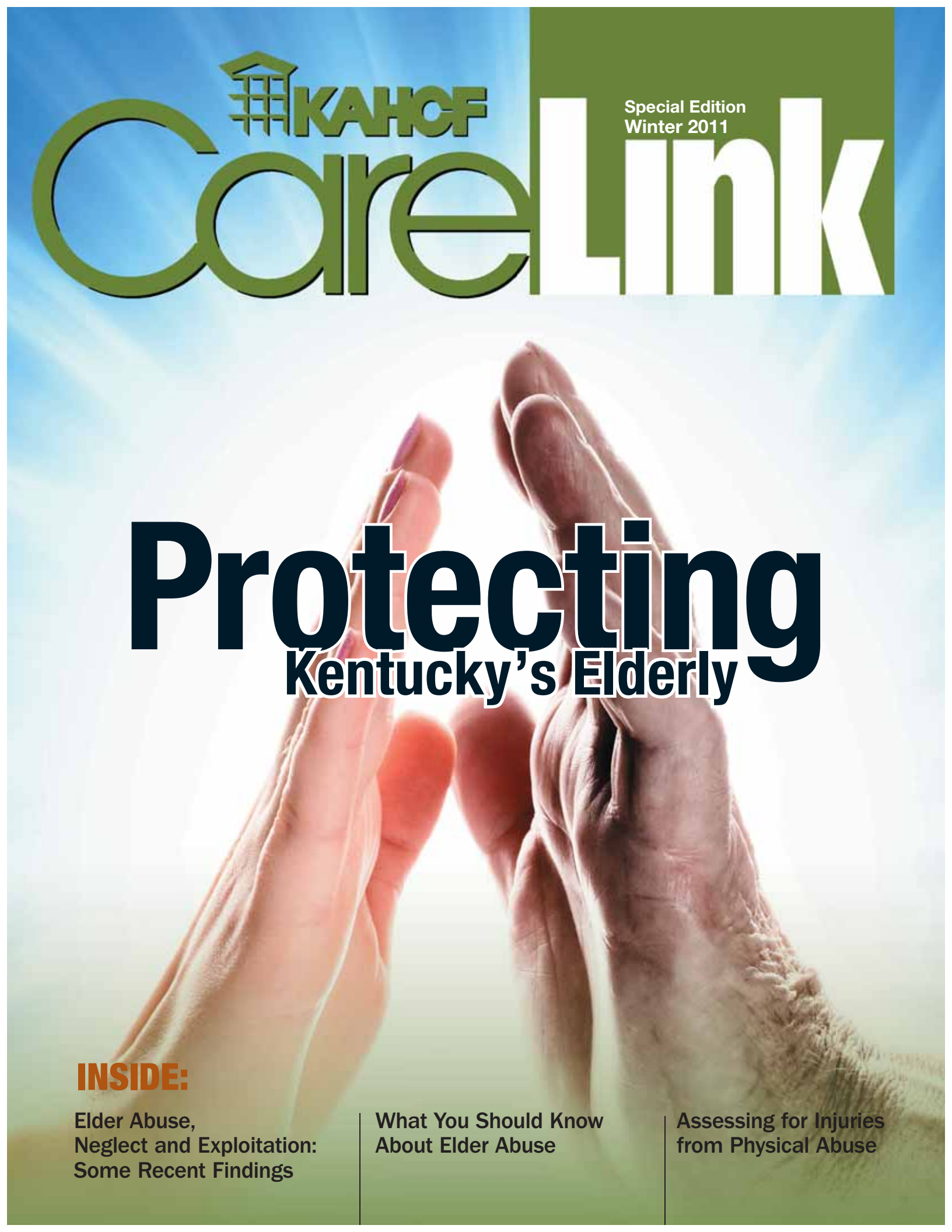
KAHCF
CareLink
Special Edition
Winter 2011



# Protecting Kentucky's Elderly

## INSIDE:

KAHCF CareLink

Special Edition
Winter 2011

*CareLink* is published biannually for the **Kentucky Association of Health Care Facilities**
9403 Mill Brook Road
Louisville, KY 40223
Phone: (502) 425-5000
Fax: (502) 425-3431
**www.kahcf.org**

Published by:
naylor
**Naylor, LLC**
5950 NW 1st Place
Gainesville, FL 32607
Phone: (800) 369-6220
Fax: (352) 332-3331
**www.naylor.com**

Publisher:
Mark Migliore

Editor:
Shani Lyon

Layout & Design:
Brenda Nowosad



PUBLISHED JANUARY 2011 / C7611

# Contents



**Settings of Alleged Abuse**

According to a study by Dr. Pamela Teaster with the University of Kentucky, which was cited in the *Louisville Courier-Journal*, out of 1,002 alleged abuse victims, 70 percent occurred in their own home. 14.8 percent occurred in unknown settings, 5.3 percent were in a nursing home, 4.2 percent were in assisted living facilities, 3.7 percent were in a relative or friend's home, and 2 percent in a hospital.

# Elder Abuse, Neglect and Exploitation: Some Recent Findings

By Susan Ann Lawrence, Ph.D., CSW
University of Kentucky

## Introduction

The past five years have seen the issue of elder abuse, neglect and exploitation (EAN&E) become visible not only in research literature, but also in the popular press. Many of the articles in local and regional newspapers seem to focus on those cases that come before the criminal justice system, as well as those that illustrate the most egregious cases of EAN&E (see, for example, Mastin, Choi, Barboza & Post, 2007; see also the daily newsfeed summary from the National Center on Elder Abuse). This increased attention to EAN&E in the popular press has resulted in shedding some light on a topic that has been largely overlooked.

The evolution of our recognition and understanding of EAN&E may, in part, also be attributed to: (a) a working definition of what comprises EAN&E – a definition that appears to be in common use among researchers; and (b) to some well-designed studies conducted recently. The National Research Council (NRC) has defined elder mistreatment as "(a) intentional actions that cause harm or create a serious risk of harm to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm." This definition includes financial exploitation of the elderly, as well as physical abuse or neglect (Bonnie & Wallace, 2003, p.39). The NRC used the term 'mistreatment' in an attempt to reserve 'abuse' and 'neglect' for law enforcement use. A final factor contributing to our understanding of EAN&E is the availability of funding to explore this difficult issue.

The National Research Council (NRC) has defined elder mistreatment as "(a) intentional actions that cause harm or create a serious risk of harm to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder, or (b) failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."

## What we know about abuse of older adults in the community

The National Institute of Justice funded the National Elder Mistreatment Study conducted by Acierno and colleagues and released its report in 2010. This study found 11.4% of respondents reported at least one form of emotional, physical or sexual mistreatment, or potential neglect within the past year. Moreover, an additional 5.2% reported having been financially abused or mistreated by a family member within the previous year.

Respondents were 60 years of age or older and were cognitively intact. There were 5,672 respondents in the final pool of this study. The sample was representative of cognitively intact, community-dwelling older adults. The study found that:

- 4.6% of older adults had experienced emotional abuse – only 7.9% were reported to police.
- 1.6% prevalence of physical mistreatment – 31% of these events were reported to the police.
- 0.6% reported sexual abuse within the past year – approximately 16% reported to police.
- 5.1% reported potential neglect (by another) over the past year.
- Young-old adults (<70) were more likely to fall victim to emotional, physical or financial mistreatment.

Two significant correlates were found for all forms of mistreatment: low social support and previous traumatic event exposure. Low social support was associated with a three-fold increased likelihood that mistreatment of any sort would be reported. An interesting finding in this study was that young-old adults (< age 70) were more likely to experience mistreatment at the hands of strangers. This study provided only limited support for the caregiver burden hypothesis: functional impairment predicted emotional and financial mistreatment, but not other forms of abuse. Neither gender nor race was a significant independent predictor of abuse, except for the elevated risk of neglect among non-white participants. Consistent with other research, older adults who needed assistance with

If, as these findings suggest, both older adult victims and their abusers are socially isolated, we must work to reverse this in any way possible.

activities of daily living (ADLs), or who reported poor health, were more likely to be targets of financial exploitation (Acierno et al., 2010).

### What we know about abuse of older adults in institutional and residential care settings

Using relative proxy responses for adults aged 60+ across the United States (70.9% of whom were receiving care in institutional settings including adult foster care, assisted living and nursing homes, and 29.1% of whom were receiving paid care in residential settings) as respondents, Post and colleagues (2010) found the following incidence and risk factors for abuse:

- One or more types of abuse were experienced by a stunning 29% of older adults, while two or more types of abuse were experienced by 15% of older adults.
- Neglect was the most commonly reported form of abuse (16.2%) – sexual abuse was the least commonly reported (.6%).
- 13% reported emotional abuse.
- 12% reported caretaking abuse.
- Behavior problems were a risk factor for all forms of mistreatment except financial.
- ADL deficit and physical functioning problems (incontinence and personal hygiene) were significant predictors for emotional mistreatment and neglect.
- Cognitive impairment was not found to be a significant predictor of mistreatment.

### What we are beginning to know about abusers of older adults

A study funded by the National Institute of Justice (NIJ; Acierno, Hernandez-Tejada, Muzzy, & Steve, 2008) explored the characteristics of perpetrators of EAN&E among community-dwelling older adults. That study found the following:

- In 57% of cases, the abuser was a spouse or partner.
- Half of perpetrators were using drugs or alcohol at the time of mistreatment.
- 30% of perpetrators had a history of mental illness.
- 40% of perpetrators were socially isolated.
- One third of perpetrators were unemployed.

Another study funded by the NIJ (Klein, Tobin, Salomon, & Dubois, 2008) examined cases of abuse of women over age 50 in the state of Rhode Island and found that among the suspected perpetrators:

- Nearly half had a prior criminal history in Rhode Island.
- More than a quarter had a prior history of domestic abuse.
- 16% had received prison sentences for previous offenses.

We are just beginning to have a better picture of the prevalence of elder abuse and to discern some of the characteristics that one should look for in the abuser. Now we must put this knowledge to active use. If, as these findings suggest, both older adult victims and their abusers are socially isolated, we must work to reverse this in any way possible. We must also encourage research and exploration of elder abuse from a multi-disciplinary perspective to determine additional risk and protective factors. As an aging society – and particularly considering the additional influx of baby-boomers who are turning 60 at a rate of one approximately every 10 seconds (U.S. Census Bureau, 2006) – we have no choice but to gain a better understanding of EAN&E and its correlates, cause, and potential cures, or we could watch our parents and ourselves become the victims.

### Works cited


Acierno, R., Hernandez, M.A., Amstadter, A.B., Resnick, H.S., Steve, K., Muzzy, W., & Kilpatrick, D.G., Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health, 100(2), 292-297. DOI: 10.2105/AJPH.2009.163089

Acierno R., Hernandez-Tejada, M., Muzzy, W., & Steve, K..(2008). National Elder Mistreatment Study. NCJ 226456, March 2008, Grant Report. Available at: www.ncjrs.gov/pdffiles1/nij/grants/226456.pdf

Bonnie, R.J., & Wallace, R.B., (Eds). (2003). Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Washington DC: The National Academies Press. Available at: www.nap.edu/openbook.php?isbn=0309084342

Klein, A., Tobin. T., Salomon, A., & Dubois, J. (2008) A Statewide profile of abuse of older women and the Criminal Justice response Final Grant Report to the National Institute of Justice, March 2008, NCJ 222459. Available at: www.ncjrs.gov/pdffiles1/nij/grants/222459.pdf

Post, L., Page, C., Conner, T., Prokhorov, A., Fang, Y., & Biroscak, B.J. (2010) Elder abuse in Long-Term-Care: Types, patterns, and risk factors. Research on Aging, 32(3), 323-348. DOI: 10.1177/0164027509357705

U.S. Census Bureau. (2006, January 3, 2006). Oldest Baby Boomers Turn 60! Facts for Features (Special Edition), CB06-FFSE.01-2. Retrieved September 5, 2006, from www.census.gov



*Dr. Susan A. Lawrence is a graduate of the University of Kentucky's doctoral program in Gerontology. Her studies focused on aging and mental health. Dr. Lawrence is also a graduate of the Kent School of Social Work (University of Louisville) where she completed an MSSW with a specialization in Gerontology. She served as a research assistant and project manager of a national study of public guardianship for three years, and worked with Pamela B. Teaster, Ph.D. on research exploring elder abuse, neglect, and exploitation. She has been actively involved with the Kentucky Mental Health and Aging Coalition, and currently serves as co-vice president for that organization.*

# What You Should Know About Elder Abuse

By James G. O'Brien, M.D.
University of Louisville

Elder abuse is not a new problem and, in fact, has been with us from antiquity. There is evidence that throughout the ages older adults were frequently mistreated. Even in the last century, the notion of multigenerational families living together in mutual harmony may not be entirely accurate, as unfortunately, there is evidence from court hearings and sermons that elders were frequently victimized. Sometimes the incentive to keep elderly patients at home had to do with the lack of options, including nursing homes, and assurance of receiving the inheritance.

And although elder abuse has been prevalent throughout time, it still has not received the amount of attention as other types and victims of abuse. Child abuse came to the attention of the public in the 1960s, followed by spouse abuse in the 1970s, and finally elder abuse in the 1980s. However, the term "granny battering" was used in a British medical journal in the late 1970s.

In contrast with the other types of abuse and neglect and their victims, the identification, management and access to elder abuse resources has made the least progress. It is estimated that somewhere between 4% and 10% of adults over the age of 65 have been victims within the past year of some form of abuse or neglect.

The National Center on Elder Abuse defines seven different types of abuse: physical, sexual, emotional, financial exploitation, neglect, abandonment and self neglect. Physical abuse can manifest itself in a variety of ways, all of which result in bodily injury, physical pain or impairment. Sexual abuse is defined as non-consensual sexual contact of any kind with an elderly person. Emotional abuse includes the infliction of anguish, pain or distress through verbal or nonverbal acts. Financial exploitation is defined as the illegal or improper use of an elder's funds, property or assets. Neglect is interpreted as the refusal or failure to fulfill any part of a person's obligations or duties to an elderly person. Abandonment is the desertion of an elderly person by an individual who has physical custody or assumed the responsibility of providing care to the elder. Self neglect, perhaps the type most often encountered, is a result of the behaviors of an elderly person that threatens his or her own health or safety.

Most abuse is perpetrated in the home, and most frequently by a family member – typically a son or daughter, followed by spouses or other relatives. Institutional abuse can occur in hospitals or long term care settings and is typically perpetrated by a staff member. Individuals receiving institutional care are probably the most frail and vulnerable to abuse in our society. Women are much more likely to be victimized than men, and the median age of victims according to recent data was 77.9 years. Older adults who are dependent and reside with a relative or in an institutional setting increase their risk of being abused or neglected.

It is estimated that only 1 in 14 abuse cases comes to the attention of authorities. There are multiple reasons for this statistic. The index of suspicion that an older adult has been abused is lower, particularly, among health professionals. Bruising and fractured bones can be attributed to falls or other accidents. In addition, older adults may not be considered as being credible witnesses. Many victims of elder abuse are reluctant to report their abuse, particularly when the perpetrator is a family member. They may fear retribution, and reporting the abuse could result in being removed from their homes and transferred to a nursing facility, which is not a desirable option for many.

Most states have mandatory reporting of elder abuse and neglect. This applies to most professionals and, in fact, any individual can report when abuse or neglect is suspected. Allegations of abuse are investigated by Adult Protective Services, which exists in some form in all states. Individuals who report abuse remain anonymous, are not obligated to verify the abuse, and can report with just a suspicion of abuse.

If elder abuse were identified as a disease, which robs elderly victims of quality of life and increases the chance of premature death and suffering, we would have very specialized programs and increased funding to combat this problem. Unfortunately, elder abuse continues to be the orphan of the various types of abuse and neglect, frequently suffering from inadequate resources to help the victim.

There is a great need to better educate the public, health care professionals, legal services, police and others who may work with older adults to recognize and prevent elder abuse. Older adults need to be aware of the potential risks of abuse and how to request assistance. Middle-aged adults entering old age need to take necessary precautions to reduce the likelihood of being victimized, either physically, financially or otherwise. Having a trusted family member, a circle of friends and legal documents to protect one's assets offer the best protection against elder abuse.

*James G. O'Brien, MD, is Professor and the Margaret Dorward Smock Endowed Chair in Geriatrics, as well as Chairman of the Department of Family and Geriatric Medicine at the University of Louisville. Dr. O'Brien's primary research interests are the study of self-neglect in old age, delirium and polypharmacy.*

# Assessing for Injuries from Physical Abuse

By Bryan Hansen, BSN, RN and
Daniel J. Sheridan, PhD, RN

*Bryan Hansen chose nursing as a second career and graduated with a Bachelor of Science in Nursing from Morningside College in Sioux City, Iowa, in May, 2009. He is a MSN/PhD student pursuing the Clinical Nurse Specialist with a Forensic Nursing Focus track at Johns Hopkins University School of Nursing. His areas of research and practice interests include elder abuse and neglect, vulnerable adult protection, death review and investigations, and the reduction of the use of restraints and seclusion in psychiatric care. He is actively involved in aggressive patient management, which is the cornerstone of a remarkably successful program to reduce the use of seclusion and restraint in psychiatric care at Johns Hopkins.*

*Dr. Dan Sheridan is a national leader in forensic nursing and has more than 25 years clinical experience working with patients who have experienced physical, sexual, and emotional abuse. At the Johns Hopkins University School of Nursing, he coordinates the forensic foci within the master's, DNP, and doctorate programs. Dr. Sheridan is a former President of the International Association of Forensic Nurses and currently is on the Board of Directors of the National Committee for the Prevention of Elder Abuse. Dr. Sheridan is nationally certified as a Sexual Assault Nurse Examiner – Adolescent/Adult and performs sexual assault and domestic violence forensic examinations at Baltimore's Mercy Medical Center.*

With an increasing amount of attention on elderly abuse, it is helpful for anyone concerned about the health of an elderly individual to understand the types of injuries that can affect this segment of the population. There are basic medical forensic terms best used when describing any injuries and other terms that highlight the types of injures more likely related to abuse.

Blunt trauma can result in many types of injuries including abrasions, bruises, lacerations and/or fractures. If someone falls against or onto a blunt, rough surface the skin will be abraded. Abrasions (or scrapes) can be relatively minor (superficial) or can involve all layers of the skin and underlying tissues. A fall onto a rough surface such as a concrete sidewalk or asphalt driveway can be a common cause of abrasions. A fall onto a carpeted surface is best described as an abrasion not a carpet or rug burn (Sheridan, Nash, Paulos, Fauerbach & Watt, 2010).

The terms bruise and contusion are synonymous. However, the terms bruise and ecchymosis are not synonymous. A bruise, which results from blunt force or squeezing force trauma, is discoloration under the skin due to ruptured blood vessels. An ecchymotic lesion is caused by a leakage of blood under the skin not directly caused by blunt or squeezing trauma (Sheridan & Nash, 2007). While bruises and ecchymotic lesions look somewhat similar, they are caused by different mechanisms.

A fresh bruise is painful and firm to touch, while an ecchymotic lesion is generally non-tender and as soft to touch as the adjacent non-discolored tissue. Fresh bruises generally have distinct outer margins similar in shape to the object that caused the bruise, while ecchymotic lesions are less marginated and more spread out.

Elderly individuals often develop ecchymoses (plural) to their arms and hands that are not caused by trauma. Age itself can contribute to more easily torn minor blood vessels, plus medications (i.e. Coumadin, Plavix) can put elderly individuals at risk to have slow bleeding under the skin. Another common example of ecchymosis is "raccoon eyes." After a person has experienced trauma to the forehead, hemorrhage may not be immediately apparent but after a day or two, discoloration can develop around the eyes. This is not bruising. The most accurate way to identify this discoloration is bilateral peri-orbital ecchymoses. Ecchymoses may appear quite large, especially if the skin is thin, lightly pigmented and the blood spreads via gravity through the tissues.

A small area of bruising may develop a much larger area of gravity dependent ecchymotic spread. For example, a small bruise to the left lateral (side) chest wall can, within a few days, spread to discolor the skin to the breast, the side of the chest wall and part of the back.

There is no science that allows a health care professional to accurately date the age of a bruise or ecchymotic lesion simply by looking at its color (Nash & Sheridan, 2009). Bruise color charts commonly available in older medical textbooks are not evidenced-based and should never be used.

Skin can be torn open (laceration) or sliced open (cut incision). The terms laceration and cut should not

If there is any confusion as to which medical term to use when describing a traumatized area of the body, describe the injury as a "wound." Additional details about what has been observed can then be added to further clarify and describe the various aspects of the wound.

be used interchangeably. Lacerations are caused by blunt or tearing force energies that rip the skin partially or totally open (partial avulsion, lacerations). This can often occur in areas where the bone lies close to the skin such as knees, elbows, chins, cheekbones and the scalp. Lacerations are usually jagged in shape, vary in depth and may tunnel under the skin. When the skin comes in contact with a sharp object (i.e., knife, scalpel, razor) it is cut open. Cuts are generally straighter in shape and the inside edges smooth and well-defined (Sheridan et al., 2009).

If there is any confusion as to which medical term to use when describing a traumatized area of the body, describe the injury as a "wound." Additional details about what has been observed can then be added to further clarify and describe the various aspects of the wound. An accurate description should include size (including measurements of location, height, width, and depth), shape, coloration, and whether any foreign substances were present in or around the wound. The term "lesion" can be used to describe any abnormal change in a body part or area.

Patterned (or geometrically patterned) injuries resemble the shape of the object or specific cause of the injury (Sheridan et al., 2009) and are often imbedded onto the skin. The presence of patterned injuries should always be suspicious for possible abuse. For example, common types of patterned injuries could be a series of circular fingertip-sized bruises to the arms consistent with being held forcefully.

All injuries and lesions found on an individual must be assessed by a health care professional and documented. Documentation must include a thorough and accurate written description of the injury or lesion, including if it has well defined margins and if it is painful or firm (indurated) to touch. The written documentation should include when the injury was first observed, specifically by whom, and who specifically was notified. Since 1992, the Joint Commission, and more recently the Centers for Medicare and Medicaid Services (CMS) strongly recommend all significant injuries, injuries from an unknown cause, suspicious injuries or injuries from known or suspected abuse be photographed. In addition, body maps should be used to highlight injury locations (Sheridan, 2007; 2001; http://cmstraining.info/pubs/AbuseAndNeglect.aspx )

Over time, bruises often will spread through underlying connective tissue and discolor large areas of skin not directly involved in the initial trauma. Taking a series of photographs over several days may be helpful in demonstrating a very normal process of ecchymotic spread whereby the discolored area is many times larger than its original size. Every time a vulnerable individual is admitted or readmitted to a health care facility, it is prudent the individual receive a prompt visual head-to-toe examination. On departure and on readmission, all injuries or acute lesions need to be documented. If an elderly individual, who is in a health care facility, had an intravenous line placed or blood drawn, the trauma is a needle stick (puncture wound). If discoloration occurs, it is best described as an ecchymotic lesion not a bruise.

Written documentation should also include verbatim statements made by the person being examined on how the injury occurred. Statements made by other people present, whether corroborating or contradicting, should also be obtained. All statements should be quoted directly and objectively (Sheridan, 2007; Sheridan, 2001).

## References

Nash, K. R., & Sheridan, D. J. (2009). Can one accurately date a bruise? State of the science.

*Journal of Forensic Nursing*, 5, 31-37.

Sheridan, D. J. (2007). Treating survivors of intimate partner abuse. In J. S. Olshaker, M.C.

Jackson, & W. S. Smock (Eds.), *Forensic emergency medicine (2nd ed.)*, (pp. 202-222). Philadelphia, Lippincott, Williams, & Wilkins.

Sheridan, D. J. (2001). Treating survivors of intimate partner abuse: Forensic

identification and documentation. In J. S. Olshaker, M.C. Jackson, & W. S.

Smock (Eds.), *Forensic emergency medicine* (pp. 203-228). Philadelphia,

Lippincott, Williams, & Wilkins.

Sheridan, D. J., & Nash, K. R. (2007). Acute injury patterns of intimate partner violence victims. *Trauma, Violence, & Abuse*, 8(3), 281-289.

Sheridan, D, J., Nash, K. R., Poulos, C. A., Watt, S., & Fauerbach, L. (2009).

Soft tissue and cutaneous injury patterns. In C. Mitchell & D. Anglin (Eds.). *Intimate partner violence: A health based perspective* (pp. 237-252). New York: Oxford University Press.

# Increasing Community Awareness of Elder Abuse

By Investigator Nikki Henderson, OAG Medicaid Fraud/ Abuse Control Unit

Elder abuse is a multi-faceted crime targeting Kentucky's aging population. Most people may think of physical crimes, but in this state, it also refers to sexual abuse, neglect and financial exploitation.

Elder abuse has been called the silent crime because we only know what is reported, and we believe much of it goes unreported. Because of the increasing number of aging baby boomers and the aging population, there will no doubt be an increase of abuse targeted at Kentucky's aging population.

But how will we know who is being abused and neglected? Simply knowing who your neighbors are is a big step to preventing abuse and caring for our elderly. The invention of television and air conditioning has caused us, as a community, to "go inside" and not know our neighbors. When the community was inclusive and everyone spent more time on their front porch or in yards, we knew each other and took care of our families and neighbors. Too many times in our current lifestyle, when an elderly person is discovered to have been abused, their neighbors are quick to say they didn't even know the victim lived there. Resorting back to times when we knew our neighbors could save their lives.

It is difficult for us to imagine that anyone would harm our elder folks. Our cherished population, who fought for our freedom and were responsible for inventing so many modern-day conveniences, are ignored and discounted at the end of their lives. And it is family members who are tagged as a main culprit of elderly person abuse. Why? It has been seen during investigations of abuse complaints that they are being abused and neglected for financial gain. Our elders, who learned through the Great Depression to be frugal, have the accumulated assets to care for themselves the rest of their lives. However, their own family members know how much money and assets they have and know where it is. It is easy to steal from their aging relatives because who will tell?

Elder abuse can also be physical, sexual and psychological. Physical is easy to detect when we have the opportunity to visually see our elders. The reason child abuse is more easily detected is that our children are in the public eye by going to school and being seen. Our elders are not so lucky. If a caretaker/family member is an abuser, and if there is evidence of physical abuse, these victims are alienated from others by being secluding in their homes, detaching them from the outside world. By maintaining visual contact with our families, friends and neighbors, we are more apt to observe signs of abuse or possibly prevent abuse from occurring just by checking in regularly.

Sexual abuse does occur, but the chance of the elderly victim reporting it is almost nil. They are so ashamed, they would just as well endure the abuse than possibly cause the caretaker/family member to face criminal charges. Watch for a change in an elder's demeanor for no particular reason; there could be abuse occurring but they are unable to report it for whatever reason.

Neglect can be either self neglect or caretaker neglect. Self neglect is not criminal but could possibly be a sign that something else is occurring such as a urinary tract infection (UTI). When an elder shows signs of unusual or bizarre behavior, make a complaint. A UTI, left untreated, can be fatal, and does give an elder symptoms of dementia. Medication could save their life. Caretaker neglect can be from a family member or an elected caregiver in a home environment and/or in an institution such as a nursing facility when there is deprivation of services by the caretaker that is necessary to maintain the health and welfare of that person. This could incorporate not providing the proper nutrition or following a care plan as developed for the individual.

Anyone caring for or checking on an elderly person must report any suspicion of abuse, neglect and/or financial exploitation. Kentucky is a mandatory reporting state, which also means failing to report could be prosecutable as a misdemeanor crime. However, in that particular situation, you must have knowledge that someone is being abused and not report it. Having a suspicion and reporting that incident could have monumental consequences, such as saving a life or protecting their life savings. Our elders deserve to be treated with respect and dignity until the end of their lives.

*Nikki Henderson is an investigator for the Kentucky Office of the Attorney General's Medicaid Fraud and Abuse Control Division. Before being hired by the Office of the Attorney General in 2006, Henderson worked in the Division of Aging Services at the Cabinet for Health and Families. She is a retired Sergeant from the Louisville Metro Police Department, where she worked to create the Jefferson County Police Crimes Against Seniors Unit and has been the Issue Specialist for Elder Abuse in Kentucky for the American Association of Retired Persons (AARP). Henderson also received the first annual "Kentucky Aging Network 2005 Advocate of the Year Award."*

# Statewide Network of Local Coordinating Councils on Elder Abuse

By Johnny Callebs
Regional/Executive Director of Independent Opportunities and
Chair of the Case Review Committee of the Madison County
Local Coordinating Council on Elder Abuse

When it comes to combating elder abuse, the state has paved a path for local communities to take an active role in protecting their elderly neighbors and families. For nearly 25 years, Kentucky has had laws on its books to create and empower local councils specifically formed to address and monitor allegations of abuse in their respective counties, in addition to educating communities on the types and signs of various forms of abuse against the elderly.

In 1976, Kentucky enacted the Protection of Adults statutes (KRS Chapter 209). These laws protect individuals 18 years of age or older who, because of a mental or physical dysfunction, are unable to manage their own resources, carry out activities of daily living or protect themselves from abuse, neglect and or exploitation.

These statutes were amended in 1998 to define "General Adult Services" to include a person 65 years or older who is not mentally or physically dysfunctional, but is being abused, neglected and/or exploited. Also that same year, Kentucky recognized the need to enhance services to victims of abuse, neglect and/or exploitation by establishing Kentucky's Local Coordinating Councils on Elder Abuse (LCCEA).

In 2005, Kentucky's "Elder Abuse Committee" was created. One of the main goals of this committee was to address issues of prevention, intervention, investigation and agency coordination on a state and local level. The Elder Abuse Committee recommended forming a statewide network of LCCEAs to address these issues.

This network in Kentucky currently consists of 29 LCCEAs covering 110 counties, leaving 10 counties not connected to established councils.

Madison County established its Council for Elder Maltreatment Prevention (CEMP) in 2003. The county adult protection social work clinician brought together community partners to meet every other month to discuss the needs and concerns of the elderly population in Madison County. The council is comprised of representatives of nursing facilities, assisted living, personal care homes, intellectual/developmental disabilities (IDD) programs, the ombudsman office, hospice, the health department, home health agencies, durable medical suppliers, senior citizen centers, local libraries, local colleges, physicians, state and local law enforcement, fire departments, local government officials, attorneys, judges, bankers and other local businesses with an interest in caring for the elderly population.

The CEMP council has remained active over the years with its members dedicated to raising awareness of elder abuse in Madison County. Each year the council establishes goals with grassroot efforts to support and educate the community on how to become involved and help prevent elder abuse. The council has hosted educational forums, participated in local health fairs and community festivals with displays and materials for educational purposes, provided speakers for churches and civic groups, and raised money to support local senior centers.

The CEMP council has taken a very active role in monitoring cases of abuse in the county that are filed with the Cabinet for Health and Family Services and cases that are being prosecuted by the County Attorney's or Commonwealth Attorney's office. By far, the vast majority of monitored cases involve financial exploitation in which the victim knew the perpetrator and the victim was still living at home.

When the council gathers to discuss issues or cases, long term care professionals play a vital role – they are able to share their knowledge about medical conditions, needs of the elders, regulatory guidelines and referral sources. It is important for nursing facilities to have a voice and help lead the fight against elder abuse.

*For information on how to join or establish a LCCEA in your county contact Stacy Carey BSW, Elder Abuse Specialist with the Cabinet for Health and Family Services, 502-564-7043. Information on the state statutes governing the LCCEA was taken from the Kentucky Elder Abuse Committee Annual Report – 2009.*

### Kentucky Elder Abuse Committee

The statewide Elder Abuse Committee, established by statute in June 2005, provides the vehicle for oversight, guidance and direction of the provisions mandated in KRS Chapter 209 by the Cabinet for Health and Family Services and its partners to the General Assembly, the public at large and the individuals served. The Committee's most critical task is to inform policy-makers of changing trends and future needs with respect to elder maltreatment on a statewide level, and to provide recommendations to the Cabinet regarding potential changes in practice designed to more effectively meet the needs of a rapidly aging population. For more information on this committee, please visit www.lrc.state.ky.us/KRS/209-00/CHAPTER.HTM.

# Preventing Elder Abuse, Neglect and Exploitation

## Background

The long term care profession's first priority is to always provide the highest quality of care possible to each resident it serves. Any form of abuse, neglect, or exploitation in any nursing home is unacceptable. KAHCF has always and continues to address the issues associated with abuse, neglect, and exploitation through ongoing training, education, and quality initiatives. In addition to addressing abuse, neglect, and exploitation within the long term care profession, KAHCF supports the involvement of state regulators, law enforcement, prosecutors, the courts, and other community service organizations in increasing elder abuse awareness and prevention. As the number of aging citizens continues to grow, Kentucky's long term care profession is making every effort toward being prepared to meet the challenges and needs of this growing population.

## Discussion

Numerous federal and state laws relating to elder abuse, neglect, and exploitation require every long term care facility to establish and maintain policies and procedures for preventing, recognizing, and reporting the first signs of abuse, neglect, or exploitation. In addition to the laws governing the long term care facility's responsibilities, there are laws that also define the state's role in investigating and prosecuting abuse, neglect, and exploitation in long term care facilities. The Office of Inspector General, Department for Community Based Services Adult Protective Services Division, and Department for Aging and Independent Living within the Cabinet for Health and Family Services all play distinct roles in investigating and determining the presence of abuse, neglect, and exploitation in long term care facilities. The Office of the Attorney General and state and local police departments also have the authority to pursue criminal charges against perpetrators of abuse, neglect, and exploitation.

The 2008 and 2009 "Annual Reports on Elder Abuse in Kentucky" issued by the Cabinet for Health and Family Services reports an increased number of abuse complaints and investigations in Kentucky during the past five years. The 2008 report attributes these increases to: (1) increased public awareness reswulting from the government's and community service organizations' collaborative efforts across the state; and (2) the growing number of aging citizens in Kentucky. The 2008 report further states that "there are fewer protections and supports currently available to those receiving care in their private homes than are provided in long term care settings." While the long term care profession regrets that events of abuse, neglect, and exploitation occasionally occur in long term care facilities, we recognize that long term care facilities fare better than other health settings in providing "protections and supports" to our residents from abuse, neglect, and exploitation.

## Current status

KAHCF supports the federal and state laws relating to abuse, neglect, and exploitation. These laws hold long term care facilities and providers accountable while at the same time provide the public with numerous resources to address and resolve the issues associated with abuse, neglect, and exploitation.

The major federal and state laws and regulations relating to abuse, neglect, and exploitation in Kentucky are detailed beginning on Page 11. The long term care profession is proud to have worked with public policymakers from all branches of federal, state, and local governments to enact these laws. KAHCF remains committed to working with public policymakers as they consider matters that relate to abuse, neglect, and exploitation in nursing homes. Our experience and expertise on these issues are relevant and valuable as we prepare for the challenges facing Kentucky's aging population.

### Kentucky Adult Abuse Hotline (Cabinet for Health and Family Services)

**800-752-6200**

Kentucky Department of
Community Based Services
(DCBS) Central Office Staff
502-564-2927
Mike Cheek, Director
Jim Grace, Asst. Director
Steve Fisher, Branch Manager
Adult Safety Branch
502-564-7043

Kentucky DCBS Central Office
Mailing Address
275 E. Main St., 3E-A
Frankfort, KY 40621
Kentucky DCBS Central Office
Fax Number
502-564-3096

Kentucky Office of the Ombudsman
800-372-2991

# Alleged Abuse, Neglect and Exploitation

### Federal Requirements

The overall purpose of the Elder Justice Act (EJA) is to detect, prevent and prosecute elder abuse, neglect, and exploitation. The EJA is designed to address crimes committed against older persons using a multidisciplinary approach, raise national awareness of elder justice issues, and apply resources to the efforts of individuals, organizations, and government entities confronting elder abuse and neglect on the front lines in healthcare settings. The EJA adds numerous new "elder justice" provisions and specific long term care provider requirements by amending various sections in several titles of the Social Security Act (SSA). The EJA at Section 6703(b)(3) amends title XI of the SSA at section 1150 and became effective on March, 23, 2010, upon enactment of Patient Protection and Affordable Care Act (PPACA).

Section 6703(b)(3) of the PPACA requires that any reasonable suspicion of a "crime" (as defined by law) that results in "serious bodily injury" to any individual who is a resident of, or who receives care from, a federally-funded residential care provider that arranges for or directly provides care be reported within two (2) hours to the Secretary and to one or more local law enforcement entities (SSA Sec. 1105B by PPACA Sec. 6703(b)(3)).

### Key provisions of the EJA include the following:

- The facility owner or operator must determine on an annual basis whether the facility received $10,000 or more in federal funds the previous year and then notify each "covered" individual of his/her obligation to comply with the new "crime" reporting requirements.
- "Covered" individuals required to report are owners, operators, employees, managers, agents and contractors of facilities that received at least $10,000 in federal funds the prior year as determined by the owner or operator.
- Effective immediately, each covered individual is required to report any "reasonable suspicion" of a crime (as defined by law) against any individual who is a resident of or receiving care from a long term care facility.
- Reports must be made to the "Secretary" and at least one local law enforcement entity within two (2) hours of "forming a suspicion" if there is "serious bodily injury" and within twenty-four (24) hours of "forming a suspicion" if no serious bodily injury has occurred.
- Covered individuals will be subject to a civil money penalty (CMP) of up to $200,000, or may be excluded from participation in any Federal health care program for failure to report a suspected crime.
- If a covered individual's failure to report a crime results in further injury to the "victim of the crime" or "results in harm to another individual," the potential CMP penalty increases to $300,000.
- If a facility employs a covered individual who has been excluded by the Secretary from participation in any Federal health care program for violating the reporting requirements of this section, the facility itself becomes ineligible to receive Federal funds.
- A facility may not retaliate, discriminate, or file a complaint or a report against an employee who makes a report, causes a report to be made or takes steps in furtherance of making a report according to the requirements of this section.
- The facility could face up to a $200,000 Civil Monetary Penalty or up to a 2-year exclusion from any Federal health care program for

## What Causes a Person to Hurt an Older Kentuckian?

Unrealistic expectations of caregiving ... increased demands and criticism from other family members ... a strained relationship with a marriage partner ... inability to concentrate at work ... the emotional strain of worrying about a loved one's safety ... fatigue ... a lack of knowledge of techniques for dealing with disabilities, especially the behaviors associated with dementia ... little or no recognition for the unrelenting work ... feelings of being isolated and trapped ... financial problems ... drug abuse ... alcoholism ... a history of being abused as a child.

These are examples of problems that can cause caregivers to take out anger and frustration on elderly people.

Even very loving caregivers can lose control to the point of abuse.

From the Kentucky Cabinet for Health and Family Services, www.chfs.ky.gov

violation of the anti-retaliation provisions in this section.

- Additionally, the facility is required to post conspicuously in an appropriate location a sign (in a form specified by the Secretary) that notifies employees of their right to file a complaint with the Secretary against the facility for violating the anti-retaliation provisions of this section, and information on how to file such a complaint.

**42 CFR 488.332** – Investigation of complaints and monitoring of complaints

The state survey agency (Office of Inspector General) must establish procedures and maintain adequate staff to investigate complaints of violations of participation requirements.

**42 CFR 488.335** – Action on complaints of resident neglect and abuse

The state must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in Section 488.332.

**Task 5G** – Abuse Prohibition Review of the Long Term-Care Survey Process and Investigative Protocol Abuse Prohibition

This guidance is used toward determining if the facility has developed and operationalized policies and procedures that prohibit abuse, neglect, involuntary seclusions and misappropriation of property for all residents. This includes policies and procedures for the following: screening of potential hires; training of employees (both for new employees, and ongoing training for all employees); prevention policies and procedures; identification of possible incidents or allegations which need investigation; investigation of incidents and allegations; protection of residents during investigations; and reporting of incidents, investigations, and facility response to the results of their investigations.

## Dynamics of Elder Abuse

**What challenges do dependent older Kentuckians face?**

Chronic illness ... slow-to-heal injuries…difficulty moving around ... lack of transportation ... medication side effects ... confusion and disorientation… loss of appetite…sleeping difficulties…declining eyesight and hearing ... memory loss ... isolation ... depression…loneliness ... fear…financial problems…drug abuse ... alcoholism.

All of these situations can make it difficult or impossible for older Kentuckians to take care of themselves. Even the most capable person can fall into a state of self-neglect during grief and depression following the loss of a beloved family member, friend or pet.

From the Kentucky Cabinet for Health and Family Services, www.chfs.ky.gov

## Federal Regulations and Guidance to Surveyors

**42 CFR 483.13 (b)**

F223 The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

**42 CFR 483.13 (c)**

F224 –F225 Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law (including to the state survey and certification agency).

**42 CFR 483.13 (c)**

F226 The facility must develop and implement policies and procedures that include seven components:

Screen potential employees for a history of abuse, neglect, or mistreating residents.

Train employees, through orientation and on-going sessions on issues related to abuse prohibition practices.

Prevent abuse by providing residents, families, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution, and be provided feedback regarding the concerns that have been expressed.

Identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse, and to determine the direction of the investigation.

Investigate different types of incidents, the staff members responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities.

### Protect residents from harm during an investigation.

Report/Response all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigations; report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; and, analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences.

### Nurse Aide Registry
### Federal Regulations

**42 CFR 483.13 (c) (1) (ii) and (iii)**

F225 The facility must not employ individuals who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. The facility must report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.

**42 CFR 483.75 (e) (4) and (5)**

F495 & F496 The regulations require that before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements.

### State Statutes

**KRS 72.020** Duty of person, hospital, or institution finding or possessing dead body

Any nursing facility finding or having possession of the body of any person whose death occurred under any of the circumstances defined in subsections (1) through (12) of KRS 72.025, shall immediately notify the coroner, or his deputy, and a law enforcement agency, which shall report to the scene within a reasonable time.

**KRS 205.8469 Enforcement proceedings by Attorney General**

The Attorney General, on behalf of the Commonwealth, may commence proceedings to enforce KRS 205.8451 to 205.8483, and to prosecute for all other criminal offenses that involve or are directly related to the use of any Medical Assistance Program funds or services provided under this chapter.

**KRS 205.8453 Control of Fraud and Abuse**

It shall be the responsibility of the Cabinet for Health Services and the Department for Medicaid Services to control recipient and provider fraud and abuse.

**KRS 209.030** Protection of Adults

An oral or written report shall be made immediately to the cabinet upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult.

**KRS 216.515 Rights of residents – Duties of facilities**

This statute ensures the rights of every resident in a long-term care facility.

**KRS 216.532** Prohibition against long-term care facility's being operated by or employing a person on the nurse aide abuse registry.

Long-term care facilities as defined in KRS 216.510 shall not be operated by or employ any person who is listed on the nurse aide abuse registry required by 42 CFR 483.156.

**KRS 216.785 to 216.793 Criminal Record Checks**

No long-term care facility, nursing pool providing staff to a nursing facility, or assisted living community shall knowingly employ a person in a position which involves providing direct services to a resident or client if that person has been convicted of a felony offense related to theft; abuse or sale of illegal drugs; abuse, neglect, or exploitation of an adult; or a sexual crime.

### State Regulations

902 KAR 20:300 Operations and services; nursing facilities

Abuse – The resident shall have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion.

The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents.

The facility shall have evidence that all alleged violations are thoroughly investigated, and shall prevent further potential abuse while the investigation is in progress.

The results of all investigations shall be reported to the administrator or his designated representative within five (5) working days or to other officials in accordance with applicable provisions of KRS Chapter 209 or 620, if the alleged violation is verified appropriate corrective action is taken.

The facility shall document alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source, is reported immediately to the administrator of the facility or to other officials in accordance with KRS Chapters 209 and 620.

The facility shall have evidence that all alleged violations are thoroughly investigated, and shall prevent further potential abuse while the investigation is in progress.

**906 KAR 1:100 Nurse Aide registry, abuse registry and hearing procedures.**

**Abuse Registry, Notice, and Hearing Rights.**

The Cabinet for Health and Family Services shall establish an abuse registry to include information pertaining to findings of resident neglect, abuse, and misappropriation of resident property by a nurse aide.

**922 KAR 5:070 Adult Protective Services**

This administrative regulation establishes the procedures for investigation and protection of adults who are suffering or at risk of abuse, neglect, or exploitation.

# 20 Ways YOU Can Help Prevent Elder Abuse

Excerpts from an article by the Kentucky Cabinet for Health and Family Services, www.chfs.ky.gov

Somewhere along the way, we've begun to lose our sense of community. We rush to work, rush home, rush to evening activities. We rush to get our chores done on the weekends, then rush inside and lock our doors. Many of us don't even know our next-door neighbors' names.

What's causing this? Are we less compassionate? Or are we caught up in a lifestyle that allows no time to notice what's happening around us or to help when we do notice?

Whatever it is, we need to come together again as neighbors, as communities. We need to make time to help each other.

Why? Because we can make a positive difference in the lives of older people and their families.

### What YOU Can Do

Here are some actions you can take to help older Kentuckians and their caregivers.

1. Learn to identify abuse and neglect.
2. Learn to recognize the signs of abuse.
3. Be a good neighbor. Get to know your neighbors. Be aware of what's going on in your neighborhood. Visit your elderly neighbors – isolation and loneliness are major causes of depression.
4. Reach out to neighbors or relatives who are caregivers.
5. Be a friend to a caregiver. Listen. Sometimes, just being able to express anger and frustration helps ease tensions. Take a caregiver shopping or to a movie. Invite a caregiver to go walking, jogging or golfing – exercise helps relieve stress. Organize a Caregivers Support Group through your church.
6. Take action...don't wait for someone else to do it! Arrange for a speaker on adult abuse and neglect to come to your PTA, church, club or workplace.
7. Organize safety systems for your neighborhood.
8. Be alert to neighborhood scams. Many elderly people are trusting, and, therefore, vulnerable to con artists. Call the Better Business Bureau about people going door-to-door selling products or offering home improvements or repairs. Report them to your local law enforcement agency. Tell your neighbors.
9. Volunteer.Volunteer your time at an emergency shelter, a caregivers' support program, a friendly visitors' organization, meals-on-wheels, or an Area Agency on Aging. Collect holiday and birthday gifts for the elderly adults in your community.
10. Form a Carpenters Guild. Work with others in your church, club or workplace to repair elderly adults' homes to make them more livable and safe. Build ramps, install grab bars, paint, repair roofs.
11. Set up an after-school-hours program at a nursing home.
12. Start a resource room. Call your local office of the Kentucky Cabinet for Health and Family Services' Department of Community Based Services and collect clothing, adult diapers, eyeglasses and personal items for elderly people who have been removed from their homes because of abuse and neglect.
13. Work in an adult day-activity center.
14. Visit a nursing home resident, particularly a resident who seldom has visits from family or friends. Drop in at times other than your regularly scheduled visit and be aware of what's happening at times when visitors are not usually around.
15. Take your pet to visit. The simple act of petting a cat or dog can decrease blood pressure, stimulate conversation, bring back old memories and help lift depression.
16. Learn more about adult abuse and its prevention. Teach others.
17. Be aware of community services. Learn about the skilled home nursing, personal care, respite care, meals-on-wheels, day-activity care, friendly visitors, and homemaker and chore services available in your community.
18. Understand which people are most likely to be abusers. In elder abuse and neglect, the typical abuser is most frequently a middle-aged adult child of the victim. A large number of abusers are dependent on the victim for financial support and housing. In other cases, the stress of caregiving and not knowing where to get help can lead to abuse and neglect.
19. Understand which people are most likely to be abused. Older victims are typically women who are widowed, over age 75, white, highly dependent and frail.
20. Report suspected abuse and neglect.

*Call 1-800-752-6200 or your local law enforcement agency if you think an elderly person is being neglected or physically, emotionally, or financially abused.*

*Remember, victims are often afraid to ask for help for fear of being abandoned or hurt. If you suspect it, you must report it — that's the law. A report of suspected abuse makes it possible for an elderly person to get help.*

# Signs of Abuse and Neglect

If you believe that an elderly person is in imminent danger, call 800-752-6200 or your local law enforcement agency immediately. If the person is not in imminent danger but you are suspicious, watch the way the caregiver acts toward the elderly person. Look for a pattern of threatening, harassing, blaming, or making demeaning remarks to the person - or isolating the person from family members and friends. Watch for an obvious lack of helpfulness or indifference, aggression, or anger toward the person. Listen for conflicting stories about the elderly or disabled person's illnesses or injuries.

*Learn to recognize the following signs of self neglect, caregiver neglect, physical abuse, emotional abuse and financial abuse.*

### Neglect

- Obvious malnutrition, dehydration
- Dirty, uncombed hair and offensive body odor
- Torn and dirty clothes that are not appropriate for the weather
- Unshaven
- Lack of glasses, dentures, or hearing aid
- Lack of medical care
- Apparent weight loss
- Bedsores
- Recent suffering or loss of spouse, family members, or close friends
- Exterior or interior of the home in poor repair
- Filthy living environment, strong odors
- Little or no food in the refrigerator, or decayed and moldy food
- Many pets or animals who appear neglected
- Garbage or litter; excessive alcohol containers
- Unkempt lawn or walks
- Mail or newspapers not taken in

### Sexual Abuse

- Evidence of sexually transmitted disease
- Irritation or injuries to the mouth, genitals, or anus
- Upset when changed or bathed
- Fearful of a particular person
- Loss of bowel and bladder control

### Physical Abuse

- Frequent injuries such as bruises, burns, broken bones, especially when the explanation of the injury seems unrealistic
- Multiple bruises in various stages of healing, particularly bruises on inner arms or thighs
- Chronic or acute physical illness
- Pain on being touched
- Obvious malnutrition, dehydration
- Loss of bowel and bladder control
- Many medicine bottles in sight; seems sleepy, sedated
- Appears frightened or withdrawn
- Never leaves the house; never allowed visitors
- Never mentions family or friends
- Confined to a chair or bed
- Locked in a room or tied up
- Clothes that are not appropriate for the weather

### Financial Abuse

- Unusual activity in bank account; sudden large withdrawals, expenditures that are not consistent with past financial history
- Use of Automated Teller Machines (ATM) when the person has no history of using ATMs or cannot walk or get to an ATM
- A recent Will, when the person seems incapable of writing a Will
- Rights signed away on legal papers without understanding what the papers mean
- Unpaid bills, such as house payment, rent, taxes, utilities
- Lack of food, clothing, or personal supplies
- Title to home signed over in exchange for a promise of "life-long care"
- Missing personal belongings such as art, silverware, jewelry, TV

### Emotional/Psychological Abuse

- Isolated from family and friends
- Sudden dramatic change in behavior: appears withdrawn, depressed, hesitant to talk openly
- Caregiver won't let victim speak for herself
- Caregiver scolds, insults, threatens victim
- Trembling, clinging
- Fearful, hopeless, anxious
- Lack of eye contact
- Confused, disoriented
- Angry, agitated

From the Kentucky Cabinet for Health and Family Services, www.chfs.ky.gov

Advancing Excellence
in America's Nursing Homes

KCPCC
Kentucky Coalition for Person Centered Care


## It's Time to Get Involved Because …

- According to a national study, more than a half-million elderly people are abused every year in the United States – and for every reported incident, five go unreported.
- People of all ages, regardless of their mental and physical abilities, have the right to be safe.
- Society pays the price of most medical treatment, adult day care, nursing home care, home care, mental health services, intervention services and housing assistance for the abused, as well as civil or criminal prosecutions of abusers.
- The problem is too big and too costly. Government programs alone can't fix it, but it can and must be stopped.
- Each time an older person is neglected, abused, or killed, society loses the sum of a life – the knowledge gained from overcoming personal hardships and handicaps, the strengths earned by surviving tragedies and fears, and the wisdom achieved through loving others -losses that lessen us as a people and a country.

Because if we don't, who will?

From the Kentucky Cabinet for Health and Family Services, www.chfs.ky.gov