed new statutes or amended their existing adult protective service legislation. Because no model statute or data base on elder abuse existed, the child abuse law with its mandatory reporting of suspected cases became the prototype. In more than three-quarters of the states, the services are provided through the state social service departments (adult protective services); in the remaining, the state units on aging have the major responsibility. Some systems have a state administered system with a field office in the counties while others are administered by the county with state supervision. The result is not only interstate but also intrastate variation in the programs.

Generally, states or their designated units are responsible for receiving reports of suspected cases of elder mistreatment, screening for potential seriousness, conducting a comprehensive assessment if indicated, and developing a care plan. As soon as the immediate situation is addressed, the case is turned over to other community agencies for ongoing case management and service delivery.

When elder abuse was thought to be primarily a result of caregiver stress, reducing the dependency of the victim on the caregiver was the primary goal of treatment. Skilled home nursing, personal care, homemaker and chore services, respite care, meals-on-wheels, day care, friendly visitors, and emergency shelter have been employed to assist the caregiver, although not all of these programs are available throughout the country. The realization that the financial and emotional dependency of the perpetrator on the victim is an important risk factor, particularly in cases of physical and psychological abuse, has suggested another set of intervention possibilities: vocational counseling, job placement, housing assistance, alcohol and drug treatment, mental health services, and financial support. Because the emphasis in most adult protective service units is on helping the victim and funding is scarce, perpetrators with special needs are referred to other community programs; often, however, the perpetrators are unwilling to accept help or absent themselves from the situation.

As the conceptualization of the problem of elder abuse has moved further away from the child abuse model and closer to that of spouse abuse, the role of law enforcement has taken on greater significance in treatment and prevention. It is the contention of the criminal justice system that actions in violation of the criminal and civil codes should be prosecuted, even though many victims are unwilling to press charges. This attitude, as well as greater awareness of elder abuse among police and prosecutors, has resulted in a trend among the states to increase the penalties for mistreatment of older persons.

The federal government policy role is still a minor one even though the U.S. Congress finally established a *National Center on Elder Abuse* after more than a decade of advocacy by congressional partisans. The center operates a clearinghouse, disseminates information, offers technical assistance, and conducts research and demonstration projects. Under a new title in the 1992 reauthorization of the Older Americans Act of 1965, states are allocated a small amount of money to develop, strengthen and carry out programs for the prevention and treatment of elder abuse, neglect and exploitation.

Canada. Canada's response to elder abuse has been primarily at the community or municipal level. However, within the past few years, the federal, provincial, and territorial governments have formed interministerial committees on family violence, some of which have

subcommittees on elder abuse. As reported in *A Shared Concern*, an overview of Canadian programs addressing the problem of elder abuse, current activity tends to be "scattered, uncoordinated and in the early stages of development."[6] In answer to a national survey, almost three-quarters of the respondents stated that they were dealing with elder abuse as part of a broader-based approach to family violence. Health and social services were the most likely to encounter elder abuse, with the police and legal services becoming involved after the initial contact. Except for the four Atlantic provinces that have specific older-adult protection legislation, of which two include mandatory reporting, elder abuse is being addressed through existing criminal, mental health and guardianship laws. Although there are some coordinated, interdisciplinary programs across the country and ongoing research studies, the major activities have primarily been raising awareness, sharing information, and making referrals.

A 1993 report to the House of Commons by the Sub-Committee on Senior Citizens Health issues included a wide range of recommendations.[7] It called for the establishment of consistent usage of terminology, funding of research into risk factors, annual gathering of data on abuse, promotion of partnership among federal departments to address abuse, development and dissemination of educational materials aimed at prevention, provision of funds to support services, and review of existing legislation as to its effectiveness in addressing elder abuse.

United Kingdom. Despite early recognition of the problem, activities in the United Kingdom have lagged more than a decade behind the United States. Renewed interest in elder abuse, which began in the late 1980s, resulted in several research and policy reports that helped to bring together a small group of health and social service professionals committed to increasing public and professional awareness. Guidelines for identification and care management of elders at risk of abuse and neglect have been produced by professional organizations and a number of social service departments, whose social workers have been given primary responsibility for investigation. The launching of *Action for Elder Abuse* with support from Age Concern and the imprimatur of the national government, has added impetus and a national focus for mobilization of both the public and professional communities.

Australia. Most of the activity regarding elder mistreatment in Australia has been at the state level with the creation of committees or task forces to investigate the issue although a national working party was to be established in 1993. Recommendations from the various groups emphasize the need for the establishment of guidelines and procedures to deal with the cases and coordination among the health, welfare and criminal justice agencies. For Australian states, the question remains as to what agency, or whether one agency, should have primary responsibility.

Other Countries. Although studies on elder abuse have been reported from Norway, Sweden, Finland, Israel, Hong Kong, and Greece, none of these countries has a national policy. Several interesting programs have been described, such as the shelters for abused elderly women in Finland and the social worker "mediator" assigned to a senior citizens center in Norway to handle the abuse cases, but they are not part of a planned service delivery system. Two U.K. researchers, Bennett and Kingston, using Blumer's model of social problem construction, have outlined the steps that are necessary for the institution of a system for dealing with elder abuse: emergence, legitimization, mobilization of action, formulation of an official plan, and implementation of the plan.[8] To date, most countries other than U.S., Canada, and the U.K. are either in the emergence or legitimization stages.

Physical and psychological abuse are more closely associated with the problems of the perpetrator than the victim.

Conclusion

The response of the world to the problem of elder mistreatment has been encouraging even though it has been slower than that of child abuse. As with other forms of domestic violence, elder abuse challenges beliefs in the sanctity of the home and the inherent goodness of man. But unlike child abuse, it also raises basic ethical and legal dilemmas regarding the elder's right to self determination and society's desire to intervene.

The multiple dimensions and variations of elder mistreatment have forced researchers to give up the search for one unifying theoretical model. Initial efforts to arrive at a common definition have been put aside. Instead, researchers are asked to describe the parameters of their study with regard to type, frequency, duration, intensity, severity, intentionality and consequence of the behavior so that useful comparisons among findings can be made. Although some risk factors for elder abuse and neglect have been identified, additional studies are needed to determine its etiology.

Interested professionals and governments are grappling with how best to meet the needs of abuse victims and their families: through current legal codes or new protective legislation? the public or private sectors or both? a family violence or inadequate care model? or an integrated or segregated system of service delivery? New studies from the U.S. and Canada reveal that perceptions of elder mistreatment among sub-groups of diverse racial and ethnic backgrounds may differ from community standards. To arrive at a better understanding of this difficult problem, the experience of all countries will be needed. ■

Rosalie S. Wolf, PhD, is Executive Director of the Institute on Aging, The Medical Center of Central Massachusetts in Worcester. She is the organizer and president of the National Committee for the prevention of Elder Abuse and co-editor of the *Journal of Elder Abuse & Neglect.*

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Fighting Against Financial Exploiters

Case History

At the age of 91, Lillian Mitchell found herself evicted May 9, 1992, from the home where she had lived for more than 45 years in Santa Barbara, CA. Though a Superior Court judge later ruled that she had been evicted illegally and allowed her to move back into her home, Mrs. Mitchell filed a lawsuit in August 1992 alleging that several people, including her one-time financial consultant, conspired to steal her home. The suit lists breach of fiduciary duty, fraud, elder abuse and negligence. No. 193704 (Santa Barbara Super. Ct. 1992).

With the graying of America, cases like Mrs. Mitchell's may become depressingly common. Already reports of financial exploitation cases are on the rise. The National Aging Resource Center on Elder Abuse estimates that financial exploitation is the second or third most reported type of elder mistreatment. Abusers can include:

1. Family members taking money or abusing the authority granted in a power of attorney or guardianship.

2. Phony contractors and other vendors selling substandard services or unneeded mortgages.

3. New "friends" who formally or informally take on the role of helping elders.

Vulnerable elders all too often find that traditional legal actions put roadblocks in the way of their getting adequate remedies. Elders may be confused, dependent upon the perpetrator, or unable to afford the cost of litigation. They also may have a difficult time finding attorneys willing to prosecute. Or they may be unable to meet the burden of proof in a tort or contract action.

How to Protect Elders

To combat the problems, two states have enacted legislation aimed at protecting the rights of vulnerable elders.

Maine's Solution

The Improvident Transfers of Title law seeks to protect dependent elders in Maine from being taken advantage of by people who have a confidential or fiduciary relationship with them. The law defines a dependent elder as someone 60 or older who is wholly or partially dependent upon another person for care or support. These elders need care either emotionally or physically because they:

- Suffer from a significant limitation in mobility, vision, hearing, emotional or mental functioning.
- Suffer or are recovering from a major illness.
- Face or are recovering from major surgery.

Most importantly, the law creates a presumption of undue influence if a transfer of property takes place for less than full financial value to a person with whom the dependent elder has a confidential or fiduciary relationship. The only exception is if an independent counsel represented the dependent elder.

The Maine law thus shifts the burden of proof in such cases to the perpetrator. This is important since clients may not be capable of providing sufficient proof of bad faith on the perpetrator's part.

Failure of the perpetrator to rebut the presumption allows the dependent elder to avoid the transfer. The law provides such remedies as reformation of deeds, the imposition of constructive trusts on property, or orders to return the property.

The National Aging Resource Center on Elder Abuse estimates that financial exploitation is the second or third most reported type of elder mistreatment.

California's Remedy

California's Elder Abuse and Dependent Adult Civil Protection Act (EADACPA) is the first significant attempt by a state to protect the legal rights of vulnerable adults from abuse.

The new law targets all people over 65 as well as "dependent adults." The term "dependent adult" includes "any person between 18 and 64 who has physical or mental limitations which restrict his or her ability to . . . protect his or her rights."

EADACPA protects elders and dependent adults from physical abuse, neglect and fiduciary abuse. Fiduciary abuse is defined as a situation in which a person who has the care and custody of, or who stands in a position of trust to an elder or dependent adult, takes, hides, or appropriates the person's money or property to any use or purpose not in the due and lawful execution of his or her responsibility.

According to the state law, friends of impaired elders, attorneys-in-fact, guardians, businesses and perhaps even banks may find themselves within the ambit of the definition of trust. EADACPA also broadens the remedies available to elders:

1. It requires courts to award attorney's fees and costs to a successful plaintiff.

This is important in encouraging attorneys to take these cases, even if the plaintiff cannot afford to pay attorney's fees. People may be agreeable to settle the cases more promptly if the plaintiff's attorney's timeclock is ticking.

2. It allows post-mortem recoveries for the victim's pain and suffering up to a limit of $250,000.

This is important since frail abused elders often die before damages are awarded. Pre-EADACPA, recovering anything for pain and suffering after the victim's death was not possible. This gave defendants an incentive to delay going to trial.

3. It gives the Probate Court general jurisdiction to hear and decide all aspects of claims for relief under the Act, if a conservator has been appointed for plaintiff prior to the initiation of the action for abuse.

This is important since the Probate Court traditionally deals with protecting vulnerable adults. These courts also expedite their procedures to get matters before the judge more rapidly.

EADACPA provides one of our best hopes for preventing abuse in the future. Other states may want to follow California's lead in this effort.

DaCosta R. Mason

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The Elder Abuse and Dependent Adult Civil Protection Act
(Chap. 774, Stats. 1991)

by Marc Hankin, Esq.
Grayson, Givner, Booke, Silver & Wolfe
Encino, California

December 2, 1991

The Elder Abuse And Dependent Adult Civil Protection Act ("EADACPA" pronounced *ee-dak-pa*)[1] was signed into law by Governor Pete Wilson on October 10, 1991. Co-authored by Senators Henry Mello (D) and Ed Davis (R), and lobbied extensively by Senator Herschel Rosenthal, the new law is likely to have more impact on the quality of life for elders and dependent adult than any civil rights legislation within the last several years.[2]

EADACPA was the outgrowth of the perception of the author of this article that because elderly people are frail, (i) they are particularly vulnerable to physical and financial abuse, (ii) they gravitate into situations in which they are easily abused, such as mortgage swindles due to cash flow problems, and nursing home abuses due to health care problems, (iii) they are sought out by a growing army of people who prey on them, and (iv) they are unable to benefit from the protections which the criminal and civil tort systems currently purport to afford them.

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[1] Senate Bill 679 renames Chapter 11 (commencing with Section 15600) of Part 3 of Division 9 of the Welfare and Institutions Code as the "Elder Abuse and Dependent Adult Civil Protection Act." Article 8.5 (Sections 15657 through 15657.3) is added to Chapter 11 and entitled "Civil Actions for Abuse of Elderly or Dependent Adults."

[2] EADACPA was a Beverly Hills Bar Association resolution conceived and drafted by the author of this article. The resolution was adopted at the 1989 State Bar Conference of Delegates after having been proposed twice, and was enacted in its third trip through the Legislature. It was formally sponsored by the Beverly Hills Bar Association with principal lobbying support provided by California Advocates for Nursing Home Reform, the L.A. Caregiver Resource Center, the Alzheimer's Disease Association, Catholic Charities and, of course, the Beverly Hills Bar Association. Significant support was also provided by Lieutenant Governor Leo McCarthy, the Executive Committee of the State Bar's Estate Planning, Trust and Probate Section, the District Attorneys Association, the Crippled Children's Society, the Multiple Sclerosis Society, Senior Alliance, the California Society for Clinical Social Work, the L.A. District Attorney's Office, AARP, the Mental Health Association in California, and the Long Beach Frail Elderly Task Force, etc.

The author wishes to thank the forgoing persons for their behind the scenes lobbying and organizational support without which this legislation would not have been enacted: Wayne Friedlander of the L.A. Caregiver Resource Center, Patricia McGinnis of California Advocates for Nursing Home Reform and Burns Vick, Esq.

For example, ill elderly nursing home patients often have been over-drugged and tied up for the convenience of the staff. Unable to care for themselves, they have voluntarily or involuntarily moved into facilities where the health care industry has often neglected their hygiene and bedsores. Too demented by their illnesses or the drugs they are fed, they cannot testify about the wrongs inflicted on them. The criminal system rarely intervenes because the burden of proving criminal malice and responsibility *beyond a reasonable doubt* is usually an insurmountable burden.

The civil tort system also has largely abandoned the elderly to health care facility abuse. Too frail to survive long enough for a lawsuit to come to the judgement phase *before their death, even with a special trial setting*, the elderly have often been unable to attract plaintiff's counsel, even when the facility's abuse is obvious and egregious. Lawyers know that the victim's pain and suffering, the main damages in these cases, is *not* recoverable under existing law if the victim dies before the judgement is entered, and elderly victims of facility abuse often die quickly.

Plaintiff's personal injury lawyers typically get their fees out of a recovery for the victim's pain and suffering. But if the victim dies before the judgment is entered, the lawyer gets no pay for the work and money invested in representing the client. The lawyers therefore have had little financial incentive to take cases involving abuse of the frail elderly. Moreover, such cases are expensive to litigate inasmuch as they are characterizable as medical malpractice and require extensive discovery and expert witnesses. Thus, the contingent fee system, which was designed to enable the little person to hire a lawyer he or she could otherwise not afford, has failed to serve the frail elderly.

Financial abuse of the elderly has been growing, largely unimpeded by the tort system. Phony contractors and other vendors find declining elders and sell them substandard services or an un-needed mortgage at usurious interest rates. Then, there is also the new "friend" who cuts the declining victim off from family and the rest of the world "because they don't really care about you anyway." The new friend often gets a durable power of attorney, a new will, and hurries things along by using the durable power of attorney to move the money from the elder's account into the new friend's account "for safekeeping." Sometimes the money goes to the new friend as "compensation" for the friend's self-sacrifice in providing so much service to the progressively disoriented elder or dependent adult. It is not uncommon for the frail elder to then "forget" to take his or her medication, to "refuse" to see a doctor, and to die of a treatable condition aggravated by malnutrition. "She refused to eat anything. There was nothing I could do."

Criminal suits are rarely filed against such abusers because it is usually not possible to prove beyond a reasonable doubt that the old lady was incompetent when she gave away her money *and* that the "friend" knew it. Civil tort cases, brought by a conservator for the victim, are often unsuccessful because the abuser uses the victim's own money to pay for a vicious war of litigation attrition. Abusers know that the most they have to fear is a court order to give the money back, and they tend to fight long and hard. Conservators and their attorneys know that the Probate Court is uneasy about awarding big fees to the conservator and the conservator's attorney for protracted litigation if the conservatee may be left without enough to pay for the care he or she needs. Accordingly, blatant cases often settle for a relative pittance.

1. PURPOSE.

EADACPA proclaims that it is intended to protect elders[3] and dependent adults.[4]

EADACPA makes a legislative finding that:

(i) Elders and dependent adults are a disadvantaged class,
(ii) criminal prosecutions against abusers of elders and dependent adults are rare; and
(iii) few civil suits are filed due to problems of proof and court delays.[5]

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[3] Welf. & Inst. Code §15610(a) provides that anyone over the age of 65 who resides in California is an "elder."

[4] "Dependent adult" means "any person between the ages of 18 and 64 who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including but not limited to persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. Welf. & Inst. Code §15610(b)(1). The term "Dependent adult" also includes "any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2 and 1250.3 of the Health and Safety Code. Welf. & Inst. Code §15610(b)(2).

[5] Welf. & Inst. Code §15600(h).

EADACPA's purpose is "to enable interested persons to engage attorneys to take up the cause of abused elderly persons and dependent adults."[6] EADAPCA attracts attorneys by broadening the remedies available to elders and dependent adults who have suffered egregious abuse. EADACPA (i) requires courts to award attorneys fees and costs to a successful plaintiff, and (ii) allows post-mortem recoveries for the victim's pain and suffering. No less important, (iii) EADAPCA also gives victims of abuse a more expeditious and expert forum by giving the *Probate Court general jurisdiction to hear and decide all aspects of* claims for relief from abuse to an elderly or dependant adults. These new developments give plaintiff's attorneys incentives to file civil suits to enforce the rights of abused elders and dependent adults through injunctive relief, and to obtain damages for violations of those rights. These incentives reach across the board to private, public interest and governmental attorneys.

The impact EADACPA may have on the business world should not be underestimated. This is true even though EADACPA's broadened employer liability is limited to cases where (i) the wrong was perpetrated with recklessness, oppression, fraud or malice *and* (ii) the employer knowingly either participated in or ratified the wrong.[7]

The new law targets a *broadly* defined class of people called *dependent adults* and all people over age 65. The term dependent adult includes "any person between the ages of 18 and 64 who has physical or mental limitations which restrict his or her ability to . . . protect his or her rights." It remains to be seen whether a fairly normal person's neuroses or emotional handicaps are sufficient "physical or mental limitations" to entitle that person to protection as a "dependent adult" within the meaning of EADACPA. A person may be more entitled to membership in the protected class in some situations, such as the purchase of a complicated third mortgage, than in other situations, such as an automobile accident.

EADACPA protects elders and dependent adults from, among other things, an *amorphously* defined wrong called *fiduciary abuse.* The definition of fiduciary abuse

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[6] Welf. & Inst. Code §15600(j).

[7] Welf. & Inst. Code §15657(c). *See* the text following footnote 12.

mercifully appears to be a codification of existing law.[8] But the term may apply to just about any business deal in which a person owes a fiduciary duty to an elder or dependent adult.

2. EADACPA TARGETS THE MOST COMMON FORMS OF ABUSE.

EADACPA *requires* the court to award attorneys fees and costs if the plaintiff proves by *clear and convincing* evidence that the defendant was guilty of recklessness, oppression, fraud or malice in the commission of physical abuse[9], neglect or fiduciary abuse.

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[8] As proposed by its proponents, EADACPA was *explicitly* limited to wrongs which are both currently actionable and committed with malice. Sen. Bill 679, as amended on April 30, 1991. As a result of a compromise with critics of the Bill, who claimed that EADACPA created new causes of action, Welf. & Inst. Code §15610(f), which defines "fiduciary abuse," became a statutorily defined tort in the chaptered version of the Bill. The newly codified tort seems to add nothing new to existing case law, but only time will tell.

[9] Physical abuse is defined in Welf. & Inst. Code §15610(c) and "means all of the following:

(1) Assault, as defined in § 240 of the Penal Code.

(2) Battery, as defined in § 240 of the Penal Code.

(3) Assault with a deadly weapon or force likely to produce great bodily injury, as defined by § 245 of the Penal Code.

(4) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.

(5) Sexual assault, which means any of the following:

(A) Sexual battery, as defined in § 243.4 of the Penal Code.

(B) Rape, as defined in § 261 of the Penal Code.

(C) Rape in concert, as described in § 264.1 of the Penal Code.

(D) Incest, as defined in § 285 of the Penal Code.

(E) Sodomy, as defined in § 286 of the Penal Code.

(F) Oral copulation, as defined in § 288a of the Penal Code.

(G) Penetration of a genital or anal opening by a foreign object, as defined in § 289 of the Penal Code.

(6) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:

(A) For punishment.

(B) For a period significantly beyond that for which the restraint or medication was authorized pursuant to the instructions of a physician licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.

(C) For any purpose not consistent with that authorized by the physician.

"Physical abuse" is defined in Welfare & Institutions Code §15610(c), and includes among other things (i) assault and (ii) battery, as defined in § 240 of the Penal Code. "Physical abuse" also includes the prolonged or continual deprivation of food or water, and

> "the (iv) *use of a physical or chemical restraint or psychotropic medication* under any of the following conditions:
>
> (A) For punishment.
> (B) For a *period* significantly *beyond* that for which the restraint or medication was *authorized* pursuant to the *instructions of a physician* licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
> (C) For any purpose not consistent with that authorized by the physician." (emphasis added.)

The italicized language above targets the over-medication of patients and the over-use of "passive restraints" in nursing homes or other health care facilities, *i.e.* tying patients to their beds or wheelchairs.

"Neglect," as defined in Welf. & Inst. Code §15610(d), means:

> "the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care which a reasonable person in a like position would exercise. Neglect includes, but is not limited to, all of the following:
>
> (1) *Failure to assist in personal hygiene*, or in the provision of food, clothing, or shelter.
>
> (2) *Failure to provide medical care for physical* and mental *health needs*. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.

(3) Failure to protect from health and safety hazards.

(4) *Failure to prevent malnutrition.* (emphasis added.)

Among other things, the definition of "neglect" targets bedsores, malnutrition and other illnesses that are the product of simple neglect by a person or health care facility responsible to provide the "care which a reasonable person in a like position would exercise. "

"Fiduciary abuse," as defined in Welf. & Inst. Code §15610(f), "means a situation in which an person who has the care and custody of, or who stands in a position of trust to, and elder or a dependent adult, takes, secretes, or appropriates their money or property, to any use or purpose not in the due and lawful execution of his or her trust."

Fiduciary abuse is broadly defined and far reaching, but presumably is limited to fiduciary abuses that are currently actionable. But the term fiduciary abuse could apply to any type of business relationship in which the wrongdoer "stands in a position of trust to an elder or a dependent adult." The defendant may be an employer, a co-worker, colleague, or vendor of goods or services.

The wrongdoer may be liable for the victim's attorneys fees and costs and for the victim's pain and suffering, if the business person intentionally or recklessly "takes [the victim's] property" or "set[s it] aside or assigns [it] to a particular purpose[10]"which is "not in the due and lawful execution of the [elder's or dependent adult's] trust."[11]

Banks, trust companies, lenders, insurance companies, C.P.A.'s and others, who serve as financial planners, and any other fiduciaries may have to reassess their operating practices in light of their new exposure under EADACPA. Lest these new incentives for lawsuits arouse unnecessary anxiety, it should be noted that an employer is in no way liable

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[10] The meaning of the term "appropriate" figures prominently in the definition of "fiduciary abuse." Webster's New Collegiate Dictionary says that "appropriate" means "*to set aside or assign to a particular purpose* or use; or to take or make use of, without authority or right." (emphasis added.)

[11] The quoted language is drawn from the definition of fiduciary abuse set forth in footnote 9 supra.

for a wrong under EADACPA unless (i) an actionable tort took place, (ii) the tort was committed by an agent of the employer with recklessness, oppression, fraud or malice, (iii) both *(i)* and *(ii)* are proven to a judge's satisfaction, and not merely a jury's satisfaction, by clear and convincing evidence, and (iv) a managerial agent of the employer knowingly participated in the wrong or ratified it within the meaning of Civil Code §3294(b), or committed some other wrong sufficiently bad to bring it within the punitive damages provisions of §3294(b).

"Fiduciary abuse" obviously targets the growing cottage industry of new "friends" who cut the impaired elders and dependent adults off from friends and family, and then take the victim's property away. Fiduciary abuse may also target *businesses* which "stand in a position of trust" with respect to elders and dependent adults, and who use that trust to appropriate personal or real property from the victim "to any use or purpose not in the due and lawful execution of [that] trust." The usurious loan broker, the phony contractor and the dishonest investment counselor or financial manager will clearly find themselves within the ambit of this definition.

> "A typical come-on offers homeowners a 'special' on roofing, carpeting or drapes where the homeowner gets 25% off or free lottery tickets if he signs a contract right away . . . What the potential victim doesn't know is that the unscrupulous contractor is working hand-in-hand with the lender [who convince the elders] to take out loans they can never realistically repay."[12]

There is some possibility that the term "fiduciary abuse" could apply to lawyers, physicians and other service providers who stand in a position of trust to the elder or dependent adult when (i) they "take" a retainer from the elder or dependent adult, and (ii) intentionally fail to perform services which the provider agreed to perform. The plaintiff's argument would be that, if such a service provider uses the retainer for his or her own benefit or recklessly fails to perform, the defendant has "take[n] . . . property to [a] use or purpose not in the due and lawful execution of his or her trust."

Most civil complaints for damages arising from disputes over money include an allegation that the defendant breached a fiduciary duty to the plaintiff. It thus appears likely

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[12] Los Angeles Times, Misdeeds of Trust, Real Estate Section, page K9, Sunday, October 20, 1991.

that most lawsuit complaints brought by elders or dependent adults over a financial dispute will now include a request for attorneys fees and costs under EADACPA. For example, this could include, rental disputes, condo conversions, real property purchases, consumer contracts. investor fraud, securities frauds, abuses such as those alleged in the Lincoln Savings controversy, and many employment disputes.

3. ATTORNEYS FEE AWARDS.

EADACPA rewards the victorious plaintiff with attorneys fees and "costs," and says that the term "costs" includes reasonable fees for a conservator's services devoted to the lawsuit. Knowing that the conservator's and the plaintiff's attorney's timeclocks are ticking, abusers have an incentive to resolve disputes promptly under the new law, rather than wage the time honored war of legal attrition.

EADACPA's attorneys' fees provisions are not mere window dressing. EADACPA requires the court to consider three factors when awarding attorneys fees, the first *two* of which are designed to *reward* plaintiff's attorneys for standing up to litigious abusers. The third encourages both sides to settle promptly, and penalizes unreasonable litigation. Specifically, EADACPA provides that in determining the amount of attorneys' fees, the court must consider[13] all relevant factors *specifically including* the following three:[14]

(a) The value of the abuse-related litigation in terms of the quality of life of the elder or dependent adult, and the results obtained,

(b) Whether the defendant took reasonable and timely steps to determine the likelihood and extent of liability, and

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[13] Section 15657.1 sets out the factors for the determination of attorneys fees allowable under Section 15660. It is obvious from the context that the chaptered version of the bill has a typographical error, and that the reference in §15657.1 should have been to §15657 rather than 15660.

[14] Welf. & Inst. Code §15657.1(a), (b) and (c).

(c) The reasonableness and timeliness of any written offer in compromise made by a party.

In light of EADACPA's overriding statement of purpose, factor (a) should be interpreted as a factor that can only *enhance* the plaintiff's attorneys fees award, and may *not* be used to *limit* attorneys fees. Thus, factor (a) would be irrelevant in cases where the victim dies before a remedy is obtained, or where a suit is filed after the victim's death, requesting damages newly allowable under §15657(c) for the victim's pain and suffering.

> "It is the further intent of the Legislature in adding Article 8.5 (commencing with Section 15657[15]) to this chapter to enable interested persons to engage attorneys to take up the cause of abused elderly and dependent adults."[16]

EADACPA's purpose is to extend *additional* rewards to lawyers to entice them to take elder and dependent adult abuse cases. The goal of this *Civil Protection Act* is to encourage potential champions to use the civil tort system as a means of protecting the rights of a frequently victimized group of people who have not been adequately protected by the criminal system. EADACPA therefore explicitly provides that the attorneys fee awards are cumulative and supplemental to any damage awards.[17]

Fees should be awarded under EADACPA in an amount great enough to sufficiently reward the attorney for the litigation and the risks he or she assumes. Under EADACPA, the heirs and the attorney should not be compelled to enter into a contingency agreement under which they would share the damages recovered. In many cases, the pain and suffering of the victim may be unascertainable.

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[15] Due to typographical errors in the chaptered version of the legislation, Chapter 8.5 is erroneously identified as Chapter 6, and section 15657 is erroneously identified as section 15660. These erroneous cross-references will likely be corrected in clean-up legislation in this coming session.

[16] Welf. & Inst. Code §15600(j).

[17] Welf. & Inst. Code §15657(a) and (c).

> The intent of this bill is to discourage the commission of elder abuse by creating *additional* incentives for attorneys to represent the victims of abuse.
>
> Under existing law, the limitations on a victim's recovery, particularly if the victim dies before judgment, discourage attorneys from representing victims because the recovery is so little. Also, complex damage questions arise in cases of neglect where it may be argued that the neglected victim suffered little, if any, harm or injury, because he or she was so disoriented, ill, or infirm. What are the damages if the victim is alive, but not sentient?[18]

The goal of EADACPA is to make the abuser pay for the full cost of the legal proceedings that the abuse made necessary. The abuser should pay the full cost of vindicating the victim's rights. The fees that should be enough to entice the attorney to take such a case again, without being compelled to do so merely because of charitable motivation.[19] If there happen to be ascertainable damages for pain and suffering, the abuser should *also* make the victim or the victim's heirs whole by providing compensation for the actual harm caused.

The abuser may complain that an award of significant attorneys fees is inappropriate when there is also a post-mortem award for the victim's pain and suffering. The abuser would contend that the damage award provides more than enough reward for both the heirs and their attorney to share; but a pitifully small sum of unreimbursed medical expenses may be the only damages other than the pain and suffering. The abuser might retort: "So what? The victim is deceased and cannot be made whole. The idea of compensation no longer applies." But EADACPA tells us that, if the court has found *clear and convincing evidence* that the abuse was inflicted *intentionally or recklessly*, there is no public policy which favors

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[18] Report for July 16, 1991 hearing by the analyst for the Assembly Subcommittee on the Administration of Justice, Lloyd Connelly, Chairperson, a subcommittee of the Assembly Judiciary Committee.

[19] Welf. & Inst. Code §15600(j).

allowing the abuser to evade paying (i) full compensation for the amount of the harm he or she caused, *plus* (ii) the cost of the legal proceedings which he or she made necessary.

> The sponsor argues that existing limitations on damages, and fees, should not apply in such extreme cases.

The legislative history indicates that attorneys fees for the plaintiff's lawyers are to be given financial incentives to cut down on the frequency of unpunished abuse:

> In 1988, counties reported 31,004 cases of abuse within the meaning of the Act. In 1989, the total number of reports rose to 42,053.SB 679 creates a private enforcement mechanism that will augment the resources of counties in this regard.

A. The Paragraph (a) Enhancement Factor: Impact on Quality of Life.

If the victim is still living, paragraph (a)[20] may be the basis for the award of significant attorneys' fees. For example, if a conservator successfully seeks an injunction requiring a nursing home to clean the beds of incontinent people more frequently to prevent bedsores, the value of such successful litigation will have a great impact on the quality of the plaintiffs' lives, and the reward should reflect that. Similarly, an order requiring a facility to adhere to minimum staffing obligations required by law may have a significant impact on the frequency with which disabled people are given assistance with feeding, and therefore a large impact on their quality of life. The successful attorney's fee award should be large enough to reflect the importance of the feeding in terms of the victim's quality of life.

Although OBRA and other laws[21] purport to give nursing home residents a private

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[20] *See* the text accompanying footnote 14.

[21] OBRA is codified within the federal Medicare and Medicaid statutes, i.e., 42 U.S.C. 1395, et seq., and 42 U.S.C. 1396, et seq., respectively. The patients' rights provisions occur at 42 U.S.C. 1395i-3(c), and 42 U.S.C. 1396r(c), respectively. OBRA specifically provides that the remedies it provides are "in addition to those otherwise available under

right of action, few attorneys in private practice have found courts to be sufficiently liberal in awarding fees to be attracted into the field of nursing home litigation. The new provision, Paragraph (a) above, which bases an attorneys fee award on the effect of the litigation upon the victim's "quality of life," will put teeth into the law by enticing lawyers to take abuse cases. Successful suits for damages and injunctive relief in the nursing home context will induce remedial changes in the industry, and thereby give a practical meaning to many of the grandiose rights codified in various places.

In the context of *consumer fraud* or *fiduciary abuse*, litigation to recover an elderly person's home or life savings from a con artist comes squarely within paragraph (a) due to the importance of an elder's home and life savings with respect to his or her quality of life. It's usually too late for the elder to earn it again. Attorneys' fee awards for the successful recovery of property should now reflect (i) that importance and (ii) the fact that rewards under Paragraph (a) are subject to the risk and contingency that the plaintiff's attorney can prove his or her case by clear and convincing evidence. Litigation that prevents flagrant financial abusers from profiting from their wrong may deter prospective abusers from starting down the wrong path.

Rewards for successful public interest litigation may be enhanced by these new attorneys fees award factors, but that is yet to be seen. Attorneys fee applications under the private attorney general statute, Code of Civil Procedure §1021.5, "need not represent a tangible asset or a concrete gain but, in some cases, may be recognized simply from the effectuation of a fundamental constitutional or statutory policy."[22] It is unclear whether the fees awarded for the effectuation of a fundamental constitutional or statutory policy are generally expected to be in an amount that reflects the value of the litigation in terms of the quality of life of the plaintiff.

State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." 42 U.S.C. §1395i-3(h)(5); 42 U.S.C. §1396r(h)(8).

There is a private right of action under the California Health & Safety Code Sections 1430 and 1423 against licensed nursing homes for violation "of any statutory provision or rule or regulation relating to the operation or maintenance" of long term health care facilities.

[22] *See* Serrano v. Priest (1977) 20 Cal. 3d 25, 41-42, 141 Cal. Rptr. 315, 569 P.2d 1303; Rich v. City of Benicia (1979) 98 Cal. App. 3d 428, 433, 159 Cal. Rptr. 473.

Most public interest litigation will not fall squarely within the ambit of Welfare and Institutions Code §15657, and therefore attorneys fees awards for most public interest litigation will be computed under authority prescribed by other statutes. However, the Legislature's approval of the new attorneys' fees factors set out in §15657.1 suggests that those factors may be appropriate ones for a court to consider in making awards for successful public interest litigation. Attorneys who apply for fees may wish to emphasize these new factors which may be supportive in public interest litigation.

B. The Paragraph (b) Enhancement Factor: Defendant Employer Fails to Act Quickly To Find Out Whether Its Agent Committed The Alleged Wrong, and the Extent of the Employer's Obligations to the Victim.

Paragraph (b) of Section 15657.1[23] provides a defendant with an incentive to promptly take "reasonable and timely steps to determine the likelihood and extent of liability," because the plaintiff's attorneys fees will be enhanced if the defendant does not do so. But Paragraph (b) may seem unnecessary since EADACPA applies only when the abuser committed the abuse intentionally or recklessly. After all, a person who inflicted the abuse maliciously does not need to take *any* steps to determine the likelihood and extent of his or her own liability; the liability is obvious.

But an *employer* whose employee may have committed the abuse *does need* to promptly take "reasonable and timely steps to determine the likelihood and extent of liability," and Paragraph (b) encourages the employer to do so. The employer's failure to take those steps may later be cited by the plaintiff's attorney as the basis for an enhanced fee award. This will be particularly true where the guilty employer did not initiate the timely settlement efforts required by paragraph (c). On the other hand, if the defendant employer promptly does what Paragraph (b) requires, the employer's compliance will not reduce the plaintiff's attorney's fee award, but neither will Paragraph (a) enhance it.

Paragraph (b) is important also because employers are *not ipso facto* subjected to EADACPA's special liability for attorneys' fees and costs *whenever* an employee misbehaves. To be liable, the employer must either ratify the employee's misconduct or otherwise bring itself within the standards of Civil Code §3294(b) for the assessment of

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[23] See the text accompanying footnote 14 above.

punitive damages against an employer.[24] Query whether an employer's failure to obey Section 15657.1(b)'s mandate to take "reasonable and timely steps to determine the likelihood and extent of liability" constitutes a ratification within Civil Code §3294(b)?

C. The Paragraph (c) Factor: The Legislative Policy Favoring Settlement Applies to All Parties, Even the Innocent. A Close Approximation of Justice May Be Good Enough.

Paragraph (c)[25] is the sole factor in section 15657 which can serve not only as a possible enhancer of the plaintiff's attorney's fee award, but also as the basis for a reduction of the award. Assume, for example, that a defendant employer determines that it is liable for an employee's wrong, and makes a prompt and reasonable settlement offer which the plaintiff rejects without making a reasonable and timely counter-proposal. In this case, the plaintiff's attorneys fee award should be *reduced* in order to reflect the waste of the court's and the defendant's time and money caused by the plaintiff's inappropriate response to the offer.

But if the plaintiff makes a reasonable settlement offer and the defendant fails to timely respond with a reasonable counter-proposal, the defendant should be required to pay for the unnecessary waste of time and money imposed on the victim, and pursuant to Paragraph (c), the court should enhance the plaintiff's attorneys fee award. After all, once the plaintiff has proven, by clear and convincing evidence, that the defendant committed the tort recklessly or intentionally, the defendant *should* be forced to pay for all the legal proceedings that were the foreseeable result of that tort. The Legislature has now determined that it is good public policy to make blatantly malicious evildoers pay the cost of all the lawyers and experts that the evil made necessary, and particularly for dragging out the proceedings.

From a purely administrative standpoint, paragraph (c) puts all cases on a sort of "fast track", by encouraging prompt and reasonable settlement offers from either side as discovery progresses. The sanctions embodied in paragraph (c) are merely a logical extension of the approach to settlements already embodied in Code of Civil Procedure §998.

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[24] *See* the text following footnote 11.

[25] See the text accompanying footnote 14 above.

No longer. Damages for pain and suffering *will* be recoverable *even after the victim's death*, up to a limit of $250,000, if the plaintiff satisfies the tests for the recovery of attorneys' fees under EADACPA.[30] Contingency cases proving, by clear and convincing evidence, a reckless or intentional infliction of financial or physical harm on the elderly or the frail are now viable. Armed with these incentives, many elders and dependent adults will be able to enforce their own rights, knowing that they will have meaningful access to counsel and to the courthouse door. The possibility for a meaningful post-death recovery means that it is no longer categorically true that the defendant will have less exposure if the abuse was so severe that the victim died from it.

> "After all, your mother was suffering from Alzheimer's disease and, although we regret those bedsores and how she died, you must admit that you're both better off now. She's out of her misery [*i.e.* WE DO NOT HAVE TO PAY YOU DAMAGES FOR HER PAIN AND SUFFERING] and you are spared having to visit that virtually comatose woman who really didn't know you anymore [*i.e.* WE DO NOT HAVE TO PAY YOU FOR "WRONGFUL DEATH" BECAUSE YOU DID NOT LOSE MUCH "SOCIETY AND COMFORT"]. It's better to get on with you life, and forget it all now [AND WE'LL CONTINUE TO CARRY ON OUR BUSINESS AS WE HAVE]."

Similarly, people who have perpetrated fiduciary abuses, swindles or other financial harms on the frail and the elderly have had little to fear beyond an order to repay part or all of the booty. The suffering that they caused had little impact on the settlement value of a case.

But now conservators will be able to engage litigation counsel to vindicate the rights of flagrantly abused victims who have lost the ability to hire counsel themselves.

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[30] See the text accompanying footnote 9. *Both* abuse *and* recklessness or intentional misconduct must be proven by clear and convincing evidence.

If the victim of abuse dies before the lawsuit ends, the suit may be maintained by the executor or administrator, if there is one, and, if not, by those entitled to the decedent's estate.

6. PROBATE COURT: A FRIENDLY FORUM.

EADACPA encourages the filing of complaints in Probate Court *even while the victim is alive*. This legislative approach was based on the reasoning that the court which appoints conservators sees itself as the protector of the disabled, and is likely to be a friendly forum for abuse victims, and may have greater expertise in handling controversies about whether someone is taking advantage of an incompetent. EADACPA's legislative history recognizes that the Probate Court may also have a greater sensitivity to the problems of the aged and incapacitated.[31] Controversies to recover property misappropriated from conservatees are typically heard more expeditiously in Probate Court than on the general civil calendar.

Unfortunately, in connection with conservatorships and guardianships, the Probate Court is still a court whose powers "extend only to those matters *expressly conferred by statute* and certain 'incidental powers' necessary to enable probate courts to carry out their express statutory authority."[32] Thus, for example, the Probate Court has had no authority to join indispensable third parties in conservatorships.

Although the notion of the Probate department as a court of limited jurisdiction is not yet dead and buried, EADACPA puts another nail in the coffin.[33] Under EADACPA, the

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[31] The Senate Judiciary Committee Report noted: "Proponents have suggested that since probate courts are more familiar with elder and dependent adult issues, they would be more understanding in these types of cases." The Committee report was indecisive about the accuracy of the proponents' suggestion that Probate Court judges tend to be more knowledgeable and expert in these matters. Sen. Jud. Cmte. Rprt., hearing on April 30, 1991.

[32] Ross & Moore, CAL. PRAC. GUIDE: PROBATE (TRG 1990); Paragraph 3:52.1.

[33] In the context of decedents' estates (Probate Code §7050) and trust estates (Probate Code §17200), the Probate Court has become a court of general jurisdiction. Conservatorships and guardianships are the sole remaining areas suffering from a lack of general jurisdiction, and sadly those are the sole areas in which the estate belongs to a yet living person who may really need the economy and promptness that general jurisdiction in the Probate Court could provide.

Probate Court is a court of general jurisdiction over civil actions and proceedings "involving a claim for relief arising out of the abuse of an elderly or dependent adult, *if* a conservator has been appointed for plaintiff prior to the initiation of the action for abuse."[34] Thus, if a defendant has committed an abuse against a married conservatee, the conservatee's spouse may bring a suit in Probate Court for the damages suffered by the spouse as a result of the abuse.

The statute limits this broadened jurisdiction to situations in which a conservator was appointed before the "action for abuse" was "initiated." Query when "an action for abuse" has been "initiated?" Must the *general* conservator be appointed prior to the "initiation" of the "action for abuse," or will the appointment of a *temporary* conservator suffice? Three issues must be addressed by counsel seeking Probate Court jurisdiction.

First, does the temporary conservator have the *authority* to commence an action? Unless there is an emergency or the Probate Court specifically grants the temporary conservator the authority to file the action, the answer is clearly no.

Second, competent defense counsel will contend that the Legislature intended to not invest the Probate Court inappropriately with the burden of resolving civil controversies until the Probate Court has come to a firm decision that an ongoing general conservatorship is warranted. The author believes that such an argument is not reasonable and that the Probate Court judge who sees the need for a temporary conservatorship *can* specifically authorize the temporary conservator to file an action. There is no discernable reason to conclude that the Legislature intended to deprive the Probate Court of elder abuse general jurisdiction in cases where the need for protection is so severe that a temporary conservator was appointed on little or no notice, and a general conservator was thereafter appointed.

Third, is an "action for abuse" *initiated* by a request for injunctive relief? Typically a person petitioning for a temporary conservatorship will simultaneously seek a temporary restraining order ("TRO") to prevent the alienation of property obtained from the prospective conservatee. Would that request deprive the Probate Court of general jurisdiction, *i.e.* deprive the court of the power to assess damage awards and attorneys fees against the defendant, or the power to issue remedial injunctive relief against third parties?

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[34] Welf. & Inst. Code §15657.3(a).

If injunctive relief is the gist of or central to the action, then the answer is clearly *yes* that the action was *initiated* by the request for a temporary restraining order filed *simultaneously* with the request for the appointment of a temporary conservator. The Probate Court would thereafter lack *general* jurisdiction over the controversy because the "action for abuse"[35] was initiated by the request for the TRO, which request was *filed* before the temporary conservator was *appointed*.

In emergency cases, experienced counsel may therefore simultaneously prepare (i) a petition for appointment of a temporary conservator, (ii) a request for permission for the temporary conservator to file the request for the TRO, and (iii) a request for the TRO. Assume hypothetically that a victim's situation warrants an ex parte appointment of a temporary conservator. Plaintiff's counsel will get the temporary conservator appointed in the morning, and obtain the authority for the temporary conservator to file a request for the TRO. Immediately *after* the temporary conservator is appointed that morning, the attorney will file the request for the TRO application with the Probate Court and potentially have the TRO granted in the afternoon. Under the Los Angeles Superior Court Probate Policy Memorandum, Paragraph 6:2.03, only 4 hours notice of the TRO hearing must be given.

As a court of general jurisdiction, the Probate Court may hear and decide a complaint for relief from any wrong which is both (i) actionable and (ii) listed in Welfare and Institutions Code §15610. Fiduciary misconduct[36] and even *physical* abuses, such as neglect in a nursing home or elsewhere, are now the province of the Probate Court.

Like Samson unleashed, the Probate Court is no longer partially handcuffed when confronted by financial or physical abuse of its conservatees. Damages,[37] attorneys' fees,

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[35] Welf. & Inst. Code §15657.3(a).

[36] See footnote 8 for the definition of "fiduciary abuse."

[37] The availability of damages in the Probate Court, it must be admitted, is not entirely a new concept. Effective July 1, 1991, new Probate Code §2619.5 brings into the conservatorship law a double damages provision that has long applied to decedents estate. Section 2619.5 provides: "A person who in bad faith has wrongfully taken, concealed, or disposed of property in the estate of the ward or conservatee is liable for twice the value of the property, recoverable in an action by the guardian or conservator for the benefit of the estate." Unfortunately, the allowability of such double damages is solely in the discretion of the court, and such awards have been extremely rare in the context of decedents estates. The *theoretical* availability of such an award may not provide much fee incentive to the conservatorship litigator. The court may reasonably conclude that the

jurisdiction to join indispensable third parties, and injunctive relief are tools which the Probate Court, in its sound discretion, may now employ to protect its conservatees if the action arises out of the abuse of an elder or dependent adult.[38]

The breadth of the Probate Court's new jurisdiction defies imagination and will come as a surprise to many. For example, the following abusive practices may now be litigated *in a Probate Court conservatorship* proceeding as *unfair trade practices*[39] for which damages, injunctive relief and attorneys fees enhanced by the new factors[40] are sought:

(i) swindles by con artists masquerading as reverse home equity mortgage brokers,
(ii) phony contractors who prey on the elderly,
(iii) individuals who take senescent elders' assets, cut the victims off from the rest of the world, and then neglect their health,
(iv) understaffing, and institutionalized neglectful care in those "bad apple" nursing homes which put the rest of the industry in a bad light,
(v) trustee embezzlement or other misconduct,[41]
(iv) misuse of a durable power of attorney for property or for health care.[42]

7. CONCLUSION AND THE FUTURE.

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conservatee needs those double damages to pay for his or her medical and custodial care, and that compensating the lawyer is a lower priority. Poor people have accordingly had less access to conservatorships and legal representation, which is a problem that EADACPA seeks to correct.

[38] Welf. & Inst. Code §15657.3.

[39] Bus. & Prof. Code §17200.

[40] *See* the text accompanying footnote 14, *supra*.

[41] Probate Code §17200.

[42] Section 9 of Chapter 1055 of Statutes of 1991, amending Civil Code §2413. This amendment was initially a Beverly Hills Bar Association resolution conceived and drafted by the author of this article. The resolution was adopted at the 1990 State Bar Conference of Delegates.

The Legislature's hope is that by providing elders and dependent adults with the means to vindicate their rights in a tort context in the Probate and general civil courts, EADACPA will eventually make litigation unnecessary. It is the hope of the author of this article that EADACPA will be copied in other states, and will serve as a quality control device over the furnishing of services and goods to elders and dependent adults. If abusers know they must pay for the harm they inflict, they may be deterred from wrongdoing. Only time will tell.

EADACPA does nothing to address the problem of intra-family abuse of elders or dependant adults, which abuse is due primarily to caregiver overload in the opinion of the author. The author hopes that the same coalition of lawyers and social service activists, whose efforts are responsible for the enactment of EADACPA, will be successful in their efforts to generate legislation which will create a day care respite center industry. Medicare, Medicaid, tax and other incentives are being considered. The greater availability of good quality day-care respite-center services should reduce the pressure on caregiver family members and thereby reduce the frequency of intra-family abuse. Such supportive services would make it unnecessary for family caregivers to miss work as often, and obviate at least one of the causes of premature institutionalizations.

If a day care respite center industry ultimately arises, EADACPA will hopefully be a part of a network of federal laws ensuring that the quality of the care provided will never drop to the levels that have soiled the image of the nursing home industry.

OLDER PERSONS ACTION GROUP, Inc.

325 E. 3rd. Ave., #300
Anchorage, AK 99501-2606
(907) 276-1059 (Toll free 800-478-1059)
FAX (907) 278-6724

March 26, 1996

Senator Robin Taylor
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182

Dear Senator Taylor:

The Older Persons Action Group, Inc. urges you to support SB 211. This bill makes it a crime for an individual to abuse or otherwise endanger vulnerable adults entrusted to their care. When law enforcement and judicial officials refuse to prosecute perpetrators of abuse because there is no specific law against these acts, we must take action to preclude repetition of these crimes. SB 211 fulfills this need and we strongly urge you to support this legislation

OPAG also endorses SB 296 which requires a fingerprint background check before certain persons may be employed in a nursing home or assisted living facility. Elderly living in these facilities are particularly vulnerable to criminals who find ready employment in these facilities. The requirement for a fingerprint background check is a prudent management practice to prohibit persons with violent or criminal backgrounds from caring for the elderly. I urge you to support SB 296.

Sincerely,

Sara L. McCullough

Sara L. McCullough
President
Board of Directors

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM March 4, 1996

SUBJECT: Sectional Summary of SB 211
(Work Order No. 9-LS1296\C)

TO: Senator Johnny Ellis
Attn: Lynn Kenney

FROM: Gerald P. Luckhaupt
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill - the bill itself is the best statement of its contents.

Sections 1 and 2 of the bill provide technical amendments to AS 11.41.410 - 11.46.420 by recognizing that state agencies other than the Department of Health and Social Services license facilities and programs that mentally incapable persons may be residents of or participants in.

Section 3 of the bill creates new crimes of endangering the welfare of a vulnerable adult,[1] committed by intentionally deserting a vulnerable adult, and criminal neglect of a vulnerable adult,[2] committed by failing to provide support to a vulnerable adult.

GPL:klb
96-156.klb

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[1]Punishable as a class C felony. See AS 12.55.125(e).

[2]Punishable as a class A misdemeanor. See AS 12.55.135.

Ms. Maureen A O'Neill
3550 Alamosa Dr
Anchorage AK 99502 Phone: 248-4450
Affiliation: Reg. Voter: Y Date POM Sent: 03/04/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 09
Subject:
Message: I ENCOURAGE YOU TO VOTE FOR SB 211 WHICH ADDRESSES ISSUES OF ABUSE AND NEGLECT OF VULNERABLE ALASKANS WHO ARE RESIDENTS OF CARE FACILITIES IN ALASKA. THANK YOU.

Mr. Eldred J Harris
10201 Tartan Cir
Anchorage AK 99507 Phone: 248-1717
Affiliation: Reg. Voter: Y Date POM Sent: 03/14/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 20
Subject:
Message: THE PIONEERS' HOMES PLAN TO PROVIDE CARE AND MEDICAL ATTENTION WITHOUT SIGNIFICANT TRAINING CIRCUMVENTS STANDARDS JUST TO REDUCE OVERHEAD AND IS CONTRARY TO SB 211. VULNERABLE ADULT CARE WON'T BE ENHANCED.
RESIDENTS WILL HAVE TO PAY MORE FOR LESS. PLEASE VOTE IN FAVOR OF SB 211.

Ms. Angela M Deutsch
3110 Dos Cir
Anchorage AK 99507 Phone: 343-7218
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Ms. Violeta D Cho
3480 Harrier Cir
Anchorage AK 99504 Phone: 333-4319
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Mrs. Marta E Marin
12110 Buttermilk Wy
Eagle River AK 99577 Phone: 694-2309
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Mrs. Linda L Howard
6803 Hamlet Cir
Anchorage AK 99502 Phone: 243-7673
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Ms. Connie M Reimers
PO Box 111356
Anchorage AK 99511 Phone: 333-8119
Affiliation: APH Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Mr. Homer J Enrigues
PO Box 104136
Anchorage AK 99501 Phone: 258-3511
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: C
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211.

Mrs. Kathryn M Riesz
20200 Constitution Dr
Eagle River AK 99577 Phone: 696-7149
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I STRONGLY SUPPORT SB 211.

Mr. William H Riesz
20200 Constitution Dr
Eagle River AK 99577 Phone: 696-7149
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I STRONGLY SUPPORT SB 211. IT IS LONG OVERDUE.

Mrs. Dawn L Lear
4301 Merrill Cir
Wasilla AK 99654 Phone: 373-6214
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211. IT IS LONG OVERDUE.

Mrs. Molly P Hubbs
HC32 6525 E
Wasilla AK 99654 Phone: 745-3629
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211. IT IS LONG OVERDUE.

Ms. Luisa A Conrad
12457 Crested Butte Dr
Eagle River AK 99577 Phone: 696-6018
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I SUPPORT SB 211. IT IS LONG OVERDUE.

Mrs. Kathleen H Emmons
16617 Davis St
Eagle River AK 99577 Phone: 694-2184
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: PLEASE PASS THIS BILL TO PROTECT ASSISTED LIVING RESIDENTS FROM ABUSE AND NEGLECT.

Mr. Kim M Hobbs
SRA Box 6525 E
Wasilla AK 99654 Phone: 000-0000
Affiliation: Reg. Voter: Y Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: PLEASE PASS THIS BILL TO PROTECT ASSISTED LIVING RESIDENTS FROM ABUSE AND NEGLECT.

Mr. Edmaund R Lear
4301 Merrill Cir
Wasilla AK 99654 Phone: 000-0000
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N
Bill Number: SB 211 Response: Supports Distribution: 60
Subject:
Message: I STRONGLY AGREE ON THIS BILL TO PROTECT OUR VULNERABLE ADULTS.

Ms. Jean Williams
HC02 Box 7470
Palmer AK 99645 Phone: 745-4000
Affiliation: Reg. Voter: U Date POM Sent: 03/15/96 Consitutent: N

Bill Number: SB 211 Response: Supports Distribution: 19

Subject:

Message: I AM IN FAVOR OF THE BILLS TO PROTECT ELDERLY FOLKS.

Ms. Kathleen L Fitzgerald
4521 Southpark Bluff Dr
Anchorage AK 99516 Phone: 272-8270
Affiliation: Reg. Voter: Y Date POM Sent: 03/18/96 Consitutent: N

Bill Number: SB 211 Response: Supports Distribution: 01

Subject:

Message: KUDOS! THANK YOU FOR SPONSORING SB 211. I STRONGLY SUPPORT.

BRANCH OFFICE:
3601 C ST., STE. 260
FRONTIER BLDG.
ANCHORAGE, AK 99503
(907) 563-5654
FAX: 562-3010

MAIN OFFICE
P.O. BOX 110209
JUNEAU, AK 99811-0209
(907) 465-3250
FAX 465-4716

Alaska Commission on Aging

ALASKA COMMISSION ON AGING

Position paper on SB 211: An Act relating to sexual assault; and relating to endangering the welfare of vulnerable adults.

March 13, 1996

The Alaska Commission on Aging supports SB 211, and urges its enactment. The purpose of SB 211 is to increase the legal protections for vulnerable adults. Specifically, SB 211 establishes that the acts of intentional abandonment, and of neglect of the vulnerable adult, are criminal acts when they are committed in a facility or program licensed by the State, or are committed by an individual who has legally assumed responsibility for the care of such an adult. The mission of the Alaska Commission on Aging is to ensure the honor, dignity, security, and independence of older Alaskans, and to assist older Alaskans in maintaining quality and meaning in their lives. Thus we support SB 211, and the positive contribution it makes to increase the legal protections for seniors in long-term care across out State.

Donald M Hoover

Donald Hoover, Chairman
Alaska Commission on Aging

March 12, 1996

Honorable Johnny Ellis
State Capitol
Juneau, Alaksa 99801-1182

Dear Senator Ellis:

Thank you for introducing Senate Bill 211 legislation to protect vulnerable adults from abuse and neglect.

We have acknowledged that some adults, such as the elderly and the handicapped, are more vulnerable than others. SB 211 identifies and defines acts which endanger the welfare of vulnerable adults. This clarification is needed.

Senate Bill 296 is of equal importance. Legislation requiring finger print criminal background checks for persons seeking employment in a nursing home or assisted living facility is badly needed. Many residents in nursing home or assisted living facilities lack the ability to communicate their needs or follow the instructions of their caregiver. While it is true that background checks will not insure competent care, they will do much to eliminate some potential risks.

I strongly support both Senate Bill 211 and Senate Bill 296.

Sincerely,

Vera A. Gazaway

Vera A. Gazaway
415 Willoughby #414
Juneau, AK 99801

Betty S Ohse
118 E 3rd Ave
Anchorage AK 99501

Dear Senator Ellis,

On reading the article of Bobbie Watts in March 9 Anchorage Daily News. Brought to mind the heart breaking cries of abuse I saw over the years of visitation as a friend to the elderly - one end at the mercy of others to care for them. The abuse and cruelty often times you name it I saw it all and was told there is no law to protect them or nothing could be done?

Please Senator Ellis help this bill (SB 211) to pass as there is a great need for it to pass to protect the elderly from abuse making it a crime when abuse does take place.

Thanking you for caring

Betty S Ohse

Senator Taylor:

I cannot be at the 1:30PM hearing today for SB211 but want to express my support of it as well as for SB296. As the mother of a 42 year old mentally ill daughter who will likely need to be in an assisted living facility for the rest of her life, and as one in that age bracket where I see close friends going into a variety of retirement homes, I see the need for close supervision of employees in assisted living facilities. The potential for abuse is great and, as the population in Alaska increasingly "greys," it is urgent that we develop strict guide-lines and maintain proper supervision of all employees in both retirement facilities and facilities housing the mentally ill.

As President of both AAMI (The ANCHORAGE Alliance for the Mentally Ill) and CARTA (Central Alaska Retired Teachers) I urge passage of both SB211 and SB296.

Lola J. Reed, 831 W. 19th Ave., Anchorage, AK 99503, (907) 279-3006.

Distribution:

To: Robin Taylor > FAX:19074653922

9-LS1296\G.1
Luckhaupt
3/12/96

AMENDMENT

OFFERED IN THE SENATE

TO: CSSB 211(STA)

Page 1, line 13:

Delete "entrusted to"

Insert "in [ENTRUSTED TO]"

Page 2, line 15:

Delete "entrusted to"

Insert "in [ENTRUSTED TO]"

Page 3, line 17:

Delete "knowingly"

D.B. 211 / BOBBIE WATTS

Anchorage Daily News Saturday, March 9, 1996

FORUM / LETTERS

State should make abuse, neglect of elderly a crime

By BOBBIE WATTS
Part 1 of 2

I placed my father-in-law, Paul Watts, in Friendship Home Inc., an assisted living home, on March 10, 1995. Two months later, I sent a complaint to the Office of the Long Term Care Ombudsman, because I realized Paul was being abused and neglected by those we paid to care for him.

Paul had kidney disease and was allowed to go for six days without his medication to prevent fluid buildup. He gained 52 pounds, putting added strain on his already weakened heart.

Friendship Home's staff did not properly treat Paul's wounds or turn him in his bed. He was literally being eaten alive by gangrene. They even charged him for water.

One day after I moved him to a new home, he was so swollen he could not fit in a wheelchair and had to be taken on a stretcher to see a doctor. He died four days later.

Many other elderly residents of Friendship Home Inc. also were being abused and neglected. A long list of incidents is documented in a 25-page investigation by the state's Long Term Care Ombudsman.

The owners/managers of Friendship Home Inc., Debi and Tracy Batchelder, sold the home and left the state, most likely never to be charged for what they did. This kind of abuse, neglect or exploitation of our senior citizens is not a crime.

BOB HALLINEN / Daily News file photo

Bobbie Watts

□

Statistics show that by the year 2010, 14 years from now, our senior population will triple. We have the fastest growing, per capita, senior population in the nation, according to the Alaska Commission on Aging. The fast-growing senior population in Alaska will require more long-term-care facilities and homes that are staffed with trained, compassionate people to care for them.

I have come forward with my story to cry out to our Legislature to create state laws that will prevent what happened at Friendship Home Inc. from ever happening to one elder Alaskan again.

My goal is to get a bill passed this session that makes abuse, neglect and exploitation of the elderly a crime. I also hope to support legislation that would require fingerprint background checks for all employees of nursing facilities and assisted living homes. Right now, it's possible for someone convicted of assault or sex abuse or drug abuse to walk straight into a job caring for the elderly.

In the past, the Legislature has considered abuse, neglect and exploitation laws but failed to pass anything. I hope to persuade them to pass such a law.

While in Juneau Feb. 20-23, my concerns, and my support of Sen. Johnny Ellis' bill criminalizing neglect of the elderly (SB 211), got mixed reactions, and I was surprised at the opposition that I heard about while there. Many legislators and their staff are relying on the position of the Division of Senior Services in echoing their own opposition to SB 211.

How can anyone who ever heard or read the report of the investigation on Friendship Home Inc. sit there and tell me that we have adequate criminal laws on the books? Debi and Tracy Batchelder, former owners of Friendship Home, are sitting in Bangor, Maine, happy that Alaska does not have laws holding them criminally responsible for such horrible abuses.

My goal is to get a bill passed this session that makes abuse, neglect and exploitation of the elderly a crime. . . . Right now, it's possible for someone convicted of assault or sex abuse or drug abuse to walk straight into a job caring for the elderly.

The Division of Senior Services can take administrative action when dealing with abuse and neglect of the elderly, but it cannot pursue criminal sanctions against those who would victimize our loved ones. The Department of Law has stated, more than once, that the criminal code as it exists is inadequate to fight this problem.

What more do legislators need to hear? How many more "Friendship Homes" need to be brought to light before the Legislature takes action to protect the thousands of elderly citizens in Alaska from the kind of gross abuse and neglect that we have already seen?

I am encouraged by and proud of the people in Juneau who spent the time to really listen to my experience and my call for help. They committed themselves to researching and learning about the laws that we currently have and the ones that we need.

I ask lawmakers not to rely on secondhand opinions. Ask the people who have personally experienced elder abuse and neglect. Ask the people responsible for investigating and prosecuting the perpetrators. They will tell you what you need to know. They will tell you how to protect our older Alaskans.

□ Bobbie Watts lives in Anchorage. She was the winner of the Daily News "Send Me to Juneau" contest. Sunday, Part 2: A journal of her experience as a citizen lobbyist.

Chugiak – Eagle River

Alaska Star

VOLUME XXVI, Number 10 | 20 Pages and a 4 page supplement | March 2, 1996

Pioneers to pay more for leaner care

By JEANNE ENRIGHT
Alaska Star Reporter

Some seniors living in the state's Pioneers' Homes may soon be cared for by lesser trained personnel and pay more for it.

In Alaska, approximately 1,800 beds are devoted to patients receiving skilled nursing care. According to Connie Sipe, director of the Division of Senior Services (DSS), 600 of those will be affected by proposed changes at the state's six Pioneers' Homes.

Soon, all Pioneers' Homes will change their status from skilled nursing facilities to enhanced assisted living facilities.

The decision has several serious ramifications.

First of all, as skilled nursing facilities, Pioneers' Homes have been required to comply with certain federal regulations. The Department of Social Services (DSS) has been actively enforcing the homes' compliance.

As enhanced assisted living facilities, the Pioneers' Homes will no longer be under stringent federal guidelines. The licensing unit of the DSS will enforce its own enhanced assisted living regulations once the change takes place.

Secondly, for Pioneers' Home residents who require total care, the change to enhanced assisted living means that their care will no longer be provided by highly-trained registered nurses (RN). Instead, most of their care, including the distribution of medications, will be provided by lesser-trained certified nurses' aides (CNA).

And lastly, by changing patients' status to "enhanced assisted living," the elders who weren't eligible for longevity bonuses will once again receive their $200-250 per month.

However, patients who cannot afford to pay the charge for their care — about $1,000 per month, according to Division of Senior Services Director Connie Sipe — must turn over their bonuses to the homes to help pay their bills.

Meanwhile, rates charged to Pioneers' Homes residents are on their way up. However, Sipe said that even though rates charged to the patients will be increasing some time in the near future, the homes will not realize an increase in profit.

"When we increase the fees, we aren't going to get extra money. The legislature is going to take away the general fund to the tune of what-

(Please see PIONEERS, Page 2)

PIONEERS: Bills address issues

(Continued from Page 1)

ver we collect," Sipe said.

"The numbers (of residents) are staying the same, because we only have so many spaces in the buildings.

"We have been able to avoid cuts to direct care, but we've had to lay off gardeners and assistant cooks and other things, and we have spread the staff to taking care of 85 percent of the people.

"So the homes' whole operation is costing about the same ... but we've taken the staff and the staffing and we have spread it out over more as many people, every day, getting care."

"And remember, we did not fire or lay off a single nurse ... and as we (received) budget cuts, we have, so far, never laid off a direct care position. Positions would be reduced through attrition, we'll some RN positions being replaced with CNA positions.

"So there is a balance here, but it's a national trend. It's not just us. There are lots more people who are sick and frail everywhere in the country, and a huge new majority of them are being taken care of in assisted living settings instead of all in skilled nursing homes."

Sipe said that she isn't sure when the Pioneers' Homes change to enhanced assisted living or the price increase would take effect.

Bobbie Watts, who became interested in senior issues when her father-in-law was allegedly neglected by a local nursing home, is keeping a close eye on the decisions being made by legislators and officials regarding senior issues.

The citizen-turned-senior advocate just returned from Juneau, where she spoke with legislators about senior issues. She made the following statement about her experience.

"The Division of Senior Services, while responsible for administrative action when dealing with abuse and neglect of the elderly, are not in a position to pursue criminal sanctions against those people who would victimize our loved ones. The Department of Law is responsible for pursuing criminal action against abusers."

Watts is in favor of Senate Bill 211, which was introduced by Sen. Johnny Ellis (D-Anchorage) to address the issues of abuse and neglect of "vulnerable" Alaskans, since these citizens often can't defend themselves, physically or legally.

Ellis also sponsored Senate Bill 296, which mandates fingerprinting and background checks for people seeking employment in institutional settings.

Sipe said that DSS has not decided whether to support the bills.

"Another concern that I brought up," Watts said, "is that the Long-Term Care Ombudsman is definitely in the wrong department. You see. She's in the same department of those that run the Pioneers' Homes and license the adult assistance (enhanced assisted living) homes.

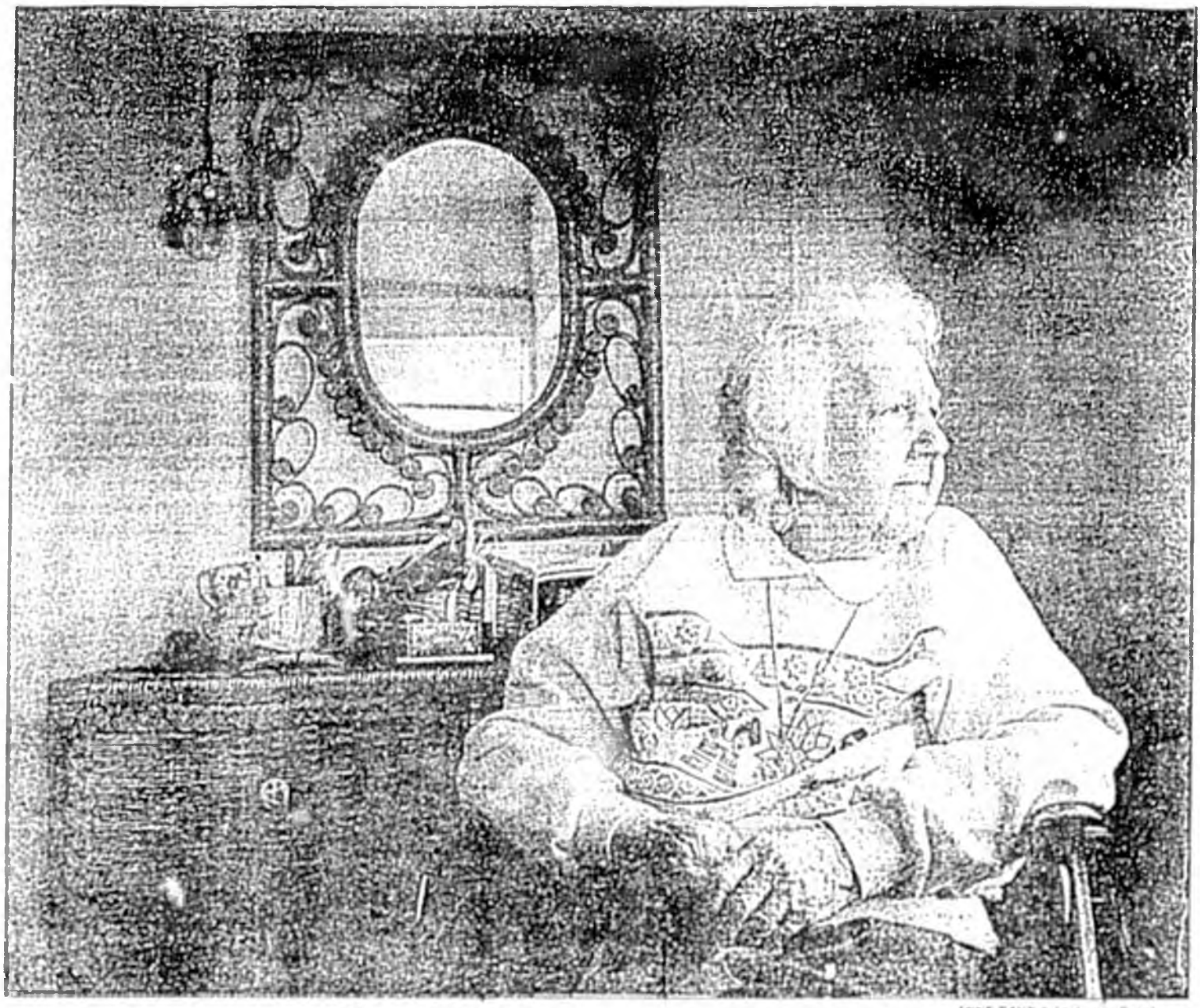
"And you see, that's, like, a big conflict and it makes me nervous when they don't want to come up with a law to protect (people from) those (crimes) that the staff or owners may commit — the charge of neglect."

When asked whose signature is necessary for the final decision to change the homes to enhanced assisted care facilities, Sipe said, "Jim Kohn, the deputy director of the Division of Senior Services ... unless she or someone else in authority over Kohn decided to contradict the decision, she said.

Kohn was unavailable for comment by press time.

VOL. L. NO.362 86 PAGES ANCHORAGE, ALASKA, THURSDAY, DECEMBER 28, 1995

Witness tells of abuse at boarding home



ANNE RAUP / Anchorage Daily News

Idesta Green, 82, helped state investigators in their examination of conditions at Friendship Home, an Anchorage boarding home licensed to care for infirm elderly people. She was moved from the home during the investigation.

State says home abused elderly

Report cites neglect, withholding medication, tormenting Alzheimer's victims

By SHEILA TOOMEY
Daily News reporter

The owners and staff of a private adult boarding home, licensed by the state to care for 16 infirm old people, neglected and abused residents, failed to get medical care for gravely ill patients, withheld necessary medication and tormented Alzheimer's victims, according to a state ombudsman's investigation.

The long-term care ombudsman, responsible for monitoring such homes, has asked the attorney general to consider criminal charges against Bob and Trace Batchelder, former owners of Friendship Home, and Autumn Lee Watts, the former manager.

An investigative report dated Nov. 30 says people running the home, on West 68th Avenue in the Fish Lake area, sometimes failed to fill patients' prescriptions or seek emergency medical care, failed to take patients to scheduled doctor appointments, failed to keep patients clean and dress their wounds, failed to provide diabetics with proper blood tests and diet, left old people sitting on toilets or in wet diapers, borrowed money from old people in their care and in general "willfully, intentionally or recklessly inflicted pain, injury or mental distress to residents" of the facility.

Efforts to reach the Batchelders over three days, through their local attorney, Roger Healy, and by leaving a message

Please see Back Page, HOME

Father-in-law's fate creates a crusader

By SHEILA TOOMEY
Daily News reporter

Guilt and its cousin anger pulled Bobbie Watts out of her safe life into a world where ugly things happen but tenacity and a talent for constructive troublemaking are keeping her there.

Watts' father-in-law died in June after three months in a local convalescent home. A diabetic double amputee with lupus and bad kidneys, Paul Watts, 69, needed heavy lifting and trained

Please see Back Page, WATTS

BOB HALLINEN / Anchorage Daily News

Bobbie Watts

HOME: Ombudsman finds abuse and neglect

Continued from Page A-1

cruel and malicious teasing ... in the form of coming up behind him and grabbing him by the trunk and lifting him up, squirting him in the face for long periods of time, or verbally poking fun at his limited mental faculties."

Two residents, including the Alzheimer's victim, died at the home this summer after managers neglected to obtain medical attention for them, the report says, but investigators did not link the deaths to the alleged neglect.

The ombudsman would have recommended the Batchelders' license be revoked, the report says, but they got out of the business in the middle of the investigation and left the state. The home is now operated by a new owner under a different name.

Acting ombudsman Suzan Armstrong also has asked the U.S. Postal Service to investigate the Batchelders for obstructing the mails by allegedly intercepting mail addressed to a resident. Her report accuses the Batchelders of interfering in the ombudsman's investigation by attempting to intimidate people cooperating with the probe.

The investigation was precipitated in May by two complaints, including one from Bobbie Watts, whose father-in-law lived at Friendship Home from March to June. A double amputee with diabetes, lupus and heart disease, he died June 12, six days after Watts moved him to another home.

Watts said she was referred to Friendship Home by Alaska Regional Hospital. She visited her father-in-law, Paul Watts, 69, almost daily during designated visiting hours. She "shook off" her early concerns about prescriptions not being picked up and complaints about not getting enough food because she knew he wanted to come home.

"They tried to convince me it wasn't true, that he had Alzheimer's," Watts said in an interview.

Assisted-living homes are intended to be a less restrictive, less expensive environment for people who can't live on their own or with relatives, but who don't require a full-blown nursing home. Watts said she and her husband paid $3,000 a month for her father-in-law to stay at Friendship Home.

The home was intended to be transitional, Watts said, a place where Paul Watts would learn how to move from his bed to a wheelchair and the bathroom on his own. Watts had cared for her father-in-law for about two years before his second leg was amputated. She says no one told her she could have gotten therapists and public health nurses to work with Paul at his Airport Heights home instead.

Alaska Regional Hospital declined to discuss specifics of the Watts case, but Gail McGuill, director of quality management, said all available resources for post-hospital care are discussed with all families.

The hospital did not make any recommendation, but merely provided the Wattses with a list of state-licensed facilities, McGuill said. "We explain to them we don't make recommendations because ... we don't have the opportunity to visit places and check them out."

Virginia Smiley, licensing coordinator for the state Division of Senior Services, said having a state license means only that the facility is available and meets minimum standards, not that a home is recommended. Smiley's agency assumed oversight of the state's 66 assisted-living homes for old people on July 1 from the Division of Family and Youth Services, which licensed the Batchelders in the 1980s.

Before the current investigation, state records show investigators confirmed other complaints against the Batchelders, including neglect of a patient who was found to be dirty, dehydrated, malnourished and with bed sores in 1991; and in 1993 for having more residents than allowed by their license.

Smiley and Armstrong, the acting ombudsman, said that Friendship Home still could be legally operating if the Batchelders hadn't gotten out voluntarily, because the state declined to revoke their license until the investigation was completed.

Armstrong said her office suggested to people inquiring about Friendship Home during the investigation that they not use the facility.

Watts' complaint, filed May 19 while her father-in-law was still a Friendship Home resident, generated the most extensive multiagency investigation in the history of the Long Term Care Ombudsman's Office, Armstrong said.

The Medicaid Fraud Unit in the Attorney General's Office got a search warrant in June to examine conditions at the home and seize records, said assistant attorney general Peter Gamache. His office got involved because several of the home's 16 residents received Medicaid.

The ombudsman and the Board of Nursing recommended Friendship Home be closed, Armstrong said. But DFYS decided it could safely remain open with monitoring, which was done for about two weeks at the end of June and beginning of July, she said. DFYS also required the Batchelders to hire a nurse to oversee patient care and dispense medicines.

The ombudsman's office helped one resident, Idest Green, 82, move out of Friendship Home in August, concerned about her condition and possible retaliation for her cooperation, Armstrong said.

"They took my mail," Green said in an interview Friday at an assistant-living home run by Providence Hospital, where she now is apparently flourishing. "It was dark and you didn't get any care. ... They would put you on the pot and you would sit there for a couple of hours because you couldn't get off."

Gamache said his office is investigating possible criminal violations based on the complaints against the Batchelders, but Alaska doesn't have patient-neglect or abuse laws, he said. "If you have a straight case of a vulnerable adult not being fed or bathed or generally cared for properly, that's wrong but it's not unlawful."

Gamache said he's not sure conditions at Friendship Home "were qualitatively much worse than other places. ... It was a difference in degree, not in specie," he said. "Let's face it, living in an institution's a drag."

During the course of the four-month investigation, the ombudsman's office interviewed 24 people, including cooperative current and past employees, Armstrong said.

"What cannot be amply stated," said the ombudsman's report, "is the sadness and frustration expressed by former employees and residents at the living conditions present at Friendship Home, Inc. It appears that the residents ... were provided only minimal tools for existence, food enough to survive, medical attention only when withholding of such might clearly result in catastrophe, and a place to sit in idleness."

WATTS: On a mission

Continued from Page A-1

watchful eyes as he recuperated from surgery and learned to live without legs.

An investigation by the state long-term care ombudsman concluded Watts was neglected by the owners and staff of Friendship Home, one of more than 60 "assisted-living" boarding homes licensed by the state to care for three or more elders or infirm adults.

Although the ombudsman did not conclude that Watts died of neglect, Bobbie Watts believes he did, and that she should have known something was wrong and gotten him out of Friendship Home earlier.

She moved him after he told her the staff was charging him for water. He died six days later.

"When he passed away, there was that guilt," she said, "being that I placed him there. ... I have all the what-ifs and all this guilt eating at me."

Instead of letting it eat her up, Watts is turning the guilt into action on behalf of Alaska's "elders," as she calls them. First on her to-do list, now that the investigation she initiated is done, is to fax a copy of the Friendship Home report to licensing officials in every state. The former owners of Friendship Home "should never, ever again be allowed to take care of one elderly person," she said.

Paul Watts, a retired track-repair supervisor for the Alaska Railroad, was more like a beloved father than a father-in-law, Bobbie said. "He was a real good guy. He made you feel important, you know. He gave a damn."

Raised in Las Vegas in a dysfunctional family, Bobbie Watts left home at 14. "There was a lack of compassion and caring in my environment when I grew up, and I always wanted to be different."

She survived a "wild" period and came to Alaska in 1960 — "for the great adventure, and to get as far away from my family as I could." Now 35, Watts has spent the last decade raising children and dogs, caring for a husband of 13 years, doing volunteer work and making the kind of home she always wanted. Now she wonders if her personal barricades against life's rougher edges left her more gullible than she should have been.

Although she saw her father-in-law almost daily during regulated visiting hours, brought food and made cookies for him and other residents, Watts said, it took her a long time to figure out that residents might be treated differently when she wasn't around.

"I could not conceive that someone would do this," Watts said. "It took me a little while to catch on. ... To think I had the poor man there since March. It gives me the creeps."

When she finally figured out something was wrong, Watts filed a complaint with the long-term care ombudsman, a monitor required by the federal government. More determined than ever after Paul Watts died, she followed every twist of the investigation. Weeks turned into months, but she stuck to it, calling regulators and politicians, writing letters, checking repeatedly on what progress was being made. Somewhere along the way, Bobbie Watts, "stay-at-home mom," evolved into Bobbie Watts, unstoppable activist for the elderly.

She even went to work briefly for the people who took over Friendship Home after Paul died, and helped clean it up.

Watts said she's lost 25 pounds since filing her complaint in May. But after months of give and take, acting long-term care ombudsman Suzan Armstrong considers Watts "a real valuable find" for her office.

"She's a very effective communicator, very compassionate, very driven," Armstrong said. "I was constantly being inspired by her, being fueled by her energy."

The ombudsman's office has plans for a program in which volunteers make unannounced visits to state-licensed homes — 380 beds in "assisted-living homes" and 758 nursing home beds around the state.

Armstrong hopes to entice Watts to help organize it. Watts can hardly wait.

"I want those owners to be scared of me when I walk in the door," she said. "I want them people shaking in their boots."

"I never knew I could cause so much trouble," Watts said with grim satisfaction after the report condemning practices she complained of at Friendship Home was released last week. "I was never a troublemaker anywhere until here.

"I've got it. I can take 'em on and then some."

SENATE COMMITTEE REPORT

DATE: 3/11/96 DATE TURNED INTO OFFICE: 3/20/96

The Judiciary Committee considered SB 211 has no further

Relating to sexual assault; ~~and relating to endangering the welfare of vulnerable adults and neglect of vulnerable adults.~~

$0 FN's

and recommends:

| | be replaced with ____ CS _____ ( )

|✓| adopt previous __ CS SB211 (STA)

| | attached amendment(s)

| | adopt Letter of Intent by _____ Committee

| | further referral to the _____ Committee

Senate Bill:
|✓| same title
| | new title
House Bill:
| | same title
| | technical change
| | new: SCR*____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
Ellis	✓				
Debra Green	✓				
Gordon	✓				
Mike Miller	✓				
CHAIR: Morris K. Taylor	✓				

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal
Public Safety	3/14	✓	

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
Administration	3/7/96	X	
Corrections	3/1/96	X	
Dept. of Law	3/6/96	X	

| | APPROPRIATION -- no fiscal note

*Include fiscal notes accompanying Governor's bill

ALASKA STATE LEGISLATURE

Senate Health, Education and Social Services Committee

•

Senate Judiciary Committee

•

Department of Health and Social Services Budget Subcommittee

•

Department of Law Budget Subcommittee

While in Session
State Capitol, Rm 9
Juneau, Alaska 99801
(907) 465-3701
fax (907) 465-2529

•

While in Anchorage
750 West 6th Ave., Ste. 410
Anchorage, Alaska 99501
(907) 258-8182
(907) 258-8551

SENATOR JOHNNY ELLIS

SPONSOR STATEMENT
SENATE BILL 211

Elder abuse has been called the hidden crime. While its extent is not completely defined, it is widely agreed that the problem affects a significant number of older persons. The National Center of Elder Abuse reports that the 241,000 reported cases of domestic elder abuse in 1994 represents a 106% increase over the number of reported cases in 1986. I don't believe that the problem in Alaska has escalated at that rate; however, a December news article about the abuse that took place at the Friendship Home in Anchorage prompted me to get to the root of this disturbing problem. I have introduced Senate Bill 211 to amend Alaska's abuse and neglect laws to better protect seniors.

As people live longer, frailty and vulnerability increase, along with the potential to become victims of abuse, fraud, and exploitation. Many Seniors have fewer options for resolving or avoiding the abusive situation due to their age, health or limited resources. They may be more vulnerable to and harmed by physical abuse because of their existing physical condition.

Like most states, Alaska does require elder mistreatment be reported to the authorities when it is discovered. Unlike some states, Alaska does not specifically make abuse or neglect of the elderly a crime. We are correcting that oversight with this legislation.

In Senate Bill 211, endangering the welfare of a vulnerable adult would become a Class C felony, punishable by a jail term of up to five years and a $50,000 fine. Criminal neglect of a vulnerable adult would become a Class A misdemeanor, punishable by a jail term of up to a year and a $5,000 fine.

Assisted-living facilities are a growth business nationwide and in Alaska. If the Friendship Home is any indication, we must provide the tools to make certain that oversight of such facilities matches industry growth and deals firmly with unacceptable behavior toward Alaska's Seniors.

LEGAL SERVICES

DIVISION OF LEGAL AND R[illegible]RCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM March 4, 1996

SUBJECT: Sectional Summary of SB 211
(Work Order No. 9-LS1296\C)

TO: Senator Johnny Ellis
Attn: Lynn Kenney

FROM: Gerald P. Luckhaupt
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, please note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill - the bill itself is the best statement of its contents.

Sections 1 and 2 of the bill provide technical amendments to AS 11.41.410 - 11.46.420 by recognizing that state agencies other than the Department of Health and Social Services license facilities and programs that mentally incapable persons may be residents of or participants in.

Section 3 of the bill creates new crimes of endangering the welfare of a vulnerable adult,[1] committed by intentionally deserting a vulnerable adult, and criminal neglect of a vulnerable adult,[2] committed by failing to provide support to a vulnerable adult.

GPL:klb
96-156.klb

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[1]Punishable as a class C felony. See AS 12.55.125(e).

[2]Punishable as a class A misdemeanor. See AS 12.55.135.

SECTIONAL ANALYSIS

STATE OF ALASKA

Office of the Long Term Care Ombudsman

Report of Investigation

Date: November 30, 1995

Case No: 95-0132-A1

Respondent: Staff and Owners of Friendship Home, Inc

Allegations: It is alleged that:

1. The staff and owners of Friendship Home, Inc., have willfully, intentionally, or recklessly inflicted physical pain, injury, or mental distress to residents of the facility. Owners of Friendship Home, Inc., are Debi and Tracy Batchelder and Friendship Home, Inc., is located at 2721 West 69th Avenue, Anchorage, Alaska.

2. The staff and owners of Friendship Home, Inc., have intentionally failed to provide essential care or services necessary to maintain the physical and mental health of the very vulnerable and frail older Alaskans who reside therein.

3. The staff and owners of Friendship Home, Inc., have unjustly or improperly used the property of another person or another person's resources for their own profit or advantage.

4. The owners of Friendship Home, Inc., contrary to law, have operated their licensed foster home in Anchorage above the 5-person capacity for which they were licensed; have operated an unlicensed home in Anchorage; have operated an unlicensed home in Fairbanks; and have operated their licensed residential care facility in Anchorage above the 16-person capacity for which they are licensed.

5. The owners and staff of Friendship Home, Inc., have administered over -the-counter medications to residents without benefit of medical supervision; have adjusted dosage levels of potent antipsychotic drugs without benefit of medical supervision; have administered the medications of a resident to another for which the medication was not prescribed; and have endangered residents in so doing.

6. The owners of Friendship Home, Inc., have intentionally interfered with the Office of the Long Term Care Ombudsman and have retaliated against persons perceived to have cooperated with the Long Term Care Ombudsman's investigation.

Allegation No. 1: The staff and owners of Friendship Home, Inc., have willfully, intentionally, or recklessly inflicted physical pain, injury, or mental distress to residents of the facility.

First, this allegation consists of several specific allegations of abuse perpetrated by certain employees and former employees against specific residents:

1) On or about May 23, 1995, Allen Hart, a former employee of Friendship Home, Inc., was rough with one of the female residents, causing bruising, while the resident was attempting to leave Friendship Home, Inc.

2) Stacy Miller, a former employee of Friendship Home, Inc., was rough getting the residents in and out of bed on an ongoing basis. Specifically, Ms. Miller would throw residents in bed and roughly pull them out of bed. This rough treatment reportedly began soon after Ms. Miller started her employment on August 17, 1994, and lasted until Ms. Miller ended her employment with Friendship Home, Inc., on July 19, 1995.

3) Autumn Tucker, sometime manager of Friendship Home, Inc., was verbally abusive with several of the residents. Specifically, when asked by the residents when morning medications would be made available to them, Ms. Tucker was overheard saying "I'm just real f---ing busy and I don't have the f---ing time" to the residents. This occurred sometime during the period April - May, 1995.

4) Stacy Miller was verbally and physically abusive with one of the residents. Specifically, Ms. Miller was overheard saying "You're really f---ing pissing me off" and next slapped the resident's hand. This occurred sometime during the period April - May, 1995. This resident, who has since passed away, had Alzheimer's Disease.

5) Stacy Miller and Allen Hart were physically abusive with a resident. Specifically, Ms. Miller and Mr. Hart squirted water from a bottle at the resident's face for a 30-minute period, and laughed at the resident. The resident first tried to defend himself by waving his arms and trying to stop Ms. Miller and Mr. Hart. The resident then tried to hug Ms. Miller and Mr. Hart in an effort to stop them from squirting him. The resident eventually held his head in his hands and shook his head in order to get them to stop. This occurred sometime during the period April - May, 1995. This resident, who has since passed away, had Alzheimer's Disease.

6) Stacy Miller was physically abusive with a resident. Specifically, Ms. Miller, while applying eye drops to a resident, forced the dropper into the eye of the resident, causing the resident to resist because of pain. Ms. Miller then attempted to restrain the resident while forcing the dropper in the resident's eye until the drops had been dispensed. The dropper made direct and painful contact with the resident's eyeball. The resident's eye appeared bloodshot for a period of time after. This occurred sometime during the period April - May, 1995.

7) Stacy Miller was verbally and physically abusive to a resident on several occasions. Specifically, Ms. Miller prepared insulin shots for one of the diabetic patients who is also wheelchair bound and came towards him saying "I'm going to stick you." The resident was frightened and attempted to defend himself. Ms. Miller would laugh, restrain the resident, and quickly jab the needle in the abdominal area of the resident. This occurred several times during the period April - May, 1995.

8) Debi and Tracy Batchelder told one resident that she would be changing internists, despite the fact that she had seen one internist for several years and was happy with him. Debi and Tracy Batchelder persisted and the resident acquiesced when pressured to do so.

9) Debi and Tracy Batchelder pressured a resident to remain at Friendship Home, Inc., despite her being eligible to reside at the Pioneers' Home and her strong desire to move to the Pioneers' Home. The resident first became eligible to transfer to the Anchorage Pioneers' Home on June 17, 1994, and she declined on the same day.

Aside from specific allegations of abuse, Allegation No. 1 also encompasses the mental anguish experienced by residents for a variety of reasons and reported by both employees and residents. This mental anguish was a result of alleged neglect of the residents' nutritional needs wherein residents were not served ample portions of meals and were not offered snacks to supplement those meals. It is reported that several residents complained of being hungry and that at least one resident lost a great deal of weight because she was not eating and not being assisted with eating.

Residents in need of assistance to reposition or shift their weight either in chairs or in bed in order to prevent skin breakdown are reported to have been frequently and consistently ignored. Further, residents wishing to be taken to the toilet or assisted with getting off the toilet (sometimes after an hour had elapsed) are reported to have been frequently ignored.

The residents' need for meaningful activity during waking hours is allegedly ignored and most residents sit idle during the day with the television as the only means of activity. It is alleged that little or no periodicals, reading materials, games, or movies are provided for the residents' enjoyment. It is also alleged that residents' are put to bed as early as 5:30 - 6:00 p.m., and awakened as early as 3:30 - 4:00 a.m., despite their personal desire to either stay up longer or sleep until later in the morning.

Many of the residents are alleged to have complained or cried out in pain, only to have their cries ignored. This allegation will be further discussed at Allegation No. 2, but is also pertinent in this discussion of alleged neglect resulting in mental anguish. Several residents are alleged to have been placed in their room with the call button either not working or placed far enough away so the resident is unable to use it. Persistent residents with more acute health problems are alleged to have been viewed as troublesome and ignoring their wishes used as a means of punishment.

Allegation No. 2: The staff and owners of Friendship Home, Inc., have intentionally failed to provide essential care or services necessary to maintain the physical and mental health of the very vulnerable and frail older Alaskans who reside therein.

1) Friendship Home, Inc., did not fill a prescription for one of its residents in a timely manner causing that resident to go without needed prescription drug treatment for a period of 5 days from May 17, 1995, to May 22, 1995.

2) It was reported by former employees that have worked at Friendship Home, Inc., over the last 2 years that the owners of Friendship Home, Inc., frequently neglected to fill many of the residents' medication trays, causing those residents to go without prescribed medication.

3) It is reported by former employees that have worked at Friendship Home, Inc., over the last year that owners or managers of Friendship Home, Inc., have retroactively filled out medication sheets indicating that residents received daily medication when, in fact, they had not, and the person signing the sheets was not on site to give the medication. In other cases, staff and owners of Friendship Home, Inc., have not filled out medication sheets at all for residents prescribed with daily medication.

4) Debi Batchelder, Tracy Batchelder, and Autumn Tucker have not immediately notified physicians when medical attention becomes necessary for some of the residents, and in some cases, not at all. At least one resident died before getting medical attention, despite repeated requests by staff who witnessed her deteriorating condition over a 2-day period and were gravely concerned. Another resident was reported as possibly having a seizure on May 17, 1995. Autumn Tucker was notified by staff at 7:00 a.m., of the possible seizure but no medical attention was sought.

5) Friendship Home, Inc., is not giving regularly scheduled baths for some its residents and several of the residents are reportedly dirty and bad-smelling for lack of adequate bathing.

6) Friendship Home, Inc., is not properly recording progress notes on many of its residents, and in the case of one resident, not at all. The proper recording of progress notes is essential to providing continuity of care, noting exceptions to normal care, and noting follow-up when problems are reported. In this case, large gaps in time occur between progress notes on residents. Progress notes for May, 1995, begin in the middle of May for most of the residents and at least 4 residents did not have progress notes recorded for the month of May, 1995 at all. Several notations appear reporting complaints of pain or seemingly extreme symptoms, but little or no follow-up is recorded. Several employees allege that the recording of progress notes was sporadic and, more often than not, depended on whether state supervision was occurring at the time.

7) Owners and staff of Friendship Home, Inc., are not properly monitoring many of the residents to prevent falls, and owners of Friendship Home, Inc., are neglectful in acquiring bedrails for residents that need them, despite being asked repeatedly by staff to do so.

8) Friendship Home, Inc., did not follow its American Diabetics Association (ADA) nutritional menu for meal planning despite its being posted in a common area and the Batchelder's claims that they followed an approved ADA menu cycle. Several former employees that have worked at Friendship Home, Inc., over a period spanning the last 2 years allege that the menu was almost never followed. Instead, owners of Friendship Home, Inc., purchased inexpensive, bulk frozen food for the residents that is high in sodium and fat. Food stores frequently ran out and one former employee reported that he had to shop for food supplies for the residents with his own money. It is alleged that the prevailing theme was to cut corners rather than provide balanced, adequate meals for the residents.

9) Friendship Home, Inc., is leaving some of its residents in bed for prolonged periods of time thereby causing the residents to develop bed sores. It is alleged that treatment for bed sores is sporadic and sometimes not at all.

10) Friendship Home, Inc., although aware that one of its residents was refusing meals for several days, did not notify a physician or the resident's family. This neglect is alleged to have occurred in May 1995. Another resident, who cannot feed herself, was reportedly left with plates of food in front of her, but she is frequently not provided assistance by staff to eat other than a few bites. This neglect is alleged to have occurred between March and May 1995.

11) A resident of Friendship Home, Inc., has been diagnosed as having a fractured pelvic bone. This resident screamed or complained of pain from at least May 16, 1995, yet went without medical attention until May 24, 1995. Untrained staff "diagnosed" this resident with herpatic lesions and were careful to show other staff the lesions and warn them to wear gloves while assisting this resident. One staff member informed the owners of Friendship Home, Inc., that this resident was in need of medical attention and attempted to consult a home health nurse who was caring for another resident. The staff member terminated her employment with Friendship Home, Inc., in frustration over the situation.

12) A resident of Friendship Home, Inc., was witnessed by several employees to have a dark discharge and was complaining of pain from at least early in May, 1995. As of July 2, 1995, no medical attention was sought for the resident despite several employees urging Autumn Tucker and Debi Batchelder to seek medical attention for the resident.

13) Friendship Home, Inc., failed to assist one of its residents in keeping a May 31, 1995, medical appointment and told the resident's family that the physician's office had called to cancel the appointment. When contacted the physician's office stated that the resident was a "no show" and that it had not canceled the appointment.

14) Friendship Home, Inc., has not had a licensed nurse on staff or on contract from September, 1994 until the end of May, 1995. Sometime during the period September, 1994, to May, 1995, Debi and Tracy Batchelder employed a family member they claimed was a licensed nurse who, in fact, was not a licensed nurse.

15) Friendship Home, Inc., failed to clean and dress wounds of one of its residents who was a double amputee and suffered from a skin condition due to renal kidney disease. This resident, who was subsequently relocated to another facility on June 6, 1995, was diagnosed as being pre-gangrenous as a result of improper care while at Friendship Home, Inc. This resident was also the resident to go without the prescription Lasix for a period of 5 days due to Friendship Home, Inc.'s failure to have the medication refilled. That resident died on June 12, 1995. The cause of death is unknown at this time.

16) Friendship Home, Inc., frequently does not adequately staff the facility during the shift of Autumn Tucker, a family member who cares for her own family upstairs from the main facility. During those times, the 16 residents are cared for by one person, who is also responsible for cooking and serving the meals. At least one resident fell while a staff member was in the facility alone and had called upstairs for assistance. Since no one appeared from upstairs to assist the staff person in a timely manner, the resident spent approximately one hour waiting to be helped up. This incident occurred between March and April of 1995.

17) Residents of Friendship Home, Inc., frequently sit in soiled and wet diapers for prolonged periods of time. This neglect was reported by employees that have worked for Friendship Home, Inc., over the last one year period.

18) A resident of Friendship Home, Inc., began to show signs of illness as early as June 4, 1995, and no later than June 6, 1995. The resident was weak, listless, congested, coughing, and would not eat. Two caregivers informed the nurse employed by the Batchelders and Autumn Tucker that the resident seemed extremely ill and needed to see a doctor immediately. The nurse remarked that he had approached Autumn Tucker about the resident but was told not to worry about it. The nurse also stated that the resident "just has a cold." The resident died on June 8, 1995. No medical attention was sought for the resident prior to her death. The resident's family was not contacted until after her death.

19) On June 14, 1994, a resident of Friendship Home, Inc., with Alzheimer's Disease walked out of the facility unsupervised and was seen by a neighbor falling to his knees by the side of the road. This resident and was taken to the Providence Hospital emergency room and diagnosed with a hip fracture.

20) On June 30, 1995, a resident was taken to the Providence Hospital emergency room because of frequent and severe vomiting. The emergency room physician was able to stop the vomiting and advised Friendship Home, Inc., to follow-up with the resident's personal physician that week **or immediately for any new or increasing symptoms**. Later that evening the resident started vomiting again. A staff member apprised Stacy Miller, who was living upstairs with the Batchelders, that the resident was vomiting again and that he needed medical attention. No one from upstairs came down to attend to the resident until the staff member on duty called to report that the resident had died at 3:40 a.m. the following morning. The staff member was not trained in CPR, despite being left alone in the facility to care for the residents, nor was the staff person informed as to which residents were to be resuscitated if necessary.

Allegation No. 3: The staff and owners of Friendship Home, Inc., have unjustly or improperly used the property of another person or another person's resources for one's own profit or advantage.

1) Friendship Home, Inc., keeps all supplies for incontinence in a shared store, regardless of whether or not that resident is on the Medicaid waiver program. Additionally, test strips belonging to diabetic residents on the Medicaid waiver program are reportedly shared with residents not on the Medicaid waiver program. Additionally, it has been reported that one resident's Medicare supplies were shared with other residents sometime in the period between May 1992 and May 1993. When questioned by an

employee, Debi Batchelder reportedly replied that it was okay - that resident owed some supplies back to the Home.

2) Monthly charges for one resident were $3,000 for board and care and $500 for medications. This resident had prescriptions totaling less than $100.00 per month, yet the owners of Friendship Home, Inc., informed the resident that she owes them more money.

3) Resident personal funds were mismanaged by Friendship Home, Inc. Specifically, one resident's funds were taken by the owners of Friendship Home, Inc., for "safekeeping" and were never given back to the resident, despite her having asked about them. This reportedly occurred between the period of October 1994 and May 1995.

4) A resident reportedly wrote a check for $500.00 to the owners of Friendship Home, Inc., despite that fact the she has guardians who pay all bills for services provided by Friendship Home, Inc. This occurred between the period November 1994 and February 1995.

5) On June 6, 1994, the owners of Friendship Home, Inc., secured a loan from a resident in the amount of $4,500. Reportedly this loan was for the purchase of a van to be used by the owners of the Home to transport residents of the Home. Although there appears to be some credit for the loan on the resident's books, not all of the $4,500 appears to have been credited, nor has any interest been paid for the loan.

6) Sometime during the period from March 10, 1995, and June 6, 1995, Terry January, an aide for Friendship Home, Inc., borrowed money from one of the residents and never repaid it.

7) One resident of Friendship Home, Inc., was covered by both the Medicaid Waiver program and the resident's family for the same 2-month period - April - May, 1995. Friendship Home, Inc., has stated that they will not reimburse the resident's family for the duplicative payments.

8) Friendship Home, Inc., has withheld mail from at least one resident for a period of approximately 2 years starting in 1993. That mail includes bills for goods and services that the resident has not had an opportunity to pay. When one of the resident's creditors was contacted, they stated that they had contacted Debi Batchelder several times regarding the overdue bill and she stated that she would check and get back in touch with the creditor. Ms. Batchelder never contacted the creditor and bill remains unpaid

Allegation No. 4: The owners of Friendship Home, Inc., contrary to law, have operated their licensed foster home above the 5-person capacity for which they were licensed; have operated an unlicensed home in Anchorage; have operated an unlicensed home in Fairbanks; and have operated their licensed residential care facility above the 16 person capacity for which they are licensed.

1) Between the period of July 1992 and May 1993, Debi and Tracy Batchelder operated their foster home over the 5-person capacity for which they were licensed. Specifically, residents were increased in number gradually until the residents numbered 12 or 13. When a staff person inquired about the situation Debi Batchelder stated that they had applied for an adult residential care facility level II license with a 16-person capacity and that since they had applied, it was all right to take in more than 5 persons.

2) From the period February 1, 1995, to May 27, 1995, Debi Batchelder, Tracy Batchelder, and Autumn Tucker operated an unlicensed "holding house" for prospective residents of Friendship Home, Inc. This residence is located at 2601 West 69th Avenue.

3), Reportedly operating on a tip from an unidentified "friend" at a state government office, Debi and Tracy Batchelder of Friendship Home, Inc., relocated an extra 17th resident to the holding house when it was learned that an inspection was imminent. This transfer occurred sometime between February 1995 and May 1995. The Friendship House is only licensed for 16 residents.

4) On May 27, 1995, while residing at the holding house, 4 residents were evacuated because of a fire and were placed in the Bonanza Lodge, an Anchorage motel. Those residents were subsequently relocated to an unlicensed facility in Fairbanks, Alaska. When visited by a social worker from the Division of Family and Youth Services, the owners stated at first that they were merely renting an apartment to the residents. The owners next stated that they had been given a temporary license from the Division of Senior Services. The Division of Senior Services did not have the authority to issue temporary or permanent licenses at that time, and when contacted, representatives from the Division of Senior Services stated that at no time did it issue a license to Friendship Home, Inc., prior to the temporary license issued on July 1, 1995.

Allegation No. 5: The owners and staff of Friendship Home, Inc., have administered medications to residents without benefit of medical supervision; have adjusted dosage levels of potent antipsychotic drugs without benefit of medical supervision; have administered the medications of a resident to another for which the medication was not prescribed; and have endangered residents in doing so.

(1) Friendship Home, Inc., has administered insulin to its some of its diabetic patients without testing their blood sugar first. This allegation was widely reported by staff employed at Friendship Home, Inc., as early as January 1995 up to May 1995.

(2) Friendship Home, Inc., allowed untrained/uncertified staff to administer medications, including subcutaneously, to the residents. This administration of medications was not delegated by a licensed nurse.

3) One resident of Friendship Home, Inc., was given the prescription drug Haldol to control "rambunctiousness." This prescription was for a different person residing at the Home. This administration of Haldol occurred between October 1994 and May 1995.

4) Two residents of the holding house were given the prescription drug Haldol to control "rambunctiousness." Haldol is an extremely potent antipsychotic drug with single dose effects that last for two to three days. This prescription was for a different person who resides at Friendship Home, Inc. This administration of Haldol occurred between February and May of 1995.

5) Some residents of Friendship Home, Inc., who have prescriptions for Haldol are being given the drug in varying doses to control rambunctiousness. Specifically, the owners of Friendship Home, Inc., are instructing staff to "jack up" the Haldol prescriptions and slowly withdraw the drug from the resident's system, causing that resident to sleep for long periods of time. This variation of doses administered is done without contacting the residents' physicians. This variation of dosage levels of Haldol was per Debi Batchelder's or Autumn Tucker's order. At least 2 residents of Friendship Home, Inc., were given varying dosage levels of Haldol and both of those residents exhibited extreme symptoms as a result.

6) Friendship Home, Inc., administered an over-the-counter sleep medication to a resident without regard to the physical effect such medication may have on the resident. This is in lieu of getting a prescribed sleep medication refilled for the resident. When the resident's physician

was contacted it was learned that the particular over-the-counter sleep medication may have a particularly bad effect on the resident given his kidney disease. This administration of over-the-counter sleep medication reportedly occurred in June 1995.

Allegation No. 6: The owners of Friendship Home, Inc., have intentionally interfered with the Long Term Care Ombudsman and have retaliated against persons perceived to have cooperated with the Long Term Care Ombudsman's investigation.

1) Operating on speculation that a particular resident's complaints were the reason for the Ombudsman's investigation, the owners of Friendship Home, Inc., enforced new, stricter eating policies for that resident as a form of retaliation. Specifically, the resident's option to order food from restaurants and have staff assist him was withdrawn by Debi Batchelder, who ordered her staff to serve the resident nothing but food prepared for all Friendship Home, Inc., residents. This alleged retaliation occurred in late May and early June of 1995.

2) An employee of Friendship Home, Inc., was contacted by Robert Collins, a family member of the Batchelders, and told that her husband (also an employee) would be in a lot of trouble if either she or her husband were to cooperate with the Ombudsman's investigation.

3) Employees of Friendship Home, Inc., have been threatened and manipulated in an effort to stop them from cooperating with the Ombudsman's investigation. Specifically, several employees have been warned that the Batchelders have a friend high up in State Government and that if a complaint is made, the Batchelders would be informed of the complaint and the person would be fired.

4) Several former employees report feeling threatened by Autumn Tucker. Specifically, the employees reported that Ms. Tucker is candid in her threats against anyone who "crosses her" and to one listener, threatened to kill anyone who crosses her.

5) An employee of Friendship Home, Inc., was allegedly fired for cooperating with the Office of the Long Term Care Ombudsman. Specifically, the employee was sent a letter early in July 1995 accusing the employee of being rude to residents and for soliciting drugs from the Batchelder's daughters. The employee stated that he had not previously been counseled for being rude to residents, nor had he attempted to solicit

drugs from anyone. The employee stated that he was fired as a means of retaliation.

6) An employee of Friendship Home, Inc., was allegedly fired for cooperating with the Office of the Long Term Care Ombudsman. Specifically, in a letter dated July 3, 1995, to the employee from Tracy Batchelder, Mr. Batchelder stated that the employee was fired for "several incidents of inappropriate behavior" on her part. The employee stated that she had called Mr. Batchelder to request an employee meeting in order to address several problems and concerns that she and other employees had while working with Stacy Miller, the principal subject or co-subject of allegation No. 1, incident Nos. 2, 4, 5, 6, and 7. The employee stated that she was never counseled for inappropriate behavior prior to her termination. The employee further stated that she was warned not to discuss the residents with the nurse monitor from the Division of Senior Services, and that she was treated coldly by Debi Batchelder when it was perceived that she had cooperated with the nurse monitor.

7) An employee of Friendship Home, Inc., was threatened with firing after it was learned that she had been to the Office of the Long Term Care Ombudsman for purposes of an interview. Specifically, Debi Batchelder called the home of the employee several times to ascertain her whereabouts and was told by the employee's husband that she had gone to the Ombudsman's office. When the employee next reported for work, Ms. Batchelder informed the employee that her "friend" from the state had told her that the employee showed up for an interview with the Ombudsman. Ms. Batchelder went further to demand that the employee admit she lied during the interview or else leave her employment with Friendship Home, Inc. Rather than make any such admission, the employee left her employment with Friendship Home, Inc.

8) On July 12, 1995, Suzan Armstrong, Assistant Ombudsman, and Gail Green, Adult Protective Services, visited Friendship Home, Inc., to interview two residents on different matters. At one point the interview was interrupted by Debi Batchelder, who demanded to know if the interviewers had permission from one of the resident's guardians. Armstrong stated that the nature of the interview did not legally require permission from the guardian and Ms. Batchelder appeared to have been satisfied. Upon leaving the interview, Ms. Batchelder approached Armstrong and stated that the resident's guardian was holding on the telephone to speak with her. After briefly informing the guardian that a call back would be more appropriate, Armstrong returned to the Ombudsman's Office and called the guardian back. The guardian informed Armstrong that Ms. Batchelder had

told her the Ombudsman's Office was there that day to immediately remove the resident from the premises in conjunction with an attempted closure of the facility. Armstrong informed the guardian that Ms. Batchelder has not told the truth about the matter.

9) On Friday, August 11, 1995, Armstrong spoke with Autumn Tucker in order to ascertain when a specific resident could legally move from the facility pursuant to the 30-day notice requirement and to ask if it was Friendship Home, Inc.'s policy to assist its residents with relocation. Armstrong specifically stated that Friendship Home, Inc., would not, in any way, be required to assist the resident any more than its policy for all residents. On Monday, August 14, 1995, the resident was moved from the facility, a full day before planned or anticipated by the new facility. A representative from the new facility stated that the Batchelders told her that the Ombudsman's Office demanded the resident be moved a day early and also demanded that they assist the resident with the move. The elderly resident was quite distressed about the nature and timing of the move.

BACKGROUND

This investigation was initiated by a telephone complaint on May 19, 1995, and a letter complaint, dated May 23, 1995, from a separate source. The Ombudsman's Office contacted Adult Protective Services in the Division of Senior Services, the Division of Family and Youth Services, and the Medicaid Provider Fraud Unit of the Attorney General's Office. Given the fact that several entities were involved in the investigation and/or outcome, it was decided that the Ombudsman's Office would lead the investigation and conduct joint interviews with the Attorney General's Office.

Because of the gravity of the allegations against Friendship Home, Inc., possible emergency closure of the facility was discussed on June 19, 1995, with representatives from the Division of Family and Youth Services, Adult Protective Services, and the Attorney General's Office. However, after a search warrant was served on the facility and representatives from the Division of Family and Youth Services (the licensing authority prior to July 1, 1995) inspected the facility, it was decided that the facility could remain open with conditions. Primarily, Friendship Home, Inc., was required to hire a nurse to oversee the care of the residents and dispense medications. Representatives from the Division of Family and Youth Services and Adult Protective Services were to daily monitor Friendship Home, Inc., to ensure strict compliance with the conditions and verify resident safety.

METHODOLOGY

During the course of the investigation, 24 people were interviewed consisting of current employees of the Home, past employees, residents, family members and guardians of the residents, and staff of other entities having some contact with Friendship Home, Inc. Additionally, voluminous amounts of medical and financial information was obtained either by consent or search warrant. The findings of this investigation are a direct result of the interviews conducted and the information reviewed during the course of this investigation.

FINDINGS[1]

Allegation No. 1: The staff and owners of Friendship Home, Inc., have willfully, intentionally, or recklessly inflicted physical pain, injury, or mental distress to residents of the facility.

Substantiated.

As previously discussed, nine specific incidents were reported regarding the willful, intentional, or reckless infliction of abuse of the residents of the facility. Of those nine, eight were substantiated by eyewitness reports. Additionally, Stacy Miller, one of the subjects of allegation No. 1, incident No. 5, admitted to squirting the resident with a water bottle. The only incident not eyewitnessed is allegation No. 1, incident No. 1, involving Allen Hart handling a female resident roughly when she tried to leave the facility. The sole reporter of the incident is the resident. This resident, while seemingly lucid and able to communicate, is very distraught about her living situation and has voiced many complaints about staff in the past. While there is no dispute that the resident did try to leave the facility and that Allen Hart brought her back inside, the degree and type of persuasion used by Mr. Hart is at dispute. Therefore, without any witnesses, allegation No. 1, incident No. 1 cannot be substantiated.

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[1] During the course of this investigation, 56 total incidents were alleged regarding Friendship Home, Inc. For purposes of simplicity, those 56 allegations were divided into 6 general allegations with specific incidents enumerated following each allegation. Since each of the six allegations are tied with a specific set of incidents in numerical order, they will be referred to throughout the section on Findings as follows: "Allegation No. 1, incident No. 2," "allegation No. 4, incident No. 2" and so on.

The narrative section in Allegation No. 1, involving complaints of small meals portions, either not offering or refusing to provide snacks, not shifting bed- and chair-fast persons, rigid bed and wake-up times, residents crying out in pain, and punishment of residents by ignoring them have all been corroborated by a large number of persons involved with Friendship Home, Inc.

Allegation No. 2: The staff and owners of Friendship Home, Inc., have intentionally failed to provide essential care or services necessary to maintain the physical and mental health of the very vulnerable and frail older Alaskans who reside therein.

Substantiated

All but one incident enumerated in this allegation were either substantiated by several reports of such, factually checked by the Ombudsman's Office, or both. For example, allegation No. 2, incident No. 1, alleging that Friendship Home, Inc., went five days before refilling a medication for one of its residents, was verified directly with the pharmacy that filled the prescription.

Allegation No. 2, incident No. 8, alleging that the posted A.D.A. cycle menu was not followed was reported by several employees and verified by directly ascertaining what was being cooked and served and inventorying the food stores.

Allegation No. 2, incident No. 13, alleging that Friendship Home, Inc., failed to assist one of its residents in keeping a medical appointment and lied to the resident's family about why the appointment was missed was directly verified by contacting the physician's office and ascertaining that the resident was a "no show."

Allegation No. 2, incident No. 14, was verified by checking a list of all employees of Friendship Home, Inc., and ascertaining with the Alaska State Board of Nursing which, if any, of the employees were licensed to practice nursing in the State of Alaska. Additionally, the Alaska Native Medical Center was contacted because the Batchelders claimed their family member worked as a nurse there in the past. Alaska Native Medical Center had no such person on their list of former employees.

Allegation No. 2, incident No. 15, alleging that Friendship Home, Inc., failed to clean and dress wounds of one of its residents was verified by direct

observation and recording of the resident's condition by the Ombudsman's Office, interviews with several persons involved in the resident's care, and taking testimony as to his condition up to, and immediately after, leaving Friendship Home, Inc.

Allegation No. 2, incident No. 19, involving a resident of Friendship Home, Inc., walking out of the home and breaking his hip was verified by checking with the Providence Hospital emergency room physician and speaking with Autumn Tucker about the incident the same day it happened.

Allegation No. 2, incident No. 20, involving the death of a resident of Friendship Home, Inc., after exhibiting symptoms that necessitated further medical attention, was verified by obtaining emergency room records from Providence Hospital and interviewing a Friendship Home staff person who was on duty the night of the incident, a staff person that was off duty but present during the incident, and a family member present at the emergency room.

Allegation No. 3: The staff and owners of Friendship Home, Inc., have unjustly or improperly used the property of another person or another person's resources for one's own profit or advantage.

Substantiated

Although the Batchelders first began to take Medicaid waivers for their residents no earlier than February of 1995, at least one account of sharing Medicare supplies among residents was reported prior to 1995, and several accounts of sharing Medicaid Waiver supplies were reported. One resident's Medicare supplies were shared among the residents because Ms. Batchelder felt the resident "owed" the home. During a May 1995 unannounced visit to the home, the Ombudsman's Office verified that the only test strips at the facility belonged to one Medicaid Waiver resident even though there were at least three residents being given insulin for diabetes at that time. Supplies for incontinence were unmarked and housed in one area of the facility, and numerous employees reported that diapers are shared among residents, regardless of the type of payment for their care.

Allegation No. 3, incident No. 2 cannot be substantiated. Initially, it was reported that the resident was being charged a total of $3500 a month - $3000 a month for care and $500 a month for prescriptions, despite the fact that the dollar sum of her prescriptions was approximately $100 per month.

However, it was later learned that the resident was only being charged $3000 a month for her care and approximately $100 a month for her prescriptions.

Allegation No. 3, incident No. 4 cannot be substantiated. Although the resident's family reported that the resident stated she had given the Batchelder's $500 with a personal check, despite the fact that all of her bills are paid by the family, a check of the resident's bank records reveal no such check made out to the Batchelder's or Friendship Home, Inc. Several checks for cash appear on the statements, but it cannot be ascertained that any of the money was given to the Batchelders.

Allegation No. 3, incident No. 5 was verified by Friendship Home, Inc.'s own ledger. A loan in the amount of $4500 was made by the resident to the Batchelders. The resident stated that the loan was so the Batchelders could purchase a van in order to transport residents. Further, although several credits to the resident's account appear in the ledger, the entire amount is not recorded as having been paid off, and no interest appears to have been paid to the resident.

Allegation No. 3, incident No. 8 involves several packets of unopened mail addressed to a resident being confiscated from the Batchelder's personal residence. The unopened mail included several bills for good and services. The Ombudsman's Office called one of the creditors on July 5, 1995. The creditor reported that the they had spoken with Debi Batchelder three times to ascertain when the bill would be paid. This bill, for $37.70, is for prescription drugs and dates back to late 1993. On June 21, 1994, Ms. Batchelder stated that she would bring a check to pay for the prescriptions. Ms. Batchelder neither appeared with a check or called the pharmacy about the overdue amount. The account remains overdue but has not been sent to a collection agency because of its amount. The resident was not given this bill, nor apprised of the overdue amount.

Although not specific allegations in this Report of Investigation, the Ombudsman's Office learned that from approximately May 1992 to May 1993, Debi and Tracy Batchelder paid a full time staff member in cash, with no funds taken out for income tax or employment security tax. Allegedly, Tracy Batchelder informed the staff member that she did not have to bother reporting her income to the IRS and that they were not going to report the income, either. Additionally, one full-time staff member and at least 2 part-time staff persons employed at the "holding house," were paid under the table and in cash for their services.

Allegation No. 4: The owners of Friendship Home, Inc., contrary to law, have operated their licensed foster home above the 5-person capacity for which they were licensed; have operated an unlicensed home in Anchorage; have operated an unlicensed home in Fairbanks; and have operated their licensed residential care facility above the 16 person capacity for which they are licensed.

Substantiated.

Allegation No. 4, incident No. 1, involving the Batchelders operating their 5-person foster home over-capacity was reported by former employees and verified by checking the Division of Family and Youth Services (DFYS) complaint file on Friendship Home, Inc. Although DFYS investigated a complaint about the Batchelders being over-capacity and found that, in fact, the Batchelders were operating over-capacity, it was reported to this Office that the Batchelders would hide residents and resident files when DFYS workers would visit for follow-up.

Allegation No. 4, incident No. 2, the operation of a "holding house" for prospective residents of Friendship Home, Inc., was widely reported by former and current employees, as well as family members who housed their loved ones at the holding house in hopes of getting a bed at the Friendship Home, Inc. Although Debi and Tracy Batchelder maintain that the other home was operated by their daughter, Autumn Tucker, family members and staff alike report that Debi Batchelder represented the home as part of the Friendship Home, Inc. Employees working at the holding house were paid, in cash, by Tracy Batchelder, Debi Batchelder, or Autumn Tucker. Additionally, supplies were purchased for both homes at the same time and by the Batchelders. Residents were shuffled between the two homes - either by moving a resident of the holding house to the larger house when a bed became available, or by moving persons in excess of the #16 capacity to the holding house in order to avoid being caught over-capacity.

Also indicative of the relationship between the holding house and Friendship Home, Inc., is the fact that Debi and Tracy Batchelder transported 3 holding house residents to Fairbanks after a fire occurred in the holding house on May 27, 1995. This fire was verified directly by contacting the Anchorage Fire Department and receiving a fire incident report. Since housing 3 or more residents in an unlicensed facility constitutes a violation of the statutes and regulations governing adult residential care facilities, a representative from the Division of Family and Youth Services (DFYS) in Fairbanks was contacted by the Ombudsman's Office and requested to make an

unannounced visit on the Batchelders. DFYS verified that the Batchelders had 3 persons living with them in their Fairbanks home. Debbie Batchelder offered to send one of the residents home to Anchorage because a bed had recently become available in their 16-bed facility in Anchorage.

Allegation No. 4, incident No. 3, involving a resident being moved between the Friendship Home and the holding house and previously discussed above, was reported by several employees and former employees. What is particularly striking is that, apparently, this resident was first placed in the 16-bed home in Anchorage, next moved to the smaller "holding house" when an inspection was imminent, next moved to a Fairbanks home after the fire in Anchorage occurred, and subsequently flown back to Anchorage after DFYS paid its surprise visit to the Fairbanks home. It is no wonder then that this resident, who has been described as having a significant degree of dementia, was wandering around the neighborhood and fell, breaking his hip (See Allegation No. 2, incident No. 17). The Batchelders moved this resident three times in the space of 3 months - between February and May of 1995, and each time the resident started to wander, he was walking in the direction of the holding house.

Allegation No. 4, incident No. 4 was verified by interviews with employees and family members of the holding house residents and by obtaining a fire incident report from the Anchorage Fire Department. Also obtained for purposes of substantiating this incident is a report by Deanna Burrows, DFYS Social Worker - Fairbanks.

Allegation No. 5: The owners and staff of Friendship Home, Inc., have administered medications to residents without benefit of medical supervision; have adjusted dosage levels of potent antipsychotic drugs without benefit of medical supervision; have administered the medications of a resident to another for which the medication was not prescribed; and have endangered residents in so doing.

Substantiated

All separate incidents of abuse of prescription drugs were widely reported by staff whose work experience with Friendship Home, Inc., dates as far back as three years. Additionally, the Ombudsman's Office verified that only 1 resident had diabetes test strips during a May 24, 1995, surprise visit to the Home. During a search of the Batchelder's private quarters, a prescription

bottle of Haldol was found that belonged to a resident that had died several months earlier. It is noteworthy that the bottle of Haldol was found in the kitchen with other medicines and vitamins used regularly and that it was reported that this resident's Haldol was used by the Batchelders on other residents not prescribed Haldol themselves.

Several persons reported that untrained, unlicensed staff were administering prescription drugs to residents, including insulin shots. During the interview process, one staff member was asked if she had given insulin shots. At first this staff member stated that she only assisted the residents in giving themselves insulin shots. When confronted with the information that several people had reported differently, the staff member admitted that, in fact, she had not merely assisted with insulin shots, but she had administered them without the resident participating in the process. It was reported that the Batchelders asked many staff persons to administer medications, as well as to learn how to administer insulin shots. Several certified nurses aids refused to do so because they were untrained by licensed medical staff and the duties had not been delegated by a licensed nurse. One untrained, unlicensed employee stated that she was taught how to give insulin shots by Autumn Tucker who gave her an orange to practice on for a few days. Ms. Tucker is neither a licensed nurse or a certified nurse's aid.

Allegation No. 6: **The owners of Friendship Home, Inc., have intentionally interfered with the Office of the Long Term Care Ombudsman and have retaliated against persons perceived to have cooperated with the Long Term Care Ombudsman's investigation.**

Substantiated

Allegation No. 6, incident Nos. 5 and 6, involve two employees being fired from Friendship Home, Inc., Neither of the employees were apprised that their job performance was under question. Both employees were perceived by the Batchelders to be cooperating with the Ombudsman's investigation, and both were intimidated because of the perceived participation. Nonetheless, although the termination of Allen Hart for retaliatory reasons is likely, it cannot be substantiated. Mr. Hart is the principal subject of allegation No. 1, incident No. 5, involving abuse of a resident, that allegation is substantiated in this Report, and this type of behavior was cited by the Batchelders as one of the reasons for firing Mr. Hart.

Allegation No. 6, incident No. 7, involves another employee who was told by Debi Batchelder that either she had to admit that she had lied to the Ombudsman's office or leave her position with Friendship Home, Inc., immediately. She left her job immediately. The employee regained her job with Friendship Home, Inc., shortly thereafter.

Allegation No. 6, incident No. 8, involves a visit to Friendship Home, Inc., on July 12, 1995, by Gail Green of Adult Protective Services and Suzan Armstrong, the Assistant Ombudsman. Reports of both employees is on file with the Division of Senior Services.

Allegation No. 6, incident No. 9, involves a resident being moved from Friendship Home, Inc., by Autumn Tucker and Tucker's misrepresentations about the move to the management of the new facility. A report regarding this incident is on file with the Ombudsman's Office, as well as a report from a representative of the new facility where the resident was relocated.

CONCLUSION:

As stated above, all six allegations against Friendship Home, Inc. have been substantiated. During the course of this investigation it was widely reported that the owners of Friendship Home, Inc., Debi and Tracy Batchelder, had very little regard for the frail, elderly residents in their care, and instead, were very concerned with the financial state of the business. Time and time again, employees and former employees commented that money was far more important to the Batchelders than the residents' health, safety, welfare, and rights. This became painfully clear during the course of this investigation. What cannot be amply stated in this report is the sadness and frustration expressed by former employees and residents at the living conditions present at Friendship Home, Inc. It appears that the residents of Friendship Home, Inc., were provided only minimal tools for existence; food enough to survive, medical attention only when withholding of such might clearly result in catastrophe, and a place to sit in idleness.

When residents or staff would complain about the conditions, retribution was swiftly handed out. Residents were ignored and rebellious staff fired. This exacerbated the problems stemming from high staff turnover. Lists of employees dating back almost 3 years were obtained from Friendship Home, Inc., and showed that at least **58** employees had worked at the home during that period. A large number of these employees were hired and fired or quit within a 6-8 week period. Several of the residents reported that they would no sooner get comfortable with the care given to them by new

employees when these employees were suddenly gone. Particularly haunting, also, is the countless reports of residents repeated expressions of gratitude for tasteful food served in ample portions by the few staff that cared to do so or gratitude for the "special" attention given them by lifting them from the toilet before the usual half or full-hour time frame elapsed.

As a final part of this section, some of the allegations have been integrated in a narrative fashion to try to illustrate the level of neglect and abuse that even one resident had to live through at Friendship Home, Inc. One male resident, who was diagnosed with Alzheimer's Disease, was repeatedly subjected to cruel and malicious teasing. This teasing was in the form of coming up behind him and grabbing him by the trunk and lifting him up, squirting him in the face for long periods of time, or verbally poking fun at his limited mental faculties. It was also reported that staff frequently became impatient with this resident when he would wander around the home or hover. This is the same resident that was reported to have been abused by a staff member who was witnessed cursing at him and slapping his hand. It is impossible to imagine what this particular resident perceived about his life. It appears that he was quite verbal in his protestations about the teasing, and, at times, would become quite angry or sad when the persons charged with his care would not listen to him when he said "no." Sadly enough, this is the same resident who began vomiting on June 30, 1995, and without proper medical attention, died on July 1, 1995.

SYSTEMIC ISSUES

During the course of this investigation, several systemic issues were identified. These issues will be addressed by separate report in the near future.

RECOMMENDATIONS

Before the conclusion of this investigation, the Batchelders took steps to divest themselves of Friendship Home, Inc., and it is presently being operated by a separate entity. Not surprisingly, it has been reported that the condition of Friendship Home, Inc., and its residents immediately after the Batchelders left the facility were deplorable. The residents were hungry, dirty, and grateful for any amount of attention and activity that was directed towards them. The beds, bedding, floor, furnishings, and appliances were also dirty. Had the Batchelders chosen to retain their positions as owners/managers of Friendship Home, Inc., the Office of the Long Term

Care Ombudsman would have recommended that the Batchelders' assisted living license be immediately revoked pursuant to AS 47.33.550. Since the Batchelders and Autumn Tucker no longer have an assisted living license, the Office of the Long Term Care Ombudsman recommends the following:

1. Neither Debi Batchelder, Tracy Batchelder, or Autumn Tucker be allowed to hold a license for assisted living in Alaska at any time in the future .

2. The U.S. Postal Inspector of the United States investigate Debi and Tracy Batchelder for obstruction of mails (18 U.S.C. 1701), obstruction of correspondence (18 U.S.C. 1702), and delay or destruction of mail (18 U.S.C. 1703).

3. The Alaska State Department of Law, Attorney General's Office, Medicaid Provider Fraud Unit continue its investigation of the Batchelders and Autumn Tucker for the numerous criminal statutes that may have been violated including several violations of AS 44.21.237 - Interference with the Long Term Care Ombudsman.

EXIT INTERVIEWS

Interviews with Allen Hart and Stacy Miller were conducted on June 12, 1995, and July 19, 1995, respectively. Additionally, a follow-up telephone interview was conducted with Allen Hart on September 5, 1995. Both Miller and Hart were informed as to the allegations against them and given an opportunity to respond.

A copy of this report was submitted to Debi and Tracy Batchelder and Autumn Tucker on November 30, 1995. The Batchelders and Autumn Tucker were given 10 working days to respond to the Report of Investigation.

DISTRIBUTION

Copies of this report are submitted to the Debi Batchelder, Tracy Batchelder, Autumn Tucker, Division of Senior Services; Division of Family and Youth Services; the Department of Law, Medicaid Provider Fraud Unit; the U.S. Postal Service, Office of the Inspector General; Anchorage Postmaster; and to the complainants.

Respectfully submitted,

Suzan M. Armstrong

Suzan M. Armstrong
Assistant Long Term Care Ombudsman[2]

[2] Mr. William O Connor, the former Long Term Care Ombudsman, oversaw the drafting of this report of investigation and concurred with the findings

January 29, 1996

"Send Me to Juneau"
Attention: Matt Zencey
Anchorage Daily News
1001 Northway Drive
Anchorage, AK 99514

Dear Mr. Zencey:

My name is Bobbie Watts and my reason for needing to go to Juneau is to contact as many lawmakers as possible regarding an issue of greatest importance: Our senior citizens need laws on our state books punishing those who abuse, neglect, or exploit them. Also, mandatory fingerprinting for all employees of assisted living facilities and nursing home facilities is imperative.

I placed my father-in-law, Paul Watts, in Friendship Home, Inc., an assisted living facility, on March 10, 1995. In May 1995 I sent a complaint to the Office of the Long Term Care Ombudsman because I realized Paul was being abused and neglected by those we paid to care for him. Many other elderly residents of Friendship Home, Inc, were also being abused and neglected.

The owners/managers of Friendship Home, Inc., Debi and Tracy Batchelder, and other staff had committed horrendous abuses towards the residents. The Batchelders left the state most likely never to be charged for what they did. There are no laws for abuse, neglect, or exploitation of our senior citizens. Mr. Zencey, our parents, grandparents, other relatives, and you or I may need to be placed in a facility one day, and it would be a little reassuring to know that our caretaker is not a criminal and that Alaska laws protect us when they are.

Statistics show that by the year 2010, 14 years from now, our senior population will triple. We have the fasted growing, per-capita, senior population in the nation, according to the Alaska Commission on Aging. The fast-growing senior population in Alaska will require more long-term care facilities and homes that are staffed with trained, compassionate people to care for them. I have come forward with my story to cry out to our legislature to create state laws that will prevent what happened at Friendship Home, Inc., from ever happening to one elder Alaskan again.

My goal is to get a bill passed this session that makes abuse, neglect, and exploitation of the elderly a crime. I also hope to support legislation that would require fingerprint background checks for all employees of nursing facilties and assisted living homes. In the past, the legislature has examined the need for abuse, neglect, and exploitation laws. For reasons unknown to me, this endeavor was discarded. I would like to bring to Juneau my experience as a concerned family member and citizen in order to enlist legislative support for crucial protections for the elderly. I'll never know if I can't try.

Sincerely,

Bobbie Watts

Bobbie Watts
1527 Columbine
Anchorage, AK 99508 ph 277-1696

PUBLIC COMMENT

Ms. Maureen A O'Neill
3550 Alamosa Dr
Anchorage AK 99502 Phone: 248-4450
Affiliation: Reg. Voter: Y Date POM Sent: 03/04/96 Consitutent: N

Bill Number: SB 211 Response: Supports Distribution: 09

Subject:

Message: I ENCOURAGE YOU TO VOTE FOR SB 211 WHICH ADDRESSES ISSUES OF ABUSE AND NEGLECT OF VULNERABLE ALASKANS WHO ARE RESIDENTS OF CARE FACILITIES IN ALASKA. THANK YOU.

NOTE: Ms. O'Neill is a registered Republican in District 12.

Volume XXVI, Number 19 March 6, 1996
Alaska Star

Bill offers protection for vulnerable adults

By JEANNE ENRIGHT
Alaska Star Reporter

A helpless elderly woman is screams in pain for eight days before getting medical attention at an assisted living home. At the same home, another elderly woman develops a cough, becomes weak, listless and congested, and loses her appetite. Caregivers become concerned and want to take her to a doctor, but the manager of the home forbids it. The resident dies two days later.

Suzanne Armstrong, acting Long-Term Care Ombudsman for the state, said these are two very real examples of neglect that recently occurred in Alaska.

On Thursday, a public hearing will be held in the Senate State Affairs Committee for a bill that would make it a criminal offense to commit such acts.

Senate Bill 211, which is sponsored by Sen. Johnny Ellis (D-Anchorage), is referred to as the "Vulnerable Adults' Bill."

The bill, which also covers crimes of sexual abuse and desertion of vulnerable adults, could be a first step in putting legislation on the books for people and issues not covered by current laws.

Ellis said two incidents prompted him to sponsor a bill protecting older or vulnerable people.

First he watched a spot on ABC's popular television news show, "20/20," which showed repeated cases of abuse and neglect in assisted living homes.

But it was Bobbie Watts' story of her neglected father-in-law that proved to be the last straw for Ellis.

Watts had placed her father-in-law in the Friendship Home in Anchorage. According to a Long-Term Care Ombudsman's report, the home had been negligent in his care, as well as that of other patients.

"I want to make it very clear that Alaska has cleaner, better, more modern facilities for nursing care and Pioneers' Homes than many other places," Ellis said.

"But you know, budget cutbacks have precipitated changes in Pio-

(Please see ELDERLY, Page 2)

ELDERLY: Abuse not covered under laws

(Continued from Page 1)

neers' Homes over the last three to four years that a number of people think are moving in the wrong direction.

"We need to make sure that (experts) look at that and say, 'Are we compromising the care of these senior citizens for some ulterior motive or for some reason that's ... not justifiable?'" he said.

Armstrong said that abuse and neglect of the elderly is not all that uncommon — even in Alaska.

"We found, time and time again, that frail elderly residents were not given adequate medical attention, nutrition and personal care. SB211 would address this portion of our investigations," Armstrong said.

However, Armstong said, neither this bill nor current laws protect seniors from physical abuse such as slapping, mental abuse such as teasing or financial exploitation.

"The numerous findings of abuse, both physical and mental, that we found at Friendship Home Inc. would not be covered under SB211, nor are they covered under current assault laws," Armstrong said.

"What I'm hearing (from a lot of people) is that criminal laws cover abuse, and they do not. If they did, the Batchelders (former owners of the Friendship Home), would be here in Alaska answering for crimes. They're not. They're sitting somewhere in Maine," Armstrong said.

"This may be for another day, but at some point, I believe it should be addressed. Criminal laws on assault often don't address cases of abuse."

What Armstrong said is true, said Assistant District Attorney Peter Gamache. Certain types of abuse do not fall under any current statutes.

Assault generally refers to using bodily force that causes someone physical pain. Harassment deals with touching someone in an "offensive" way. Reckless endangerment deals with recklessly placing another at risk of serious bodily harm. Theft statutes protect the elderly from having their property stolen.

But none of these statutes may apply to vulnerable adults, because these people, by definition, cannot defend themselves.

Gamache said a vulnerable adult is defined as a person 18 years old or older who because of physical or mental impairment is unable to meet their own needs or seek help without assistance.

Gamache thinks these people need more legal protection because they can't call for help if they are being abused or neglected. They can't name their perpetrators in a courtroom.

Lynn Kenney, legislative aide to Ellis, said that the senator wanted to address these issues, but was advised by the Department of Law that such a bill would be harder to get through.

"We worked with the Department of Law; in fact, we had drafted a (version) of the bill that went further, but we were advised (not to pursue mental abuse) because it is difficult to prove in court," she said.

Watts, who just returned from Juneau where she lobbied for the bill, said that some lawmakers said they were opposed to SB211.

When Kenney was asked who opposes the bill and why, she said, "I don't know. I've been baffled by it myself."

Kenney said that she doesn't know how much the bill, if passed, would cost taxpayers. She said she requested fiscal notes from various administrative offices, but hasn't received them yet.

Ellis has another piece of legislation in the works to help protect the elderly.

Senate Bill 296 would mandate fingerprinting and background checks for people seeking employment in nursing homes or assisted living facilities.

The bill also calls for prohibiting the hiring or retention of certain nursing home and assisted living employees convicted of specified offenses, such as drug use and sexual abuse.

Kenney said concerned citizens can go to the Legislative Information Office in Anchorage to testify, via telephone, at a Senate State Affairs hearing on SB211. The hearing is set to begin at 3:30 p.m., but Kenney advises people to get to the office by 3:15 p.m.

FORUM / LETTERS

'I went to Juneau': Diary of a citizen lobbyist

By BOBBIE WATTS
Part 2 of 2

Tuesday, Feb. 20

11:30 a.m. I meet Matt Zencey of the Daily News, and we head to the State Capitol so he can show me around. We turn a corner and he sees Gov. Knowles going into a coffee shop. We go in and meet the governor and his press secretary, Bob King. Both are very polite, and Gov. Knowles remarks that he hopes we will have a chance to meet about my issues. Wow — what a start!

I spend the rest of the day papering the Capitol building with my background information, meeting Lynn Kenney, who works for Sen. Johnny Ellis (D-Anchorage), and practicing my presentation on Rep. Ramona Barnes (R-Anchorage). I'm afraid that I didn't present very well my first time out. Hopefully, with practice, I will become more confident about speaking to these very important persons about an equally important issue.

Wednesday, Feb. 21

I finish delivering background information and check in with Lynn Kenney. Sen. Ellis has introduced Senate Bill 211, which makes it a criminal offense to neglect a vulnerable adult.

Finally someone in the Legislature recognizes the need for such legislation.

Lynn mentions that the bill is opposed by the Division of Senior Services. I am honestly puzzled at why the division, which is supposed to protect the elderly, is opposing this bill.

3 p.m. Sen. Lyda Green (R-Wasilla) cannot keep her appointment with me. So I meet with Mike (Sen. Green's staffer). He offers to do research from other states regarding abuse and neglect.

3:30 p.m. I meet with Sen. Johnny Ellis. Sen. Ellis is concerned that his bill will not be considered because of the Division of Senior Services is opposed to it. He states that he would be more comfortable if someone from the majority were to co-sponsor it. He offers to remove his name as sponsor if it means the bill would progress.

Sen. Ellis states that this is a people issue and not a political issue and that this is not a political grandstand on his part. I find him to be very honorable and desirous of seeing a bill that passes to protect the elderly no matter who sponsors it.

4:30 p.m. I arrive at the office of Rep. Cynthia Toohey (R-Anchorage) where Ben Brown, her staffer, greets me. Ben immediately states that he has spoken with Connie Sipe, Director of Senior Services, and relays the opinion that there is no need for a specific law to punish people who abuse and neglect the elderly. He also states that Alaska has laws that adequately deal with the problem.

I feel shoved into a corner. I try my best to debate with Brown and Rep. Toohey, but am truly concerned at how misinformed they are. I wouldn't be here in Juneau if Alaska had adequate laws to prosecute persons who abuse and neglect. This is a fact that somehow escapes Rep. Toohey and her staff.

Bob Hallinen / Anchorage Daily News file photo

■ **EDITOR'S NOTE:** Bobbie Watts is the winner of the *Daily News* "Send Me to Juneau" contest. This is her report on her experience.

Rep. Toohey closes our meeting by telling me to "get a life" and "get over the guilt." She also suggests that I enroll at the University of Alaska nursing program and become a nurse. I am shocked and upset at so cavalier an attitude toward my mission and my experience.

5 p.m. I head to House Speaker Gail Phillips' (R-Homer) office. I meet staffer Judy Jordan, who is very kind. I am brought into Gail Phillips' inner office. I find Rep. Phillips very attentive and concerned. As it happens, her own parents are in a long term care home in Alaska. I hope she will take a close look at SB 211 and agree it needs to be passed this session.

As I am leaving the Capitol Building, I run into Lynn Kenney, Sen. Ellis' aide. Lynn asks if I would like to attend a birthday party in honor of Pat Pourchot, legislative liaison for Gov. Knowles. I agree and later meet some very wonderful and concerned people — Patrick Lounsbury of Rep. Brian Porter's staff, Donna, assistant to Pat Pourchot, Pat Pourchot, himself, and lobbyist Fate Putman. This was quite a group! After a man named Jim Ayers leaves our company, I turn to Lynn and ask, "Was that an important person?" Everyone within hearing distance giggles, and I am informed that Mr. Ayers is the governor's right-hand man! Innocence is a fresh and somewhat comical idea in Juneau this time of year.

Thursday, Feb. 22

Back-to-back appointments. Very busy day ahead.

9:30 a.m. Sen. Robin Taylor (R-Wrangell). Fifteen minutes of chatting about families in general. He is quite pleasant. We are interrupted, and we reschedule for 3 p.m.

11 a.m. Sen. President Drue Pearce (R-Anchorage) is too busy to meet with me right away so I meet with Laura Williams, her staffer. Laura has done research and cannot find any laws regarding abuse or neglect of the elderly. She is quite concerned for elder Alaskans. She gives me some tips, and she reassures me that I am doing the right thing and to keep going. I get to chat with Sen. Pearce on my way out of her office. She is very pleasant.

1:30 p.m. What a nightmare! This appointment is with Sen. Randy Phillips (R-Eagle River), and I am dismayed as soon as his staffer Jerry starts quoting Connie Sipe, the Senior Services official who opposes SB 211.

Here we go again. Opposing SB 211 is such an amazing stance to me. Sen. Phillips' bigger issue seems to be that I must be a constituent of Sen. Ellis. He implies that only a constituent of the bill's sponsor would be here today to argue for it! As a matter of fact, I mention that I am a constituent of Sen. Phillips but what difference does it make? Sen. Phillips then looks at my current address and continues to argue whose constituent I am (I own a home in Eagle River and still vote there, even though I'm temporarily living in East Anchorage because I need to be near my doctors for medical treatment.) If your loved one is a victim of abuse and neglect, what is the difference whose constituent is whose?

2:30 p.m. Appointment with Sen. Bert Sharp (R-Fairbanks) is canceled. I am disappointed because Sen. Sharp is the committee chairman who will decide whether SB 211 will get its first hearing. Since there is no way to reschedule, I will need to get in touch with his office when I return to Anchorage. I feel that when he finally hears what a compelling need we have for such legislation, he will schedule a committee hearing as soon as possible.

3 p.m. Back to Sen. Robin Taylor's office. He tells me I am doing a great job. Thank you! But will he support SB 211?

3:15 p.m. I run into Lynn Kenney and invites me to the office of Sen. Georgianna Lincoln (R-Interior), to help celebrate the senator's birthday. Sen. Lincoln says she hopes I have time to return to her office and talk about my experience. I also meet Rep. Tom Brice (D-Fairbanks).

3:45 p.m. I meet with Pat Pourchot, legislative liaison for Gov. Knowles. He is understanding and kind. I believe he is open to SB 211. Good!

4:15 p.m. I meet with Laurie Otto, deputy attorney general, Criminal Division. She mentions a case of gross abuse and neglect that happened in the summer of 1995 in Anchorage. She states that if SB 211 had been in place, the Department of Law could have prosecuted the case more fully. Instead, the perpetrator received a suspended sentence. She likes SB 211 and states that she will return a telephone call placed to her from Connie Sipe, the bill's chief opponent. Thanks, Laurie!

I am determined to keep my mission alive! Protect Alaskan elders.

5 p.m. Time to meet Gov. Knowles! This meeting makes me the most nervous. I meet Lynn Kenney outside the governor's office. Lynn has been so supportive. We are greeted by Bruce Scandling, special assistant to the governor. We go into the inner office where I shake hands with Gov. Knowles. Gov. Knowles tells me that my issue is very important and that he is pleased with my accomplishments.

Bruce mentions a discussion he had with Connie Sipe. He surprises me by asking about my desire to volunteer for the Long Term Care Ombudsman. (I wanted to volunteer, but some people apparently think I have a conflict of interest because of my work to expose the abuses at Friendship Home.)

Bruce asks what I expected to accomplish volunteering for the program. Did I want to go into nursing homes and investigate? I answer that it was not my goal to investigate — I would have been happy to volunteer to answer telephones and do filing all day. The governor cannot understand why such a small program was unable to accept my help.

This prompts me to mention that the Long Term Care Ombudsman's Office is located in the very agency it often has to investigate (the Division of Senior Services, which manages Pioneers Homes and licenses assisted living homes). The Long Term Care Ombudsman investigated Friendship Home Inc., where my father-in-law had lived, and had identified a need for criminal abuse laws early on. Yet, the Division of Senior Services is opposing SB 211. How does this affect the position of Long Term Care Ombudsman? How can the Long Term Care Ombudsman investigate Pioneers Homes when it is in the same division? The governor looks quite puzzled and says he will investigate that concern.

The governor says that he had read the December article in the Anchorage Daily News about the Friendship Home case and that he was appalled at the gross neglect and abuse that had taken place there. The governor says he will take a close look at SB 211. He says he does not know of a bad bill coming from Sen. Ellis. The governor and I shake hands and have our picture taken together. I'm so glad that I voted for him.

6 p.m. I head out with Lynn Kenney to unwind from my long, tiring day. I am very touched when I meet others who have dealt personally with loved ones being abused and neglected. They understand the urgency to get laws on our books immediately.

Friday, Feb. 23

10:45 a.m. I head back to Anchorage with mixed emotions. I have reached a number of compassionate, caring professionals who heard my story and pledged to do something about it. I did not reach everyone. For whatever reason, their ears and hearts were closed. I feel a stronger sense of purpose after having spent almost four days with the very persons who we elect to run our state and protect its citizens.

On a lighter note, I am looking forward to getting back to my life in Anchorage — a husband, four children and three dogs, not to mention my mission to advocate for the senior citizens of Alaska and, perhaps, start a nonprofit organization that advocates for the elderly. Rep. Toohey told me to "get a life." Today, I can smile about that. I have a life. I have a mission.

After a man named Jim Ayers leaves our company, I turn to Lynn and ask, "Was that an important person?" Everyone within hearing distance giggles, and I am informed that Mr. Ayers is the governor's right-hand man!

I meet with Laurie Otto, deputy attorney general, Criminal Division. She mentions a case of gross abuse and neglect that happened in the summer of 1995 in Anchorage. She states that if SB 211 had been in place, the Department of Law could have prosecuted the case more fully.

■ Bobbie Watts lives in Anchorage.

Anchorage Daily News Monday, January 22, 1996

Elderly deserve oversight

Many of us who work with Anchorage's elderly population are appalled by the recent abuse, neglect and tormenting of elderly residents in an Anchorage boarding home, as reported in both the Long Term Care Ombudsman's report and in your newspaper.

It is important, however, for the public to understand that there are care providers in many Anchorage care settings — both large and small — who give enormous effort to provide personalized, loving care to older residents — care that goes above and beyond the basics required by licensing regulations.

The owner of each facility is ultimately responsible for establishing the tone or "philosophy" of their establishment and for the recruitment and monitoring of their staff, so care is provided in a manner that supports this philosophy.

We applaud the existence of the Office of the Long Term Care Ombudsman, which received and investigated the complaints of the families. Without this program, Alaskans would have little protection from those who would prey on this frail, vulnerable population.

— Tom Boling, operations administrator
Providence Extended Care Services
Anchorage