SEXUAL ABUSE IN NURSING HOMES

What You Need To Know

Wednesday, September 5, 2018
The Consumer Voice

- The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national, non-profit organization in Washington, D.C. that advocates for people receiving care and services at home, in assisted living, or in a nursing home.

- Clearinghouse of information and resources for empowering consumers, families, caregivers, advocates and ombudsmen in seeking quality care, no matter where.

- Provide technical assistance and support for state advocacy regarding long-term care services and supports and have a national action network.
Presenters

- Julie Schoen, J.D., Deputy Director, National Center on Elder Abuse, Keck School of Medicine (USC)
- Dr. Pamela Teaster, Director, Center for Gerontology (Virginia Tech)
- Alisha Lineswala, J.D., Public Policy & Program Specialist, National Consumer Voice for Quality Long-Term Care
- Amity Overall-Laib, Director, National Ombudsman Resource Center
- Vicki Elting, Assistant State Long-Term Care Ombudsman, Washington State Long-Term Care Ombudsman Program
- Lori Smetanka, J.D., Executive Director, National Consumer Voice for Quality Long-Term Care
Funded by a grant from the Administration on Community Living and Administration on Aging (ACL/AoA), serving as one of 27 National Resource Centers. The NCEA is a provider of up-to-date, pertinent and valuable resources, education, and information on elder abuse and neglect.

As a leader in the elder justice movement, we:

• Create valuable educational resources
• Provide training curricula tailored to a variety of audiences
• Deliver up-to-date research
• Build partnerships and make connections
• Explore innovative models
• Listen to what the field needs
• Take advantage of opportunities to advance the field
• Communicate our efforts
• Envision our goals for tomorrow
Sexual Abuse in Long-Term Care Settings: Research Findings and Practical Implications

Pamela B. Teaster, Ph.D.
Professor & Director
Center for Gerontology, Virginia Tech

National Consumer Voice for Quality Long-Term Care/
National Center on Elder Abuse
Webinar, September 5, 2018
**CDC Elder Sexual Abuse**

Forced or unwanted sexual interaction (touching & non-touching) of any kind with adult 60+. May include, not limited to, forced or unwanted completed or attempted contact between...forced or unwanted intentional touching, either directly or through the clothing...

These acts also qualify as sexual abuse if they are committed against an incapacitated person who is not competent to give informed approval.

Literature Review

  
  **Ron Acierno** PhD, **Melba A. Hernandez** MS, **Ananda B. Amstadter** PhD, **Heidi S. Resnick** PhD, **Kenneth Steve** MS, **Wendy Muzzy** BS, and **Dean G. Kilpatrick** PhD
  
  Author affiliations, information, and correspondence details
  

• Sexual Abuse of Older Women Living in Nursing Homes
  
  **Pamela B. Teaster** PhD & **Karen A. Roberto** PhD. Pages 105-119 | Published online *Journal of Gerontological Social Work*: 11 Oct 2008. [https://doi.org/10.1300/J083v40n04_08](https://doi.org/10.1300/J083v40n04_08)

• From Behind the Shadows: A Profile of the Sexual Abuse of Older Men Residing in Nursing Homes
  
  **Pamela B. Teaster** PhD, **Holly Ramsey-Klawsnik** PhD, **Marta S. Mendiondo** PhD, **Erin Abner** MPH, **Kara Cecil** BS & **Mary Tooms** BS
  
  Pages 29-45 | Published online *Journal of Elder Abuse and Neglect*: 08 Sep 2008
Acknowledgements

- Holly Ramsey-Klawsnik, Ph.D.
  Director of Research, National Association of Adult Protective Services

- Erin Abner, Ph.D.
  Associate Professor, University of Kentucky

Adult Protective Services: Oregon, New Hampshire, Tennessee, Texas, Wisconsin

Texas Department of Aging and Disability Services, Wisconsin Elder Abuse, Wisconsin Bureau of Quality Assurance
Objectives

• To investigate patterns of the sexual abuse of vulnerable older and younger adults living in long-term care institutions;

• To test a web-based system for obtaining sensitive and confidential information on the sexual abuse of vulnerable adults; and

• To refine an emergent theory of the mistreatment of vulnerable adults.
Specific Questions

– Who are the victims?
– Who are the offenders?
– Where are the cases occurring?
– What factors correlate with sexual abuse in care facilities?
– How often do these cases reach state attention?
– How are they investigated?
– Do professionals have adequate resources to respond effectively?
– What is our response to victims?
– How are perpetrators handled?
– Can we create a suggested protocol for responding to alleged cases?
Data Analysis

• **Goal**: to identify factors independently associated with substantiation of sexual abuse allegations

• **Method**: unadjusted analysis, adjusted analysis (logistic regression)
Unadjusted Results - Victim

• On average, victims in substantiated cases were:
  – about 10 years older
  – more likely to be female
  – more likely to have dementia
  – more likely to have impaired ADLs
  – less likely to be oriented to person at least some of the time
  – less likely to reside in care facilities with high level supervision

### Table 3. Care Setting Type by Sexual Abuse Allegation Substantiation Status.

<table>
<thead>
<tr>
<th>Facility</th>
<th>Substantiated (n = 72)</th>
<th>Not Substantiated (n = 338)</th>
<th>All Cases (N = 410)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lowest level of supervision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential care facility</td>
<td>3 (4.2)</td>
<td>6 (1.8)</td>
<td>9 (2.2)</td>
</tr>
<tr>
<td>Adult family home</td>
<td>0 (0.0)</td>
<td>7 (2.1)</td>
<td>7 (1.7)</td>
</tr>
<tr>
<td>Adult foster home</td>
<td>0 (0.0)</td>
<td>7 (2.1)</td>
<td>7 (1.7)</td>
</tr>
<tr>
<td>Adult day care</td>
<td>0 (0.0)</td>
<td>2 (0.6)</td>
<td>2 (0.4)</td>
</tr>
<tr>
<td>Group home†</td>
<td>9 (12.5)</td>
<td>16 (4.7)</td>
<td>25 (6.1)</td>
</tr>
<tr>
<td>Community-based residential program</td>
<td>3 (4.2)</td>
<td>16 (4.7)</td>
<td>19 (4.6)</td>
</tr>
<tr>
<td><strong>Moderate level of supervision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assisted living facility</td>
<td>4 (5.6)</td>
<td>12 (3.6)</td>
<td>16 (3.9)</td>
</tr>
<tr>
<td>Rehabilitation center</td>
<td>1 (1.4)</td>
<td>5 (1.5)</td>
<td>6 (1.5)</td>
</tr>
<tr>
<td>Enhanced care facility</td>
<td>0 (0.0)</td>
<td>1 (0.3)</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td>Skilled nursing facility†</td>
<td>37 (51.4)</td>
<td>88 (26.0)</td>
<td>125 (30.5)</td>
</tr>
<tr>
<td><strong>Highest level of supervision</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State school†</td>
<td>4 (5.6)</td>
<td>71 (21.0)</td>
<td>75 (18.3)</td>
</tr>
<tr>
<td>State mental hospital†</td>
<td>1 (1.4)</td>
<td>46 (13.6)</td>
<td>47 (11.5)</td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>0 (0.0)</td>
<td>1 (0.3)</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td>Community mental health/mental retardation facility†</td>
<td>0 (0.0)</td>
<td>27 (8.0)</td>
<td>27 (6.6)</td>
</tr>
<tr>
<td>Intermediate care facility for mental retardation or related condition</td>
<td>7 (9.7)</td>
<td>29 (8.6)</td>
<td>36 (8.8)</td>
</tr>
<tr>
<td>Unknown</td>
<td>3 (4.2)</td>
<td>4 (1.2)</td>
<td>7 (1.7)</td>
</tr>
</tbody>
</table>
Unadjusted Results - Victim

- On average, we did not see differences with regard to:
  - Orientation to place or time
  - Ability to communicate
Unadjusted Results - Allegation

• On average, sexual abuse allegations were more likely to be substantiated if:
  – there was also an allegation of neglect
  – the sexual abuse was of a “hands-on” type

• rape, attempted rape, molestation, harmful genital practices, oral-genital contact, prostitution of victim, sadistic sexual activity, or sexualized kissing
  – the accused perpetrator was another resident
Unadjusted Results - Investigation

• On average, substantiated sexual abuse was more likely if:
  – the victim disclosed abuse
  – the investigative agency had regulatory authority
  – the time between “incident” and report was less than 4 days

• On average, we did not see differences with regard to:
  – Witnesses making the allegation
  – Victims providing a written statement
Our Adjusted Model

• We included these predictors:
  – Victim
    • Age, sex, psychiatric illness, dementia, ADL impairments, ambulation, orientation, ability to communicate, care facility level of supervision
  – Allegation
    • Other abuse allegations, perpetrator relationship to victim, hands-on offense
  – Investigation
    • Victim disclosed abuse, victim written statement, victim injury, agency type
    • Subset analysis: time from incident to report
Table 5. Logistic Regression Main Effects Model Effect Estimates.

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Comparison</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim age</td>
<td>5-year increment</td>
<td>1.02 [0.91, 1.13]</td>
</tr>
<tr>
<td>Victim gender</td>
<td>Male vs. female</td>
<td>1.05 [0.47, 2.32]</td>
</tr>
<tr>
<td>Victim has psychiatric illness</td>
<td>Yes vs. no</td>
<td>0.55 [0.27, 1.10]</td>
</tr>
<tr>
<td>Victim has dementia</td>
<td>Yes vs. no</td>
<td>1.07 [0.40, 2.83]</td>
</tr>
<tr>
<td>Number of ADL impairments</td>
<td>1-unit increment (max. = 4 ADLs)</td>
<td>0.95 [0.74, 1.23]</td>
</tr>
<tr>
<td>Victim is ambulatory</td>
<td>No vs. yes</td>
<td>1.27 [0.46, 3.50]</td>
</tr>
<tr>
<td>Victim oriented to person</td>
<td>Yes vs. no</td>
<td>0.43 [0.11, 1.75]</td>
</tr>
<tr>
<td>Victim oriented to time</td>
<td>Yes vs. no</td>
<td>1.35 [0.51, 3.59]</td>
</tr>
<tr>
<td>Victim ability to communicate</td>
<td>Verbal vs. none</td>
<td>0.80 [0.18, 3.59]</td>
</tr>
<tr>
<td>Victim ability to communicate</td>
<td>Non-verbal vs. none</td>
<td>2.35 [0.44, 12.70]</td>
</tr>
<tr>
<td>Care facility level of supervision</td>
<td>Highest vs. lowest</td>
<td>0.21 [0.08, 0.60]</td>
</tr>
<tr>
<td>Care facility level of supervision</td>
<td>Moderate vs. lowest</td>
<td>1.14 [0.42, 3.14]</td>
</tr>
<tr>
<td>Staff perpetrator</td>
<td>Staff vs. non-staff/non-resident perpetrator</td>
<td>0.44 [0.17, 1.15]</td>
</tr>
<tr>
<td>Resident perpetrator</td>
<td>Resident vs. non-staff/non-resident perpetrator</td>
<td>6.31 [2.55, 15.59]</td>
</tr>
<tr>
<td>Sexual abuse allegation at intake</td>
<td>Yes vs. no</td>
<td>0.70 [0.25, 1.92]</td>
</tr>
<tr>
<td>Neglect allegation at intake</td>
<td>Yes vs. no</td>
<td>0.89 [0.36, 2.24]</td>
</tr>
<tr>
<td>Victim disclosed abuse</td>
<td>Yes vs. no</td>
<td>3.22 [1.44, 7.19]</td>
</tr>
<tr>
<td>Victim gave written statement</td>
<td>Yes vs. no</td>
<td>1.79 [0.86, 3.70]</td>
</tr>
<tr>
<td>Victim was injured</td>
<td>Yes vs. no</td>
<td>5.92 [1.60, 21.95]</td>
</tr>
<tr>
<td>Agency type</td>
<td>Non-regulatory vs. regulatory</td>
<td>1.10 [0.49, 2.47]</td>
</tr>
<tr>
<td>Hands-on offense</td>
<td>Yes vs. no</td>
<td>2.29 [0.94, 5.62]</td>
</tr>
</tbody>
</table>

Note. Model is predicting probability of sex abuse allegation substantiation (n = 403). CI = confidence interval; ADL = Activities of Daily Living.
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Comparison</th>
<th>Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victim age</td>
<td>5 year increment</td>
<td>0.98 [0.86, 1.12]</td>
</tr>
<tr>
<td>Victim gender</td>
<td>Male vs. female</td>
<td>0.92 [0.33, 2.57]</td>
</tr>
<tr>
<td>Victim has psychiatric illness</td>
<td>Yes vs. no</td>
<td>0.52 [0.22, 1.19]</td>
</tr>
<tr>
<td>Victim has dementia</td>
<td>Yes vs. no</td>
<td>1.36 [0.39, 4.75]</td>
</tr>
<tr>
<td>Number of Activities of Daily Living impairments</td>
<td>I-unit increment (max. = 4)</td>
<td>0.92 [0.66, 1.30]</td>
</tr>
<tr>
<td>Victim is ambulatory</td>
<td>No vs. yes</td>
<td>0.70 [0.20, 2.47]</td>
</tr>
<tr>
<td>Victim oriented to person</td>
<td>Yes vs. no</td>
<td>0.43 [0.07, 2.57]</td>
</tr>
<tr>
<td>Victim oriented to time</td>
<td>Yes vs. no</td>
<td>1.74 [0.55, 5.55]</td>
</tr>
<tr>
<td>Victim ability to communicate</td>
<td>Verbal vs. none</td>
<td>0.70 [0.11, 4.44]</td>
</tr>
<tr>
<td>Victim ability to communicate</td>
<td>Non-verbal vs. none</td>
<td>2.10 [0.24, 18.59]</td>
</tr>
<tr>
<td>Care facility level of supervision</td>
<td>Highest vs. lowest</td>
<td>0.21 [0.06, 0.79]</td>
</tr>
<tr>
<td>Care facility level of supervision</td>
<td>Moderate vs. lowest</td>
<td>1.37 [0.37, 5.06]</td>
</tr>
<tr>
<td>Staff perpetrator</td>
<td>Staff vs. non-staff/non-resident perpetrator</td>
<td>0.50 [0.15, 1.64]</td>
</tr>
<tr>
<td>Resident perpetrator</td>
<td>Resident vs. non-staff/non-resident perpetrator</td>
<td>7.62 [2.54, 22.91]</td>
</tr>
<tr>
<td>Sexual abuse allegation at intake</td>
<td>Yes vs. no</td>
<td>0.81 [0.23, 2.81]</td>
</tr>
<tr>
<td>Neglect allegation at intake</td>
<td>Yes vs. no</td>
<td>1.20 [0.39, 3.64]</td>
</tr>
<tr>
<td>Time from incident to report &lt; 3 days</td>
<td>Yes vs. no</td>
<td>4.51 [1.36, 15.04]</td>
</tr>
<tr>
<td>Victim disclosed abuse</td>
<td>Yes vs. no</td>
<td>2.82 [1.10, 7.23]</td>
</tr>
<tr>
<td>Victim gave written statement</td>
<td>Yes vs. no</td>
<td>1.72 [0.69, 4.31]</td>
</tr>
<tr>
<td>Victim was injured</td>
<td>Yes vs. no</td>
<td>5.95 [1.22, 28.96]</td>
</tr>
<tr>
<td>Agency type</td>
<td>Non-regulatory vs. regulatory</td>
<td>1.20 [0.46, 3.17]</td>
</tr>
<tr>
<td>Hands-on offense</td>
<td>Yes vs. no</td>
<td>2.13 [0.68, 6.72]</td>
</tr>
</tbody>
</table>

Note: Time from incident to report to agency is included. Model is predicting probability of sex abuse allegation substantiation (n = 293). CI = confidence interval.
Conclusions/Determining Risks

- Based on this analysis, key factors in predicting substantiation of sexual abuse cases in the five states were:
  - Care facility level of supervision
  - Perpetrator relationship to victim
  - Victim injury
  - Victim disclosure
  - Time from incident to report
Caveats

• Results may not be generalizable in other states

• Other unmeasured factors likely to be important, e.g.:
  – Past experience of the investigator
  – Victim cognitive status
To Consider...

• 18% of facility sexual abuse investigations substantiated vs. 46% of all allegations (Teaster et. al., 2006)

• How much of this difference is due to facility cases?

• How much is due to sexual abuse allegations?

• Practice question: Are sexual abuse allegations harder to investigate? Harder to substantiate?
Not Surprising

- More female than male victims in substantiated cases
- Alleged physical contact substantiated more frequently than no physical contact
- Questions:
  - How do we consider non-touching forms of sexual abuse?
  - Do state and regulation definitions include non-touching sexual offenses?
Significant Finding

- Over $\frac{1}{2}$ of alleged perpetrators were facility employees, $\frac{1}{4}$ were residents
- Yet 63% of substantiated cases involved resident alleged perpetrators
- Staff alleged perpetrator sub rate = 19.4%
- Resident alleged perpetrator substantiation rate vs staff alleged perpetrators = 62.5% (2.5 x)
Profound Finding

• Substantiation was more likely when the abuse report was received within 3 days of the alleged incident

• 4-fold greater odds of substantiation

• Implications...
  – On mandatory reporting & time limits
  – On investigation commencement time
Victim Disclosure

• If the alleged victim disclosed abuse, substantiation was more likely – 3-fold greater

• However, among older women, over ¼ who disclosed sexual abuse did not have case substantiated (Teaster, Ramsey-Klawsnik, Abner & Kim, 2015)

• Implications - those disclosing but not believed

• Implications for non-verbal victims

• High need for special communication remedies
Injuries

- Substantiated cases included more visible injuries
- In fact, 5-fold greater odds of substantiation
- However, very few victims received forensic exams
Signs and Indicators of Sexual Abuse

- Sustaining a pelvic injury
- Having problems walking or sitting
- Developing a sexually transmitted disease or STD
- Torn, bloody, or stained underwear
- Bruises of the genitals or inner thigh
- Bleeding from the anus or genitals

Signs and Indicators of Sexual Abuse (continued)

- Panic attacks
- Signs of Post-Traumatic Stress Disorder (PTSD)
- Symptoms of agitation
- Social or emotional withdrawal from others
- Engaging in inappropriate, unusual or aggressive sexual activities
- Suicide attempts
- Engaging in unusual or inappropriate actions that appear to be from a sex role relationship between the perpetrator of elder sexual abuse and the victim

Response to Victim

- **LISTEN TO THE VICTIM**
- **Act quickly**, conduct forensic examination, look for injuries
- Maintain a high index of suspicion
- Intervention that protects, not punishes the victim
- Consider a spectrum of sexual abuse AND polyvictimization
- Response to the perpetrator(s), the family, and the affected organization
Thank you very much!
FEDERAL REGULATIONS
Freedom from Abuse

• § 483.12 Freedom from Abuse, Neglect, and Exploitation
  • The resident has the right to be free from abuse....as defined in this subpart.

• § 483.12(a) The facility must—
  • (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

• Guidelines: Each resident has the right to be free from abuse, neglect and corporal punishment of any type by anyone.
  • Staff (permanent and temporary)
  • Visitors (including family, friends, and strangers)
  • Even other residents
Employment & Reporting

- § 483.12(a) The facility must—
  - § 483.12(a)(3) Not employ or otherwise engage individuals who—
    - Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
    - Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
    - Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
  - § 483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.
Written Policies & Procedures: Prohibition and Prevention of Abuse

• § 483.12(b) The facility must develop and implement written policies and procedures that:

  - (1) **Prohibit and prevent abuse**, neglect, and exploitation of residents and misappropriation of resident property,

  - (3) Include training as required at paragraph § 483.95,
Written Policies & Procedures: Investigations of Allegations

• § 483.12(b) The facility must develop and implement written policies and procedures that:

  • (2) Establish policies and procedures to investigate any such allegations [of abuse]
Written Policies & Procedures: Reporting

• § 483.12(b) The facility must develop and implement written policies and procedures that:

  • (5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.
    • (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual’s obligation to comply with the following reporting requirements.
    • (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.
    • (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
Facility Response to Alleged Violations

- § 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

  1. Ensure that all alleged violations involving abuse...are reported immediately, but not later than 2 hours after the allegation is made.
• 483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

• (2) Have evidence that all alleged violations are thoroughly investigated.
• (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.
• (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
ROLE AND RESPONSIBILITIES OF THE OMBUDSMAN PROGRAM IN INVESTIGATING COMPLAINTS INVOLVING ABUSE
What is NORC?

- Funded by the Administration on Aging/Administration for Community Living grant
- Operated by the National Consumer Voice for Quality Long-Term Care (Consumer Voice) in cooperation with the National Association of States United for Aging and Disabilities (NASUAD)
- Provides support, technical assistance, and training for state long-term care ombudsman programs and their program representatives:
  - Information, consultation, and referral for Ombudsman programs
  - Training and resources for state ombudsman programs and program representatives
  - Promotes awareness of the role of the Ombudsman program
  - Works to improve ombudsman skills, knowledge, and effectiveness in both program management and advocacy
What is the Long-Term Care Ombudsman Program (LTCOP)?

- LTCOP representatives are resident-directed advocates.

- LTCOPs advocate for quality of care and quality of life of residents in long-term care (nursing homes, board and care/assisted living, other similar adult care facilities).

- Per the Older Americans Act (OAA) and LTCOP Rule the program:
  - Investigates and resolves complaints.
  - Provides information to residents, families, staff (e.g., residents’ rights).
  - Advocates for systemic changes to improve residents’ care and quality of life.
  - Provides technical support for the development of resident and family councils.
  - Represents resident interests before governmental agencies.
  - Advocates for changes to improve residents’ quality of life and care.
  - Seeks legal, administrative, and other remedies to protect residents.
  - Ensures residents have regular and timely access to the LTCOP.
LTCOP Activity Highlights (2016)

- Visited 27,822 long-term care facilities at least quarterly
- Attended 22,205 Resident Council Meetings and 1,974 Family Council Meetings
- 10,690 community education sessions
- 4,702 trainings for LTC facility staff
- 115,708 consultations to LTC facility staff
- 378,526 information and consultation to individuals (residents, family members, others)
National Ombudsman Reporting System (NORS)
Data
2016

199,493 complaints in 2016

• **11,225** nursing home complaints involving abuse, gross neglect, or exploitation

• **819** complaints involving sexual harassment, sexual coercion, or sexual assault by facility staff, management, or an unknown/unknown individual that gained access to a resident due to facility negligence.

• **2,764** complaints involving willful physical or sexual abuse by a resident against one or more other residents.
LTCOP Complaint Investigations

• Ombudsman program representatives:
  • Investigate individual complaints and address concerns that impact several or all residents in a facility.
  • Can address general concerns they personally observe during a visit (e.g. odors, concerns about the environment, staff not knocking on resident doors before entering).
  • Cannot share information without resident consent.
  • Investigate to gather the facts, but the main goal is to resolve the issue to the residents’ satisfaction.
  • Call upon others to fulfill their responsibilities to residents.
  • Represent resident needs by working for legislative and regulatory changes (e.g., coordinated systems advocacy lead by the State Ombudsman).
Resident-Directed Advocacy

- As resident advocates:
  - The resident guides LTCOP action.
  - The LTCOP needs resident consent prior to taking any action on a complaint or sharing resident information.*
  - The LTCOP seeks to resolve complaints to the residents’ satisfaction.
  - The LTCOP represents residents’ interests, both individually and systemically.
  - The LTCOP empowers residents and promotes self-advocacy.

*If the resident cannot provide consent, the LTCO will work with the resident’s legal representative or follow their state procedure if the resident doesn’t have a legal representative.
**Person-Centered Complaint Processing**

*Ombudsman Program Final Rule 45 CFR 1324.19(b)*

*Person-centered* complaint processing approach—the Ombudsman or representative of the Office shall:

- Support and maximize resident participation;
- Offer privacy;
- Discuss the complaint with the resident (and/or resident’s representative) in order to:
  - Determine the perspective of the resident;
  - Request informed consent in order to investigate the complaint;
  - Determine the wishes of the resident with respect to resolution of the complaint, including:
    - whether the allegations are to be reported
    - disclosure of information to the facility and/or appropriate agencies.
- Advise the resident of his/her rights;
- Work with the resident to develop a plan of action for resolution of the complaint;
- Investigate to determine whether the complaint can be verified; and
- Determine whether the complaint is resolved to the resident’s satisfaction.
Why is resident-directed advocacy important?

- By providing confidential, conflict free, resident-directed advocacy:
  - Trusted, person-centered problem solver
  - Build rapport
  - Enhanced trust
  - Credible source of information

*From the resident’s perspective, “if I have a complaint, do I trust the Ombudsman program to investigate and resolve my complaint?”*
# Key Distinctions between the Ombudsman Program and Adult Protective Services

<table>
<thead>
<tr>
<th></th>
<th>LTC Ombudsman</th>
<th>Adult Protective Services</th>
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<tbody>
<tr>
<td><strong>Mission</strong></td>
<td>• Resolve complaints to satisfaction of the resident</td>
<td>• Stop abuse, neglect and exploitation;</td>
</tr>
<tr>
<td></td>
<td>• Improve the quality of care and quality of life of residents</td>
<td>• Protect the victim</td>
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<tr>
<td><strong>Role of individual self-determination</strong></td>
<td>Resident-directed advocate; represents resident interests</td>
<td>Stress victim self-determination, but protects victim even if not consistent with individual wishes</td>
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<tr>
<td><strong>Abuse, neglect, exploitation</strong></td>
<td>• Respond to any resident-related complaint (ACL provides 119 complaint types)</td>
<td>Respond to reports of abuse, neglect, exploitation (and self-neglect in some states)</td>
</tr>
<tr>
<td></td>
<td>• 8% abuse/neglect/exploitation, 2016</td>
<td></td>
</tr>
<tr>
<td><strong>Purpose of “investigation”</strong></td>
<td><strong>RESOLVE:</strong> &lt;br&gt;• Not the official finder of fact; do not “substantiate” abuse &lt;br&gt;• “Verify” to determine whether sufficient information to continue toward resolution &lt;br&gt;• Gather information in order to resolve the problem, not for any legal proceeding</td>
<td><strong>DETERMINE:</strong> &lt;br&gt;• Official finder of fact &lt;br&gt;• Determine whether reported allegation occurred &lt;br&gt;• Many states use the term “substantiate” &lt;br&gt;• If determined, case often referred to law enforcement for prosecution</td>
</tr>
<tr>
<td><strong>Systems level advocacy</strong></td>
<td>Required by the Older Americans Act and LTCOP Rule.</td>
<td>Not a responsibility (may be prohibited by state law)</td>
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</tbody>
</table>
To recap…the Ombudsman program

- Cannot be mandatory reporters

- Provides resident-directed advocacy to resolve issues to the resident’s satisfaction

- Investigates complaints involving abuse, but is not the official “fact finder” to substantiate abuse or determine whether a law or regulation has been violated.
How to Contact the LTCOP

- Nursing homes are required to post contact information for the LTCOP and some states require assisted living facilities/board and care facilities to post information about the LTCOP.

- Visit the NORC website to locate your local or state LTCO: http://www.ltcombudsman.org/
STATE EXAMPLES
The Prevention and Detection of Sexual Assault of Nursing Home Residents

• Developed by the Nursing Home Ombudsman Agency of the Bluegrass and the Bluegrass Rape Crisis Center.
• This manual and training resource is intended for use by ombudsmen in collaboration with local rape crisis programs.
• My Body, My Rights brochure

http://ltcombudsman.org/omb_support/training/materials-created-by-ombudsman-programs#abuse
Sexuality and Intimacy in Long-Term Care Facilities

- Examples of facility policies and procedures
- Consumer education
- Training for facility-staff by Ombudsman programs

RESOURCES
Abuse, Neglect, Exploitation, and Misappropriation of Property

- Based on revised nursing home regulations
- On-Demand Training Course
- PowerPoint
- Fact Sheet

LTCOP Reference Guide

Responding to Allegations of Abuse: Role and Responsibilities of the Ombudsman Program

Overview

Key Points

AoA Statements

What Can An Ombudsman Do?

LTCO Advocacy Strategies

Resources

Balancing Privacy & Protection Surveillance Cameras in Nursing Home Residents’ Rooms


Balancing Privacy & Protection: Surveillance Cameras in Nursing Home Residents’ Rooms

You and your family members might have considered installing a surveillance camera in your room to help determine that you are receiving appropriate care and being treated with dignity and respect, or to be a deterrent to abuse. Surveillance cameras can record video only, audio only, or both video and audio. While surveillance cameras and other devices can offer information about the type of care you are receiving and how you are being treated by nursing home staff, other residents, and visitors, they can be invasive and may violate your or your roommate’s right to privacy. They are also no substitute for personal involvement and monitoring.

Right to Dignity, Respect, and Privacy

Federal regulations give nursing home residents the right to be treated with dignity and respect. This includes while receiving care and during any interactions with nursing home staff, other residents, and visitors. In addition to showing good care being provided, surveillance cameras may record incidents of poor care, neglect, aggression or abuse.

Residents are also guaranteed the right to privacy. This right to privacy includes the right to privacy in your resident rooms, personal care, and in any communication during visits. A surveillance camera would be recording you and your roommate (if you have one) all the time when you are in your own room. It would be video recording you while you are receiving help getting dressed, during your visits with family members and friends, and even recording when you may want to talk to your physician to discuss confidential health issues. Some surveillance cameras may even record audio, which may mean that your conversations may no longer be private.

State Laws & Guidelines on Surveillance Cameras In Resident Rooms

Many high-profile news articles where abuse has been captured on video cameras has led some states to propose the use of surveillance cameras in nursing homes. As of 2017, Illinois, New Mexico, Oklahoma, Texas, and Washington have laws that permit the installation of cameras in residents’ rooms, if the resident and roommate have consented. Each state law addresses issues including consent, and who can provide it; notice requirements, including who must be notified of the camera in use and placement of notice; assumption of costs associated with the cameras; penalties for obstruction or tampering with the cameras; and access to the recordings. While not having a law in place, Maryland has issued guidelines for the use of cameras in nursing home residents’ rooms; and New Jersey’s Office of Attorney General will loan camera equipment to families who want to monitor their loved one’s care.

If your state does not have a law or rules on this issue, or if you have questions about their use, before installing any type of recording device, you should consult an attorney to discuss your rights and options.
Resident-to-Resident Mistreatment

Consumer Fact Sheet

LTCOP Advocacy

Additional Information

- Nursing Home Regulations
  http://ltcombudsman.org/library/fed_laws/federal-nursing-home-regulations

- Abuse, Neglect, Exploitation Issue Page

- Ombudsman Program Final Rule
  http://ltcombudsman.org/library/fed_laws/ltcop-final-rule
Question: Does the Rule prohibit an Ombudsman or representatives of the Office from being mandated reporters under state abuse reporting laws?

Answer: Yes. Both the Older Americans Act and the Rule prohibit reporting of resident-identifying information without the resident’s consent. By logical extension, this precludes mandated reporting of suspected abuse which discloses such information. Through the strict disclosure limitations within the Act, Congress has indicated its intent for the Ombudsman program to be a safe, person-centered place for residents to bring their concerns. Residents can be assured that their information will not be disclosed without their consent, the consent of the resident representative, or court order. (OAA Section 712(d)(2)(B)). Despite numerous Congressional reauthorizations of the Act, Congress has never provided an exception for abuse reporting in the Act.
Question: Does the Rule prohibit Ombudsman programs from investigating abuse complaints?

Answer: No. Both the Older Americans Act and the Rule require the Ombudsman program to “identify, investigate, and resolve complaints that … relate to action, inaction or decisions that may adversely affect the health, safety, welfare, or rights of the residents.” Abuse, neglect and exploitation of residents are among the complaints that fall within this purview. However, Ombudsman programs are not the official entity to substantiate (or, finder of fact) for abuse complaints on behalf of the state or other governmental entity. Ombudsman programs represent the interests of residents, rather than the interests of the state or other governmental entity. (See OAA Section 712(a)(3)(E), (a)(5)(B)(iv); 45 CFR 1324.13(a)(5), 1324.19(a)(4)).
The National Long-Term Care Ombudsman Resource Center (NORC)

www.ltcombudsman.org

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A single bracelet does not jingle.
-Congolese proverb
The Alliance to End Sexual Violence in Long Term Care
Who we are
Statewide partnership to provide technical assistance and build capacity and effectiveness together for the advocacy of long term care residents who have experienced sexual violence today, tomorrow, or in the past.

Who you are
Disability advocates, sexual assault advocates, long-term care ombudsmen, and any individual or organization that cares for or about the lives of residents of long term care.
Who Is Affected By Sexual Violence?

Sexual Violence knows no boundaries - it can affect every age, race, class, culture, gender, ability, sexual orientation, gender identity, and sex, but in the end, we are all affected.

Residents of long term care facilities are highly vulnerable to sexual violence because of their isolation and dependence on others for their care.

Residents are largely silent about sexual violence.
Retaliatiobn is a reality

- May be for any complaint or problem: residents are encouraged to not cause or “be a problem”.
- May be for forming relationships with other residents
- May be because one is perceived as difficult
- Can include:

  longer waits for assistance, not allowing one to leave the facility, restricting visitors, outings, access to resources, events, and activities, restricting relationships, showers, over or under medicating, cold food or food one can’t eat, and the most frightening: the threat of discharge.
We must be Resident/Survivor driven

- Take time, be with the person
- Role may just be to listen and be present, without resolution
- Advocate is not the fixer: role is to support and empower
- Assure confidentiality
- Question and mirror survivor experience for support
- Recognize with trauma, things may not be in chronological order
- Take time, be with the person
- Be trauma-informed
Vision

To bring the silence surrounding sexual violence in long term care facilities out of the shadows and into the community for support and healing.

Thank you
This project is supported by Grant No. 2012-FW-AX-K003 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this publication/program/exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.
QUESTIONS?
GETTING HELP
If You Suspect Sexual Abuse
Getting Help

- Facility’s administrator, director of nursing, social worker, or other trusted staff-person
- Law Enforcement
- Long-Term Care Ombudsman Program
- State Survey Agency that licenses the facility
- Protection and Advocacy or Adult Protective Services
- Citizen Advocacy Group
How to Contact the LTCOP

- Nursing homes are required to post contact information for the LTCOP and some states require assisted living facilities/board and care facilities to post information about the LTCOP.

- Visit the National Consumer Voice website to locate your local or state LTCO: http://theconsumervoice.org/get_help
RESOURCES
Sexual Abuse in Nursing Homes: What You Need to Know

Sexual abuse is non-consensual sexual contact by one person upon another. It may happen as the result of deceiving, manipulating, or forcing the resident into sexual contact. Sexual abuse is a form of elder abuse that frequently goes underreported, under-investigated, and unnoticed. In 2016, Ombudsman programs investigated 819 complaints regarding sexual abuse.¹

Sexual abuse can take on many forms and includes:

- Unwanted intimate touching of any kind, especially to breasts or genital area;
- Rape, oral or anal sex;
- Forced nudity;
- Forced observation of masturbation and/or pornography; and
- Taking sexually explicit photographs or audio/video recordings of a resident and distributing them online or in-person. This includes pictures or recordings of residents that are not fully clothed while they are being cared for (bathing, dressing, etc.).

Women and residents with dementia are more likely to be victims of sexual abuse. Women comprise nearly two-thirds (65.6%) of the nursing home population.² Residents with dementia are particularly susceptible to sexual abuse because of their impaired memory and communication skills. While women and residents with dementia are more likely to become victims of sexual abuse, all residents are vulnerable to abuse.

The abuser can be anyone who has contact with the resident. Residents may know their abuser, such as a family member, friend, or staff person, or they could be complete strangers. Abusers could include permanent and temporary staff, visitors to the facility, and even other residents. Some residents may have dementia or another mental health issue that impacts their choices and behavior and result in resident-to-resident sexual aggression (RRSA). Dementia-driven RRSA is the most common form of sexual abuse in nursing homes.³

It is important to note that residents have the right to engage in consensual sexual activity, but this is dependent on both residents having the capacity to consent. A resident’s ability to consent to sexual activity needs to be carefully and adequately assessed through proper legal and ethical processes, as

Consumer Voice to Offer FREE Advocacy Skills Training Webinars

As part of our Consumers for Quality Care, No Matter Where initiative, Consumer Voice will be conducting four FREE advocacy skills training webinars throughout the year.

More Information

www.theconsumervoice.org
• Fact Sheets
  • Assessment and Care Planning
  • Basics of Individualized Care
  • Residents’ Rights
  • Guide to Choosing a Nursing Home
  • Abuse and Neglect
  • Emergency Preparedness
  • Restraint Free Care

• Guides
  • Piecing Together Quality Long-Term Care: A Consumer’s Guide to Choices and Advocacy
  • Nursing Homes: Getting Good Care There

• Resident and Family Council information
The National Center on Elder Abuse

The goal of the NCEA is to improve the national response to elder abuse, neglect, and exploitation by gathering, housing, disseminating, and stimulating innovative, validated methods of practice, education, research and policy.

Find the NCEA Online!

ncea.aoa.gov  gero.usc.edu/cda_blog/

NationalCenteronElderAbuse  @NCEAatUSC
Connect with us online!

www.theconsumervoice.org

National Consumer Voice for Quality Long-Term Care

@ConsumerVoices