STATE OF CONNECTICUT

PERFORMANCE AUDIT

Protective Services for the Elderly

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ CLARK J. CHAPIN

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Acronyms/ Abbreviations	Definition
ACL	Administration for Community Living
APS	Adult Protective Services
CGS	Connecticut General Statutes
CMS	Centers for Medicare and Medicaid Services
CWCSEO	Commission on Women, Children, Seniors, Equity & Opportunity
DCF	Connecticut Department of Children and Families
DCP	Connecticut Department of Consumer Protection
DDS	Connecticut Department of Developmental Services
DMHAS	Connecticut Department of Mental Health and Addiction Services
DOB	Connecticut Department of Banking
DPH	Connecticut Department of Public Health
DSS	Connecticut Department of Social Services
FFY	Federal Fiscal Year
FLIS	Connecticut Department of Public Health Facility Licensing and Investigations Section
IJ	Immediate Jeopardy
LTCI	Department of Social Services Long-Term Care Investigations and Interventions program
LTCOP	State Long-Term Care Ombudsman Program
NORS	National Ombudsman Reporting System
PA	Connecticut Public Act
POST	Department of Emergency Services and Public Protection Police Officer Standards and Training Division
PSE	Connecticut Department of Social Services Protective Services for the Elderly Program
RA	Volunteer Residents' Advocate for the State Long-Term Care Ombudsman Program
RCSA	Regulations of Connecticut State Agencies
SMQT	Surveyor Minimum Qualifications Test

Performance Audit Highlights

August 11, 2021
Protective Services for the Elderly

Background

The purpose of this audit was to assess how state agencies provided protective services for the elderly during 2017-2019. We focused on the efficiency and effectiveness of the Department of Public Health Facility Licensing and Investigations Section (FLIS), Department of Social Services Protective Services for the Elderly Program (PSE), and Department of Aging and Disability Services Long-Term Care Ombudsman Program (LTCOP). Specifically, the audit examined elder maltreatment prevention, identification, investigation, and intervention. We also assessed the level of coordination and communication across agencies with any responsibility for protecting elders.

According to the Connecticut Coalition of Elder Justice, approximately one in ten adults age 60 or older are abused, neglected, exploited, or abandoned (i.e., maltreated) each year. PSE elder maltreatment complaint investigations increased by 29% from 2016 to 2019. During that same time, annual cases rose from 93 to 122 per worker. Attracting and retaining LTCOP volunteers has been a challenge, decreasing from 35 to 12 from 2014 to 2018. FLIS received 25% more complaints from facilities and services for elders from 2017 to 2019.

Key Findings

1. Higher caseloads have hindered the ability of Protective Services for the Elderly (PSE) workers to visit with elder clients every 30 days as required
2. The Department of Public Health Facility Licensing and Investigations Section (FLIS) does not begin investigating many of the less critical complaints it receives within the required 45 days, and inconsistently contacts the Department of Aging and Disability Services Long-Term Care Ombudsman Program (LTCOP) when investigating nursing home complaints
3. LTCOP personnel are required to conduct non-complaint related visits to nursing homes, but there are no standards on the expected frequency, documentation, and reporting of such visits
4. There has been a steep decline in the number of LTCOP volunteer resident advocates available for weekly nursing home visits
5. Many mandated reporters of elder maltreatment may be unaware of their reporting requirements
6. Mandated reporters of elder maltreatment are not required to complete related training, and PSE does not widely publicize the availability of training on its website
7. There is confusion about where to file alleged elder maltreatment reports, and many nursing home resident complaints are forwarded to FLIS from PSE
8. CT background checks for homemaker-companions are inadequate and permit the hiring of employees with certain criminal convictions that could be harmful to elders

Recommendations

We developed 47 specific recommendations to help protect elderly Connecticut residents. In general, we recommend:

- PSE should establish a maximum caseload per worker and increase efficiencies by exploring options for working in the field and providing relevant training and resources
- FLIS should investigate non-critical complaints within the 45-day requirement and automatically contact LTCOP when investigating nursing home complaints
- LTCOP should develop standards related to frequency, documentation, and reporting of non-complaint related visits to nursing homes
- LTCOP should develop a plan to recruit and retain volunteers and report on the plan's implementation
- Mandated reporter training and reporting requirements need to be publicized and accessibility to the reporting system improved
- Mandated reporters of elder maltreatment should be required to complete related training, and training already on the PSE website should be more widely publicized
- All nursing home complaints should be filed directly with FLIS and the state agencies should clarify which agency to contact for specific complaints
- The General Statutes should be amended to require prospective employees of homemaker-companion agencies to submit to state and national criminal background checks and prohibit the hiring of employees with certain criminal convictions

View the full report, including management's responses, by visiting www.cga.ct.gov/apa

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August 11, 2021

AUDITORS' REPORT
PROTECTIVE SERVICES FOR THE ELDERLY
JANUARY 1, 2017 – DECEMBER 31, 2019

Audit Objectives

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes and Generally Accepted Government Auditing Standards, we have conducted a performance audit of Protective Services for the Elderly. The audit focuses on how well three key agencies are providing protective services for Connecticut adults aged 60 or older. The scope of our audit included, but was not necessarily limited to, January 1, 2017 through December 31, 2019. We based this performance audit on the following objectives:

1. Efficiency and effectiveness of the Department of Social Services Protective Services for the Elderly Program (PSE)

2. Efficiency and effectiveness of the handling of elder abuse complaints by the Department of Aging and Disability Services State Long-Term Care Ombudsman Program (LTCOP)

3. Efficiency and effectiveness of the handling of elder abuse complaints by the Department of Public Health Facility Licensing and Investigations Section (FLIS)

4. Level of coordination and communication across state agencies working to reduce the risk of elder abuse

Methodology

We used multiple sources and methods to conduct this performance audit, including a review of relevant state statutes and proposed bills, federal and state regulations, policies and procedures manuals, forms, and other documents from state agencies.

To assess how well Connecticut is protecting elders from abuse, neglect, exploitation, and abandonment, we conducted virtual interviews with employees, representatives, personnel, and staff from these entities:

- Department of Social Services Protective Services for the Elderly Program
- Office of the State Long-Term Care Ombudsman Program
- Department of Public Health Facility Licensing and Investigations Section
- Department of Consumer Protection
- Department of Banking
- Office of the Attorney General
- Department of Aging and Disability Services State Unit on Aging
- Office of Legislative Research
- Commission on Women, Children, Seniors, Equity & Opportunity
- AARP Connecticut
- Alzheimer's Association Connecticut Chapter
- LeadingAge Connecticut
- Jewish Senior Services of Bridgeport
- United Way of Connecticut 2-1-1
- Connecticut Community Care
- Vernon Police Department
- Department of Emergency Services and Public Protection Police Officer Standards and Training Council
- Massachusetts State Long-Term Care Ombudsman Program
- Centers for Medicare & Medicaid Services

We analyzed a DPH Facility Licensing and Investigations Section database of complaints and incidents received during January 2017-December 2019, a DSS Protective Services for the Elderly Program database of alleged elder abuse, neglect, exploitation or abandonment (i.e., elder maltreatment) reports received during 2017-2019, and a state Long-Term Care Ombudsman Program database of facility visits during October 2017-September 2018. We also examined 30 case records from the Protective Services for the Elderly Program. Through this methodology, we obtained an understanding of internal controls that we deem significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We conducted our audit in accordance with the standards applicable to performance audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. These standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence we obtained provides such a basis.

The accompanying background is presented for informational purposes. We obtained this information from interviews, documents, and data provided by key stakeholders, and this information was not subject to the procedures applied in our audit of protective services for the elderly. For the areas audited, we determined/identified the following:

1. Higher caseloads have hindered the ability of Protective Services for the Elderly (PSE) workers to visit with elder clients every 30 days as required

2. The Department of Public Health Facility Licensing and Investigations Section (FLIS) does not begin investigating many of the less critical complaints it receives within the required 45 days, and inconsistently contacts the Department of Aging and Disability Services Long-Term Care Ombudsman Program (LTCOP) when investigating nursing home complaints

3. LTCOP personnel are required to conduct non-complaint related visits to nursing homes, but there are no standards on the expected frequency, documentation, and reporting of such visits

4. There has been a steep decline in the number of LTCOP volunteer resident advocates available for weekly nursing home visits

5. Many mandated reporters of elder maltreatment may be unaware of their reporting requirements

6. Mandated reporters of elder maltreatment are not required to complete related training, and PSE does not widely publicize the availability of training on its website

7. There is confusion about where to file alleged elder maltreatment reports, and many nursing home resident complaints are forwarded to FLIS from PSE

8. CT background checks for homemaker-companions are inadequate and permit the hiring of employees with certain criminal convictions that could be harmful to elders

The State Auditors' Findings and Recommendations in the accompanying report presents any findings arising from our audit of Protective Services for the Elderly.

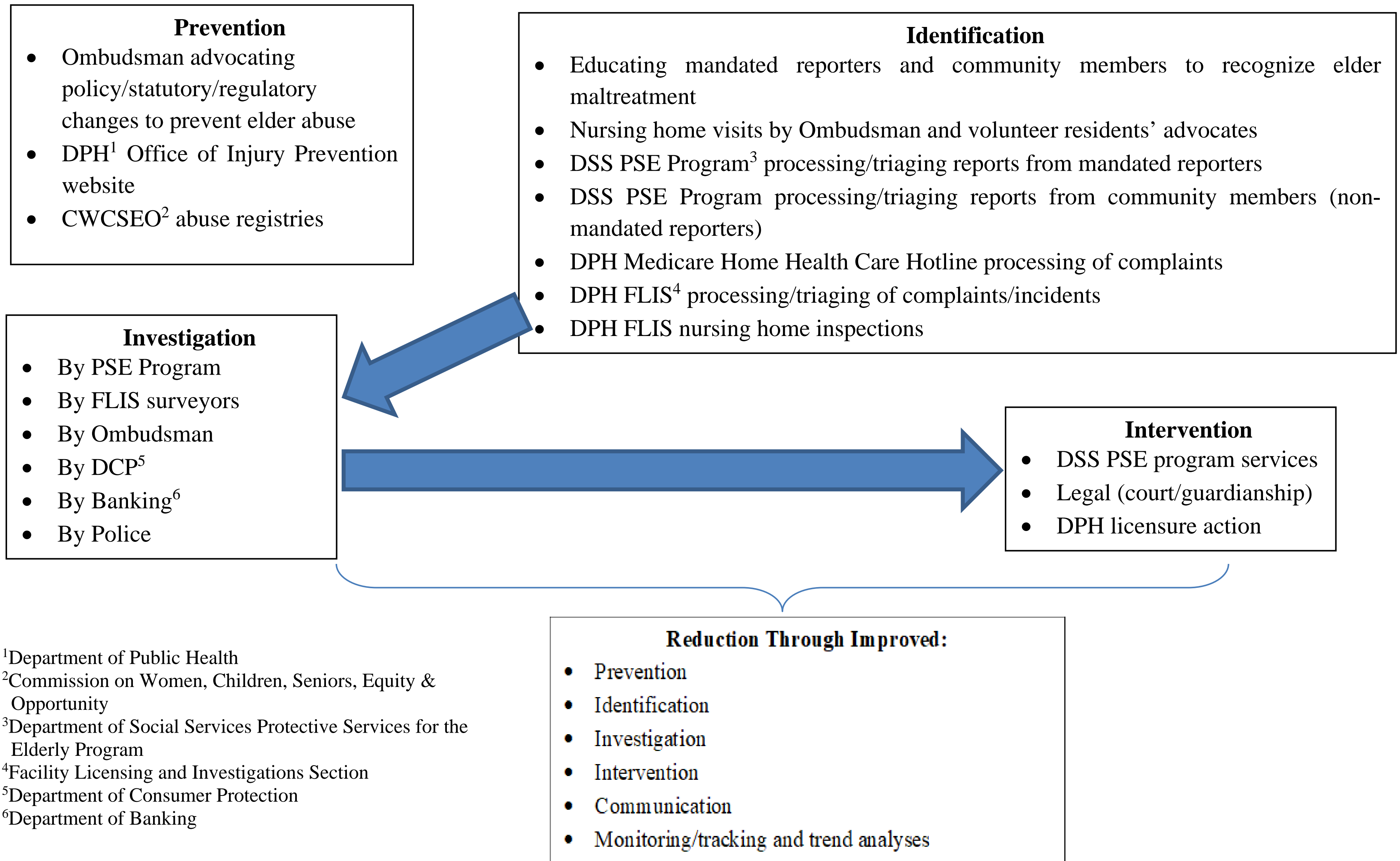
PROGRAM BACKGROUND

According to the Coalition of Elder Abuse in Connecticut website:

- Approximately one in ten adults age 60 or older are abused each year
- Cases of elder abuse remain vastly underreported, approximately one in every 23 cases gets reported to DSS' Protective Services for the Elderly Program
- In almost 60% of elder abuse and neglect incidents, the perpetrator is a family member
- People with dementia are at significantly higher risk of abuse or neglect
- Each year, at least $36.5 billion is lost by elder victims of financial abuse

As shown in **Exhibit 1** on the next page, a multitude of entities has some level of responsibility for the protection of elders across a variety of strategies: prevention, identification, investigation, and intervention.

Exhibit 1. How Elders are Protected in Connecticut



Department of Social Services Protective Services for the Elderly Program (PSE)

Connecticut's Protective Services for the Elderly Program (PSE), administered by the Department of Social Services (DSS), was established in 1978 pursuant to Sections 17b-450 through 17b-461, inclusive, of the Connecticut General Statutes. DSS workers investigate reports of known or suspected physical, mental and emotional abuse, neglect and abandonment and/or financial abuse and exploitation of adults aged 60 and over living in the community, including assisted living facilities. A separate DSS program called the Long-Term Care Investigations Program receives and investigates reports from mandated reporters of suspected maltreatment of individuals residing in nursing homes and other long-term care facilities.

A centralized intake unit receives all reports and determines whether they meet the criteria for PSE, such as age, state of residence, and reason for call. Reports of elder maltreatment can be received by fax or mail on standardized forms. In 2019, the intake unit accepted 66% of reports for investigation. Accepted reports are then distributed to one of the ten regional supervisors to be assigned to a social worker. The social worker meets with the elderly individual in person to identify unmet needs and develop a comprehensive plan to address those needs. When necessary, staff will intervene immediately to safeguard the individual's health and well-being.

Two-thirds of reports to PSE had just one allegation, 31% had two allegations, and the remainder had three to five allegations. The most frequent allegation was self-neglect, followed by exploitation and neglect (**Exhibit 2**).

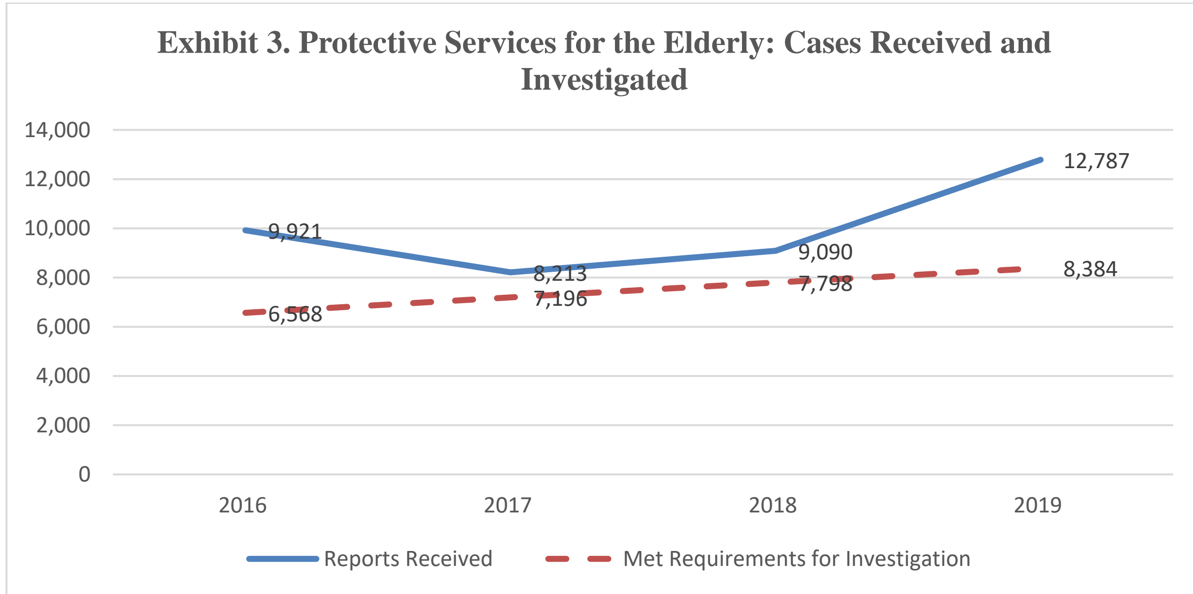
Exhibit 2. Frequency of Suspected Complaint Allegations Reported to PSE 2017-2019

Allegation	# of complaints with this allegation	% of complaints with this allegation	# of complaints with only this allegation	% of complaints with only this allegation
Self-Neglect	9,226	43.7%	6,500	48.3%
Exploitation	7,707	36.5%	3,646	27.1%
Neglect	6,657	31.5%	2,717	20.2%
Emotional Abuse	4,081	19.3%	0	0%
Physical Abuse	2,195	10.4%	531	3.9%
Sexual Abuse	114	0.5%	56	0.4%
Abandonment	110	0.5%	13	0.1%
Total	**21,131[a]**		**13,463**	

[a]21,131 is the total number of complaints, with each complaint containing 1-5 allegations.

From 2016 to 2019, the program has served an increasing number of elders **(Exhibit 3)**. There was a 29% increase in PSE investigations from 2016 to 2019. In 2019, 66% of cases received met the statutory requirements for investigation. An increasing number of reports have been made for every type of allegation from 2016 to 2019. In 2018, the PSE program implemented changes to the intake process, including adding additional staff, changing the supervisory review process, and retraining staff. PSE management suggests that these changes resulted in better screening of

incoming reports. Due to the aging population, the need for PSE is expected to continue increasing annually.



In each of the last four years, about 63% of the clients have been female. In 2019, most of the clients were between 65 and 84, with a median age of 78, and 41% lived alone.

Findings and Recommendations to Improve PSE

Finding 1: Mandated reporters must contact the Department of Social Services Protective Services for the Elderly Program (PSE) within 72 hours of suspected elder abuse, neglect, exploitation, abandonment, or need for protective services. However, PSE does not confirm the date the suspicion or belief first arose, making it impossible to determine whether the reporting occurred on time.

Section 17b-451(a) of the General Statutes requires mandated reporters to contact DSS within 72 hours of suspicion of elder abuse, neglect, exploitation, abandonment or need for protective services. If reporting does not occur within this time, the individual may be fined up to $500 and be guilty of a class C misdemeanor for the first offense and a class A misdemeanor for any subsequent offenses.

PSE staff told us they do not collect information on when the mandated reporter first suspected elder abuse, neglect, exploitation, abandonment or need for protective services. Intake workers ask mandated reporters how long the maltreatment has been going on, but the information is not collected in a way that could be calculated. Additionally, elder maltreatment could have been occurring before the mandated reporter became aware of the situation. In this case, asking how long the maltreatment has been ongoing may not coincide with the mandated reporter's duty to report. PSE management does not believe there is a significant delay in reporting and believe that

asking for such information could be a barrier for mandated reporters concerned about being fined for not reporting within 72 hours.

Without information on when elder maltreatment is first suspected, it is difficult to know whether reports are being received within 72 hours. PSE staff cannot verify that reporting is occurring in a timely manner. PSE should collect this information when receiving reports of suspected elder maltreatment from mandated reporters.

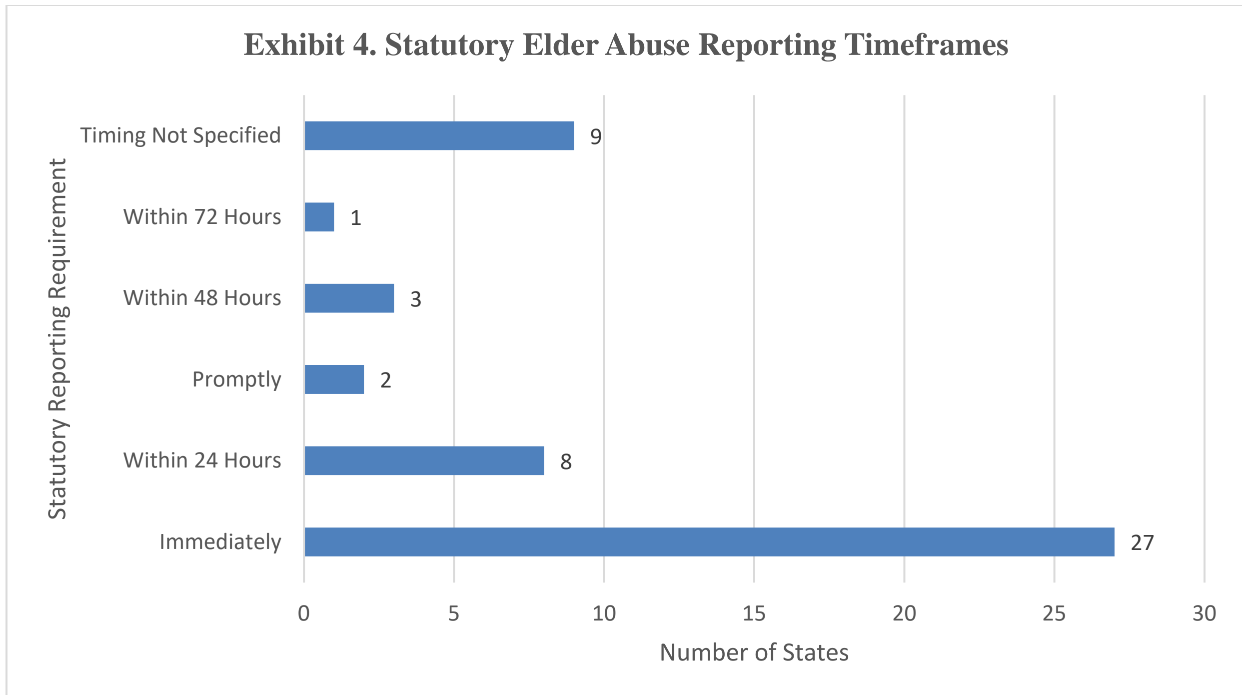
To address concerns about fines and misdemeanor charges becoming a barrier to reporting elder maltreatment, a first occurrence of failure to report within 72 hours could result in retaking the PSE elder abuse training course for mandated reporters as specified in Section 17b-451(g) of the General Statutes. Proof of successful completion of this training could be provided to DSS. Failure to report elder maltreatment within 72 hours a second time could result in a fine of up to $500 and a class C misdemeanor, and a class A misdemeanor for any subsequent offenses.

Recommendation: Section 17b-451(a) of the General Statutes should be amended to require the Department of Social Services Protective Services for the Elderly Program to collect the date when mandated reporters first suspect elder abuse, neglect, exploitation, abandonment, or the need for protective services. To encourage timely reporting, the penalty for a first offense for not contacting the program within 72 hours should be changed to require that the mandated reporter retake the elder abuse training and provide the program with proof of successful completion of such training. **(See Recommendation 1.)**

DSS Response: "A modification to the Social Work case management database is needed to comply with this recommendation. The Department will explore possible future modifications that could align with this recommendation."

Finding 2: Connecticut statute allows 72 hours for mandated reporters to report suspicion of elder maltreatment, which is longer than most states, potentially leading to a delay in elders receiving protective services.

Although Connecticut mandated reporters are required to contact PSE within 72 hours of suspicion of elder abuse, neglect, exploitation, abandonment, or need for protective services, 40 states require shorter reporting periods that range from immediately to within 48 hours (**Exhibit 4**).



Connecticut law requires mandated reporters of child maltreatment to report such suspicions "as soon as practicable but not later than twelve hours after the mandated reporter has reasonable cause to suspect or believe that a child has been abused or neglected or placed in imminent risk of serious harm." Both children and elders are vulnerable populations and should have comparable reporting requirements. Timely reporting allows state agencies to respond promptly to serious cases.

Recommendation: Section 17b-451(a) of the General Statutes should be amended to require mandated reporters to make their reports to the Department of Social Services Protective Services for the Elderly Program as soon as practicable but not later than twelve hours after the mandated reporter has reasonable cause to suspect or believe that an elder has been abused, neglected, exploited, abandoned, or is in need of protective services. **(See Recommendation 2.)**

DSS Response: "A decrease in the timeframe to report maltreatment would be a positive enhancement to the program."

Finding 3: Mandated reporters can make suspected elder maltreatment reports to the Department of Social Services Long Term Care Investigations Program only via fax or mail, which is potentially burdensome for some mandated reporters and could delay reporting.

The DSS Long Term Care Investigations Program (LTCI) is statutorily authorized to receive reports from mandated reporters of suspected elder abuse, neglect, exploitation, or abandonment of nursing home residents. The LTCI has different statutory authority than PSE, but the programs

are staffed by the same workers and supervisors. The statute requires mandated reporters suspecting elder abuse in long-long term care facilities to send form W-410 to DSS. Currently, form W-410 is accepted only by fax and mail, which could potentially be a barrier to timely reporting. Mail does not easily provide a confirmation receipt and can take days to arrive.

An online reporting tool that supports the transmission of the W-410 form could save intake workers time entering data and allow automated receipt confirmation of the report. Intake workers favor an online reporting tool for the W-410 form. They noted that poor handwriting on faxes makes some of them challenging to read. An online tool would eliminate this difficulty and provide timely receipt of reports.

Recommendation: The Department of Social Services Long Term Care Investigations Program should develop an online system for the transmission and acknowledgment of reports from mandated reporters suspecting elder maltreatment of long-term care residents. **(See Recommendation 3.)**

DSS Response: "Online reporting would be a positive enhancement to the program. DSS has initiated the process to support this method of reporting for the Protective Services for the Elderly Program and this process can be extended to the Long Term Care Investigations Program."

Finding 4: The Department of Social Services Protective Services for the Elderly Program currently only receives reports of suspected elder abuse, neglect, exploitation, and abandonment by telephone, fax, or mail. Absence of an online reporting option is inefficient and inconvenient and could lead to reporting delays.

PSE reports of suspected elder maltreatment are primarily received by telephone, although the program also accepts reports via fax and mail on the standardized W-675 reporting form. Some Connecticut state agencies and protective service programs in other states, such as California and Arizona, have online electronic reporting tools. Allowing online reporting could save intake workers time on the telephone and entering data, provide an automatic link to the PSE client database, and increase the completeness and accuracy of reports.

Some of the mandated reporters we spoke with are shift workers who do not work during regular business hours when PSE intake staff are available to answer calls. This makes reporting suspicions of elder abuse challenging for second and third-shift workers. Mandated reporters we spoke with believe an online system would be more convenient and could generate an automated confirmation email when they submit a report. PSE social and intake workers thought an online reporting tool would be beneficial if security and technology concerns are addressed.

Recommendation: The Department of Social Services Protective Services for the Elderly Program should develop an online reporting tool to receive reports of suspected elder abuse, neglect, exploitation or abandonment. The reporting tool should generate an automated confirmation email to document the submission of the report. **(See Recommendation 4.)**

DSS Response: "Online reporting would be a positive enhancement to the program. DSS has initiated the process to support this method of reporting for the Protective Services for the Elderly Program."

Finding 5: Department of Social Services Protective Services for the Elderly Program social workers did not consistently meet the requirement to conduct face-to-face visits with clients every 30 days, which led to a lower quality of service.

The PSE Procedure Manual states, face to face visits should be made at least every 30 days by the investigating social worker. In a review of 30 randomly selected cases from 2017 through 2019, there were 21 cases open for at least 30 days. Just two of the 21 clients (10%) received face-to-face visits every 30 days.

During interviews, PSE social workers reported that the requirement is logical and would ensure the highest level of care. However, they are unable to make face-to-face visits every 30 days due to significant caseloads, extensive travel time, and unavailable elders.

Social workers may substitute a telephone call for a face-to-face visit to save time. However, telephone calls do not provide the same level of information. Social workers report that telephone calls are not as effective when the elder has cognitive issues. Despite saving time, telephone calls do not replace face-to-face visits.

The National Association of Social Workers (NASW) Standards for Social Work Practice with Family Caregivers of Older Adults addresses ongoing assessment and responsive care as a standard, emphasizing the importance of assessing the elder in the context of their home environment. Telephone calls do not provide the non-verbal or contextual information necessary to assess an elder and develop responsive case plans.

PSE management agrees that visiting elders every 30 days is a best practice. However, in some case-specific circumstances, this frequency of visits may not be appropriate. For example, the elder may not want visits this often and their right to self-determination needs to be respected. In this case, management suggested that social workers can document the reasons for changing the visitation frequency in the case record.

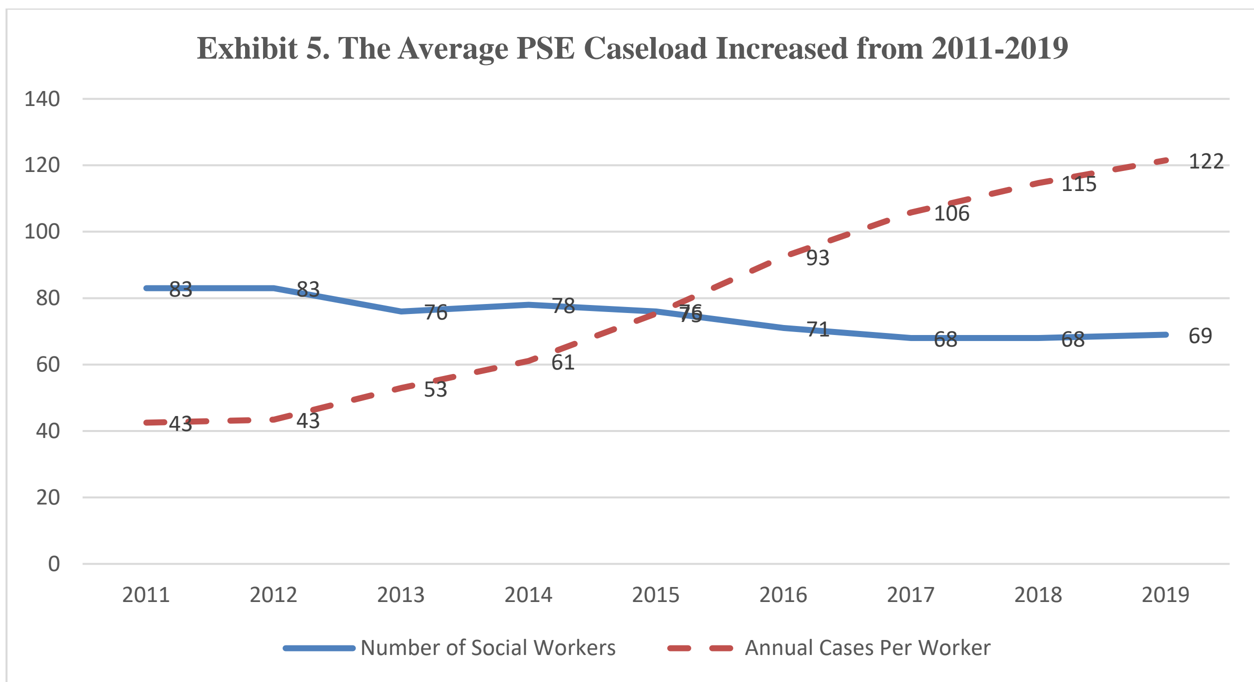
Recommendation: Department of Social Services Protective Services for the Elderly Program supervisors should ensure that social workers conduct face-to-face visits with elders every 30 days. Management should consider modifying the PSE Procedure Manual to allow for exceptions to the 30-day visitation policy when an appropriate reason is clearly documented in the case record. **(See Recommendation 5.)**

DSS Response: "Face-to-face visits every 30 days is best practice but there are several factors that influence whether visits can occur at this interval. Case practice can be enhanced to document why a face to face visit is deferred. The

Department will look into adding language to the procedural manual that addresses this topic."

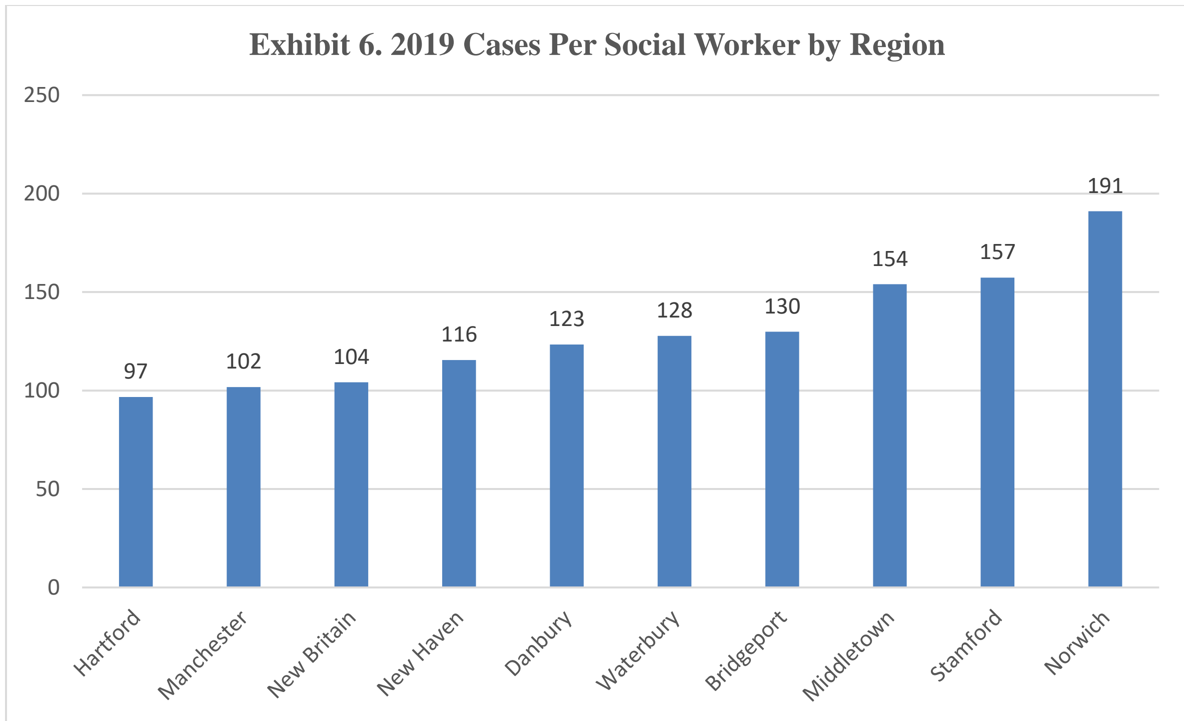
Finding 6: Elder maltreatment cases that meet statutory requirements for investigation by the Department of Social Services Protective Services for the Elderly Program (PSE) have been increasing annually while the number of available social workers has decreased, leading to less timely services for some clients.

Exhibit 5 shows the impact on average PSE social worker caseloads as the number of cases requiring investigation more than doubled from 2011 to 2019 while the number of social workers decreased.



The need for additional PSE staffing is expected to grow proportionate to the increase in Connecticut's elderly population. According to PSE management, staff also spend about 38% of their time working in other DSS programs. Workers' responsibilities have changed as the programs have been restructured. Program social and intake workers expressed concern about these trends and suggested additional social workers would be needed to handle the higher number of cases.

Social workers we interviewed reported that their current caseloads average between 15 and 50 cases, depending on the regional office, with caseloads sometimes reaching as high as 80 cases. Depending on the DSS regional office, the number of cases per worker each year varies from 97 to 191 cases (**Exhibit 6**). Some social workers reported difficulties managing their caseloads and indicated that they need to prioritize high-risk cases when they have heavy caseloads, leading them to set some cases aside until they resolve the higher-risk cases.



Some states establish maximum caseloads for adult protective services (APS) workers. The Administration for Community Living recommends limiting the number of cases assigned to each worker warning that, "Failure to implement a limit on the number of cases assigned to each APS worker may result in serious risks to the APS system's efficiency and efficacy." PSE managers favor maximum caseloads of 25 cases per worker, which is in line with best practice recommendations. The National Association of Adult Protective Services recommends a maximum of 25 cases per worker per month.

Notably, regions with average caseloads of 25 cases per worker also report stronger community partnerships than regions with higher caseloads. Working with other agencies and community partners can provide elders more comprehensive services and increase their willingness to accept assistance. Monitoring the caseload could enable social workers and supervisors to better meet the program's needs.

Recommendation: Department of Social Services Protective Services for the Elderly Program management should establish a maximum caseload per social worker and ensure that staffing remains adequate to meet the needs of the program. **(See Recommendation 6.)**

DSS Response: "An established maximum caseload per social worker and commensurate staffing would be a positive enhancement to the program. The Department will look into incorporating this into program guidelines."

Finding 7: The Department of Social Services Protective Services for the Elderly Program does not accept reports from first responders who witness elders in self-neglectful situations if they are subsequently admitted to the hospital. This could cause elder maltreatment to go uninvestigated.

According to the PSE Procedure Manual, if an elder is admitted to a hospital prior to receipt of a first responder report of self-neglect, the case will not be investigated. In this instance, intake workers record the report as "non-case activity." PSE workers believe hospitalized elders needing PSE assistance should be referred by hospital personnel. PSE management suggested that the hospital would address the self-neglect through a discharge plan.

In our interview with the police, we were told of instances in which they observed serious self-neglect and arranged for the elder to be brought to the hospital. If the elder was admitted to the hospital prior to the police reporting the matter to PSE, PSE would not investigate the referral. In one case, a police officer told us about witnessing piles of human waste in an elder's home, but since the elder had been admitted to the hospital prior to the police reporting it, the referral was not accepted for investigation. When interviewed by hospital personnel, the elder denied there was a problem. The hospital did not report this to PSE, and did not address the matter in the discharge plan. The police had to wait for the elder to be released from the hospital and referred the case to PSE again. Upon investigation, PSE found serious concerns, and the elder had to be conserved.

As demonstrated in this example, there may be instances in which hospital personnel do not report cases of self-neglect to PSE or appropriately plan for the elder's discharge. Additionally, some PSE social workers we interviewed did not think the current policy makes sense and would rather receive reports of maltreatment as soon as possible to enable a proactive approach. Accepting referrals from first responders, regardless of hospital admission status, would ensure that elders are not overlooked when services are needed.

PSE management expressed concern about supporting hospitalized elders due to an inability to assess their home environment and status of daily care. While the elder is hospitalized, this may be a challenge. However, social workers could begin the investigation by speaking with the elder and interviewing other relevant parties. They can also follow up with the reporter and work with hospital staff to ensure that an appropriate discharge plan is in place. Accepting reports of self-neglect for hospitalized elders and ensuring that the elder receives needed supports should be a vital part of Connecticut's elder protection system.

Recommendation: The Department of Social Services Protective Services for the Elderly Program should accept all first responder reports of elder self-neglect regardless of hospital admission status and amend the PSE Procedure Manual to reflect this change. **(See Recommendation 7.)**

DSS Response: "The Department will review its policy to determine how elders alleged to be self-neglecting who are hospitalized can be supported. While an elder is hospitalized, DSS cannot assess the elder's environment nor the status of their care, which is the nature of these types of cases. An elder must be present in their environment for our work to be done. It is important to note

that hospital discharge planners also have a responsibility to ensure a safe discharge."

Finding 8: Some Department of Social Services Protective Services for the Elderly Program employees do not have enough guidance to determine the substantiation of allegations, leading to potential subjectivity and inconsistency in worker determinations.

The PSE Procedure Manual states that, "allegations should be found substantiated or unsubstantiated no later than 45 days after receipt of referral by intake." It further states that, "Within 45 days of receipt of referral, the investigating social worker will be asked to determine if each of the allegations made at intake have been found to have enough supporting data that it is more likely true than not and will note those allegations to be substantiated." Although the manual lists examples of conditions that support an allegation, it may not provide enough guidance for staff to substantiate allegations consistently and appropriately.

When asked, some social workers and their supervisors indicated that they do not have enough guidance on substantiating allegations. Additionally, many of the social workers do not reference the PSE Procedure Manual and may not be aware of the information in the manual.

Recommendation: Department of Social Services Protective Services for the Elderly Program employees should be trained on substantiating allegations to ensure consistency. **(See Recommendation 8.)**

DSS Response: "Additional training on substantiating allegations would be a positive enhancement to the program and is in development."

Finding 9: More than 36% of referrals made to the Department of Social Services Protective Services for the Elderly Program (PSE) include allegations of financial exploitation; however PSE does not have the necessary resources to adequately investigate financial exploitation cases.

From 2017 to 2019, 36.5% of referrals included allegations of financial exploitation. PSE social workers do not have the education or training to analyze financial transactions to determine financial exploitation. Social workers report that these cases require extensive time. Some workers report being unable to assist elders with these cases due to a lack of forensic accounting knowledge. Social workers and supervisors report that it would be beneficial to have a forensic accountant or specialist to assist with financial exploitation cases. The availability of expert resources is supported as a best practice for increasing efficiency and effectiveness.

In 2020, the Administration for Community Living published "The National Voluntary Consensus Guidelines for State Adult Protective Services Systems" with the goal of promoting effective and consistent adult protective services across the country. The resource is intended to assist states with the development of efficient and effective adult protective services programs. The guidelines note that, "while financial exploitation is one of the top areas in APS, access to forensic specialists and accountants were not available in over 60% of the states." To address this oversight, the guidelines state, "It is recommended that APS systems dedicate sufficient resources

and develop systems and protocols to allow for expert consultation from outside professions in the fields identified as most needed by APS workers, including but not limited to…finance and accounting."

Recommendation: The Department of Social Services Protective Services for the Elderly Program should contract with or hire a forensic accountant or other specialist to support social workers on financial exploitation cases. **(See Recommendation 9.)**

DSS Response: "A Forensic accountant or specialist to assist with financial exploitation would be a positive enhancement to the program and is under consideration."

Finding 10: Department of Social Services Protective Services for the Elderly Program social workers receive information for financial exploitation cases via compact discs (CD) that cannot be read in a timely manner because the regional offices do not have CD readers.

Social workers reported in interviews that they do not have access to a CD drive in their office. One social worker reported that it took several months to get access to bank statements needed for a financial exploitation case, because the bank sent the information on a CD. Other social workers reported similar experiences. Social workers currently send the CDs to the DSS Information Technology Unit and request assistance; however, this process can cause significant delays in accessing information.

Recommendation: Each Department of Social Services Protective Services for the Elderly Program regional office should have a compact disc drive. **(See Recommendation 10.)**

DSS Response: "Regional access to a compact disc drive would be a positive enhancement to the program. Implementation will be considered."

Finding 11: Department of Social Services Protective Services for the Elderly Program social workers report barriers to conducting work in the field, potentially leading to decreased efficiency and delays in service.

Completing work in the field is a growing trend in adult protective services. In their publication, "Doing More with Less: Replicable, Innovative, and Cost-Saving Measures in Adult Protective Services," the National Adult Protective Services Association recommends flexibility through the use of technology and non-traditional work environments to save time and money. PSE social workers identified barriers to conducting work in the field during interviews. They included:

- Concerns for safety and lack of consistent direction on conducting home visits in pairs;

- Inability to find an appropriate work location while in the field; and

- Need to be in the office to complete paperwork.

Social workers reported concern for their safety when visiting elders in difficult living situations. In some regional offices, social workers told us they are able to visit the elder with a coworker if they have safety concerns. In other offices, the social workers told us they are discouraged from conducting visits with a coworker and feel uncomfortable making such a request despite their safety concerns. Workers may not make timely visits with elders when they feel unsafe.

The PSE Procedure Manual states that, "Based on review of current referral, past referrals, and/or collateral information, determine whether a visit should be alone, with another DSS social worker/supervisor, or with another entity (e.g., treatment provider, family member, law enforcement)." Despite this policy, PSE workers are unclear regarding which situations they should request a joint visit.

PSE already provides social workers with laptops and cell phones. However, workers reported feeling uncomfortable using these devices while in their cars. Partnering with community resources, such as libraries, to provide workspace may enable workers to be more productive while in the field. This increased workspace flexibility would enable workers to conduct more timely face-to-face visits.

The practice of partnering with community resources is being implemented successfully in other states. For example, Florida adult protective services uses a hoteling work model to maximize efficiency, where they have formed partnerships with community resources, such as libraries, to allow safe workspace in the field. These social workers conduct much of their work in the field using laptops and cell phones and only report to the office on a weekly basis. As a result, the agency reports increased efficiency and cost savings.

PSE social workers report needing to be in the office to complete paperwork, which reduces time available to visit with elders. The social workers suggested that the creation of online, fillable forms would increase the effectiveness of working in the field. Reducing office work would enable social workers to spend more time in the field and reduce travel.

Recommendation: Department of Social Services Protective Services for the Elderly Program management should explore options to promote working in the field, including providing training and written guidance clarifying when joint visits are appropriate, strengthening community partnerships to arrange for safe workspace in the field, and streamlining processes to reduce office paperwork. **(See Recommendation 11.)**

DSS Response: "The Department will review its policy to determine if any program enhancements are warranted to align with the recommendation."

Finding 12: The number of Department of Social Services Protective Services for the Elderly Program (PSE) cases referred for legal assistance has decreased despite an increase in PSE conservatorship cases, which suggests that social workers are handling more legal matters independently. Without proper training, this could lead to decreased service quality.

Most legal matters for the PSE social work team involve filing a petition for conservatorships. The process can be complex and require talking with the elder and collateral contacts, obtaining a medical assessment, writing a petition, revising the petition based on supervisory review, filing it with the probate court, and attending a probate court hearing. The medical assessment is only valid for 45 days for probate court purposes, requiring timely completion of the process to prevent delays and avoid the need to obtain a new medical assessment.

Combining data we received from the Department of Social Services Legal Unit and PSE program shows that the number of cases in which PSE filed for conservatorship on behalf of a client increased, while the number of PSE consultations for legal assistance decreased (**Exhibit 7**). This suggests that PSE social workers are handling more legal matters independently.

Exhibit 7. Decreasing Percent of Cases with Legal Consult

Year	Cases with Legal Consult	Conservatorship Cases	Estimated % of Conservatorship Cases with Legal Consult
2017	361	339	100%
2018	315	360	88%
2019	171	369	46%

In 2016, all PSE social workers were trained on the process of filing for a conservatorship, court procedure, and testimony. New employees also received this training. Employees could review the PowerPoint slides from the training at any time. Given the trend of completing more cases with legal matters without legal assistance, PSE social workers could benefit from ongoing training in these areas to ensure they have the necessary background to promptly complete the conservatorship process, reduce revisions required on petitions, and avoid delays due to outdated medical assessments.

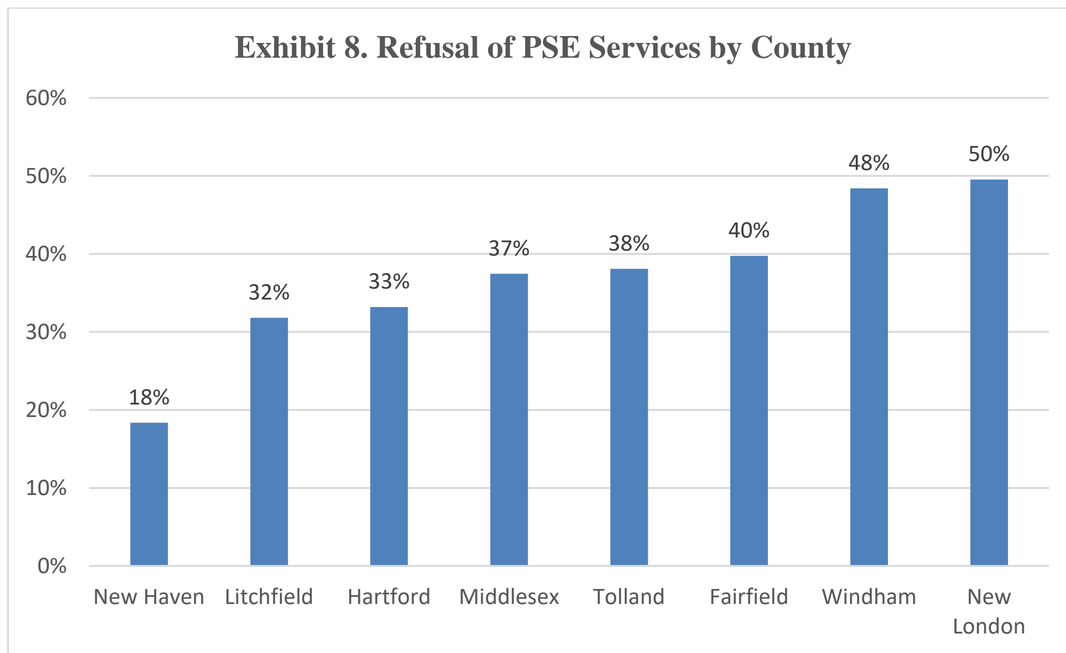
Recommendation: The Department of Social Services Protective Services for the Elderly Program should consider annual staff training on handling cases with legal matters, including conservatorship petitions. **(See Recommendation 12.)**

DSS Response: "Enhanced legal training would be a positive enhancement to the program and is currently being considered."

Finding 13: Elders refuse Department of Social Services Protective Services for the Elderly Program (PSE) services at different rates, depending on the service regions. This may be due to differences in PSE office approaches and could result in depriving elders of needed services.

The PSE electronic case management system has a closing description field in which social workers select one of 12 options to summarize why the case was closed. Of the cases in which a closing description was provided, the largest reason for case closure was elder maltreatment not being verified during the PSE investigation (40%). Elder refusal of services (33%) was the second largest category. The other ten categories each accounted for 6% or less of cases.

Elders have the right to self-determination and can refuse services. Elders may choose to refuse services for a variety of reasons. However, differences in the number of refusals by county suggest that elders may be refusing services due to differences in approaches. In New Haven County, only 18% of cases closed due to the elder refusing services. In contrast, in New London County, 50% of cases were closed due to the elder refusing services (**Exhibit 8**). PSE management suggest there may be cultural differences across the state that contribute to how elders receive the program in the various regions.



Recommendation: Department of Social Services Protective Services for the Elderly Program management should determine why some regions have higher service refusal rates and implement strategies to encourage program participation. **(See Recommendation 13.)**

DSS Response: "There are several factors that influence rates of refusal. A review of these factors and subsequent mitigation would be positive enhancement to the program."

Finding 14: The Department of Social Services Protective Services for the Elderly Program (PSE) Procedure Manual states that all cases will be closed within 90 days of intake with extensions approved by supervisors. However, some social workers informed us that they were not aware of this requirement.

The PSE Procedure Manual states that, "All PSE cases will be closed **within 90 days of receipt of referral by intake**. Extensions of this time limit must be approved by supervisor, based on compelling factors necessitating ongoing service provision." Notably, the manual does not address the documentation of extensions.

In 2019, 73% of cases were closed within 90 days of intake. PSE managers informed us that any cases open for more than 90 days would have had an extension granted. Therefore, in 2019, 27% of cases should have had extensions granted by a supervisor. In a review of ten cases open for longer than 90 days, none of the cases had documented extensions. This included two cases that were left open for longer than a year after being transferred to the Department of Disability Services.

Additionally, PSE social workers and their supervisors were unaware of the need for an extension for cases open for longer than 90 days. PSE social workers informed us that cases remained open for as long as needed to provide services. Social workers told us they were not aware of the extension process.

Recommendation: The Department of Social Services Protective Services for the Elderly Procedure Manual should include procedures for documenting case closure extensions. PSE should train its employees on the policy. **(See Recommendation 14.)**

DSS Response: "Case closure within 90 days is best practice but there are several factors that influence whether this can occur. Supervisors and managers regularly review "outliers" that exceed normal timeframes to closure. Case practice can be enhanced to document why cases exceed the 90-day timeframe."

Finding 15: Some mandated reporters question whether the Department of Social Services Protective Services for the Elderly Program (PSE) received and investigated reports of elder maltreatment, since PSE does not consistently notify them of its investigation findings.

PSE is statutorily required to provide the results of the investigation to mandated reporters within 45 days of completing the investigation. The PSE Procedure Manual requires social workers to mail mandated reporters the resulting investigation findings on form W-676. Social workers reported that they consistently sent the form for every case referred by a mandated reporter. Despite this assertion, mandated reporters we interviewed stated that they only occasionally received the forms. There appears to be a systemic issue in the follow-up process, causing some mandated reporters to question whether PSE received and investigated their referrals. One mandated reporter

told us that the level of PSE follow-up is "severely lacking" and suggested that more consistent follow-up would greatly improve PSE's relationship with the community.

PSE employees referenced incorrect address information as a potential issue contributing to the discrepancy in reporters receiving forms. Mandated reporters favor an online referral system, citing benefits such as instant confirmation of the receipt of a referral and an opportunity to provide contact information. Other strategies to increase the likelihood that follow-up communication is received include requiring intake workers to verify contact information and modify PSE policy to allow the investigation results to be emailed to mandated reporters.

Recommendation: The Department of Social Services Protective Services for the Elderly Program should consider implementing processes that would ensure follow-up communication is sent to mandated reporters, including modifying program policy to allow the investigation results to be sent electronically and verifying contact information. **(See Recommendation 15.)**

DSS Response: "There are several factors that influence follow-up communication. This modification would be a positive enhancement to the program."

Finding 16: There are currently outdated and inaccurate statutory references in the Department of Social Services Protective Services for the Elderly Program regulations.

Section 17b-461 of the Regulations of State Agencies was last updated March 6, 2015. There are currently three instances in which the regulations are no longer correct:

- Regulations state that mandatory reporters must report suspected cases of abuse, neglect, exploitation or abandonment of elderly persons to DSS within 5 calendar days. It should be changed to within 72 hours (Section 17b-461-2(a) of the regulations).
- The list of mandatory reporters currently includes residents' advocate. It should be changed to "any residents' advocate, other than a representative of the Office of the State Long-Term Care Ombudsman Program, as established under Section 17a-405, including the State Long-Term Care Ombudsman" (Section 17b-461-2(a)(1) of the regulations).
- The list of mandatory reporters omits the more recently added "any person licensed or certified as an emergency medical services provider pursuant to chapter 368d or chapter 384d, including any such emergency medical services provider who is a member of a municipal fire department" (Section 17b-461-2(a)(1) of the regulations).
  - It also incorrectly omits psychologists, any person paid for caring for a resident in a residential care home, and any staff person employed by a residential care home.

- It also incorrectly omits any person paid for caring for an elderly person by any institution, organization, agency or facility, including without limitation, any employee of a community-based services provider, senior center, home care agency, homemaker and companion agency, adult day care center, village-model community, and congregate housing facility.

Recommendation: There are outdated and inaccurate statutory references in Section 17b-461 of the Regulations of State Agencies for the Department of Social Services Protective Services for the Elderly Program which need to be updated. **(See Recommendation 16.)**

DSS Response: "An update to the regulations would be a positive enhancement to the program and is in development."

The State Long-Term Care Ombudsman Program (LTCOP)

Mandated by the Federal Older American's Act and Chapter 319h of the General Statutes, the State Long-Term Care Ombudsman Program (LTCOP) protects and promotes the rights and quality of life for residents of skilled nursing facilities, residential care homes, and managed residential care communities (also known as assisted living facilities). Located within the Connecticut Department of Aging and Disability Services, the current State Long-Term Care Ombudsman, 8 regional ombudsmen, and seven certified volunteer residents' advocates provide a voice to residents' concerns and, as importantly, empower residents to have a voice in ensuring their rights. This is accomplished through individual consultation and complaint resolution and work with other state agencies and advocacy organizations. The regional ombudsmen are each assigned to cover a portion of Connecticut and identify, investigate, and resolve complaints made by or on behalf of residents in long-term care facilities in their assigned territories. Under supervision of regional ombudsmen, the volunteer residents' advocates are assigned to one nursing home and are required to spend four hours a week at the home helping to resolve complaints and be the "eyes and ears" for the regional ombudsmen. **Exhibit 9** summarizes the efforts of the State Long-Term Care Ombudsman Program.

Exhibit 9. Efforts of the State Long-Term Care Ombudsman Program Information

Effort	2018	2017	2016	2015
Complaints Received	3423	3090	3044	2694
Cases Opened	1964	1791	1809	1635
Nursing Home Visits for Other than Complaints	38	**	**	**
Facility Visits (Nursing Home, Residential Care Homes and Assisted Living Facilities)	**	290	272/205*	290
Consultations to Individuals	363	400	960	1,096
Consultations to Facilities	340	231	235/248*	201
Training Sessions for Ombudsman Staff and Volunteers	91	91	100	118
Licensure and Certification Survey	49	51	89	93
Community Education Presentations	39	48	68/78*	116

Training to Facility Staff	1	7	12	25
Nursing Home Closures	5	4	6	2
Resident Council Meetings Attended	**	**	204	**

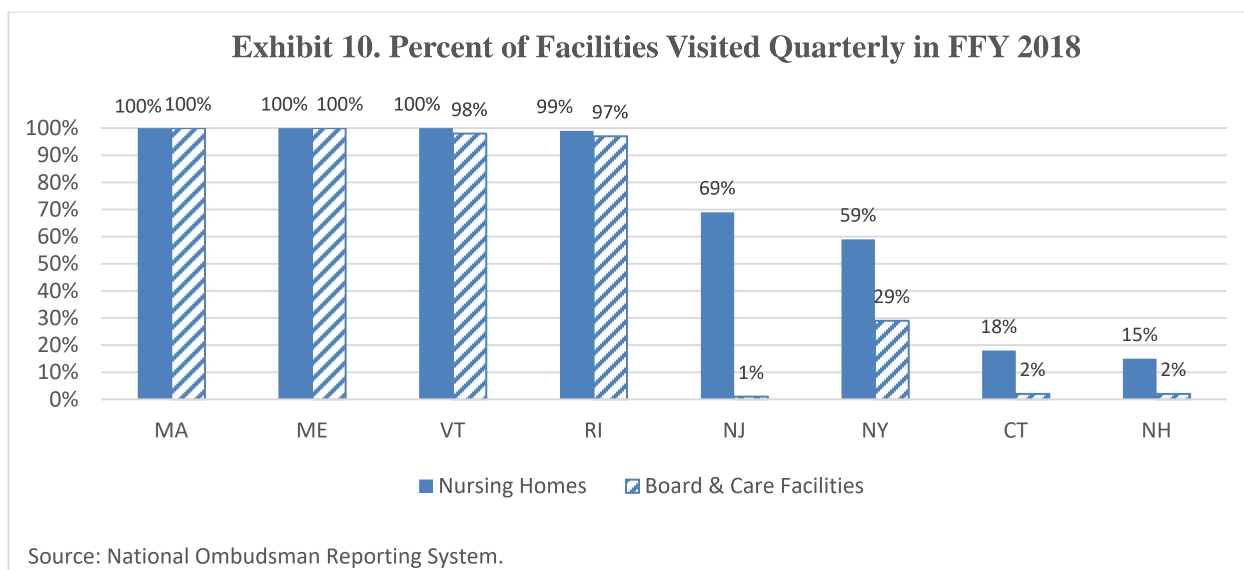
Source: 2015-2018 State Long-Term Care Ombudsman Program Annual Reports
*Different numbers listed in the annual report
** Reporting not listed

Findings and Recommendations to Improve LTCOP

Ombudsman Responsibilities

Finding 17: Although program responsibilities include regular, non-complaint related visits to nursing homes, the State Long-Term Care Ombudsman Program (LTCOP) does not specify the anticipated frequency of such visits, making expectations unclear and accountability difficult for consumers, providers, and others.

State statute and state and federal regulations require LTCOP to ensure that nursing home residents have "regular and timely access" to the program. The National Ombudsman Reporting System (NORS) defines "regular and timely access" as no less than quarterly non-complaint related visits to each facility. LTCOPs in each state submit statistics to NORS, including the number of quarterly visits to facilities (unduplicated count). **Exhibit 10** shows that 38 of Connecticut's 216 nursing homes (18%) received quarterly non-complaint related visits during the federal fiscal year ended September 30, 2018, a lower percentage than many nearby states' programs.



LTCOP does not have minimum standards (i.e., quarterly visitation requirements) in its policies and procedures or in state statutes and regulations. Without these requirements, residents, facilities, consumers, providers, and others do not have clear expectations for the frequency of

regular visits and program access. Federal guidance acknowledges that some states do not attain quarterly facility visitation and strongly encourages states to develop their own minimum standards to provide consumers, providers, and others with an expectation of the frequency of regular visits and program accountability.

Recommendation: The State Long-Term Care Ombudsman should develop a minimum standard of frequency of non-complaint visits to nursing homes and other long-term care facilities and amend section 17-408 of the General Statutes to reflect that standard. Section 17a-417 of the General Statutes should be amended to require the State Long-Term Care Ombudsman to include outcomes of meeting the visitation standard and each facility's visitation frequency in its annual report. **(See Recommendation 17.)**

LTCOP Response: "Agreed, quarterly visits are the standard and it will now be documented differently to accurately capture the visits that are happening."

Finding 18: Regional ombudsmen do not have a uniform documentation method for non-complaint facility visits, which may lead to inconsistent assessments and reporting.

Through several interviews with regional ombudsmen, we found that there is variability in performing and documenting complaint and non-complaint facility visits. While the LTCOP residents' advocates use a checklist for monthly facility visits, regional ombudsmen do not use checklists.

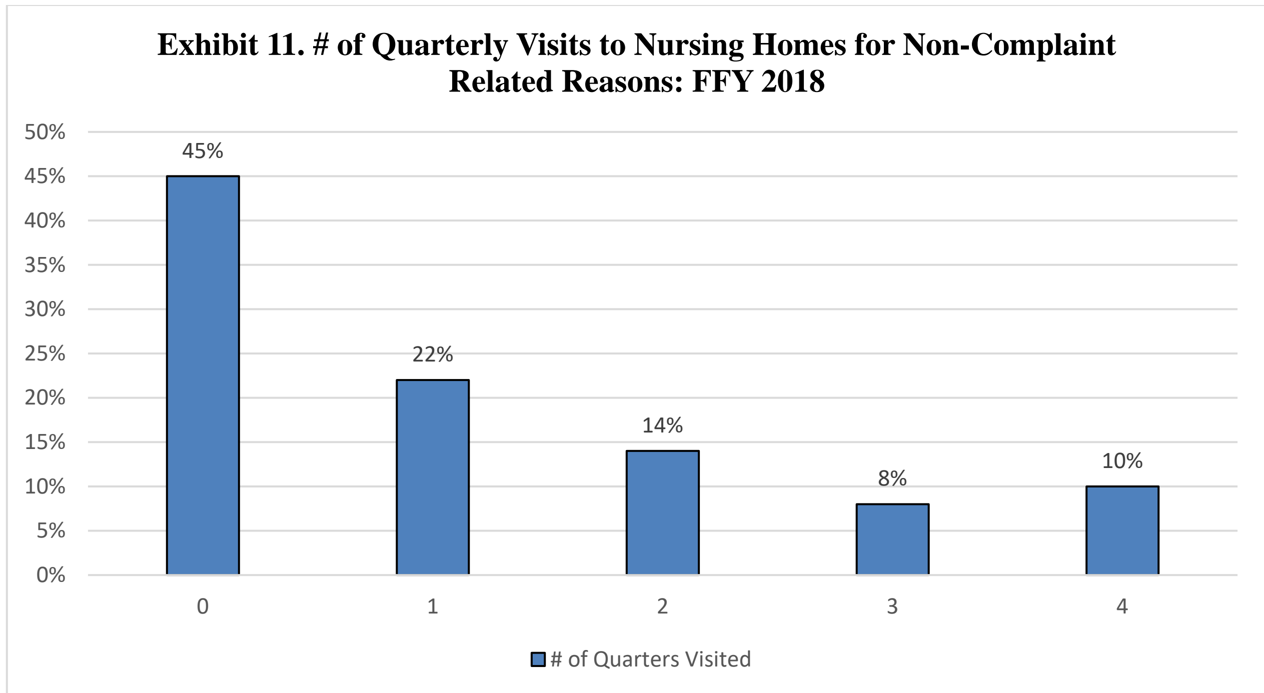
Long-Term Care Ombudsman programs in Iowa and Idaho use standardized checklists for facility visits. Use of standardized checklists ensures that all non-complaint visits are reviewed for the same items and the results are documented consistently.

Recommendation: The State Long-Term Care Ombudsman should develop and use a checklist for documenting non-complaint visits to long-term care facilities. **(See Recommendation 18.)**

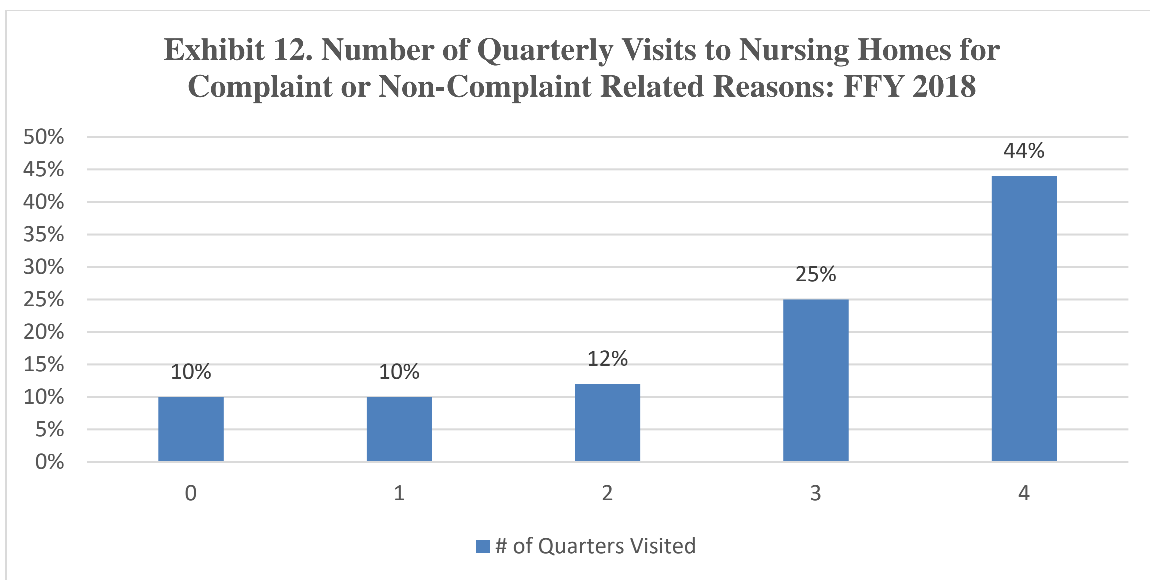
LTCOP Response: "Agreed and implemented form one of the Regional Ombudsman (RO) had been using, now all RO's will use it and document concerns."

Finding 19: While visiting a nursing home because of a complaint, some state Long-Term Care Ombudsman programs expand their visit to assess non-complaint related areas. Similarly, the Connecticut program appears to conduct a broader assessment during a complaint visit but does not document the non-complaint related aspects of the visit, leading to an underreporting of such visits.

Using the National Ombudsman Reporting System definition of "regular and timely access" to long-term care facilities as at least quarterly non-complaint related visits, we found that most Connecticut nursing homes are not visited quarterly (**Exhibit 11**).



Idaho, Missouri, Massachusetts, and other states allow facility visits in response to a complaint to count as a quarterly non-complaint visit. In a sample review of Connecticut LTCOP case files, we often found that, when ombudsmen conduct a complaint-related visit, they are also checking the same areas they would during a non-complaint visit (i.e., LTCOP postings, safety, and cleanliness). Because ombudsmen appear to check for broader issues during a complaint visit, an argument could be made that complaint visits could also be counted as non-complaint visits. **Exhibit 12** shows the increased number of quarters nursing homes are deemed visited for non-complaints by LTCOP personnel when complaint and non-complaint visits are combined.



Recommendation: The State Long-Term Care Ombudsman should consider assessing and reporting on non-complaint related areas while conducting complaint related visits to nursing homes. **(See Recommendation 19.)**

LTCOP Response: "Agreed, this is currently done, but have trained staff to now document these findings as non-complaint when appropriate."

Finding 20: The State Long-Term Care Ombudsman Program is required to report the number of annual facility inspections (surveys) their personnel participated in with the Department of Public Health Facility Licensing and Investigations Section (FLIS). However, we found participation was not consistently documented, leading to an undercounting of this required activity.

Department of Public Health Facility Licensing and Investigations Section (FLIS) personnel must contact the State Long-Term Care Ombudsman Program to discuss the nature of long-term care facility complaints prior to the LTCOP annual inspection (referred to as a "survey") or during a separate complaint investigation. According to the Administration for Community Living (ACL), all state LTCOPs are required to report the number of facility surveys in which their personnel participated. This participation includes any aspect of complaint investigation or annual surveys, including but not limited to, pre-survey briefing, sharing complaint summary reports, informal dispute resolution, and participation in exit interviews. In fiscal year 2020, ACL began requiring LTCOPs to report facility survey participation by the nursing facility and residential care community.

In federal fiscal year 2018, 216 nursing homes required annual surveys, and 112 complaints required on-site investigations within two to ten days. We reviewed LTCOP information on "participation in facility surveys" and found LTCOP reported participation in just 62 FLIS long-term care facility surveys.

In interviews with regional ombudsmen, we were told that Facility Licensing and Investigations Section surveyors may contact them before or at the beginning of their process to ask whether there are any issues or concerns. The ombudsmen may also suggest that residents interview as part of their survey process (including residents with complaints). FLIS surveyors told us that regional ombudsmen are always invited to participate in exit surveys to discuss deficiencies identified during the process. The regional ombudsmen also told us that they did not consistently document their participation in facility surveys, including communication with FLIS before and during the survey. They consistently documented their participation in the exit survey.

Recommendation: The State Long-Term Care Ombudsman should clarify documentation requirements in its policy manual regarding its participation in Department of Public Health Facility Licensing and Investigations Section complaint investigations or annual surveys. LTCOP should train regional ombudsmen on its new policy. **(See Recommendation 20.)**

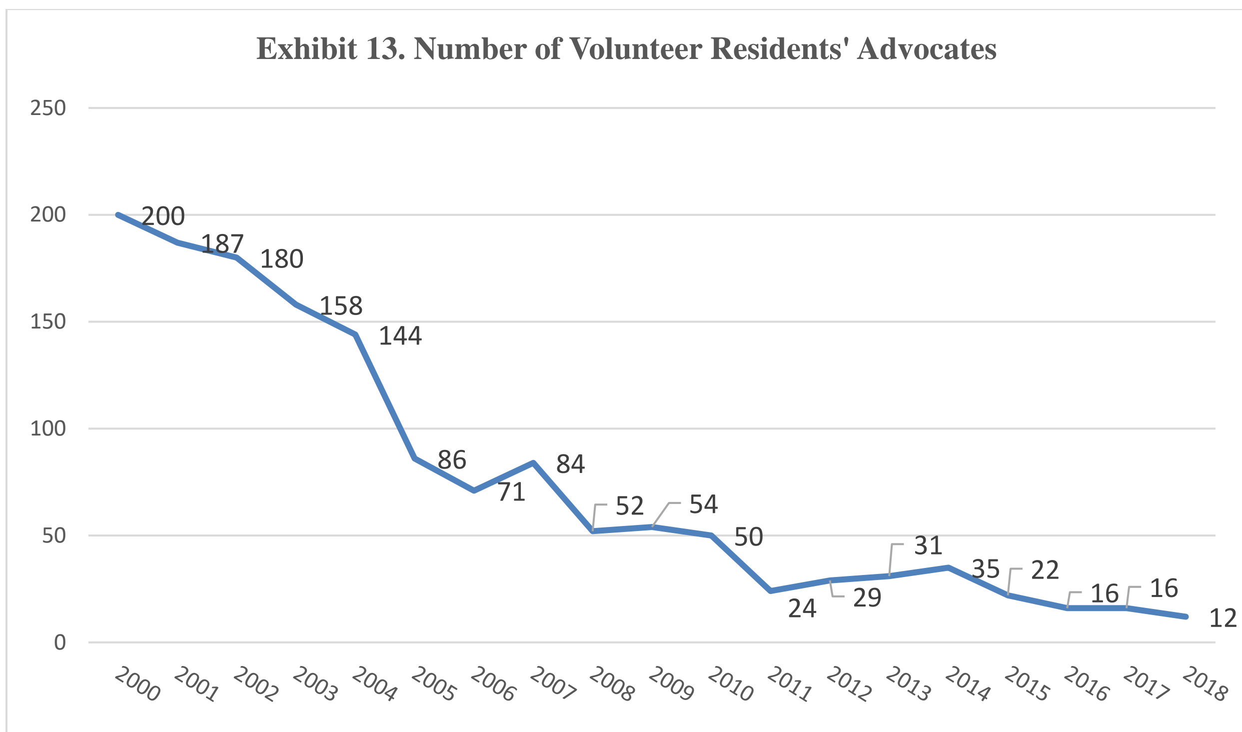
LTCOP Response: "Agreed, policy manual will be updated. Participation is subject to timely notification by the survey team and Regional staff will participate as often

as able to. RO's have all been reeducated on proper documentation of survey participation."

Volunteer Residents' Advocates

Finding 21: There has been a steep decline in the number of volunteer residents' advocates, potentially impacting protective services3 and advocacy for nursing home residents.

The number of volunteer residents' advocates (RAs) has declined precipitously from 2000 through 2018 (**Exhibit 13**). Members of the General assembly have introduced legislation to create a plan to increase recruitment and retention of volunteers.



There are challenges in recruiting and retaining volunteer residents' advocates due to time constraints, volunteers aging, lack of appreciation, and family responsibilities. LTCOP took appropriate steps to identify and understand reasons for the decline in volunteers, such as surveying current or previous RAs and conducting formal exit interviews. Many who go through the RA training program leave after their job shadowing experience because they find it was not what they expected. LTCOP had previous success recruiting volunteers from presentations at senior centers and using a virtual platform.

Other states, such as Massachusetts, successfully recruit and retain RAs. The Massachusetts LTCOP has over 296 volunteers, with their recruitment and retention attributed in part to agreements with local agencies on aging who use professional recruiters to attract and retain

volunteers. Recruits undergo an extensive screening process to ensure they will be a good fit with the program.

Recommendation: The State Long-Term Care Ombudsman should identify the reasons for the decline in the number of volunteer residents' advocates and develop a plan to increase recruitment and retention of volunteers. LTCOP should include a progress report on plan implementation in its annual report. **(See Recommendation 21.)**

LTCOP Response: "Partially Agree, State Ombudsman had started new recruitment strategies in the fall of 2018, but the pandemic impacted continued implementation. The Ombudsman is already seeing recruitment improvement now that the program is returning to the strategy."

Finding 22: The State Long-Term Care Ombudsman Program does not allow people to become volunteer residents' advocates if they have family members living in any Connecticut nursing home, reducing the pool of potential volunteers.

Through several interviews, we were told that individuals with family members or loved ones residing in Connecticut long-term care facilities are not permitted to participate in the Volunteer Residents' Advocate program. LTCOP believes this restriction is a federal rule, but we read the Code of Federal Regulations and consulted with the federal Administration for Community Living and found that "having a family member in a LTC facility does not prohibit a person from volunteering to be a designated representative of the Office (VRA/certified) rather, that individual cannot provide Ombudsman services at the facility where their loved one resides." Clarifying that there is no federal restriction and allowing individuals with family members in nursing homes to become volunteer residents' advocates would expand the pool of potential volunteers.

Recommendation: Applicants with family members residing in Connecticut nursing homes should be considered- for State Long-Term Care Ombudsman Program volunteer residents' advocate positions, provided the volunteer is not placed in the same facility as the family member. **(See Recommendation 22.)**

LTCOP Response: "Agreed, change already made and have put this out as part of our volunteer recruitment."

Administrative

Finding 23: The State Long-Term Care Ombudsman Program (LTCOP) voicemail system does not instruct after-hours callers to contact 9-1-1 in case of emergency or 2-1-1 United Way Infoline to speak with someone immediately for urgent matters. This could lead to potential delays for elders in need of emergency assistance or human contact for urgent matters.

LTCOP does not answer calls or check voicemails after regular business hours or on weekends. Callers may leave a message on the program's voicemail, and staff will then check it on the next business day. The ombudsman informed us that the voicemail is not for emergencies; however, the voicemail message does not instruct callers to dial 9-1-1 in case of emergency, or to call 2-1-1 (United Way Infoline) for urgent matters. In contrast, the DSS Protective Services for the Elderly Program answering system instructs callers to call 9-1-1 in case of emergency.

Connecticut 2-1-1 personnel informed us of the after-hours protocols for the DSS Protective Services for the Elderly Program and DPH Facility Licensing and Investigations Section. Establishing a similar protocol for the LTCOP would be more responsive to callers and would guide them to speak with someone immediately for urgent matters. Although the LTCOP stated that instructing people to call 2-1-1 could create confidentiality concerns, 2-1-1 successfully handles sensitive calls for numerous state agency programs, including the Department of Children and Families.

Recommendation: The State Long-Term Care Ombudsman Program should change its after-hours voicemail system to instruct callers to dial 9-1-1 for emergencies and 2-1-1 to speak with a person immediately regarding urgent matters. **(See Recommendation 23.)**

LTCOP Response: "Agreed and done."

Finding 24: The postings at long-term care facilities notifying residents and relatives to contact the State Long-Term Care Ombudsman Program for complaints are in English. The information is not available in Spanish, potentially depriving some residents and relatives of this information and access to the State Long-Term Care Ombudsman Program.

There are postings in nursing homes and other long-term care facilities about how to reach the State Long-Term Care Ombudsman Program. The postings are currently in English. Translating the posting into Spanish or other frequently spoken languages in the region would make the information more accessible to all residents and their relatives. At least one of the regional ombudsmen is fluent in Spanish and would be able to receive complaints in this language.

Recommendation: The State Long-Term Care Ombudsman Program should post contact information for residents and their relatives in English, Spanish, and other frequently spoken languages in the region. **(See Recommendation 24.)**

LTCOP Response: "Agreed, will get new postings out to all SNF."

Finding 25: The State Long-Term Care Ombudsman Program Annual Report excludes information necessary to understand the number of volunteers and types of elder maltreatment complaints received from Connecticut long-term care facilities.

We reviewed the 2015 through 2018 State Long-Term Care Ombudsman Program (LTCOP) Annual Reports and found the number of volunteer Residents' Advocates (RAs) and other program

volunteers is excluded even though the State Ombudsman collects this information. The 2018 LTCOP Annual Report states that the program has a historically low number of RAs. With people working later in life or choosing to leave the state once they retire, the pool of volunteers has greatly diminished.

The LTCOP Annual Report contains general information about the types of complaints the office received. For example, the 2018 LTCOP Annual Report describes the incidence of complaints in major categories in sentences:

> Of the 3,423 complaints received in 2018, the highest category of complaints was related to "Residents' Rights." This category received 1,348 complaints with the majority of the complaints, 495, being in the subcategory "Admission, Transfer, Discharge, Eviction."
>
> There has been an increase in this type of complaint nationally, however in Connecticut we saw a 4.81% decrease from 2017-2018.

A better understanding of complaints, however, could be gained by providing more detailed information using tables and graphs as illustrated in **Exhibits 14** and **15**.

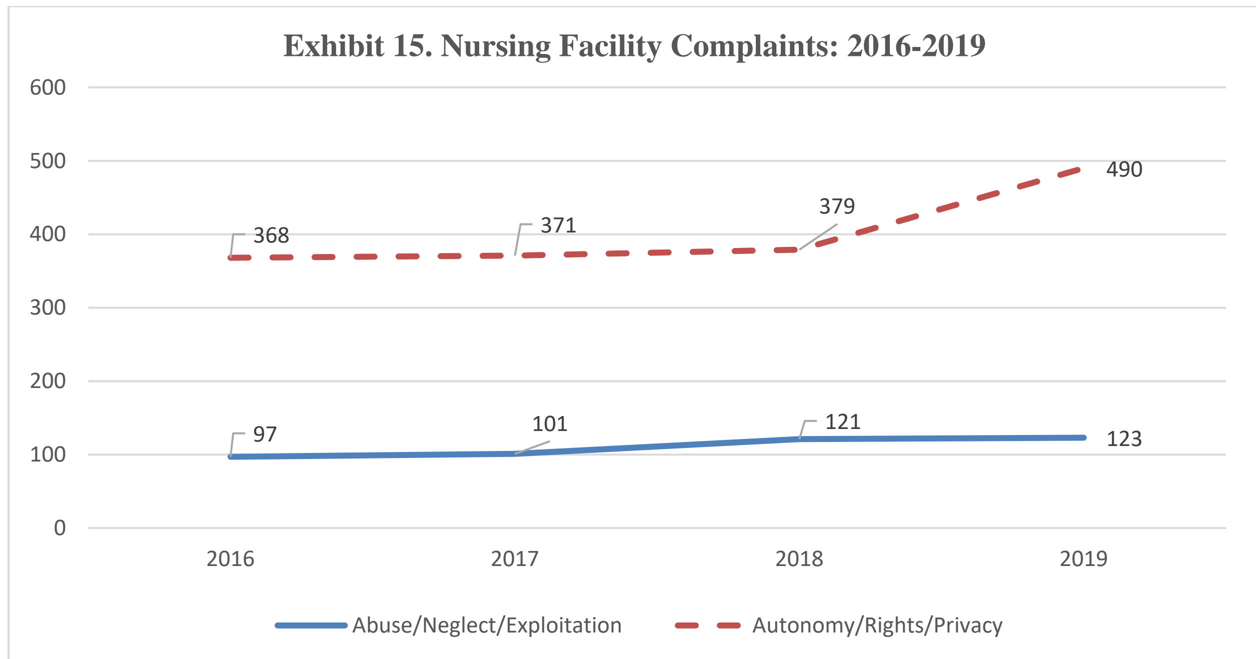
Exhibit 14 shows the more detailed categories and number of complaints from Connecticut nursing facilities provided by the National Ombudsman Reporting System (NORS) database submitted by the LTCOP.

Exhibit 14. 2018 CT Nursing Facility Complaints Reported to National Ombudsman Reporting System

Type of Complaint	# of complaints
Residents' Rights	
A. Abuse, Gross Neglect, Exploitation	121
B. Access to Information by Resident or Resident's Representative	148
C. Admission, Transfer, Discharge, Eviction	469
D. Autonomy, Choice, Preference, Exercise of Rights, Privacy	379
E. Financial, Property (Except for Financial Exploitation)	166
Subtotal	1,283
Resident Care	
F. Care	875
G. Rehabilitation or Maintenance of Function	177
H. Restraints – Chemical and Physical	6
Subtotal	1,058
Quality of Life	
I. Activities and Social Services	123
J. Dietary	215
K. Environment	215
Subtotal	553
Administration	
L. Policies, Procedures, Attitudes, Resources	57

M. Staffing	135
Subtotal	192
Not Against Facility	
N. Certification/ Licensing Agency	4
O. State Medicaid Agency	69
P. System/ Others	128
Subtotal	201
Total	**3,287**

Exhibit 15 shows trends for specific residents' rights types of nursing facility complaints.



Recommendation: The State Long-Term Care Ombudsman Program Annual Report should include the number of its program volunteers and more detailed complaint information using tables and graphs. **(See Recommendation 25.)**

LTCOP Response: "Partially agree, volunteers are important, but unsure if tables and graphs tell the story of the program."

Finding 26: The State Long-Term Care Ombudsman Program last issued its policies and procedures manual in 2002, making it outdated for employees and volunteers relying on it to perform their duties and responsibilities.

The State Long-Term Care Ombudsman is required to prepare a statewide operational policies and procedures manual. The ombudsman told us that it is updating the policies and procedures manual, which was last updated in 2002, and some of the processes and rules have changed. We subsequently received a draft policies and procedures manual dated March 2020.

Employees and volunteers need an updated policies and procedures manual. LTCOP must regularly incorporate changes to federal and state requirements and other efforts to improve program efficiency and effectiveness into the policies and procedures.

Recommendation: The State Long-Term Care Ombudsman should regularly review its policies and procedures manual and make necessary updates to reflect changes in state and federal policy or efforts to improve the program's efficiency and effectiveness. LTCOP should post the manual on its website and distribute it to every program employee and volunteer. **(See Recommendation 26.)**

LTCOP Response: "Agree, the manual should be updated and distributed."

Finding 27: The Office of the State Long-Term Care Ombudsman's regulations contain outdated statutory references, making them inaccurate.

Section 17b-411 of the Regulations of State Agencies (RCSA) was last updated November 2, 2015. Due to the renumbering of sections in Chapter 319h (Protection of the Elderly), there are nine instances of incorrect statutory references in the regulations:

- Definition of "Applicant" currently refers to Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- Definition of "Long-term care facility" currently refers to Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- Definition of "Office" currently refers to Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- Definition of "Program" currently refers to Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- Definition of "Resident" currently refers to Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- "Appointment of the State Ombudsman" currently refers to the requirements of Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- "Statewide reporting system requirements" currently refers to Section 17b-413 of the General Statutes. It should be changed to Section 17a-418.
- "State Long-Term Care Ombudsman Program independence" currently refers to the requirements of Section 17b-400 of the General Statutes. It should be changed to Section 17a-405.
- "Duties of Volunteer Residents' Advocates" currently refers to Section 17-406 of the General Statutes. It should be changed to Section 17a-411.

Recommendation: The Office of the State Long-Term Care Ombudsman Program should update statutory references in Section 17b-411 of the Regulations of State Agencies. **(See Recommendation 27.)**

LTCOP Response: "Agreed and in process of updating."

Department of Public Health Facility Licensing and Investigations Section (FLIS)

The Department of Public Health Facility Licensing and Investigations Section (FLIS) is the primary unit that identifies and intervenes to provide protective services for the elderly. FLIS has regulatory oversight of nursing homes and other licensed healthcare entities in Connecticut. In addition to annual onsite inspections (referred to as "surveys"), FLIS also receives and processes complaints about treatment or services received by nursing home and assisted living residents, some of which may pertain to elder abuse or neglect.

The Centers for Medicare and Medicaid Services (CMS) provides states with guidelines for conducting these complaint investigations. FLIS surveyors/investigators are also certified using a Surveyor Minimum Qualifications Test (SMQT) through CMS that requires proficiency in complaint investigation guidelines found in Chapter 5 of the CMS State Operations Manual.

Complaints are triaged into priority levels:

- **Immediate Jeopardy (IJ)** – This is the most serious priority level and is assigned to situations in which the provider's noncompliance with one or more requirements has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.
- **Non-Immediate Jeopardy High (Non-IJ High)** – This second priority level is assigned to complaints (when the provider's noncompliance may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and are of such consequence to the person's wellbeing that a rapid response by the DPH FLIS is indicated (e.g., verbal abuse, inappropriate use of physical or chemical restraint resulting in serious injury, if it is clear that this is not an ongoing situation).
- **Non-Immediate Jeopardy Medium (non-IJ Medium)** – This frequently used third priority level is assigned when the complaint alleges harm that is of limited consequence and does not significantly impair the person's mental, physical, and/or psychosocial status to function (e.g., cold food, lost items, problems with odors).
- **Non-Immediate Jeopardy Low (non-IJ-Low) –** This rarely used priority level four complaint (non-IJ-low) is given when the complaint alleges noncompliance with one or more requirements or conditions that may have caused physical, mental, and/or psychosocial discomfort, but not injury or damage (e.g., housekeeping complaints, medication errors in which no adverse consequences occurred).

Exhibit 16 shows when investigations must begin for each of the priority levels.

Exhibit 16. Required Timeframes for Investigating Complaints	
Priority Level	**Onsite nursing home investigation must begin within:**
Priority 1: Immediate Jeopardy (IJ)	2 business days of receipt
Priority 2: Non-IJ High	10 business days of prioritization
Priority 3: Non-IJ Medium	45 business days of receipt
Priority 4: Non-IJ Low	Must investigate during next (annual) onsite survey

Procedure for processing complaints received by FLIS

Exhibit 17 shows a 24.9% increase in the number of long-term care complaints received by FLIS from 2017 to 2019, and a 47.7% increase in the number of long-term care complaints investigated. In addition, the number of investigations required to begin within two (IJ) or ten (non-IJ High) days of receipt of complaint increased from 40 in 2017 to 115 in 2019.

Exhibit 17. Long-Term Care[1] Complaints and Incidents						
Complaints/Incidents	**2017**		**2018**		**2019**	
Complaints	#	%	#	%	#	%
# IJ	10	1.5%	9	1.2%	16	2.0%
# Non-IJ High	30	4.6%	67	8.8%	99	12.2%
# Non-IJ Medium	422	64.9%	498	65.6%	560	68.9%
# Non-IJ Low	1	0.2%	1	0.1%	9	1.1%
# not investigated by FLIS	187	28.8%	184	24.2%	128	15.8%
Total # of Complaints	**650**	**100%**	**759**	**100%**	**812**	**100%**
Incidents						
# IJ	8	3.8%	8	2.8%	10	3.4%
# Non-IJ High	28	13.3%	42	14.5%	50	16.8%
# Non-IJ Medium	159	75.7%	192	66.2%	206	69.4%
# Non-IJ Low	0	0.0%	1	0.3%	0	0.0%
# not investigated by FLIS	15	7.1%	47	16.2%	31	10.4%
Total # of Incidents	**210**	**100%**	**290**	**100%**	**297**	**100%**

[1]Includes complaints primarily from nursing homes, assisted living service agencies, home health care agencies, and residential care facilities.

Exhibit 18 shows quality of care/treatment as the most frequent type of non-IJ medium priority complaint.

Exhibit 18. Non-IJ Medium Priority Complaints for Residents in Long-Term Care Facilities

Allegation Category	**2017**	**2018**	**2019**
Quality of Care/Treatment	294 (70%)	325 (65%)	381 (68%)
Accidents	29 (7%)	31 (6%)	22 (4%)
Resident Abuse	17 (4%)	12 (2%)	11 (2%)
Resident Rights	15 (3%)	18 (4%)	15 (3%)
Resident Neglect	9 (2%)	16 (3%)	5 (1%)
Other	58 (14%)	96 (19%)	126 (22%)
Total	**422 (100%)**	**498 (99%)***	**560 (100%)**

***Due to rounding, percent does not total 100%**

The duration of a complete investigation can vary significantly due to extenuating circumstances, including the number of allegations, priority allegations, and staffing limitations. Generally, our office concluded that 180 days is an appropriate benchmark for FLIS to determine whether the allegations are substantiated.

Findings and Recommendations to Improve FLIS

Finding 28: The Department of Public Health's website incorrectly states the number of days mandated reporters must contact DSS when they have reasonable cause to suspect abuse, neglect, exploitation, or abandonment of an older adult. This may lead to a longer period an elder is in danger.

The DPH website has a section on "Mandatory Reporters of Abuse, Neglect, Exploitation, and Impaired Practitioners." There are links to click on "Residents of Long-Term Care Facilities" and "The Elderly." In both sections, the website incorrectly reports that mandated reporters have five calendar days to report suspected elder abuse to DSS. Public Act 03-267 amended Section 17b-451 (a) of the General Statutes to require that the report be made "not later than seventy-two hours after such suspicion or belief arose." Other organizations rely on accurate information so they can inform the public of how to comply with the statute. The same incorrect information was recently publicized on the 2-1-1 statewide information line.

Recommendation: The Department of Public Health should update its website to reflect that mandated reporters have 72 hours to report suspected elder abuse, neglect, exploitation, and abandonment to the Department of Social Services. **(See Recommendation 28.)**

DPH Response: "The CT Department of Public Health website currently maintains a webpage that addresses mandatory reporting requirements. Please see the link below.

https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/PLIS/Mandatory-Reporters-of-Abuse-Neglect-Exploitation-and-Impaired-Practitioners"

Finding 29: The Department of Public Health Facility Licensing and Investigations Section (FLIS) did not send or did not promptly send acknowledgment letters to complainants 54% of the time in 2019 in violation of its complaint policy, creating potential uncertainty among complainants.

The FLIS complaint investigation policy states that, upon receipt of a complaint, the department must send the complainant an acknowledgment letter within four working days (business days) of receipt of the complaint.

As part of an internal audit process, FLIS tracked and reported on 57 complaints received during January through December 2019, two of which were submitted anonymously. **Exhibit 19** shows that FLIS did not send or did not promptly send acknowledgment letters within four working days to 30 (55%) of the remaining 55 complainants.

Exhibit 19. Number of Acknowledgment Letters Sent to Complainants in 2019		
	Number	**Percent**
Letter sent within 4 working days	22	40%
Reported as letter sent on time, but date letter sent missing	3	5%
Letter sent later than 4 working days	25	46%
Letter not sent	5	9%
Total	**55**	**100%**

Recommendation: The Department of Public Health Facility Licensing and Investigations Section should send acknowledgment letters to complainants within four working days as required by its complaint policy. **(See Recommendation 29.)**

DPH Response: "The Department agrees with this finding. The Facility Licensing and Investigations Section (FLIS) conducted audits and identified deviations from the complaint policy. Emails were sent to staff May – August 2020 to correct the issue and staff were re-educated on the Department's complaint policy."

Finding 30: The January 2019 Department of Public Health Facility Licensing and Investigations Section (FLIS) Complaint Policy does not specify a timeframe to begin investigation of non-immediate jeopardy medium priority level complaints, making it unclear that FLIS chose to require investigations to begin within 45 business days.

Chapter 5 of the CMS State Operations Manual states that non-immediate jeopardy medium (Priority 3) level complaint investigations must be scheduled but does not specify when the investigation must begin. In contrast, the FLIS July 2009 complaint policy has a stricter guideline that requires investigations for non-immediate jeopardy medium level complaints to begin within 45 days. FLIS confirmed that it intends to begin non-immediate jeopardy medium level complaints within 45 days. Adding this requirement to the January 2019 FLIS complaint policy will make clear that FLIS requires investigations of non-immediate jeopardy medium level complaints to begin within 45 days.

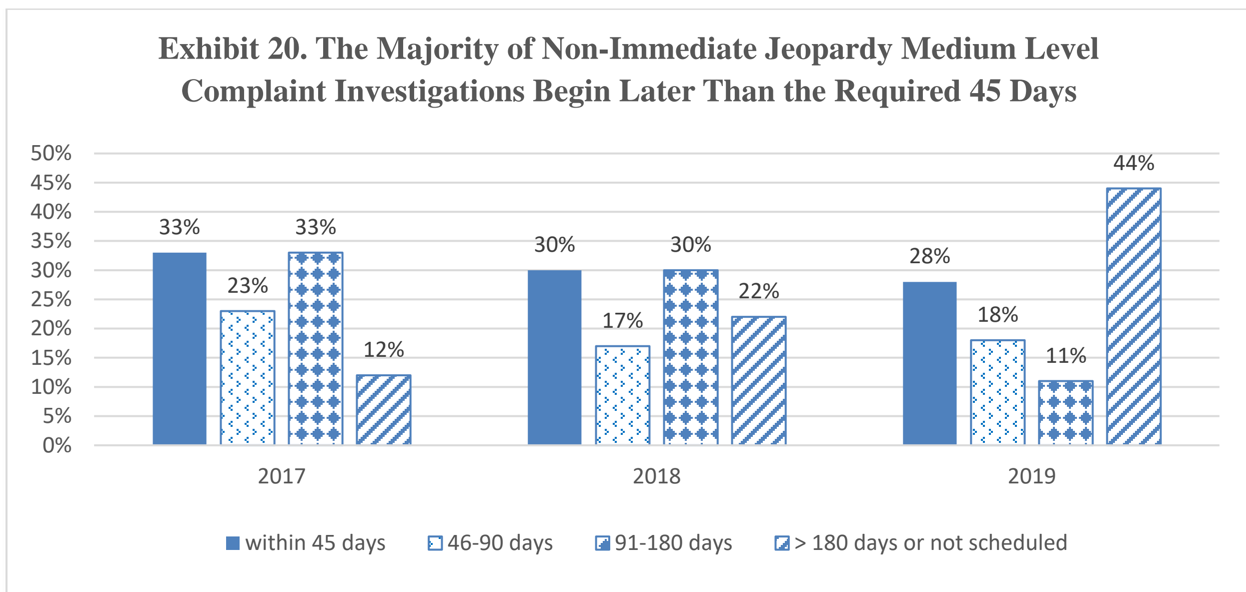
Recommendation: The Department of Public Health Facility Licensing and Investigations Section should update its complaint policy to require investigations of non-immediate jeopardy medium level complaints to begin within 45 business days of receipt of the complaint. **(See Recommendation 30.)**

DPH Response: "The Department agrees with this finding. The FLIS complaint policy identified the Centers for Medicare and Medicaid Services link to Chapter 5 of the State Operations Manual (SOM) to assign maximum triage timeframes to investigate complaints. The policy has since been revised to include that investigations triaged as a non-immediate jeopardy medium

level will be investigated within 45 business days since this triage level is not specific in Chapter 5 of the SOM."

Finding 31: The Department of Public Health Facility Licensing and Investigations Section (FLIS) begins most non-immediate jeopardy medium level complaint investigations after 45 days, making them untimely according to its standard and potentially delaying needed assistance for elders.

FLIS requires investigation of non-immediate jeopardy medium level complaints to begin within 45 business days of complaint receipt. FLIS met this requirement 33%, 30% and 28% of the time during 2017, 2018, and 2019, respectively (**Exhibit 20**). This could delay the correction of deficiencies and needed assistance for elders residing in nursing homes and other long-term care facilities.



Recommendation: The Department of Public Health Facility Licensing and Investigations Section should begin investigation of its non-immediate jeopardy medium level complaints within 45 days. **(See Recommendation 31.)**

DPH Response: "All FLIS surveyors/investigators are certified utilizing a Surveyor Minimum Qualifications Test ("SMQT") through the Centers for Medicare and Medicaid Services ("CMS") and as a continuum of such SMQT certification, are trained regarding Chapter 5 prior to demonstrating competency with investigations of healthcare institution complaints. Currently, there are 7 Nurse Consultant and 3 Supervising Nurse Consultant vacancies which make it difficult to adhere to the designated timeframes for investigation. This will be addressed as soon as we get more staff. There were numerous staff vacancies during the audit period. In federal fiscal year 2018 there were 1,721 total complaints submitted to the Department compared to 1,452 in federal fiscal year 2017, and 1,510 in

federal fiscal year 2016 which demonstrates a significant increase in complaints received by the Department. Staff will be re-educated on the complaint policy and timeframes for investigation during out next staff meeting."

Finding 32: There is no uniform template and automated system for Department of Public Health Facility Licensing and Investigations Section (FLIS) surveyors to request police, emergency medical services, hospital, and other reports needed to investigate alleged elder maltreatment. This delays the completion of complaint investigations and needed assistance to elders.

As part of their complaint investigation, FLIS surveyors often need reports from emergency medical services, police, hospitals, and other entities. Each organization has unique requirements to handle report requests, and it is up to the individual surveyor to make these requests. Developing an automatic and uniform process to make these requests would save surveyors time and provide any needed assistance to elders more quickly.

Recommendation: The Department of Public Health should consider developing an automatic and uniform process to request police, emergency medical services, hospital, and other reports necessary to investigate alleged elder maltreatment. **(See Recommendation 32.)**

DPH Response: "FLIS requests any pertinent reports relative to the investigation or information needed for decision making during an investigation and/or to make a referral. Sometimes a report is available in the patient's medical record and therefore may not need to be requested. Additionally, there are memo templates on state letterhead in our letter management system to request documents or reports needed to investigate elder maltreatment."

Finding 33: The Department of Public Health Office of Injury Prevention is not meeting all of its statutory obligations in providing awareness and education on elder abuse, potentially eliminating an effective means of reducing this abuse.

In addition to the DPH Facility Licensing and Investigations Section, DPH also has an Office of Injury Prevention. Statutorily, the purpose of the Office of Injury Prevention is to coordinate and expand prevention and control activities related to intentional and unintentional injuries. The office is required to develop collaborative relationships with other state agencies and private and community organizations to establish programs promoting injury prevention, awareness, and education to reduce automobile, motorcycle, and bicycle injuries; and interpersonal violence, including homicide, child abuse, youth violence, domestic violence, sexual assault and elderly abuse (Section 19a-4i(3) of the General Statutes). **Exhibit 21** shows how the Office of Injury Prevention is meeting each of the statutory requirements. Providing awareness and education to reduce elder abuse is the only requirement that the office is not meeting.

Exhibit 21. How Office of Injury Prevention Statutory Requirements are Met

Office of Injury Prevention Requirement	Resource Reference
Programs promoting injury prevention	Injury Prevention Fact Sheets
Awareness and education to reduce automobile, motorcycle and bicycle injuries	Traffic and Motor Vehicle Accident Prevention Program
Awareness and education to reduce homicide	Violence and Homicide Prevention Program
Awareness and education to reduce child abuse	Resources and link to Child Sexual Abuse
Awareness and education to reduce youth violence	Youth Violence Prevention Program
Awareness and education to reduce domestic violence	Resources and link to Violence Against Women
Awareness and education to reduce sexual assault	Sexual Violence Prevention Program
Awareness and education to reduce elderly abuse	No Information

Office of Injury Prevention staff told us that it does not conduct activities specifically aimed at elder abuse prevention. The office is primarily federally funded, and current programs and initiatives focus on the following topics:

- CT Violent Death Reporting System (surveillance)
- Fall Prevention
- Opioid and Drug Overdose Prevention Program (and surveillance)
- Sexual Violence Prevention Program
- Suicide and Self-Directed Violence Prevention
- Traffic Safety – (motor vehicle/car seat safety)

The Coalition for Elder Justice in Connecticut, State Long-Term Care Ombudsman Program, and other websites have information that promote awareness and education to reduce abuse of the elderly. Sharing links to such resources would provide increased awareness and education aimed at reducing elder abuse.

Recommendation: The Department of Public Health Office of Injury Prevention website should include existing resources and links related to elder maltreatment awareness and education to reduce elder maltreatment. **(See Recommendation 33.)**

DPH Response: "The Department agrees with this finding. This will be addressed by the OIP as soon as staff complete their research on existing resources on elder maltreatment awareness and education available through other state agencies' web sites, including DSS's Protective Services for the Elderly, the Long-Term Care Ombudsman Program, and the Department of Aging

and Disability Services, as well as United Way/2-1-1. The Department will include links to this information on the DPH OIP web page:

https://portal.ct.gov/DPH/Health-Education-Management-Surveillance/The-Office-of-Injury-Prevention/Office-of-Injury-Prevention, by October 1, 2021."

SYSTEMIC CHANGES TO REDUCE THE RISK OF ELDER MALTREATMENT

During our audit work, we developed the following findings and recommendations to potentially reduce the risk of elder maltreatment through systemic changes to background checks, mandated reporters, mandatory training, and coordination and communication across agencies.

Background Checks

Finding 34: The Abuse Registry Repository housed on the Commission on Women, Children, Seniors, Equity & Opportunity website was used six times from July 2019 through July 2020, indicating a lack of regular use during this time period.

Public Act 19-116 required the Commission on Women, Children, Seniors, Equity & Opportunity to provide a registry repository on its website with links to publicly available background databases. The following databases are intended to give information to people hiring providers to care for adults aged 60 and older, children, or individuals with disabilities:

- U.S. Department of Justice's sex offender public website
- Connecticut sex offender registry
- U.S. Department of Health and Human Services Office of the Inspector General's list of individuals and entities excluded from participating in federally funded health care programs for reasons such as Medicare or Medicaid fraud
- Department of Public Health's nurse's aide registry
- Judicial Branch's criminal and motor vehicle conviction database
- Department of Public Health's professional licensure verification database
- Department of Social Services' (DSS) database of practitioners and entities suspended or excluded from participating in DSS-administered programs

The registry repository is provided on the commission's website. The act also required the creation of a working group to develop strategies to raise public awareness of these databases among people hiring providers to care for adults aged 60 and older, children, or individuals with disabilities. The act further required the commission to keep records on the number of times the portal was used and report this information to the Connecticut General Assembly Committees on Aging, Children, Human Services, and Public Health by January 1, 2021.

The commission provided us with data that indicated the portal was visited 149 times from July 2019 through July 2020. Of those 149 visits, 81% closed the page outright and did not pursue information while six visitors sought information from a link on the page. State agencies responsible for protecting elders from maltreatment could share information about the portal and increase the likelihood of its usage.

Recommendation: The state agencies protecting elders from abuse, neglect, exploitation, and abandonment, including the departments of Public Health, Social Services, and Consumer Protection, and the State Long-Term Care Ombudsman Program should publicize the availability of, and provide a link to, the abuse registry repository available on the Commission on Women, Children, Seniors, Equity & Opportunity website. **(See Recommendation 34.)**

DPH Response: "The Department agrees with this finding. The Department of Public Health, Office of Communications will collaborate with Social Services, Consumer Protection and the State Long-Term care Ombudsman Program to publicize through numerous traditional and digital tactics, the availability, and a link to the abuse registry repository on the Commission on Women, Children, Seniors, Equity and Opportunity website. The DPH Office of Communications will have these tactics deployed no later than Aug. 2, 2021."

DSS Response: "An update to our website to include this link would be a positive enhancement to these programs."

DCP Response: "DCP agrees that greater use of the abuse registry repository is an admirable goal and will consider adding it to the consumer guide for selecting a homemaker companion agency, which is available on the department's website."

LTCOP Response: "Agree and we can put this on our website."

CWCSEO Response: "CWCSEO agrees with the recommendation of Finding 34."

Finding 35: Connecticut law does not specify certain criminal convictions or findings of elder abuse that would prevent an individual from being hired by a homemaker-companion agency, potentially putting elders at risk.

Homemaker-companion agencies (HCAs) must register with the Department of Consumer Protection (DCP) before conducting business in Connecticut. In 2019, the state had 656 homemaker companion agencies with approximately 35,000 employees. During 2019, the state received 78 complaints related to HCAs. The number of HCA complaints has increased over the years in part because there are a lot more agencies registered. DCP informed us that the most

frequent consumer HCA complaints involve billing/overbilling, financial exploitation, and employees not showing up or not doing what they are supposed to do.

While Section 20-670 of the General Statutes requires homemaker-companion agencies to perform general background checks on potential employees, it does not specify which offenses would disqualify the applicant from employment. In contrast, Section 19a-491c(3) of the General Statutes prevents nurse's aides and volunteers at nursing homes and certain other long-term care facilities from being hired or volunteering if their state and nationally required background checks disclose convictions of crimes that are program-related, or related to patient abuse, health care fraud, or controlled substances. As specified in federal statute, Connecticut also does not allow long-term care facilities to hire nurse's aides with substantiated findings of neglect, abuse, or misappropriation of property by a state or federal agency.

Recommendation: Section 20-670 of the General Statutes should be amended to prohibit homemaker-companion agencies from hiring employees with a disqualifying offense as described in Section 19a-491c(3) of the General Statutes. **(See Recommendation 35.)**

DCP Response: "DCP agrees and submitted a legislative proposal this year, which was approved and signed into law, to strengthen the background check language in Sections 20-670 and 20-678."

Finding 36: Connecticut law does not specify the type of background check required for homemaker-companions, leading to potentially inadequate background checks that may put the safety of elders at risk.

Section 20-678 of the General Statutes currently requires homemaker-companion agencies to perform general background checks on their prospective employees that require, among other things, a check of the sex offender registry and review of Connecticut criminal conviction information through public records. If the applicant/employee resided in Connecticut for less than three years, then a review is conducted of criminal conviction information from states resided in during the past three years.

It is left up to each homemaker-companion agency to determine how the background check is conducted. The Department of Consumer Protection (DCP), the agency where all homemaker-companion agencies must register, recently testified that there is no consistency in how these agencies choose to conduct these background checks, and DCP receives consumer complaints as a result of the inadequate background checks. DCP recently testified that investigations have disclosed HCA background check processes in which critical information was missed that would have been caught if the HCA conducted a state and national background check. In an interview with DCP personnel, we were told of an example of a mother-daughter team from a homemaker-companion agency who had a history of committing larceny, including illegally accessing checks and credit card information.

Similar to Department of Public Health statutes, DCP supports requiring prospective employees of homemaker-companion agencies to submit to state and national criminal background checks conducted in accordance with Section 29-17a of the General Statutes.

Recommendation: Section 20-678 of the General Statutes should be amended to require prospective employees of homemaker-companion agencies to submit to state and national criminal background checks conducted in accordance with Section 29-17a of the General Statutes. **(See Recommendation 36.)**

DCP Response: “DCP agrees and submitted a legislative proposal this year, which was approved and signed into law, to strengthen the background check language in Sections 20-670 and 20-678.”

Mandated Reporters/Mandatory Training

The list of mandated reporters of elder abuse, neglect, exploitation, or abandonment is extensive (**Exhibit 22**). In addition, Section 17b-463 of the General Statutes requires mandatory training in detecting potential fraud, exploitation, and financial abuse of older adults for any financial agent who has direct contact with an elderly person within the officer's or employee's scope of employment or professional practice, or reviews or approves an elderly person's financial documents, records, or transactions. Financial agents are listed in **Exhibit 23**.

Exhibit 22. Mandated Reporters of Elder Abuse, Neglect, Exploitation or Abandonment

- All nursing home and residential care home staff members
- All people paid to care for nursing home resident or residential care home residents
- All people paid to care for the elderly by a home care agency or homemaker and companion agency
- All people paid to care for the elderly in a congregate housing facility, adult day care center, senior center, village-model community or other community-based service, institution, organization, agency or facility
- Chiropractors
- Clergymen
- Dentists
- Licensed practical nurses
- Licensed registered nurses
- Medical examiners
- Nurse’s aides or orderlies in a nursing home facility or residential care home
- Nursing home administrators
- Optometrists
- Pharmacists

- Podiatrists
- Police officers
- Physical therapists
- Physicians (including osteopaths) or surgeons
- Psychologists
- Resident physicians or interns in any hospital in the state
- Residents' advocates
- Social workers
- Those certified or licensed for emergency medical services

Source: Section 17b-451(a) of the General Statutes

Exhibit 23. Financial Agents Required to Take Mandatory Financial Exploitation Training

Officer or employee of:

- Trust company
- Bank
- Savings bank
- Credit union
- Saving and loan association
- Insurance company
- Investment company
- Mortgage banker
- Trustee
- Executor
- Pension fund
- Retirement fund
- Other fiduciary or private financial institution

Source: Sections 17b-463 and 32-350 of the General Statutes

Mandated training is different from mandated reporting, and financial agents are not required to report suspicion of financial elder abuse, fraud, and exploitation to the DSS Protective Services for the Elderly Program (PSE). Financial agents in Connecticut may, however, voluntarily report suspected criminal activity to law enforcement or to PSE (as non-mandated reporters) concerns about an elder's well-being and safety, financial activity, or behavior. They may also contact relevant regulatory entities such as the state's Department of Banking and Insurance Department.

Finding 37: Mandated reporters may be unaware that they must report suspected elder abuse, neglect, exploitation, or abandonment to the Department of Social Services. Financial agents may be unaware that they are required to attend mandatory training in detecting potential fraud, exploitation, and financial abuse of older adults. This lack of awareness may result in a lack of necessary services and interventions to reduce or eliminate elder abuse, neglect, financial exploitation, or abandonment.

In interviews with the State Unit on Aging, a community care management organization, and other entities, we were informed that mandated reporters and financial agents may be unaware of these responsibilities. Publicizing this information can increase awareness and alert individuals to training that will help them detect elder abuse, neglect, financial exploitation, and abandonment. For example:

- The Department of Public Health oversees the majority of professions and positions on the mandated reporter list and could identify this responsibility on its website.
- The Department of Social Services Social Work Services states on its website: “Many categories of human service, medical, law enforcement and other professions are required by state law to cause a report to be made.” Listing which particular professions and positions would promote greater awareness of who is considered a mandated reporter.
- The Coalition for Elder Justice in Connecticut, which includes representation from multiple state agencies, refers website readers to the statutory reference to understand who is considered a mandated reporter. However, the full list as shown in **Exhibit 22** makes this information clearly and readily available.
- The Department of Banking and the Insurance Department could provide information on types of financial agents who are required to complete training to detect financial exploitation of older adults as shown in **Exhibit 23**.
- The information on World Elder Abuse Awareness Day on the State Long-Term Care Ombudsman Program website could publicize who is considered a mandated reporter and which financial agents are mandated to receive training in detecting potential fraud, exploitation, and financial abuse of older adults.

Through better coordination and communication, state agencies could share and publicize detailed lists of mandated reporters of elder maltreatment and financial agents required to complete training to detect financial exploitation of older adults.

Recommendation: The departments of Public Health, Social Services, Banking, and Insurance and the State Long-Term Care Ombudsman Program should publicize information about specific mandated reporters and the types of financial agents required to complete training to detect financial exploitation of older adults. **(See Recommendation 37.)**

DPH Response: “The Department agrees with this finding. The Department of Public Health, Office of Communications will collaborate with Social Services,

Banking, and Insurance and the State Long-Term Ombudsman Program to publicize information about mandated reporters and the types of financial agents required to complete training to detect financial exploitation of older adults. The DPH Office of Communications will have completed this publicity campaign no later than Aug. 23, 2021."

DSS Response "Increased publication regarding these requirements would be a positive enhancement to these programs and is in development."

LTCOP Response: "Agree, LTCOP will continue to support this work through the Coalition for Elder Justice and work with other agencies."

Finding 38: Due to a potential lack of awareness of their mandated reporter status, police may be underreporting elder abuse, neglect, exploitation, and abandonment. This could result in the absence of needed services and interventions to reduce or eliminate elder abuse, neglect, exploitation, or abandonment.

PSE collects information on entities reporting suspected elder abuse, neglect, exploitation, or abandonment. While police are often called when safety is a concern, including the maltreatment of elders, just 1.7% of such reports were from the police in 2019 (**Exhibit 24**).

Exhibit 24. Reports of Elder Abuse, Neglect, Exploitation, Abandonment to PSE in CY 2019

Reporter Type	Number of Reports	Percent of Reports
Social worker	1,271	17.0
Bank/credit union staff	1,247	16.7
Community-based provider/homecare agency staff	861	11.5
Nurse	710	9.5
Relative	625	8.3
Other mandatory reporter (not specified)	524	7.0
Town social service/municipal staff	311	4.1
Self	180	2.4
Friend/neighbor	180	2.4
Physician	134	1.8
Police/law enforcement	128	1.7
Emergency medical services	124	1.6
Judicial system	105	1.4
Assisted living/congregate housing staff	64	0.8
Occupational therapist/physical therapist	48	0.6
Other DSS staff	21	0.3
Attorney	23	0.3

Clergy/other religious/spiritual leaders	16	0.2
DMHAS, DDS, or DCF staff	31	0.4
Adult day care staff	13	0.2
Anonymous	240	3.2
Other/none of the above	626	8.4
Reporter not recorded/field left blank	113	1.5
Total complaints received in CY 2019	**7,482**	**100%**

The Police Officer Standards and Training (POST) is one of the six divisions of the Department of Emergency Services and Public Protection (DESPP) charged mainly with municipal recruit basic training. The six-month basic training curriculum currently does not inform recruits that police officers have mandated reporter status and are required to report suspected elder abuse, neglect, exploitation and abandonment to the Department of Social Services within 72 hours of such suspicion or belief. In addition to informing basic training recruits, current police officers could receive this information as part of in-service education during roll call, brochures, bulletins, general notices, or other means.

Recommendation: The Department of Emergency Services and Public Protection Police Officer Standards and Training Division should notify basic training recruits and state and municipal police departments that police officers are mandated reporters and are required to report suspected elder abuse, neglect, exploitation and abandonment to the Department of Social Services Protective Services for the Elderly Program within 72 hours of such suspicion or belief. **(See Recommendation 38.)**

DESPP Response: "The Police Officer Standards and Training (POST) is one of the six divisions of the Department of Emergency Services and Public Protection (DESPP) charged mainly with municipal recruit basic training.

The POST Council is a separate statutorily mandated Council made up of Legislative and Governor appointments which mandates the training and curriculum, among other things. The make up of the Council was reworked under the recently enacted police accountability bill.

We are entirely in favor of the recommendations and will forward them to the POST Council once they are finalized."

Finding 39: Current Department of Emergency Services and Public Protection Police Officer Standards and Training Council Division (POST) basic training for police trainees has limited information on elder abuse, neglect, exploitation, and abandonment. This lack of information could decrease the likelihood of detecting elder maltreatment and effectively handling such situations.

The POST basic training curriculum has classes about victim/witness advocacy and criminal law. They include information on identifying the specific needs and concerns of elderly or special needs victims, geriatric patients and being aware of signs of abuse, and understanding elderly human behavior. Police, PSE, and others interviewed said it could be useful for officers to have additional information about elder maltreatment such as recognizing signs of elder maltreatment, financial exploitation, understanding the role of PSE, and how to evaluate calls from long-term care facilities.

Recommendation: The Department of Emergency Services and Public Protection Police Officer Standards and Training Division should consider revising its basic training curriculum to educate officers on how to detect and address elder abuse, neglect, financial exploitation, and abandonment. **(See Recommendation 39.)**

DESPP Response: "The Police Officer Standards and Training (POST) is one of the six divisions of the Department of Emergency Services and Public Protection (DESPP) charged mainly with municipal recruit basic training.

The POST Council is a separate statutorily mandated Council made up of Legislative and Governor appointments which mandates the training and curriculum, among other things. The make up of the Council was reworked under the recently enacted police accountability bill.

We are entirely in favor of the recommendations and will forward them to the POST Council once they are finalized."

Finding 40: Employers of financial agents are not required to document that their employees completed mandatory training in detecting financial exploitation of older adults, so it cannot be confirmed that they received this training.

Training to detect financial exploitation of older adults is available to financial agents on the Commission on Women, Children, Seniors, Equity & Opportunity web portal. The commission has an online (PowerPoint) training module on financial abuse and exploitation of Connecticut residents aged 60 or older. Financial agents may receive this training from other sources. For example, Department of Banking personnel informed us that financial agents request its Senior$afe training to satisfy this requirement.

Although the training is required in statute, there is currently no requirement for employers to document completion of the mandatory training. The Commission on Women, Children, Seniors, Equity & Opportunity web portal states that this training is the responsibility of the employer and suggests that employers keep basic information in their files, including: 1) name, 2) date of training, and 3) type of training/resources utilized. Employers should document that their employees completed this mandatory training so those with oversight responsibilities can confirm that the financial agents received it.

Recommendation: Section 17b-463 of the General Statutes should be amended to require employers to document completion of mandatory training to detect potential fraud, exploitation, and financial abuse of elderly persons. The documentation should include the employee's name, date of training, type of training, and resources utilized. **(See Recommendation 40.)**

DSS Response: "Documentation of the completion of mandatory training would be a positive enhancement to these programs and is in development."

CWCSEO Response: "CWCSEO agrees with the recommendation of Finding 40. Furthermore, our agency has begun conversations with the Department of Banking (DOB) to update the mandatory financial abuse training on our website, which was originally created in 2016 by DOB staff."

Finding 41: The Department of Social Services Protective Services for the Elderly Program mandated reporter training is currently only available on the Department of Social Services (DSS) website and is not widely publicized. This potentially limits its use by many mandated reporters.

Public Act 16-149 required DSS to develop an educational training program for mandated reporters and other interested parties to promote accurate and prompt reporting of suspected elder maltreatment. Online training is currently posted on the DSS website. Mandated reporters may choose the DSS online training or other similar training.

The DSS online training has not been widely publicized, and mandated reporters may not be aware of its availability, leading to potential underuse. To reach more mandated reporters, the training should be available on other state agency and partner websites. The Department of Public Health (DPH) oversees many professions and positions on the mandated reporter list and could post a link to the training on its website.

Recommendation: The Department of Public Health's website should include a link to the Department of Social Services Protective Services for the Elderly Program mandated reporter training. **(See Recommendation 41.)**

DPH Response: "The Department agrees with this finding. The Department of Public Health, Office of Communications has a close working relationship with the Department of Social Services and will post a link to the DSS Protective Services for the Elderly Program mandated reporter training. The DPH Communications Department will have this link posted by July 30, 2021."

DSS Response: "This is for DPH's consideration."

Finding 42: Mandated reporters are not required to complete training in the detection of elder abuse, which decreases their ability to identify elder abuse.

Mandated reporters must report suspected elder abuse, neglect, exploitation, or abandonment to DSS within 72 hours.

Section 17b-451(g) of the General Statutes requires DSS to develop training to promote and encourage the accurate and prompt identification and reporting of elder abuse, neglect, exploitation, or abandonment; however, there is no requirement for mandated reporters to participate in this training. FLIS and PSE staff and others interviewed informed us that mandated reporters are sometimes uncertain when or where to report suspected elder maltreatment.

In contrast, section 17b-463(b) of the General Statutes requires financial agents to participate in mandatory training to detect potential fraud, exploitation, and financial abuse of elderly persons. They may use resources on the Commission on Women, Children, Seniors, Equity & Opportunity web portal and must complete such training within six months of their employment. The commission recommends that employers document the completion of training, including the employee name, date of training, type of training, and resources utilized.

Recommendation: Section 17b-451(g) of the General Statutes should require mandated reporters to complete related training within the first six months of their employment. Employers should document that their employees completed this training. The documentation should include the employee's name, date of training, type of training, and resources utilized. **(See Recommendation 42.)**

DSS Response: "Completion and documentation of mandatory training within six months of employment would be a positive enhancement to these programs and is in development."

Coordination and Communication Across Agencies

Finding 43: Non-mandated and mandated reporters may not be sure which agency to contact when they have a concern about suspected elder abuse, neglect, exploitation, or abandonment, which may delay an elder from receiving necessary assistance.

We were informed in multiple interviews that non-mandated reporters (e.g., friend, neighbor, relative) and mandated reporters are uncertain regarding which agency to report a complaint about potential elder abuse, neglect, exploitation, or abandonment. The Department of Social Services (DSS) Protective Services for the Elderly (PSE), Department of Public Health (DPH) Facility Licensing and Investigations Section (FLIS), and State Long-Term Care Ombudsman Program (LTCOP) all report receiving complaints that are handled by another agency as well as the departments of Consumer Protection (DCP) and Banking:

- Complaints regarding DCP-registered companion-homemaker agencies received by DPH are forwarded to DCP
- Complaints regarding DPH-licensed home health care agencies received by DCP are forwarded to DPH FLIS
- Complaints regarding long-term care residents filed with DSS PSE are forwarded to DPH FLIS
- Complaints received by LTCOP (often via 2-1-1) are forwarded to DSS PSE
- Complaints received by DSS PSE (sometimes via 2-1-1) are sometimes forwarded to LTCOP
- Calls received by the State Unit on Aging/State Department on Aging are sometimes forwarded to LTCOP or DSS FLIS
- Calls received by the Department of Banking from financial institutions regarding potential financial exploitation of an elder may encourage the institution to contact DSS PSE

Recommendation: The departments of Public Health and Social Services, and the State Long-Term Care Ombudsman Program should develop guidance to clarify the appropriate agency for certain elder abuse, neglect, exploitation, or abandonment complaints. This guidance should be posted on websites of state agencies, World Elder Abuse Awareness Day, the Elder Justice Coalition, and other partners such as United Way 2-1-1. **(See Recommendation 43.)**

DPH Response: “The Department agrees with this finding. The Department of Public Health Communications Department will solicit the Department of Social Services and the State Long-Term Care Ombudsman Program for this guidance content to be posted online. The DPH Communications Department will have this project completed by Sept. 30, 2021.”

DSS Response: “An update to our website to include this information would be a positive enhancement to these programs and is in development.”

LTCOP Response: “Agreed, new hotline to assist with triaging calls and will work with sister agencies to develop guidance and post appropriately. Since the LTCOP is not a mandatory reporting program, guidance will clarify that the LTCOP cannot be the primary investigatory entity.”

Finding 44: Mandated reporters suspecting potential abuse, neglect, exploitation, or abandonment of long-term care residents may file their reports with the Department of Public Health Facility Licensing and Investigations Section (FLIS) or the Department of Social Services Long-Term Care Investigations and Interventions Program (LTCI), which leads to confusion and inefficiency in the protection of elders.

Mandated reporters suspecting potential abuse, neglect, exploitation, or abandonment of nursing home and other long-term care residents may file their reports with the Department of Public Health Facility Licensing and Investigations Section (FLIS) or the Long-Term Care Investigations and Interventions Program (LTCI). This overlap leads to unnecessary extra steps in the reporting process as LTCI refers these cases to FLIS.

The FLIS website states: "Anyone with knowledge or concerns about the care of a patient/resident in a licensed healthcare facility may file a complaint with their State Survey Agency. Facility Licensing and Investigation Section (FLIS) is the agency that has regulatory oversight for all the licensed healthcare entities in the state." The FLIS complaint submission form is intended for use by both mandated and non-mandated reporters.

Section 17a-412 of the General Statutes requires all mandated reporters suspecting abuse, neglect, exploitation or abandonment of long-term care residents to make such reports to the Department of Social Services, which are handled by LTCI.

In a recent DSS memo to mandated reporters for residents of long-term care facilities, the department instructed mandated reporters to use the W-410 "Mandated Reporting Form for Long Term Care Facilities" to file reports with DSS. Mandated reporters were also told, "This memo in no way impacts your reporting obligation to the Connecticut Department of Public Health," suggesting that the same report could be filed with two state agencies. The Director of DSS Social Work Services informed us that LTCI forwards information to DPH.

LTCI receives a relatively small number of reports (approximately 60 referrals in 2015) from mandated reporters about suspected resident abuse, neglect, exploitation, or abandonment in long-term care facilities. Although mandated reporter status was not captured, DPH FLIS received 812 complaints pertaining to long-term care facility residents in calendar year 2019, making it likely that many mandated reporters are contacting DPH directly.

FLIS oversees the regulation of nursing homes and other long-term care facilities and is required to process complaints in a timely manner. DSS reported transferring complaints about residents living in long-term care facilities to FLIS. A DSS memo reminds mandated reporters of their reporting obligation to FLIS. It would be more efficient and timelier to have mandated reporters file their complaints directly with FLIS.

Recommendation: Section 17a-412 of the General Statutes should be amended to require all mandated reporters suspecting abuse, neglect, exploitation, or abandonment of long-term care residents to make such reports to the Department of Public Health Facility Licensing and Investigations Section. **(See Recommendation 44.)**

DPH Response: "DSS may be more appropriate for a response."

DSS Response: "This is for DPH's consideration."

Finding 45: The Department of Social Services (DSS) is statutorily required to receive reports of potential elder abuse, neglect, exploitation, and abandonment of long-term care residents from non-mandated reporters. DSS cannot meet this statutory requirement because it has not allocated specific resources to receive these complaints.

Section 17a-412 of the General Statutes requires mandated reporters to report suspected elder abuse, neglect, exploitation, or abandonment of long-term care residents to DSS. The statute also specifies that non-mandated reporters may also report similar concerns to DSS. Section 17b-451 of the General Statutes also specifies that mandated reporters and others may report potential elder abuse, neglect, exploitation, and abandonment to DSS, regardless of whether the elder resides in the community or in a long-term care facility.

However, DSS does not have a specific unit to receive reports from non-mandated reporters about suspected elder abuse, neglect, exploitation, or abandonment of elders residing in long-term care facilities. The Long-Term Care Investigations and Interventions program only addresses reports from mandated reporters about elders residing in long-term care facilities, and the Protective Services for the Elderly program only addresses mandated and non-mandated reporter concerns about elders residing in the community. Similar to Connecticut, the Massachusetts Elder Protective Services program only investigates abuse cases when the individual is over age 60 and resides in the community. However, individuals are directed to report abuse of nursing home residents to the Massachusetts Department of Public Health.

Recommendation: Section 17b-451 of the General Statutes should be amended so that mandated and non-mandated reporters suspecting abuse, neglect, exploitation, or abandonment of long-term care residents make all reports to the Department of Public Health. **(See Recommendation 45.)**

DPH Response: “DSS, specifically Elderly Protective Services may be more appropriate for a response.”

DSS Response: “This is for DPH’s consideration.”

Finding 46: The Department of Public Health Facility Licensing and Investigations Section (FLIS) surveyors do not always contact the State Long-Term Care Ombudsman Program (LTCOP) to discuss the nature of their nursing home complaint investigations and determine whether LTCOP received and substantiated similar complaints.

Chapter 5 of the federal Centers for Medicare and Medicaid Services (CMS) State Operations Manual specifies certain off-site survey preparation prior to investigating nursing home complaints. FLIS personnel must review any information about the facility that would be helpful in planning their investigation. This includes contacting the LTCOP to discuss the nature of the complaint and whether LTCOP has received and substantiated similar complaints. CMS instructs surveyors to consider practical methods to obtain such information.

FLIS and LTCOP personnel informed us that FLIS surveyors regularly contact LTCOP to gather information for annual surveys, but do not consistently contact LTCOP to gather information for complaint investigations. To encourage more communication between the agencies and obtain complaint investigation information from LTCOP, FLIS could send LTCOP a standard, automatic email at the start of an investigation requesting that the regional ombudsman contact the surveyor if there are similar complaints at the facility or additional information that might be helpful to the complaint investigation.

Recommendation: The Department of Public Health Facility Licensing and Investigations Section should develop a system to automatically contact the State Long-Term Care Ombudsman Program about nursing home complaints to solicit any information about similar complaints at the facility or other information helpful to the investigation. **(See Recommendation 46.)**

DPH Response: "The Long-Term Care Survey Process currently includes notification to the LTCOP regarding certification and or licensure survey activity that is occurring. This communication will be extended for complaint investigations as well. FLIS staff were educated in April 2021 on the need to send a template email to the long-term care ombudsman about an upcoming complaint investigation and for the ombudsman to respond to the investigator with any additional information or questions."

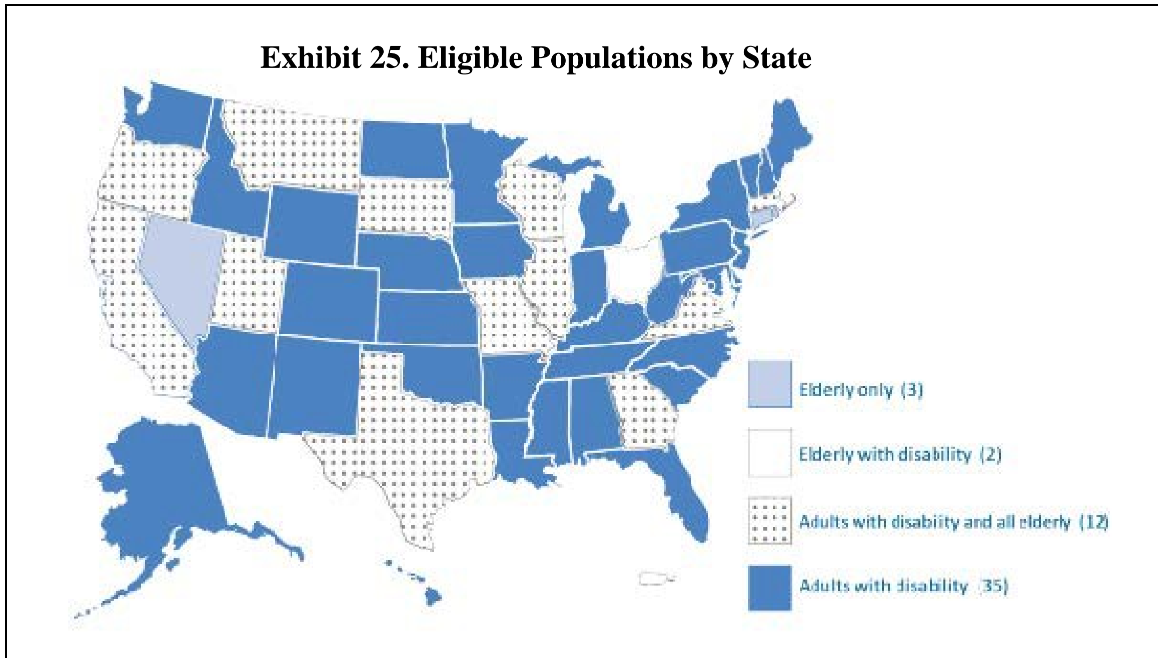
LTCOP Response: "Agree."

The Protective Services for the Elderly Model

Finding 47: Connecticut uses a protective services for the elderly model rather than an adult protective services model, which may leave a service gap for unprotected vulnerable individuals ages 18 to 59.

Connecticut has a protective services for the elderly model rather than an adult protective services model. Only Rhode Island, Ohio, and Puerto Rico currently have a similar program model (**Exhibit 25**). The map does not reflect that Nevada changed to an adult protective services model in 2019. Most states have an adult protective services model that provides protective services for individuals ages 18 and older. Under both models, states have various eligibility requirements that may consider living arrangement and disabilities.

Exhibit 25. Eligible Populations by State



The Commission on Aging released a report in 2016 recommending that the General Assembly consider an adult protective services model. Public Act 16-149 required the Commission on Aging to evaluate the Connecticut protective services for the elderly system and recommend whether it should be expanded to include individuals 18 and older, but the report was never produced due to the dissolution of the commission. The frequency of incoming referrals on 60th birthdays suggests that there may be a lack of services for people aged 59 and younger. Several stakeholder groups expressed that the lack of an adult protective services program is a service gap in the state.

Recommendation: The General Assembly should consider establishing a taskforce to evaluate moving from a protective services for the elderly model to an adult protective services model. The task force should include representatives from the Department of Social Services Protective Services for the Elderly, Department of Developmental Services, and Commission on Women, Children, Seniors, Equity & Opportunity. **(See Recommendation 47.)**

DSS Response: "This has potential to be a positive enhancement to the program but requires statutory change and a significant increase in resources (i.e., personnel and program funding)."

CWCSEO Response: "CWCSEO agrees with the recommendation of Finding 47. In 2016, the then Commission on Aging published the *Study of Best Practices for Reporting and Identification of Abuse, Neglect, Exploitation and Abandonment of Older Adults*, pursuant to PA 15-236. This report highlights the importance of federal funding and leadership as necessary for the development of a successful APS program. Furthermore, the report notes the important roles of other agencies beyond those

recommended for Task Force participation currently in Recommendation 47. We would request that representatives from DCP, LTCOP, DPH, OCPD and CSAO be included in any Task Force to study this issue."

RECOMMENDATIONS

This is our first audit of Protective Services for the Elderly, and there are no prior audit recommendations to address. Our current audit resulted in 47 recommendations:

Department of Social Services Protective Services for the Elderly Program

1. Section 17b-451(a) of the General Statutes should be amended to require the Department of Social Services Protective Services for the Elderly Program to collect the date when mandated reporters first suspect elder abuse, neglect, exploitation, abandonment, or the need for protective services. To encourage timely reporting, the penalty for a first offense for not contacting the program within 72 hours should be changed to require that the mandated reporter retake the elder abuse training and provide the program with proof of successful completion of such training.

2. Section 17b-451(a) of the General Statutes should be amended to require mandated reporters to make their reports to the Department of Social Services Protective Services for the Elderly Program as soon as practicable but not later than twelve hours after the mandated reporter has reasonable cause to suspect or believe that an elder has been abused, neglected, exploited, abandoned, or requires protective services.

3. The Department of Social Services Long Term Care Investigations Program should develop an online system for the transmission and acknowledgment of reports from mandated reporters suspecting elder maltreatment of long-term care residents.

4. The Department of Social Services Protective Services for the Elderly Program should develop an online reporting tool to receive reports of suspected elder abuse, neglect, exploitation or abandonment. The reporting tool should generate an automated confirmation email to document the submission of the report.

5. Department of Social Services Protective Services for the Elderly Program supervisors should ensure that social workers conduct face-to-face visits with elders every 30 days. Management should consider modifying the PSE Procedure Manual to allow for exceptions to the 30-day visitation policy when an appropriate reason is clearly documented in the case record.

6. Department of Social Services Protective Services for the Elderly Program management should establish a maximum caseload per social worker and ensure that staffing remains adequate to meet the needs of the program.

7. The Department of Social Services Protective Services for the Elderly Program should accept all first responder reports of elder self-neglect regardless of hospital admission status and amend the PSE Procedure Manual to reflect this change.

8. Department of Social Services Protective Services for the Elderly Program employees should be trained on substantiating allegations to ensure consistency.

9. The Department of Social Services Protective Services for the Elderly Program should contract with or hire a forensic accountant or other specialist to support social workers on financial exploitation cases.

10. Each Department of Social Services Protective Services for the Elderly Program regional office should have a compact disc drive.

11. Department of Social Services Protective Services for the Elderly Program management should explore options to promote working in the field, including providing training and written guidance clarifying when joint visits are appropriate, strengthening community partnerships to arrange for safe workspace in the field, and streamlining processes to reduce office paperwork.

12. The Department of Social Services Protective Services for the Elderly Program should consider annual staff training on handling cases with legal matters, including conservatorship petitions.

13. Department of Social Services Protective Services for the Elderly Program management should determine why some regions have higher service refusal rates and implement strategies to encourage program participation.

14. The Department of Social Services Protective Services for the Elderly Procedure Manual should include procedures for documenting case closure extensions. PSE should train its employees on the policy.

15. The Department of Social Services Protective Services for the Elderly Program should consider implementing processes that would ensure follow-up communication is sent to mandated reporters, including modifying program policy to allow the investigation results to be sent electronically and verifying contact information.

16. There are outdated and inaccurate statutory references in Section 17b-461 of the Regulations of State Agencies for the Department of Social Services Protective Services for the Elderly Program which need to be updated.

State Long-Term Care Ombudsman Program

17. The State Long-Term Care Ombudsman should develop a minimum standard of frequency of non-complaint visits to nursing homes and other long-term care facilities and amend section 17-408 of the General Statutes to reflect that standard. Section 17a-417 of the General Statutes should be amended to require the State Long-Term Care Ombudsman to include outcomes of meeting the visitation standard and each facility's visitation frequency in its annual report.

18. The State Long-Term Care Ombudsman should develop and use a checklist for documenting non-complaint visits to long-term care facilities.

19. The State Long-Term Care Ombudsman should consider assessing and reporting on non-complaint related areas while conducting complaint related visits to nursing homes.

20. The State Long-Term Care Ombudsman should clarify documentation requirements in its policy manual regarding its participation in Department of Public Health Facility Licensing and Investigations Section complaint investigations or annual surveys. LTCOP should train regional ombudsmen on its new policy.

21. The State Long-Term Care Ombudsman should identify the reasons for the decline in the number of volunteer residents' advocates and develop a plan to increase recruitment and retention of volunteers. LTCOP should include a progress report on plan implementation in its annual report.

22. Applicants with family members residing in Connecticut nursing homes should be considered for State Long-Term Care Ombudsman Program volunteer residents' advocate positions, provided the volunteer is not placed in the same facility as the family member.

23. The State Long-Term Care Ombudsman Program should change its after-hours voicemail system to instruct callers to dial 9-1-1 for emergencies and 2-1-1 to speak with a person immediately regarding urgent matters.

24. The State Long-Term Care Ombudsman Program should post contact information for residents and their relatives in English, Spanish, and other frequently spoken languages in the region.

25. The State Long-Term Care Ombudsman Program Annual Report should include the number of its program volunteers and more detailed complaint information using tables and graphs.

26. The State Long-Term Care Ombudsman should regularly review its policies and procedures manual and make necessary updates to reflect changes in state and federal policy or efforts to improve the program's efficiency and effectiveness. LTCOP should post the manual on its website and distribute it to every program employee and volunteer.

27. The Office of the State Long-Term Care Ombudsman Program should update statutory references in Section 17b-411 of the Regulations of State Agencies.

Department of Public Health Facility Licensing and Investigations Section

28. The Department of Public Health should update its website to reflect that mandated reporters have 72 hours to report suspected elder abuse, neglect, exploitation, and abandonment to the Department of Social Services.

29. The Department of Public Health Facility Licensing and Investigations Section should send acknowledgment letters to complainants within four working days as required by its complaint policy.

30. The Department of Public Health Facility Licensing and Investigations Section should update its complaint policy to require investigations of non-immediate jeopardy medium level complaints to begin within 45 business days of receipt of the complaint.

31. The Department of Public Health Facility Licensing and Investigations Section should begin investigation of its non-immediate jeopardy medium level complaints within 45 days.

32. The Department of Public Health should consider developing an automatic and uniform process to request police, emergency medical services, hospital, and other reports necessary to investigate alleged elder maltreatment.

33. The Department of Public Health Office of Injury Prevention website should include existing resources and links related to elder maltreatment awareness and education to reduce elder maltreatment.

Systemic Changes to Reduce the Risk of Elder Maltreatment

Background Checks

34. The state agencies protecting elders from abuse, neglect, exploitation, and abandonment, including the departments of Public Health, Social Services, and Consumer Protection, and the State Long-Term Care Ombudsman Program should publicize the availability of, and provide a link to, the abuse registry repository available on the Commission on Women, Children, Seniors, Equity & Opportunity website.

35. Section 20-670 of the General Statutes should be amended to prohibit homemaker-companion agencies from hiring employees with a disqualifying offense as described in Section 19a-491c(3) of the General Statutes.

36. Section 20-678 of the General Statutes should be amended to require prospective employees of homemaker-companion agencies to submit to state and national criminal background checks conducted in accordance with Section 29-17a of the General Statutes.

Mandated Reporters/Mandatory Training

37. The departments of Public Health, Social Services, Banking, and Insurance and the State Long-Term Care Ombudsman Program should publicize information about specific mandated reporters and the types of financial agents required to complete training to detect financial exploitation of older adults.
38. The Department of Emergency Services and Public Protection Police Officer Standards and Training Council should notify basic training recruits and state and municipal police departments that police officers are mandated reporters and are required to report suspected elder abuse, neglect, exploitation and abandonment to the Department of Social Services Protective Services for the Elderly Program within 72 hours of such suspicion or belief.

39. The Department of Emergency Services and Public Protection Police Officer Standards and Training Council should consider revising its basic training curriculum to educate officers on how to detect and address elder abuse, neglect, financial exploitation, and abandonment.

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41. The Department of Public Health's website should include a link to the Department of Social Services Protective Services for the Elderly Program mandated reporter training.

42. Section 17b-451(g) of the General Statutes should require mandated reporters to complete related training within the first six months of their employment. Employers should document that their employees completed this training. The documentation should include the employee's name, date of training, type of training, and resources utilized.

Coordination and Communication Across Agencies

43. The departments of Public Health and Social Services, and the State Long-Term Care Ombudsman Program should develop guidance to clarify the appropriate agency for certain elder abuse, neglect, exploitation, or abandonment complaints. This guidance should be posted on websites of state agencies, World Elder Abuse Awareness Day, the Elder Justice Coalition, and other partners such as United Way 2-1-1.

44. Section 17a-412 of the General Statutes should be amended to require all mandated reporters suspecting abuse, neglect, exploitation, or abandonment of long-term care residents to make such reports to the Department of Public Health Facility Licensing and Investigations Section.

45. Section 17b-451 of the General Statutes should be amended so that mandated and non-mandated reporters suspecting abuse, neglect, exploitation, or abandonment of long-term care residents make all reports to the Department of Public Health.

46. The Department of Public Health Facility Licensing and Investigations Section should develop a system to automatically contact the State Long-Term Care Ombudsman Program about nursing home complaints to solicit any information about similar complaints at the facility or other information helpful to the investigation.

The Protective Services for the Elderly Model

47. The General Assembly should consider establishing a taskforce to evaluate moving from a protective services for the elderly model to an adult protective services model. The task force should include representatives from the Department of Social Services Protective Services for the Elderly, Department of Developmental Services, and Commission on Women, Children, Seniors, Equity & Opportunity.

ACKNOWLEDGMENTS

The Auditors of Public Accounts wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Departments of Social Services and Public Health, and the Department of Aging and Disability Services Long-Term Care Ombudsman Program during the course of our examination.

The Auditors of Public Accounts would also like to acknowledge the auditors who authored this report:

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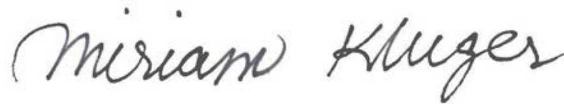
Miriam Kluger
Rebekah Lyon

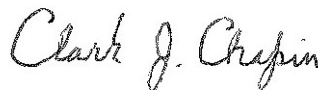
We want to especially acknowledge Miriam Kluger, who served as lead auditor on this audit. Miriam retired on August 1, 2021. We wish Miriam the best in her retirement and thank her for many years of service to the State of Connecticut and our office.



Miriam Kluger
Principal Auditor

Approved:

John C. Geragosian
State Auditor



Clark J. Chapin
State Auditor