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Pennsylvania Association of Home Health Agencies
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January 11, 2000

Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

RE: Pennsylvania Bulletin, Volume 29, Saturday, November 27, 1999, Protective Services for Older Adults

Dear Mr. Hussar:

The Pennsylvania Association of Home Health Agencies (PAHHA) regrets that we failed to submit our comments within the thirty-day comment period provided in the Notice. We were unaware of the publication of the proposed regulations until after the close of the comment period. We request the Department to take our comments into consideration despite this failure on our part.

PAHHA supports the proposed regulations. We particularly endorse the definitions in Section 15.2 of ***home health care agency*** and ***Care***, and Sections 15.131 through 15.138 **Criminal History Record Information Reports**. We believe that the proposed definitions are both thorough and accurate. These definitions assure that employees and administrators of all Pennsylvania home care providers are equally obligated. This equal obligation helps to insure maximum protection for Pennsylvania citizens. We also believe that the combination of the statutory language in Acts 169 and 13 and the proposed regulatory language in Sections 15.131 through 15.138 create Pennsylvania criminal record check requirements that are a model for the country.

Thank you for this opportunity to record our support for the proposed regulations.

Sincerely,

(Ms.) Terry O'H. Stark, CAE
Executive Director

cc: Independent Regulatory Review Commission
House Aging and Youth Committee
Senate Aging and Youth Committee

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January 12, 2000

John J. Jewitt
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Re: Comments on the Older Adult Protective Services Act proposed regulations

Dear Mr. Jewitt:

Right now, many highly qualified and caring workers are being fired from their jobs in the human services field and being prohibited from finding similar employment because of amendments to the Older Adults Protective Services Act. This has serious consequences not only for them but also for human service providers and for the vulnerable individuals they serve.

We are writing to you in the hope that the Independent Regulatory Review Commission (IRRC) will interpret the law the way that legislators meant it to be interpreted — to affect vulnerable elderly citizens only.

In 1996, the Older Adults Protective Services Act was amended to require adult care facilities to do a criminal background check on prospective employees and deny employment to persons who have committed any of the listed criminal offenses. It provided an exemption for crimes committed more than 10 years earlier.

But before that law took effect, the General Assembly passed an additional amendment that eliminated the exemption and applied the ban to a job applicant's lifetime. The list of offenses ranges from murder to nonviolent crimes such as retail theft, and includes misdemeanors. The law also calls for the termination of any employee with such a criminal record, regardless of job performance, if the person was hired after June 30, 1997. The law does not allow for the possibility of recovery or rehabilitation following a conviction for one of the included offenses.

In reviewing the history, we find that the legislators seemed to believe that they were passing legislation that would protect vulnerable elderly citizens who are care-dependent — certainly a laudable goal. But, as it is currently being interpreted, the law has a much broader impact, with very serious and apparently unintended consequences for the human services agencies that provide care to people with mental illness, people with mental retardation, people with physical disabilities, and people in substance abuse and recovery programs, as well as to the elderly.

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Many affected employees are being fired or denied employment because of crimes that are more than 10 years old (and sometimes decades old). Many of these valuable employees have specialized training as well as life experiences (in the case of drug & alcohol and mental health workers) that uniquely qualify them to work in this field. Others have spent years working in care-giving, demonstrating their complete rehabilitation by devoting their lives to helping others.

These employees are now restricted to their current jobs, since changing employers within the same field would expose them to the amendment's prohibitions. The law apparently also applies to individuals who are employed in facilities in non-care-giving capacities, such as grounds keeping or kitchen work.

In the course of applying this law as it now stands, many human service agencies have lost and will continue to lose many exemplary employees, who are unfairly losing their livelihoods because of mistakes made long ago. Furthermore, many "care-dependent individuals" who have been served well over the years are losing critical connections and support. The amendments also make it difficult to find qualified direct-care workers in an already tight job market.

It should be noted that employers in the human service field believe that a criminal background check is an appropriate mechanism for screening prospective employees. The agencies have always utilized this mechanism, along with individual review, as a way of finding quality employees.

We strongly urge you to develop regulations that narrowly define the population and the facilities that the Act will cover. The regulatory process is now the only means available to protect individuals who have paid their debt to society, are truly rehabilitated, and have a great deal to offer in the service of people who need care, as well as the hundreds of provider agencies who would like to be able to hire them. It is also the only way to protect the many, many people with disabilities who have and would continue to benefit from their care.

Therefore, we respectfully request that the final regulations reflect the following:

- The Act should be interpreted as narrowly as possible. Specifically, the provisions of this Act should be restricted to programs for persons 60 years and older. Institutions that serve the mentally ill/mentally retarded or substance abusers should be excluded from the definition of "facilities".
- The final regulations should provide for a timely and effective appeals process that would allow case by case review of individual situations for those applicants or employees toward whom OAPSA has been unfairly or incorrectly applied.
- The final OAPSA regulations should eliminate the employment restriction on individuals who have arrests only and no convictions, and are therefore not covered by the Act itself.

Finally, we endorse the comments submitted by the Employment Unit of Community Legal Services (CLS), and ask that you incorporate the restrictions and additions that CLS has requested.

Thank you for this opportunity to comment on the proposed regulations.

Sincerely,

Mary Hurtig

Mary Hurtig
Director of Policy

COMMUNITY LEGAL SERVICES, INC.

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January 10, 2000

By fax only

John H. Jewitt, Regulatory Analyst
Independent Regulatory Review Commission
333 Market Street, 14th floor
Harrisburg, PA 17101

Re: Draft comments on proposed regulations regarding Protective Services for Older Adults

Dear John:

As we discussed last week, Community Legal Services wishes to weigh in on the employment aspects of the proposed regulations governing the Protective Services for Older Adults. Given the schedule of IRRC's consideration of these regulations, an initial draft follows. A final version will follow by the end of the week.

I will call you to discuss this matter shortly, but if you wish to speak with me before you hear from me, you can reach me at **(215) 981-3719**. Thanks for your help.

Very truly yours,

Sharon M. Dietrich

SHARON M. DIETRICH

Comments of Employment Unit of Community Legal Services, Inc., On Proposed Regulations About Protective Services for Older Adults (Draft)

The following are comments concerning the proposed regulations on 6 Pa. Code Ch. 15, governing protective services for older adults. The proposed regulations were published in the Pennsylvania Bulletin on November 27, 1999, Vol. 29, No. 48 at pp. 6010-6027.

The Employment Unit of Community Legal Services, Inc. ("CLS") has received many requests for representation from workers who have lost their jobs, and sometimes their livelihoods, because of the implementation of the amendments to the Older Adult Protective Services Act ("the OAPSA" or "the Act"). A sample of case descriptions of some of our clients is attached. While the statutory goal of protecting vulnerable adults is of course commendable, the consequences of the amendments to the workers who provide their care can be extreme. Many of our clients were terminated by employers who regretted having to let go valued and trusted employees. Many have worked in the nursing home or home health care industries for years and now face foreclosure from the only occupation for which they are trained because of a crime for which they have served their punishment, sometimes a decade or more ago.

Because the stakes are so high for workers, we urge both the Department and the Independent Regulatory Review Commission to carefully consider their interests when reviewing the proposed regulations. Our comments below about the proposed regulations seek to protect employee interests by: (1) urging an appropriately narrow construction of the Act to limit the circumstances under which workers are precluded from employment; (2) seeking remedies for persons who have been wrongly denied employment as a result of the Act; and (3) requesting appropriate assistance, communication, and confidentiality by facilities. In some cases, we point out that the proposed regulations are overbroad and inconsistent with the Act; in others, we indicate that additional provisions are needed and would be consistent with the statute.

The OASPA Should Be Construed Narrowly To Limit the Circumstances Under Which Workers Are Precluded from Employment.

- **The definition of "facility" should make clear that it applies only to the nursing home or long-term care facility itself, and not to a larger entity of which that facility may be a unit (such as a hospital).**

Problems have already arisen, and presumably will arise in the future as health care entities grow, wherein applicants are not hired or employees are terminated because health care administrators–facing a threat of potential criminal prosecution–read the statute more broadly than required. Gregory McCoy's situation provides an example. Mr. McCoy was employed through a temp agency to provide housekeeping services at Albert Einstein Medical Center from

November of 1998 until July of 1999. When a full-time position came open, Mr.McCoy applied for it, but was informed that Albert Einstein, which runs a long-term care facility on one floor of one of its buildings, could not hire him because of a single drug-related conviction from many years before.

The facilities that are covered by this Act are limited to domiciliary care homes, home health care agencies, long-term nursing facilities, older adult living centers, and personal care homes. The regulations should clarify that the Act does not cover hospitals, nor does it prohibit hospitals or other entities from hiring or retaining as employees individuals with convictions merely because they run long-term facilities as a small part of their operations. Rather, it merely prohibits employment of those individuals within the physical confines of those long-term care units.

- **The regulations should provide that an employee of a facility is not required to provide criminal record information (and thus lose his "grandfathered" status) where that facility is bought by another owner.**

The proposed regulations fail to make clear that an employee of a facility is not required to provide criminal record information to a new owner where that employee and the facility had already been in compliance with the law, 35 PS § 10225.508 (1).

One of our clients, Norman Sturgis, provides an example of a situation which requires clarification of the regulations. Mr. Sturgis was employed as a housekeeper at the Philadelphia Geriatric Center (PGC) for 13 years. When Temple Continuing Care Center (TCCC) bought the facility in July, 1999, it retained all former employees of PGC and rolled over the existing Collective Bargaining Agreement. However, TCCC notified Mr. Sturgis that it would have to terminate his employment under the Older Adult Protective Services Act because of a conviction for forgery from 1980.

This result should not have occurred under the OAPSA, which clearly exempts from the criminal records provisions employees who are continuously employed by a particular "facility" for over one year.

- **The proposed regulations impermissibly add requirements about arrests for crimes that might prohibit hiring applicants or retaining employees, even though the statute only prohibits employment of persons with convictions.**

The OAPSA prohibits facilities that fall under the statute to hire or retain as employees individuals who have been convicted of certain enumerated criminal offenses. The regulations as proposed place an added burden on applicants and employees to track and document arrest information for which there has been no final resolution, grading of the offense, or "other information required in making a determination regarding an applicant or employe." See

proposed 6 Pa. Code § 15.133(c), and definition of "open disposition" found in proposed 6 Pa. Code § 15.2.

There are several problems with this provision. First, the regulation states that facilities are required to terminate employees with open dispositions of greater than 60 days, despite the OAPSA mandate that only convictions require termination. The inferred presumption that an [open] arrest or the incomplete reporting of the disposition of an arrest [ungraded crime] is equivalent to a finding of guilt violates due process. Pennsylvania law clearly prohibits employers from not hiring or from firing employees based on arrests alone. 18 P.S. §9125; Cisco v. United Parcel Service, 328 Pa. Super. 300; 476 A.2d 1340 (Sup. Ct. 1984). Second, the regulations require applicants or employees to submit documentation of disposition within sixty (60) days of receipt of the original report, regardless of whether or not it is in the applicant's or employee's power to do so. Finally, the regulations inexplicably fail to provide the same exemptions for court scheduling in out-of-state open dispositions that they do for in-state open dispositions.

Remedies Should Be Provided to Workers Who Are Wrongly Denied Employment or Removed from their Employment.

- **The proposed regulations do not provide a remedy for employees who are wrongfully terminated or who resign based on misinformation provided by the facility.**

The proposed regulations provide that facilities must reinstate employees in situations in which an employee successfully challenges the accuracy of his criminal record. But the proposed regulations do not provide any remedy for employees who are terminated in circumstances in which facilities have misapplied the law, in error or in an excess of caution. We have already seen several such cases.

Similarly, facilities should be required to reinstate employees who resign their positions (in which they are exempt from the application of the statute) based on misinformation provided to them by the facility administrators or personnel. In one such example, a long-term employee of a nursing home applied for a better-paying job at a different facility (with a different owner). After being assured by the human resources personnel at both facilities that his criminal history would not present a bar to his new employment, he quit his job at the old facility and began work at the new one. One month later, his new job was terminated, with great apologies, when it was determined that he could not, in fact, be hired at the second facility under the OAPSA.

- **The proposed regulations should require a facility to reconsider an applicant whose criminal record has been successfully challenged.**

The proposed regulations provide that facilities may reconsider the applicant's application for employment in situations in which an applicant successfully challenges the accuracy of his

criminal record. The proposed regulations should make clear that, as with all employment determinations, the employer's hiring determination must be made subject to 18 P.S. §9125. Consequently, the regulations should provide that facilities "shall" reconsider the applicant's application for employment in situations in which an applicant successfully challenges the accuracy of his criminal record, and may hire the applicant where the only impediment had been the erroneous application of the Act that had prevented/precluded employment.

- **In order to avoid incorrect and harmful employment decisions by facilities based on misinterpretation of the Act, each applicant or employee whom a facility has discharged or failed to hire pursuant to the Act must have a right of appeal to the Department of Public Welfare, which is charged with implementation of the OAPSA.**

The final regulations should require that each facility provide written notice to each applicant and employee at the time of a decision not to hire or to terminate pursuant to the Act, which notice explains the right and procedure for an appeal. The final regulations should establish the procedure for such an appeal.

Without such an appeal mechanism, there would be no forum to determine the correctness of any facility's individual decision under the Act, and no forum to ensure reinstatement as discussed above.

In addition, the final regulations should establish a procedure by which facilities and/or applicants or employees could request advisory opinions from one of the enforcing agencies regarding coverage of the OAPSA in individual circumstances. Such a process could avoid needless denials of employment or terminations from employment where not required by the Act, particularly as such opinions may reassure facilities concerned with the possibility of the assessment of civil or criminal penalties if they employ someone in less that certain circumstances.

Workers Should Be Entitled to Appropriate Assistance, Communication and Confidentiality by Facilities.

- **The proposed regulations do not reflect the statute's requirement that facilities are required to pay for the criminal history records of their current employees.**

The statute requires applicants to submit criminal record histories, but clearly places the burden on facility administrators to determine whether current employees must be terminated under the Act. §10225.502. In one exceptional provision, the proposed regulations recognize this distinction and state that although the burden to obtain criminal records is on the applicant, the facility may decide to "assume financial responsibility for the fees." See §15.134(c). The proposed regulations, however, generally lump together applicants and employees in their mandate to obtain and pay for criminal record history information. The final regulations should

make clear that current employees are, under the statute, to be treated differently from applicants and that the burden remains on the facility to pay for the criminal records that are required for their retention determinations.

- **Employees should not be made responsible for determining whether they are required to obtain criminal history record information, as the Act places that responsibility on the facilities.**

The statute clearly places the responsibility (both criminal and civil) for determining an employee's eligibility to remain employed on the employer. 35 P.S. §10225.505. The proposed regulations, however, appear to contradict the statute by placing the burden on the employees to determine whether they are covered by the OAPSA and by providing them with no remedy should they receive little or incorrect information on how to comply with the statute.

- **Written information should be made available to applicants affected by this Act.**

Explanations of the applicant's responsibility to provide criminal records should be provided in writing as well as orally. See 6 Pa. Code Ch. 15, §15.133(e). Furthermore, upon receipt of an applicant's criminal record and a decision not to hire that individual because of prohibited offenses, the applicant should be informed of the reason for this decision in writing, pursuant to 18 P.S. §9125, and should be notified of his or her appeal rights under these proposed regulations. Additionally, the facilities should be required to provide copies of criminal record information to the subject individual.

- **Facilities should be required to provide copies of criminal record information which they receive to the affected employees.**

- **Confidentiality of criminal history records should apply to employees as well as applicants.**

The proposed provision applies only to applicants. See 6 Pa. Code Ch. 15, §15.133(f).

Miscellaneous Provisions

- **The proposed regulations should define clearly the term "similar in nature," with regard to federal or out-of-state crimes that bar employment of an applicant or employee.**

The statute enumerates of list of crimes found in the Pennsylvania crimes code that prohibit facilities from hiring applicants or retaining employees and also bars employment of those convicted of a Federal or out-of-state offense "similar in nature." This language is arguably

unconstitutionally vague and the proposed regulations should provide a clear definition that cannot give rise to arbitrary interpretations of that phrase.

Additionally, the final regulations should establish a procedure by which applicants or employees who have been barred from employment because of the "similar in nature" provision could appeal this determination or request advisory opinions from the Department of Public Welfare regarding coverage of the OAPSA in their particular circumstances.

- **Facilities at which care is provided by employees supplied, referred or arranged by other facilities should not be permitted to have criminal history record information made available "when necessary."**

Section 15.133(i)(2) of the proposed regulations states that criminal records shall be made available "when necessary" to facilities at which care is provided by employees supplied, referred or arranged by other facilities. This provision is troublesome for several reasons. First, it is superfluous; the proposed regulations already provide that written assurance of compliance is sufficient to meet the terms of the Act. Second, the term "when necessary" is extremely vague and could open the door to situations in which the statute is read in an overbroad manner. Finally, this provision could be read and used in a manner inconsistent with the confidentiality provisions of the regulations. See 6 Pa. Code Ch. 15, §15.133(f).

Selected Stories of Clients of Community Legal Services
Who Have Lost Employment Because of the Older Adult Protective Services Act

B. J.

B.J. was convicted of voluntary manslaughter 15 years ago. After suffering more than 10 years of battering at the hands of her boyfriend, B.J. accidentally stabbed a third party with a knife when he jumped between her and her boyfriend during a violent fight. She was sentenced to three months in jail and five years of probation, but the judge released her from supervision so that she could move away from the continually violent boyfriend. After her ex-boyfriend found her in Erie, B.J. was forced to move to Pittsburgh, where she settled for a number of years.

While she was living in Pittsburgh, B.J. went to school and became a Certified Nurse's Aide. She worked for three years in a nursing home before leaving to raise her grandchildren. Now that she is trying to get back into nursing and caring for the elderly, she finds that the OAPSA blocks her from employment because of her 15-year-old conviction.

Marie Martin

Marie Martin was convicted of felony drug delivery in 1988. She describes herself as using drugs because she was "young and dumb" and rebelling against her parents. She started working as a Certified Nurse's Aide in August of 1997 but is now unable to gain employment in her profession because of the OASPA. Her former employer, Resources for Human Development, terminated her with great reluctance, as she was a model employee, well-loved by her patients and colleagues alike. Ms. Martin's story has another tragic twist: she has cancer and is unable to pay for COBRA to cover her health insurance. She is understandably concerned that any other job she gets will be unable to cover her health care because of this pre-existing condition.

Patricia Ashmore

Pat Ashmore is a registered nurse in Delaware County who was terminated from Mercy Home Health Care after her employer learned that she had a misdemeanor theft conviction from 1977. At that time, Ms. Ashcroft was approached by her husband (now ex-husband) came home with a silver plate and asked her if she knew anyone who sold antiques. Ms. Ashcroft sold the plate to a friend for $60, and was arrested when it turned out to be stolen property. Ms. Ashmore had been under the impression that the conviction was erased because of her successful participation in an ARD program. She is currently working to get the record expunged. However, it should be noted that Mercy was not required to terminate Ms. Ashmore for a single misdemeanor theft conviction, and this case is an example of the ways in which this statute is being applied overly broadly.

LaVerne Smith

LaVerne Smith was convicted of involuntary manslaughter in 1967 when one of her four children died of malnutrition. She was 17 or 18 years old at the time. Ms. Smith served three years of probation and for the next ten years or so held various jobs. She has been on public assistance ever since.

In 1997, as part of the welfare-to-work initiative, Ms. Smith was required to find work. She wanted to get training in the culinary arts, but her caseworker pressured her to go to nurse aide training, which she completed in 1998. Ms. Smith went to work at IAMA Home Health Services. She was very successful at her job and enjoyed it very much, until a criminal record check by her employer required their terminating her service with them. She is frustrated that a tragic occurrence over thirty years ago should bar her from employment now, particularly since it was DPW that directed her toward that employment in the first place.

COMMUNITY LEGAL SERVICES, INC.

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ORGANIZATION: Indep. Regulatory Review Comm.

FROM: SHARON DIETRICH

DIRECT DIAL: (215) 981-3719

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December 30, 1999

Robert Hussar
Division of Program and Regulatory Coordination
Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:

First, let me say that, as part of the aging network in Pennsylvania, my staff and I are pleased with the Department's efforts in updating the Protective Services Regulations. I believe the changes made reflect the intents to update the language, and incorporate the 10 years of network experience as well as incorporating new legislation regarding employment practices and reporting of abuse in state licensed facilities.

My staff and I have reviewed the draft and would offer the following thoughts and questions:

Page 6-H. Are reports categorized "No Need for Protective Services" included in this section?

Section 15.13 (B) Does the deletion of the former (4) mean that the Ombudsman or Pre-Admission Assessment Case Worker MAY be designated as a protective service worker? There had been a perception that this was a conflict of interest. Has that opinion changed?

Section 15.21 (b) A clearer direction is needed regarding emergency involuntary intervention situations to assist the staff and the court in making decisions.

Section 15.26 (b 5) We are very pleased to see the addition of this section. It clarifies a previously problematic area.

Section 15.27 (b) Does the term "Completed report" refer to the Report of Need or the newly developed report form? Is it correct to assume that oral reports are no longer sufficient?

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Section 15.41 (a) Good addition

Section 15.42 (b) Depending upon how this section is utilized, it can either be good or bad. Caution needs to be taken to avoid "political" motives.

Section 15.43 (c) There has been some confusion regarding the interpretation of "maintained for a period of 6 months." Does it mean that records should be destroyed on the 183 day?

Section 15.81 (2) Should record remain report to comply with section 15.105?

Section 15.96 (c) We concur that the elimination of the requirement for reassessment at least every 30 days is a good deletion. The timing of reassessment should be based on the consumer's needs.

15.96 Agree that verbal notification of termination of protective services is sufficient.

15.121 (c) 2 Do staff assigned to Protective services on-call also need to have one year direct aging casework experience?

Section 15.141 What will be the format of the facility's written report to the agency?

Section 15.145 We appreciate the clarification in this section.

Section 15.147 We generally appreciate the clarifications made in this section. However, in section (d) "...an alleged perpetrator and victim may receive a copy of all information." We question the use of the term "all"?

Should you need clarifications on any of the comments or questions raised please feel free to contact me.

Again, we appreciate the opportunity to provide input into the development of the regulations.

Sincerely yours,

M. Crystal Lowe
Director

cc: Mary Reiss, YCAAA Director of Social Services
Dianna Meals, YCAAA Protective Services Supervisor
Valarie Weiner, P4A, Executive Director

philadelphia corporation for aging

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December 27, 1999

VIA FACSIMILE (717-783-6842) AND FIRST CLASS MAIL

Mr. Robert F. Hussar
Chief, Division of Program & Regulatory Coordination
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919

Re: Proposed Changes to the OAPSA Regulations

Dear Mr. Hussar:

Thank you for the opportunity to comment on the proposed amendments to the regulations promulgated under the Older Adults Protective Services Act ("OAPSA") at 6 Pa. Code Chapter 15. Philadelphia Corporation for Aging ("PCA") has the following comments:

(1) PCA is concerned, generally, with the definitional changes made by the Department where the original definition appears in the OAPSA statute itself. For example, the Department has deleted from the definitions of abuse and neglect the requirement that an older adult will not be found to be abused or neglected solely on the basis of environmental factors. (See paragraph 3, below, for further comments on this change.) Similarly, the Department has removed from the definition of caretaker the proviso that OAPSA is not intended to impose responsibility on a caretaker where it does not otherwise exist as a matter of law. Also, the Department has eliminated investigative activities from the definition of protective services. It is unclear to PCA what the Department's intended effects are in eliminating the Legislature's language from the regulations. It is PCA's understanding that the Department cannot by regulation modify a statute absent a clear grant of administrative authority. PCA respectfully requests further articulation of the Department's regulatory intent prior to the amendment of the regulations in these areas.

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(2) There is a change to the definition of incapacitated older adult that is well meaning but incomplete. The reference to the Act of June 30, 1972 (pertaining to incompetents) should not be deleted because that Act was not repealed by the Act of April 16, 1992 (pertaining to incapacitated persons). Thus, there currently exist both incompetent persons and incapacitated persons under Pennsylvania's Probate, Estates and Fiduciaries Code. Accordingly, the definition of incapacitated older adult should make clear that the term carries no reference either to capacity or incapacity, or competence or incompetence, as defined in Pennsylvania's guardianship statutes.

(3) The Department's addition to Section 15.21, general reporting provisions, of language pertaining to environmental factors is internally contradictory and confusing and fails to take into account a difference between the statutory definitions of abuse and of neglect. OAPSA provides that a person consenting to the provision of protective services may, in fact, be found to be neglected solely on the basis of environmental factors; a person may not be found to be abused solely on this basis even with his or her consent. Admittedly, this is an area of OAPSA that would benefit from further clarification but the proposed regulation does not provide necessary guidance.

(4) Revised Section 15.27 would require an area agency on aging ("AAA") to release a report of need, in an unredacted form, directly to the appropriate state licensing agency. PCA believes that the sensitive and confidential information essential to a protective services investigation is not necessarily relevant to the mission of a licensing agency and, accordingly, that an AAA should only be required by the regulation to turn over sufficient information so that the licensing agency may pursue its own investigation of a licensed facility. Under no circumstance should such information identify a person making a report of need or cooperating with an investigation under OAPSA.

(5) Revised Section 15.42 (d) would delete language carefully crafted by former Department Chief Counsel David Hoffman in an effort to protect older adults from retaliation by alleged perpetrators. Under existing language, an investigation is completed only when a report of need has been determined to be substantiated or unsubstantiated and, if substantiated, after necessary steps have been taken to reduce an imminent risk. Thus, and the Department has been consistent about this over the years, if the AAA cannot remove the risk for any reason at all, the investigation is not deemed to be completed and the alleged perpetrator has no notice or appeal right. There is a body of literature and a clinical sense among many protective services people suggesting that, in cases where there is no ability to remove risk, notification of alleged perpetrators has

the potential to put clients at even greater risk of harm or retaliation (and this even though the clients may not have asked for help to begin with!). It is PCA's position that the Department should attempt to find a way to continue the protections given in the past rather than to argue (as PCA understands the Department's position) that the Pennsylvania Constitution's recognition of a "reputation" interest requires notice. There is no authority squarely on point supporting the Department's position and there are compelling arguments that any reputation interest would have to be balanced against the client's interest in privacy and even life. Moreover, it is questionable whether a reputation interest is at all present when the AAA's findings remain confidential within the protective services file (as required under OAPSA) and there is accordingly no public dissemination of the investigatory information. See PCA's letter to you of August 27, 1999, in response to the Draft Aging Program Directive entitled "Perpetrator Designation and Notification in Protective Services," for amplification of PCA's position; a copy of this letter is enclosed for your convenience.

(6) PCA applauds the proposed amendment to Section 15.95 that would eliminate the need for monthly reassessment without regard to the individual facts of a case.

(7) Section 15.122, subsection (9), should make reference both to incompetence and incapacity as curriculum topics.

(8) Proposed Section 15.146 would represent one of the most onerous unfunded mandates ever imposed upon an AAA. There is quite literally an infinite number of facilities, licensed and unlicensed, within an AAA's service area. (See the definition of facility contained in the regulations.) Even if limited to nursing homes, personal care homes, adult day care centers, domiciliary care homes and licensed home health agencies (and the regulation is not so limited), it is inconceivable that the Department could expect the AAA to engage in a review of the plans to be submitted by each and every one of these agencies, to review revisions to these plans, to convey written approvals of these plans or to monitor compliance or non-compliance by facilities with this requirement.

(9) Proposed Section 15.148 (a)(4) and (c), pertaining to AAA notification of regulatory agencies and police in the case of failure by a facility to adhere to mandatory reporting requirements, should be clarified. Not every failure to report on the part of a facility is subject to administrative or criminal penalties; the failure to report must be made with a requisite degree of intent. The regulation should specify the standard to be applied by the AAA in identifying and reporting such failures, taking into account that the AAA is not charged with making findings in this regard.

Thank you very much for the opportunity to comment on these proposed regulations.

Sincerely,

PHILADELPHIA CORPORATION FOR AGING

RODNEY D. WILLIAMS
President

Enclosure

cc: Valerie Weiner, Director, PAAAA (with enclosure)
Independent Regulatory Review Commission (with enclosure)

philadelphia corporation for aging

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August 27, 1999

VIA FACSIMILE (717-783-6842) AND FIRST CLASS MAIL

Mr. Bob Hussar, Division Chief
Program & Regulatory Coordination Division
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919

RE: Draft APD, "Perpetrator Designation and Notification in Protective Services"

Dear Mr. Hussar:

Thank you for the opportunity to comment on the Draft Aging Program Directive entitled "Perpetrator Designation and Notification in Protective Services" ("Draft APD"). Philadelphia Corporation for Aging ("PCA") has the following comments:

(1) The Draft APD is not consistent with existing statutory and regulatory language pertaining to substantiation and notification, which in all cases refers to the rights of "alleged perpetrators" rather than "perpetrators." The Department of Aging ("PDA") should carefully consider whether the Area Agencies on Aging ("AAA's") should be asked to label individuals or entities as perpetrators of abuse, neglect, exploitation or abandonment ("ANEA").

(2) The Draft APD is not consistent with existing statutory and regulatory language, which expressly limits the information available to alleged perpetrators (who receive notice of substantiation along with a "brief summary of the allegations") to the information contained in reports of need *but not the findings of the AAA's* (which the AAA's are generally *prohibited* from releasing, but which PDA is certainly free to consider releasing in the course of the appeal process).

(3) AAA's are required under the Older Adults Protective Services Act ("Act") and the Crimes Code to make certain reports to law enforcement and regulatory agencies *without regard to whether the underlying reports of need have been fully investigated or substantiated.* In such cases, the alleged perpetrators would have available to them the due process rights associated with those forums and would appear to have no need for notice and appeal rights under the Act. Conversely, in those cases in which alleged perpetrators are referred to law enforcement and regulatory agencies "for the purpose of initiating action against the individual . . . subsequent to an investigation," the AAA's would have substantiated the reports of need, and notice and appeal rights under the Act would already apply. PCA recommends that the Draft APD be revised to clarify the requirements in these circumstances. (PCA also asks that PDA clarify the circumstances in which an individual would be reported to a court.)

(4) The Draft APD makes no attempt to define "timely" as it relates to notification to alleged perpetrators; clarification in this area would be greatly appreciated.

(5) Most importantly, the Draft APD would undo existing regulatory authority (and PDA policy) that allows notification of an alleged perpetrator to be postponed until the risk has been removed; indeed, if the risk cannot be removed, existing law and policy permit notification to be postponed indefinitely. PCA is extremely concerned that any change in the existing practice will place an extremely vulnerable population, which in many cases did not seek help from the AAA's in the first instance, at greater risk than existed before the reports of need were made.

PDA is reported to have predicated the changes to existing law, policy and practice, as found in the Draft APD, upon its understanding of the due process rights of alleged perpetrators and their reputation interests under the Pennsylvania Constitution. PCA respectfully requests that PDA undertake a careful review of state and federal jurisprudence in an effort to address:

(a) whether an individual's reputation interests are legitimately at issue when the AAA's findings, including substantiation of ANEA, have not been reported to anyone outside the agency and are maintained as confidential, as required under the Act; and

(b) whether (assuming reputation interests of alleged perpetrators become at some point legitimately at issue) the Commonwealth does not have a sufficiently compelling interest in the safety and well-being of older adults so as to preclude notification, without offending constitutional principles, when the AAA has been unable to fashion a remedy that would eliminate the risk to an older adult who has been the victim of ANEA.

PCA respectfully submits that the issues posed here were carefully considered by the authors of the Act, the Legislature, and several administrations at PDA over a lengthy period of time, and that PDA should engage in a very inclusive analysis and discussion before finalizing the Draft APD because of the great potential to harm the very class of citizens that the Act is designed to protect.

Sincerely,

PHILADELPHIA CORPORATION FOR AGING

Rodney D Williams /hc

RODNEY D. WILLIAMS
President

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December 27, 1999

VIA FACSIMILE (717-783-6842) AND FIRST CLASS MAIL

Mr. Robert F. Hussar
Chief, Division of Program & Regulatory Coordination
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919

Re: Proposed Changes to the OAPSA Regulations

Dear Mr. Hussar:

Thank you for the opportunity to comment on the proposed amendments to the regulations promulgated under the Older Adults Protective Services Act ("OAPSA") at 6 Pa. Code Chapter 15. Philadelphia Corporation for Aging ("PCA") has the following comments:

(1) PCA is concerned, generally, with the definitional changes made by the Department where the original definition appears in the OAPSA statute itself. For example, the Department has deleted from the definitions of abuse and neglect the requirement that an older adult will not be found to be abused or neglected solely on the basis of environmental factors. (See paragraph 3, below, for further comments on this change.) Similarly, the Department has removed from the definition of caretaker the proviso that OAPSA is not intended to impose responsibility on a caretaker where it does not otherwise exist as a matter of law. Also, the Department has eliminated investigative activities from the definition of protective services. It is unclear to PCA what the Department's intended effects are in eliminating the Legislature's language from the regulations. It is PCA's understanding that the Department cannot by regulation modify a statute absent a clear grant of administrative authority. PCA respectfully requests further articulation of the Department's regulatory intent prior to the amendment of the regulations in these areas.

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(2) There is a change to the definition of incapacitated older adult that is well meaning but incomplete. The reference to the Act of June 30, 1972 (pertaining to incompetents) should not be deleted because that Act was not repealed by the Act of April 16, 1992 (pertaining to incapacitated persons). Thus, there currently exist both incompetent persons and incapacitated persons under Pennsylvania's Probate, Estates and Fiduciaries Code. Accordingly, the definition of incapacitated older adult should make clear that the term carries no reference either to capacity or incapacity, or competence or incompetence, as defined in Pennsylvania's guardianship statutes.

(3) The Department's addition to Section 15.21, general reporting provisions, of language pertaining to environmental factors is internally contradictory and confusing and fails to take into account a difference between the statutory definitions of abuse and of neglect. OAPSA provides that a person consenting to the provision of protective services may, in fact, be found to be neglected solely on the basis of environmental factors; a person may not be found to be abused solely on this basis even with his or her consent. Admittedly, this is an area of OAPSA that would benefit from further clarification but the proposed regulation does not provide necessary guidance.

(4) Revised Section 15.27 would require an area agency on aging ("AAA") to release a report of need, in an unredacted form, directly to the appropriate state licensing agency. PCA believes that the sensitive and confidential information essential to a protective services investigation is not necessarily relevant to the mission of a licensing agency and, accordingly, that an AAA should only be required by the regulation to turn over sufficient information so that the licensing agency may pursue its own investigation of a licensed facility. Under no circumstance should such information identify a person making a report of need or cooperating with an investigation under OAPSA.

(5) Revised Section 15.42 (d) would delete language carefully crafted by former Department Chief Counsel David Hoffman in an effort to protect older adults from retaliation by alleged perpetrators. Under existing language, an investigation is completed only when a report of need has been determined to be substantiated or unsubstantiated and, if substantiated, after necessary steps have been taken to reduce an imminent risk. Thus, and the Department has been consistent about this over the years, if the AAA cannot remove the risk for any reason at all, the investigation is not deemed to be completed and the alleged perpetrator has no notice or appeal right. There is a body of literature and a clinical sense among many protective services people suggesting that, in cases where there is no ability to remove risk, notification of alleged perpetrators has

the potential to put clients at even greater risk of harm or retaliation (and this even though the clients may not have asked for help to begin with!). It is PCA's position that the Department should attempt to find a way to continue the protections given in the past rather than to argue (as PCA understands the Department's position) that the Pennsylvania Constitution's recognition of a "reputation" interest requires notice. There is no authority squarely on point supporting the Department's position and there are compelling arguments that any reputation interest would have to be balanced against the client's interest in privacy and even life. Moreover, it is questionable whether a reputation interest is at all present when the AAA's findings remain confidential within the protective services file (as required under OAPSA) and there is accordingly no public dissemination of the investigatory information. See PCA's letter to you of August 27, 1999, in response to the Draft Aging Program Directive entitled "Perpetrator Designation and Notification in Protective Services," for amplification of PCA's position; a copy of this letter is enclosed for your convenience.

(6) PCA applauds the proposed amendment to Section 15.95 that would eliminate the need for monthly reassessment without regard to the individual facts of a case.

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Thank you very much for the opportunity to comment on these proposed regulations.

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RODNEY D. WILLIAMS
President

Enclosure

cc: Valerie Weiner, Director, PAAAA (with enclosure)
Independent Regulatory Review Commission (with enclosure)

philadelphia
corporation
for
aging

August 27, 1999

VIA FACSIMILE (717-783-6842) AND FIRST CLASS MAIL

Mr. Bob Hussar, Division Chief
Program & Regulatory Coordination Division
Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919

RE: Draft APD, "Perpetrator Designation and Notification in Protective Services"

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Sincerely,

PHILADELPHIA CORPORATION FOR AGING

Rodney D Williams /bc

RODNEY D. WILLIAMS
President

Post-it Fax Note 7671	Date 12/27/99	pages 6
To John E. Nanorta, Jr.	From Betty Simmonds	
Co./Dept. IRRC	Co. PANPHA	
Phone #	Phone # 717-763-5724	
Fax # 783-2664	Fax # 717-763-1057	

P·A·N·P·H·A PENNSYLVANIA ASSOCIA
Kevin W. Jones, *Board Chair*

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MEMORANDUM

TO: Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging

FROM: Betty M. Simmonds, Public Policy Analyst

DATE: December 27, 1999

SUBJECT: Comments regarding proposed rulemaking to amend Chapter 15, Protective Services for Older Adults

Thank you for this opportunity to provide comment on the proposed rulemaking to amend the regulations regarding protective services for older adults. I appreciate the inclusion of many of PANPHA's comments on the April 1998, draft rulemaking in these proposed rules. Attached are PANPHA's comments on the proposed amendments to 6 Pa. Code Chapter 15, Protective Services for Older Adults. If you have any questions regarding these comments, please call me at (717) 763-5724.

Attachment

cc: Jeffrey Wood
Robert Klugiewicz
John E. Nanorta, Jr.
Richard H. Lee
Patsy Taylor-Moore

Comments by PANPHA on amendments to 6 Pa. Code Ch. 15.

It would be helpful to include a section regarding expungement of the criminal history record. Currently, there is no time limit regarding the criminal history record. Many facilities and potential employes do not know that expungement may be a possibility to enable a rehabilitated offender to work in a facility. In order to maximize the pool of potentially good applicants, an awareness of the availability of expungement is needed.

In order to maximize the effectiveness of limited resources, the Commonwealth may consider a stepwise investigative process for situations that currently involve multiple agencies. Either a licensing agency or the protective services agency could initiate investigation, and share information with the others that have a need to know. The other agencies could then accept the information, or at least use the information to focus further investigation to meet their statutory and regulatory requirements.

Guidance is needed in this proposed rulemaking regarding monitoring of contract employes that have direct contact with residents or unsupervised access to their personal living quarters.

§15.2 Definitions.

Abuse - The concept of intent is needed in the definition of abuse. A definition as the infliction of injury with resulting physical harm, pain, or mental anguish does not contemplate accidental injury, which results in physical harm, pain, or mental anguish.

Care - "Medical social services" should be "social services."

Case file - Language in the definition for "case file" to define items to be included in the file changes "client assessment" to "assessment". Client assessment is defined in § 15.2, but "assessment" is not.

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State licensed facility - A home health agency is also a state-licensed facility, although it does not provide a place of residence, and should be added to the definition.

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(e) Interference. Although not intending to interfere in the course of an investigation, nursing facility and personal care facility administrators may have to intervene in order to exercise their responsibility to safeguard the well being of their residents. In the course of an investigation in which protective services is involved, residents are often subject to questioning by facility staff, by representatives of the Department of Health or the Department of Public Welfare, representatives of the Department of Aging, and perhaps the police, which can be overwhelming for residents. The administrator, or his agent, may have to intervene in order to protect the resident.

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(d) Why is "service plan" changed to "care plan" in this section? The term care plan is not used elsewhere.

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In order to prevent multiple agencies from asking the same questions of victims of abuse or neglect, provision is needed to make information regarding protective services investigations available to all agencies that are required to be involved in investigation of the incident. This would provide a core of information, then the various agencies could follow up on additional information that they need in order to complete their investigations.

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(b) New hires or assignees to protective services investigative, assessment and service planning functions must submit an FBI criminal history record report for those who are not residents of the Commonwealth How long must an individual reside in the Commonwealth before he is a resident? § 15.131 establishes requirements for FBI reports for prospective facility personnel who are not residents of the Commonwealth, or who have not resided in the Commonwealth for an uninterrupted period of 2 years preceding the date of application for employment. Does this same criteria apply to applicants for protective services staff positions?

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(14) This section requires the protective services investigation training curriculum to include coordination with other State agencies, but there is no provision for actually sharing information in § 15.105.

§ 15.132 Facility personnel requirements.

(a)(5) Staffing agencies must be required to provide criminal history record information to facilities for staff that they assign.

§ 15.133 Facility responsibilities.

The facility's responsibility is unclear in the case of a current employe who was not required to submit criminal history record information, but who is subsequently convicted of one of the listed offenses.

(c) Language should be inserted in this section to clarify that if the reason for open disposition is court scheduling, the facility can hire or retain the individual, provided that the facility checks the status every 30 days.

(d),(e),(g), and (h) - The language "criminal background check" and "criminal history record checks" should be changed to "criminal history record report, or information," as appropriate.

§ 15.134 Procedure.

(d) Language should clarify that "facility personnel" is meant to be facility personnel as listed in § 15.132(a).

(e) The term "clearance" should be changed to report.

§ 15.136 Facility personnel rights of review and appeal.

(b) If the facility is required to terminate an employe as a result of criminal history record information, then the report is changed as a result of a challenge by the employe, and the employe is reinstated, the facility should be held harmless for the termination.

§ 15.137 Provisional hiring.

(5)(ii) What is the expectation for "regular supervisory observation" of the applicant? Does this mean merely observation of the applicant is done as a supervisor would observe any employe?

(7)(b) Language should be changed from "criminal background check results" to "criminal history record information reports."

§ 15.138 Violations.

(a)(4) Which agency is meant in the statement, "To assist Commonwealth agencies to implement the responsibilities set forth in paragraph (3), representatives of these agencies who have knowledge of violations shall report them to the appropriate Commonwealth licensing agency?"

§ 15.142 Additional reporting requirements.

(a) It must be clear that it is sexual abuse, not sexual harassment that must be reported under the mandatory reporting requirements.

§ 15.145 Investigation.

(a)(6) "Adult day care center" should be changed to "older adult daily living center."

(b) Cooperation. As previously stated, all agencies involved in investigation must cooperate, and share relevant information, in order to preserve the well-being of the recipient to the greatest extent possible.

§ 15.146 Restrictions on employes.

Information should be included regarding the expected turnaround time for the agency and the State licensing agency to approve the facility supervision/suspension plan, and also the supervision/suspension/termination plan pertaining to the individual(s) involved in a specific instance. Agency resources must be sufficient to permit review of thousands of plans.

Will the department provide criteria that must be included in the plans?

How is "immediately" quantified, for example, "upon notification that an employe is alleged to have committed abuse, the facility shall immediately implement the plan of

supervision...The facility shall immediately submit to the agency and the Commonwealth agency with regulatory authority over the facility a copy of the employe's supervision plan...?"

§ 15.147 Confidentiality of and access to confidential reports.

(5) What is an "other medical institution where a victim is being treated?" Does this mean a long-term care nursing facility, a physician's office, or something else?

§ 15.148 Penalties.

(a)(4) It is unclear to whom "these agencies" refers.

No further comments.

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P·A·N·P·H·A PENNSYLVANIA ASSOCIATION OF NON-PROFIT HOMES FOR THE AGING

Kevin W. Jones, *Board Chair* • Ronald L. Barth, *President/CEO*

MEMORANDUM

TO: Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging

FROM: Betty M. Simmonds, Public Policy Analyst

DATE: December 27, 1999

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(d),(e),(g), and (h) - The language "criminal background check" and "criminal history record checks" should be changed to "criminal history record report, or information," as appropriate.

§ 15.134 Procedure.

(d) Language should clarify that "facility personnel" is meant to be facility personnel as listed in § 15.132(a).

(e) The term "clearance" should be changed to report.

§ 15.136 Facility personnel rights of review and appeal.

(b) If the facility is required to terminate an employe as a result of criminal history record information, then the report is changed as a result of a challenge by the employe, and the employe is reinstated, the facility should be held harmless for the termination.

§ 15.137 Provisional hiring.

(5)(ii) What is the expectation for "regular supervisory observation" of the applicant? Does this mean merely observation of the applicant is done as a supervisor would observe any employe?

(7)(b) Language should be changed from "criminal background check results" to "criminal history record information reports."

§ 15.138 Violations.

(a)(4) Which agency is meant in the statement, "To assist Commonwealth agencies to implement the responsibilities set forth in paragraph (3), representatives of these agencies who have knowledge of violations shall report them to the appropriate Commonwealth licensing agency?"

§ 15.142 Additional reporting requirements.

(a) It must be clear that it is sexual abuse, not sexual harassment that must be reported under the mandatory reporting requirements.

§ 15.145 Investigation.

(a)(6) "Adult day care center" should be changed to "older adult daily living center."

(b) Cooperation. As previously stated, all agencies involved in investigation must cooperate, and share relevant information, in order to preserve the well-being of the recipient to the greatest extent possible.

§ 15.146 Restrictions on employes.

Information should be included regarding the expected turnaround time for the agency and the State licensing agency to approve the facility supervision/suspension plan, and also the supervision/suspension/termination plan pertaining to the individual(s) involved in a specific instance. Agency resources must be sufficient to permit review of thousands of plans.

Will the department provide criteria that must be included in the plans?

How is "immediately" quantified, for example, "upon notification that an employe is alleged to have committed abuse, the facility shall immediately implement the plan of

supervision...The facility shall immediately submit to the agency and the Commonwealth agency with regulatory authority over the facility a copy of the employe's supervision plan...?"

§ 15.147 Confidentiality of and access to confidential reports.

(5) What is an "other medical institution where a victim is being treated?" Does this mean a long-term care nursing facility, a physician's office, or something else?

§ 15.148 Penalties.

(a)(4) It is unclear to whom "these agencies" refers.

No further comments.

PENNSYLVANIA HEALTH LAW PROJECT

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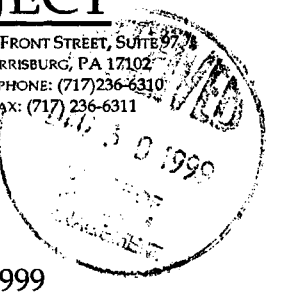

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Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging
555 Walnut Street
5th Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:

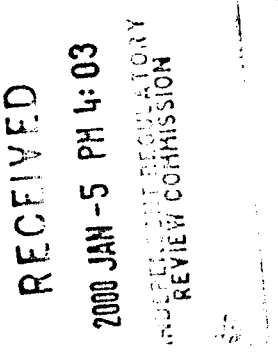
Enclosed please find the Pennsylvania Health Law Project's Comments to the Older Adult Protective Services Act Proposed Regulations, which we are filing on behalf of our client, the Armstrong County Low Income Rights Organization.

Sincerely,

Alissa Eden Halperin

Alissa Eden Halperin
Staff Attorney

cc: Mrs. Shirley Beer



Pennsylvania Health Law Project's Comments to the Older Adult Protective Services Act Proposed Regulations on behalf of the Armstrong County Low Income Rights Organization

DEFINITIONS

There are several confusing changes and additions to the definitions section of the proposed revisions to the Protective Services for Older Adults regulations.

a. **New Definitions.**

Administrator. The Administrator is the person responsible for administration of the facility. The term includes a person responsible for employment decisions or an independent contractor.

Applicant. The Applicant is a person who submits an application, which is being considered for employment, to a facility. The regulations should clarify that the applicant is a person who submits an application and is seeking employment with the facility. The way the proposed definition is drafted it might seem that the Applicant is the person who submits the application even though the person who physically submits the application could be someone other than the person seeking employment.

Care-dependent individual. A Care-dependent individual is an adult who, due to physical or cognitive disability or impairment, requires **assistance** to meet needs for food, shelter, clothing, personal care or health care. What does assistance mean in this context? This should be clarified. A suggested revision would be "financial, psychosocial, physical and other assistance".

Facility. A Facility is defined to include Personal Care Homes, Domiciliary Care Homes, Nursing Homes, Home Health Aides, and Adult Day Centers. For fairness reasons, hospitals must be included to the extent that they are providing long term care.

Intimidation. This is defined as An act or omission by a person or entity toward another person which is intended to, or with knowledge that the act or omission will, obstruct, impede, impair, prevent or interfere with the administration of the act or a law intended to protect older adults from mistreatment. Clearly, the actor who intends to obstruct, impede, impair, prevent or interfere with the administration of the act must be held accountable for that conduct that might or could achieve the result the actor intended. An actor who intends such a result can never know that the result **will** actually happen and their acting with the intention that it happen and the knowledge that

the intended results might or could happen must constitute punishable intimidation under the regulations.

b. **Revised Definitions.**

Caretaker - This revision removes from the regulations a provision that is in the act "It is not the intent of the act to impose responsibility on an individual if the responsibility would not otherwise exist in law." This is a good thing.

Client Assessment. - If in (iii) of the Case file definition, rename "client assessment" as "assessment", the regulations must do so here too in order to be consistent.

PROGRAM ADMINISTRATION

a. §15.27 Handling of Complete Reports. This section is amended to require that all reports regarding a licensed facility be provided to the licensing authority. This is an important addition to the regulations that provides for information sharing so that all responsible agencies and authorities can be kept apprised on actions or inactions relating to their licensees. This provision, however, lacks a timeframe within which such information should be provided to the licensing authority. How long after the completion of a report should the information be shared with the licensing authority? One month, one year? This should be clarified.

INVESTIGATING REPORTS OF NEED FOR PROTECTIVE SERVICES

a. §15.45 - Situations involving state-licensed facilities. This section requires that agencies notify the licensing authority immediately upon receipt of a report of need. This section, in conjunction with §15.27, will insure that information is promptly shared so that all responsible agencies and authorities can take appropriate actions within a timely fashion. Notwithstanding, immediately must be defined. A suggested language change would be "immediately but no later than 48 hours after the receipt of a report of need."

PROVISION OF SERVICES

a. §15.95 - Case Management. This section is revised so that individuals are no longer reassessed every 30 days and so that reassessment is no longer comprehensive nor involving the areas of client functioning evaluated in assessment. Additionally, reassessment no longer leads to a revision of an individual's service plan. According to the draft revised regulations,

reassessment now occurs only on termination, transfer or agency determination of need for reassessment. While receiving protective services, individuals who have been the subject of abuse or neglect require more continual care and continual assessment than provided by the revised regulations.

b. §15.96 - Termination of protective services. This section is revised to delete the requirement that the agency secure, where possible, a signed statement of understanding by the client. There is no apparent basis for eliminating this protection. The existing regulations recognize that, where possible, it is important to ensure that older adults understand the need and basis for the termination of their protective services. This is especially the case where the older adult has been a victim of abuse or neglect. Additionally, in a regulatory system wherein there is no appeal process for such decisions, an effort to determine the understanding of the older adult can prove to be an effort to ensure that the older adult knows of the availability of the Ombudsman program or the PDA 24 hour hotline.

STAFF TRAINING AND EXPERIENCE STANDARDS

a. §15.127 - In-service training. This section is revised to make three specified topics for annual in-service training optional, rather than mandatory. These topics are 1) an update on laws and regulations relating to protective services, 2) technical assistance for common problems, and 3) best practice presentations. These are crucial areas of training. If annual in-service training is deemed necessary for those required to administer the sections of this Act, clearly these features are imperative. To train annually but not on the laws and regulations that the trainees are charged with effectuating does not withstand logic.

CRIMINAL HISTORY RECORD INFORMATION REPORTS

a. §15.138. Violations. Subsection (a)(4) requires representatives of Commonwealth agencies having knowledge of violations of the OAPSA to report them to the appropriate licensing agency.

REPORTING SUSPECTED ABUSE

a. §15.141. General Requirements. Subsection (c) requires that AAAs notify State licensing agencies when written reports of abuse are received. This is an important addition to the regulations that provides for information sharing so that all responsible agencies and authorities can be kept apprised on actions or inactions relating to their licensees.

b. §15.144. Reports to Department and coroner by agencies. Adds a requirement that AAAs provide the Department with a copy of all reports involving a victim/recipient either over or under age 60. This requirement will be of great value to individuals for the Department of Aging will be able to monitor, respond to, and, where necessary, forward to proper authorities reports of abuse that involve individuals of all ages.

c. §15.145. Investigation. Subsection (a) establishes responsibility for conducting investigations in response to reports of abuse of persons over 60 and of persons under 60. They also direct that reports and notification be made to agencies consistent with victim/recipient place of residence or with the presence or absence of mental health or mental retardation issues. This requirement will be of great value to individuals for the Department of Aging will be able to monitor, respond to, and, where necessary, forward to proper authorities reports of abuse that involve individuals of all ages.

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ORGANIZATION: Div of Program & Regulatory Cord.

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DIRECT DIAL: 215(227)-2400

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December 23, 1999

Robert R. Hussar
Chief, Division of Program and Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, 5th floor
Harrisburg, PA 17101-1919

Re: Proposed Rulemaking on Protective Services for Older Adults

Dear Mr. Hussar:

We appreciate the opportunity to comment on the proposed rulemaking concerning protective services for older adults which was published in the Pennsylvania Bulletin on November 27, 1999. The Elderly Law Project of Community Legal Services, Inc. provides legal assistance to low-income elderly residents of Philadelphia. Most of our clients are frail and vulnerable, and many suffer from dementia or other cognitive impairments. A significant proportion of our clients are residents of nursing homes or personal care homes. We receive referrals from protective services workers for individuals needing legal assistance as part of their protective services plan. We also make reports of need to the Philadelphia Corporation for Aging's protective services unit when we become aware of an elderly person who is at risk. The comments which follow are in the order in which they appear in the regulations, and not in order of importance.

To begin with, we question why §15.12(b)(2) is proposed to be deleted. Area agencies of aging (AAA's) carry out a multitude of functions which raise serious questions of conflict of interest. For example, a protective services caseworker could be called upon to investigate reports of abuse or neglect by staff within the AAA responsible for providing services to the senior. The requirement that an agency maintain an organizational structure and staffing patterns which will prevent conflict of interest is important and should not be deleted.

Similarly, we are concerned about the proposed deletion of the requirement of separation between protective services functions and other functions such as case managers and ombudsmen. Case managers rely on good relationships with facilities and other providers in order to facilitate placements and referrals, while protective services workers need to feel comfortable in assuming an investigative, quasi-adversarial role vis-a-vis a provider reported to have committed abuse or neglect. The two roles are in conflict.

Combining the roles of ombudsman and protective services worker in the same staff person is even more problematic. Ombudsmen and protective services workers approach their cases from different perspectives and perform two distinct roles. Ombudsmen take their

instructions from the resident concerning the goal to be achieved and steps to be taken to try to achieve that goal. It is a highly client-directed model. Protective services workers, on the other hand, are mandated to investigate the circumstances alleged in a report of need without regard to whether the older person desires intervention. Although protective services workers are directed to make contact with the older person and explain the nature of the report, they may initiate the investigation prior to this contact if the circumstances so dictate and they conduct their investigation not in the manner directed by the older person but according to sound investigative techniques. Where an older person lacks capacity, protective services may be imposed even if the older person does not consent. Assigning the same staff to act in both capacities is fraught with the possibility of role confusion. In addition, assigning the same person both roles (even if in different cases) is likely to prove confusing for facilities and to inhibit the relationships with facility staff which help ombudsmen resolve problems for residents.

We are very pleased with the addition of §15.26(b)(5)(iii), which provides that an older person may not be determined not to be in need of protective services due to his temporary relocation to a safe environment such as a hospital. This change is needed. We have seen frustrating situations in the past where the protective services unit refused to become involved because the older person was "not in danger" since he was currently in the hospital or another temporary setting, yet it was clear that the older person would be at risk as soon as he left the temporary haven.

The new section unfortunately does not address a related situation which has been problematic: it has been our experience that the protective services unit will put a report of need into the category of "no need for protective services" where the older person resides in a nursing home or other facility if the older person is at risk for reasons other than malfeasance by the facility. For example, where a resident is financially exploited by an individual outside the facility, it has been our experience that protective services will decline to intervene despite the fact that the facility has no ability to protect the older person from the financial exploitation. In one case of which we aware, a demented man was dropped off at a nursing home by neighbors who were concerned about his self-neglect. The man immediately began trying to leave the facility. When the facility contacted protective services, they were told that the man was not at risk because he was in their facility and that only if the man insisted upon walking out of the facility would protective services become involved. In response to the nursing home's concerned that if the man left he might be hit by a car or suffer dehydration due to the extreme summer heat, the protective services unit responded that if the man insisted upon leaving, a staff member should follow him down the street to keep him safe until a protective services worker arrived. This suggestion seemed absurd and unsatisfactory to the nursing home, the ombudsman and the legal services attorney involved in the case. Language should be added to new subsection 15.26(b)(5)(iii) clarifying that a report of need should not be found to be unsubstantiated solely because of victim's residence in a nursing home or other facility.

We agree with CARIE's comment that §15.147 should be revised to permit the disclosure of relevant information to the ombudsman. Currently, even if an ombudsman is the reporter of abuse or neglect in a facility, he or she cannot obtain any information concerning whether or not the report was found to be substantiated or what steps were taken to protect the resident. This

greatly impairs the ombudsman's ability to follow up with the facility to make sure that corrections have been made and to be aware of care problems which may affect other residents. Confidentiality would not be compromised by revealing relevant information to ombudsmen in appropriate circumstances, because ombudsmen are required to keep all client information strictly confidential.

The confidentiality provisions of the protective services regulations have also been highly problematic for legal services providers, who share protective services' goal of protecting the older person. Title III-B legal services providers are sometimes asked to help obtain protection from abuse or neglect for older adults. To this end, we may take a range of actions, including obtaining a protection from abuse (restraining) order, legal action against financial exploitation, or referral to protective services. However, in cases where we make referrals to protective services, we are frequently unable to follow up in any meaningful way to ensure that the older adult is safe or that his or her legal interests are protected because the confidentiality provisions of the regulations prohibit disclosure of the outcome of the investigation or of steps taken to ensure the safety of the older adult. This impairs our ability to protect the older adult's legal rights.

In at least two recent cases, the Elderly Law Project continued over a long period of time to hear allegations that an elderly person was being neglected by her caregivers despite the fact that protective services had been notified. In one of the cases, we made the report of need to protective services. We checked back at a later date with a neighbor and a service provider involved with the alleged victim and learned that the neglect appeared to be continuing. When we called the protective services unit to follow protective services, care management, ombudsman, and service provision up, they refused to give us any information at all, including whether or not the report was substantiated or any action taken. In the second case, we were contacted by an individual who believed that an elderly relative was being neglected by her caregiver. When we called the agency's protective services unit, its staff were unwilling to discuss the matter because, as it turned out, there was an open case on it. According to the agency, the confidentiality provisions prohibited protective services from revealing the basis for their belief that the elderly person was not in fact at risk. This left us essentially powerless to intervene, since protective services was the only entity which had the power to gain access to the alleged victim without the caregiver's cooperation. The confidentiality provision should be amended to provide for disclosure of relevant information to an attorney providing legal services to the alleged victim.

Thank you for the opportunity to comment on these important proposed regulations.

Sincerely,

Pamela Walz
Director
Elderly Law Project

PW

NORTHUMBERLAND COUNTY
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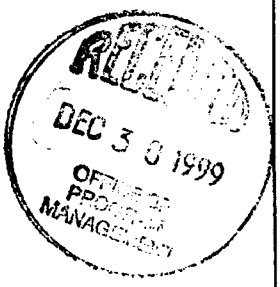
Patricia Crone-Zalinski, M.S.; B.A.
Director
Patricia A. Rumberger, B.A.
Deputy Director

December 27, 1999



Mr. Bob Hussar
Division of Regulatory Coordination
Commonwealth of Pennsylvania
Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

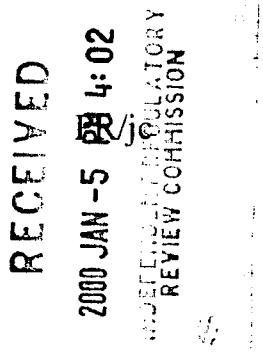
Dear Mr. Hussar:

The purpose of this letter is to comment on the proposed rules for the Protective Service Regulations.

The proposed regulations seem to provide the necessary procedures needed to enforce the Older Adults Protective Service Act. The regulations are descriptive, clear and concise.

Sincerely,

Patricia Rosini
Protective Service Supervisor



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Margaret Eby, Director
Personal Care Resource Center
41 Londonvale Road,
Gordonville, PA 17529

December 24, 1999

Robert F. Hussar, Chief of Division
Program & Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street. Fifth Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:
I would like to present the following comment to the Proposed Rulemaking for Protective Services of Older Adults.

1: The high number of current unresolved complaints should be the high priority.
2. A review of public policy that discriminates against the elderly most at risk of abuse should also be a priority.
3. Investigation must be able to provide resolutions.
4. Ombudsman must be advocates and not policeman.

Power without responsibility is not acceptable. Thank you for your consideration of my comments.

Sincerely,
Margaret Eby
Margaret Eby

CC: Independent Regulatory Review Commission

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COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE AUDITOR GENERAL
HARRISBURG, PA 17120-0018

THE AUDITOR GENERAL

December 23, 1999

Mr. Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging
Attention: OAPSA Regulations
555 Walnut Street
Fifth Floor
Harrisburg, Pennsylvania 17101-1919

Dear Mr. Hussar:

As Auditor General, I have focused particular attention on improving the quality and oversight of long-term care for older Pennsylvanians. To that end, the Department of the Auditor General last year offered thirty recommendations in a report entitled, *Improving the Quality of Care: A Plan of Action to Improve Long-Term Care in Pennsylvania.* I have enclosed a copy of our report for your review.

Chapter II of our report focused on the extent to which Pennsylvania law provides whistleblower protections for nursing home employees and other individuals. In an effort to strengthen such protections, our report discussed actions that would be taken by this Department, as well as those that should be taken by the Ridge Administration and the General Assembly. Therefore, we reviewed with much interest the proposed Older Adults Protective Services Act ("OAPSA") regulations which your department recently published in the *Pennsylvania Bulletin.* I hope that the comments set forth below are helpful as you finalize the regulations.

As you know, OAPSA provides whistleblower protections for anyone making a report of abuse of an older Pennsylvanian under the act. It also protects the victim of the abuse from discriminatory, retaliatory, or disciplinary action that could arise as a result of a report. *However, we have found that there is a profound lack of awareness about the OAPSA protections by the people whom the law is supposed to protect.* This is due in part to the fact that, unlike the Whistleblower Law, OAPSA does not require employers to post notices informing employees of their rights and obligations under the law.

Therefore, we recommend that the OAPSA regulations include a notice provision based on the following language:

> Notice.—The administrator of a facility shall post notices and use other appropriate means to notify employees, residents, and other individuals of protections and obligations under the act, and keep them informed of such protections and obligations.

Appendix B of the enclosed report includes a sample notice which was developed by our Department for use by facilities subject to OAPSA.

We were also interested in the proposed OAPSA regulations in light of our Department's current performance audit of the Department of Public Welfare and the counties' oversight of community homes for individuals with mental retardation. The proposed regulations raise issues implicated in our audit, particularly the criminal history background checks for prospective employees and the period of provisional employment while the background check is being conducted. While it would not be appropriate to discuss our findings and recommendations on those issues before the audit is finalized, we do want you to be aware that the issues are under review and that our audit may therefore impact the proposed regulations. We expect to release the audit report early next year, and will send you a copy at that time for your review and consideration.

My thanks to you and Secretary Browdie in advance for considering these comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Robert P. Casey, Jr.

Robert P. Casey, Jr.
Auditor General

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Margaret Eby, Director
Personal Care Resource Center
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December 24, 1999

Robert F. Hussar, Chief of Division
Program & Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street. Fifth Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:
I would like to present the following comment to the Proposed Rulemaking for Protective Services of Older Adults.

1: The high number of current unresolved complaints should be the high priority.
2. A review of public policy that discriminates against the elderly most at risk of abuse should also be a priority.
3. Investigation must be able to provide resolutions.
4. Ombudsman must be advocates and not policeman.

Power without responsibility is not acceptable. Thank you for your consideration of my comments.

Sincerely,
Margaret Eby
Margaret Eby

CC: Independent Regulatory Review Commission

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C|A|R|I|E
FOR THE RIGHTS AND INTERESTS OF THE ELDERLY

December 23, 1999

John Nanorta
Independent Regulatory Review Commission
333 Market Street, 14th Floor
Harrisburg, PA 17101

Dear Mr. Nanorta:

Thank you for your call regarding the protective services proposed rulemaking. Enclosed is a copy of the comments we sent to the Department of Aging. Happy holidays!

Sincerely,

Diane A. Menio

Diane A. Menio
Executive Director

A United Way Agency
1315 Walnut Street, Suite 1000 | Philadelphia, PA 19107
PHONE 215-545-5728 | FAX 215-545-5372 | E-MAIL carie@libertynet.org

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December 23, 1999

Robert F. Hussar
Chief, Division of Program and Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

RE: Protective Services for Older Adults – Proposed Rulemaking

Dear Mr. Hussar:

On behalf of CARIE, the Center for Advocacy for the Rights and Interests of the Elderly, I thank you for the opportunity to comment on the proposed rulemaking for "Protective Services for Older Adults." We offer the following comments to the regulations that were published in the Pennsylvania Bulletin on November 27, 1999.

To begin, we suggest offering clarification in the regulations for Act 28, in addition to Act 13 and Act 169. The proposed regulations attempt to define procedures necessary to comply with Acts 13 and 169. It seems that the confusion surrounding Act 28 could also be addressed in these regulations. For example, further definition of who should be filing reports would be helpful. Should everyone involved in a case file a report?

We urge you not to delete Section 15.13.(4). Since protective services workers depend on facilities for placement, there is an inherent conflict in their role as advocate. Therefore, there is value in having more than one person responsible for investigating and advocating for quality of care.

Through our experience with the Long-Term Care Ombudsman Program, we have seen first hand the value of the protective services worker and the ombudsman working in tandem on the same complaint. We approach our work from a different perspective, two very important and distinct roles. We provide complaint handling and general advocacy services for approximately 7,500 residents in 140 nursing and personal care homes located in Philadelphia.

As you know, it's the ombudsman role to intervene on behalf of a resident in a variety of situations, including abuse and neglect, inadequate care, resident/staff conflict, and the list goes on. Our experience has demonstrated that staff, in particular, relates very differently to the ombudsman compared to an

A United Way Agency
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"investigator" from protective services or the Department of Health. While the ombudsman clearly represents the resident's point of view, the relationships with staff can make a big difference in terms of resolving problems. The ombudsman and protective services caseworker can work well together on cases, but they clearly serve two distinct roles that are not easily interchangeable in an institutional setting. The commingling of roles can compromise the effectiveness of an ombudsman to resolve problems.

We are also pleased to see the addition of language in Section 15.26. that prohibits categorizing individuals as not needing protective services when they are hospitalized or temporarily removed from their abusive situation. The idea that someone is "safe" in the hospital, and therefor is not in need of protective services, creates confusion among those who are trying to help the victim and delays an effective response to the problem.

Section 15.145.(4) states that if an alleged victim is under 60 years of age and is receiving home health services, the case should be referred to the regional office of the Department of Health. Many home care agencies are not licensed. In these situations, the regulations are not clear as to who will assume responsibility for the case.

Finally, we recommend adding specific information related to the ombudsman program in Section 15.147. When protective services investigates an alleged case of abuse they look to the individual's situation. An ombudsman does not substantiate cases of abuse, but can look at problems in the entire facility, can follow-up with a facility to ensure needed corrections have been made to prevent the problem from occurring again, and can monitor the facility in the future to ensure problems will not recur. The ombudsman follows a strict code of confidentiality. When protective service workers state they can not relay information about a case to the ombudsman, it prevents the ombudsman from being effective in their role and can potentially jeopardize the safety of other residents in a facility. Explicitly stating that the protective services worker can share information with the ombudsman would alleviate any discrepancies in the interpretation of the regulations.

Founded in 1977, CARIE is a non-profit organization dedicated to improving the quality of life for frail older adults. CARIE's focus of concern spans the long term care continuum of long-term care needs from those who are homebound to those who are institutionalized. Older adults who experience physical or psychological impairment frequently have difficulty advocating for themselves and are often a silent group. CARIE works to protect their rights and promote awareness of their special needs and concerns.

If you need any further clarification regarding these comments, please do not hesitate to contact me at (215) 545-5728, extension 244 or at menio@carie.org.

Sincerely,

Diane A. Menio

Diane A. Menio
Executive Director

COMMUNITY LEGAL SERVICES, INC.

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December 23, 1999

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Robert R. Hussar
Chief, Division of Program and Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, 5th floor
Harrisburg, PA 17101-1919

Re: Proposed Rulemaking on Protective Services for Older Adults

Dear Mr. Hussar:

We appreciate the opportunity to comment on the proposed rulemaking concerning protective services for older adults which was published in the Pennsylvania Bulletin on November 27, 1999. The Elderly Law Project of Community Legal Services, Inc. provides legal assistance to low-income elderly residents of Philadelphia. Most of our clients are frail and vulnerable, and many suffer from dementia or other cognitive impairments. A significant proportion of our clients are residents of nursing homes or personal care homes. We receive referrals from protective services workers for individuals needing legal assistance as part of their protective services plan. We also make reports of need to the Philadelphia Corporation for Aging's protective services unit when we become aware of an elderly person who is at risk. The comments which follow are in the order in which they appear in the regulations, and not in order of importance.

To begin with, we question why §15.12(b)(2) is proposed to be deleted. Area agencies of aging (AAA's) carry out a multitude of functions which raise serious questions of conflict of interest. For example, a protective services caseworker could be called upon to investigate reports of abuse or neglect by staff within the AAA responsible for providing services to the senior. The requirement that an agency maintain an organizational structure and staffing patterns which will prevent conflict of interest is important and should not be deleted.

Similarly, we are concerned about the proposed deletion of the requirement of separation between protective services functions and other functions such as case managers and ombudsmen. Case managers rely on good relationships with facilities and other providers in order to facilitate placements and referrals, while protective services workers need to feel comfortable in assuming an investigative, quasi-adversarial role vis-a-vis a provider reported to have committed abuse or neglect. The two roles are in conflict.

Combining the roles of ombudsman and protective services worker in the same staff person is even more problematic. Ombudsmen and protective services workers approach their cases from different perspectives and perform two distinct roles. Ombudsmen take their

instructions from the resident concerning the goal to be achieved and steps to be taken to try to achieve that goal. It is a highly client-directed model. Protective services workers, on the other hand, are mandated to investigate the circumstances alleged in a report of need without regard to whether the older person desires intervention. Although protective services workers are directed to make contact with the older person and explain the nature of the report, they may initiate the investigation prior to this contact if the circumstances so dictate and they conduct their investigation not in the manner directed by the older person but according to sound investigative techniques. Where an older person lacks capacity, protective services may be imposed even if the older person does not consent. Assigning the same staff to act in both capacities is fraught with the possibility of role confusion. In addition, assigning the same person both roles (even if in different cases) is likely to prove confusing for facilities and to inhibit the relationships with facility staff which help ombudsmen resolve problems for residents.

We are very pleased with the addition of §15.26(b)(5)(iii), which provides that an older person may not be determined not to be in need of protective services due to his temporary relocation to a safe environment such as a hospital. This change is needed. We have seen frustrating situations in the past where the protective services unit refused to become involved because the older person was "not in danger" since he was currently in the hospital or another temporary setting, yet it was clear that the older person would be at risk as soon as he left the temporary haven.

The new section unfortunately does not address a related situation which has been problematic: it has been our experience that the protective services unit will put a report of need into the category of "no need for protective services" where the older person resides in a nursing home or other facility if the older person is at risk for reasons other than malfeasance by the facility. For example, where a resident is financially exploited by an individual outside the facility, it has been our experience that protective services will decline to intervene despite the fact that the facility has no ability to protect the older person from the financial exploitation. In one case of which we aware, a demented man was dropped off at a nursing home by neighbors who were concerned about his self-neglect. The man immediately began trying to leave the facility. When the facility contacted protective services, they were told that the man was not at risk because he was in their facility and that only if the man insisted upon walking out of the facility would protective services become involved. In response to the nursing home's concerned that if the man left he might be hit by a car or suffer dehydration due to the extreme summer heat, the protective services unit responded that if the man insisted upon leaving, a staff member should follow him down the street to keep him safe until a protective services worker arrived. This suggestion seemed absurd and unsatisfactory to the nursing home, the ombudsman and the legal services attorney involved in the case. Language should be added to new subsection 15.26(b)(5)(iii) clarifying that a report of need should not be found to be unsubstantiated solely because of victim's residence in a nursing home or other facility.

We agree with CARIE's comment that §15.147 should be revised to permit the disclosure of relevant information to the ombudsman. Currently, even if an ombudsman is the reporter of abuse or neglect in a facility, he or she cannot obtain any information concerning whether or not the report was found to be substantiated or what steps were taken to protect the resident. This

greatly impairs the ombudsman's ability to follow up with the facility to make sure that corrections have been made and to be aware of care problems which may affect other residents. Confidentiality would not be compromised by revealing relevant information to ombudsmen in appropriate circumstances, because ombudsmen are required to keep all client information strictly confidential.

The confidentiality provisions of the protective services regulations have also been highly problematic for legal services providers, who share protective services' goal of protecting the older person. Title III-B legal services providers are sometimes asked to help obtain protection from abuse or neglect for older adults. To this end, we may take a range of actions, including obtaining a protection from abuse (restraining) order, legal action against financial exploitation, or referral to protective services. However, in cases where we make referrals to protective services, we are frequently unable to follow up in any meaningful way to ensure that the older adult is safe or that his or her legal interests are protected because the confidentiality provisions of the regulations prohibit disclosure of the outcome of the investigation or of steps taken to ensure the safety of the older adult. This impairs our ability to protect the older adult's legal rights.

In at least two recent cases, the Elderly Law Project continued over a long period of time to hear allegations that an elderly person was being neglected by her caregivers despite the fact that protective services had been notified. In one of the cases, we made the report of need to protective services. We checked back at a later date with a neighbor and a service provider involved with the alleged victim and learned that the neglect appeared to be continuing. When we called the protective services unit to follow protective services, care management, ombudsman, and service provision up, they refused to give us any information at all, including whether or not the report was substantiated or any action taken. In the second case, we were contacted by an individual who believed that an elderly relative was being neglected by her caregiver. When we called the agency's protective services unit, its staff were unwilling to discuss the matter because, as it turned out, there was an open case on it. According to the agency, the confidentiality provisions prohibited protective services from revealing the basis for their belief that the elderly person was not in fact at risk. This left us essentially powerless to intervene, since protective services was the only entity which had the power to gain access to the alleged victim without the caregiver's cooperation. The confidentiality provision should be amended to provide for disclosure of relevant information to an attorney providing legal services to the alleged victim.

Thank you for the opportunity to comment on these important proposed regulations.

Sincerely,

Pamela Walz
Director
Elderly Law Project

PW
cc: IRRC

COMMUNITY LEGAL SERVICES, INC.

Law Center North Central
3638 North Broad Street, Philadelphia, PA 19140
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FROM: Pam Walz

DIRECT DIAL: (215) 227-2400

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CARIE
FOR THE RIGHTS AND INTERESTS OF THE ELDERLY

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RA

December 23, 1999

Robert F. Hussar
Chief, Division of Program and Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

RE: Protective Services for Older Adults – Proposed Rulemaking

Dear Mr. Hussar:

On behalf of CARIE, the Center for Advocacy for the Rights and Interests of the Elderly, I thank you for the opportunity to comment on the proposed rulemaking for "Protective Services for Older Adults." We offer the following comments to the regulations that were published in the Pennsylvania Bulletin on November 27, 1999.

To begin, we suggest offering clarification in the regulations for Act 28, in addition to Act 13 and Act 169. The proposed regulations attempt to define procedures necessary to comply with Acts 13 and 169. It seems that the confusion surrounding Act 28 could also be addressed in these regulations. For example, further definition of who should be filing reports would be helpful. Should everyone involved in a case file a report?

We urge you not to delete Section 15.13.(4). Since protective services workers depend on facilities for placement, there is an inherent conflict in their role as advocate. Therefore, there is value in having more than one person responsible for investigating and advocating for quality of care.

Through our experience with the Long-Term Care Ombudsman Program, we have seen first hand the value of the protective services worker and the ombudsman working in tandem on the same complaint. We approach our work from a different perspective, two very important and distinct roles. We provide complaint handling and general advocacy services for approximately 7,500 residents in 140 nursing and personal care homes located in Philadelphia.

As you know, it's the ombudsman role to intervene on behalf of a resident in a variety of situations, including abuse and neglect, inadequate care, resident/staff conflict, and the list goes on. Our experience has demonstrated that staff, in particular, relates very differently to the ombudsman compared to an

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"investigator" from protective services or the Department of Health. While the ombudsman clearly represents the resident's point of view, the relationships with staff can make a big difference in terms of resolving problems. The ombudsman and protective services caseworker can work well together on cases, but they clearly serve two distinct roles that are not easily interchangeable in an institutional setting. The commingling of roles can compromise the effectiveness of an ombudsman to resolve problems.

We are also pleased to see the addition of language in Section 15.26. that prohibits categorizing individuals as not needing protective services when they are hospitalized or temporarily removed from their abusive situation. The idea that someone is "safe" in the hospital, and therefor is not in need of protective services, creates confusion among those who are trying to help the victim and delays an effective response to the problem.

Section 15.145.(4) states that if an alleged victim is under 60 years of age and is receiving home health services, the case should be referred to the regional office of the Department of Health. Many home care agencies are not licensed. In these situations, the regulations are not clear as to who will assume responsibility for the case.

Finally, we recommend adding specific information related to the ombudsman program in Section 15.147. When protective services investigates an alleged case of abuse they look to the individual's situation. An ombudsman does not substantiate cases of abuse, but can look at problems in the entire facility, can follow-up with a facility to ensure needed corrections have been made to prevent the problem from occurring again, and can monitor the facility in the future to ensure problems will not recur. The ombudsman follows a strict code of confidentiality. When protective service workers state they can not relay information about a case to the ombudsman, it prevents the ombudsman from being effective in their role and can potentially jeopardize the safety of other residents in a facility. Explicitly stating that the protective services worker can share information with the ombudsman would alleviate any discrepancies in the interpretation of the regulations.

Founded in 1977, CARIE is a non-profit organization dedicated to improving the quality of life for frail older adults. CARIE's focus of concern spans the long term care continuum of long-term care needs from those who are homebound to those who are institutionalized. Older adults who experience physical or psychological impairment frequently have difficulty advocating for themselves and are often a silent group. CARIE works to protect their rights and promote awareness of their special needs and concerns.

If you need any further clarification regarding these comments, please do not hesitate to contact me at (215) 545-5728, extension 244 or at menio@carie.org.

Sincerely,

Diane A. Menio

Diane A. Menio
Executive Director

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Ltr

December 22, 1999

Robert F. Hussar, Chief
Division of Program and Regulatory Coordination
Department of Aging
555 Walnut Street, 5th. Floor
Harrisburg, PA 17101-1919

Re: Comments on the Proposed Rulemaking by the Department of Aging - 6 Pa. Code Chapter 15, Protective Services for Older Adults - Published in The Pennsylvania Bulletin on November 27, 1999

Dear Mr. Hussar:

We are writing to express our strong support for and wholehearted agreement with the comments presented by PAR (The Pennsylvania Association of Resources for Persons with Mental Retardation) in its letter to you dated December 21, 1999.

In order to comply with the law, we have had to take action that we felt was unduly punitive and inequitable in terminating employees who worked very well with the people we serve. These former employees had committed crimes (not against people) years before and appeared to be totally rehabilitated. As an agency that provides services to people with mental retardation, it is not easy to find good employees, especially at the rate we can afford to pay.

We support all the issues raised in PAR's letter and respectfully request the Department's serious consideration of these points.

Sincerely,

David M. Miller
Executive Director

Gloria D. Rohlfs
Asst. Executive Director

Pennsylvania Association of Resources
for People with Mental Retardation

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Harrisburg, Pennsylvania 17102
Phone • 717-236-2374
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December 21, 1999

Robert F. Hussar, Chief
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Re: Comments by The Pennsylvania Association of Resources for Persons With Mental Retardation ("PAR") on the Proposed Rulemaking By the Department of Aging – 6 Pa. Code Chapter 15, Protective Services for Older Adults -- Published in The Pennsylvania Bulletin on November 27, 1999

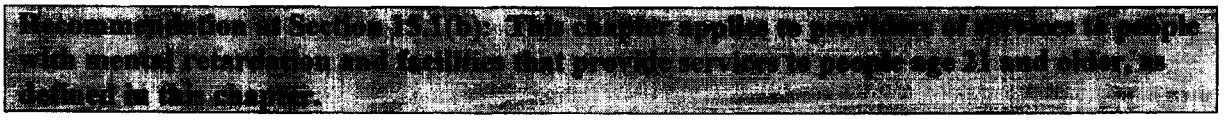
Dear Mr. Hussar:

I am writing to you on behalf of PAR, an association composed of service providers dedicated to serving the needs of people with mental retardation in Pennsylvania, to comment upon the amendments to Title 6, Chapter 15 of the Pennsylvania Code regarding Protective Services for Older Adults. PAR members provide a full range of services and supports to individuals with mental retardation of all ages at more than 2000 sites in Pennsylvania in addition to numerous non-residential and in-home supports.

SCOPE AND AUTHORITY
Section 15.1

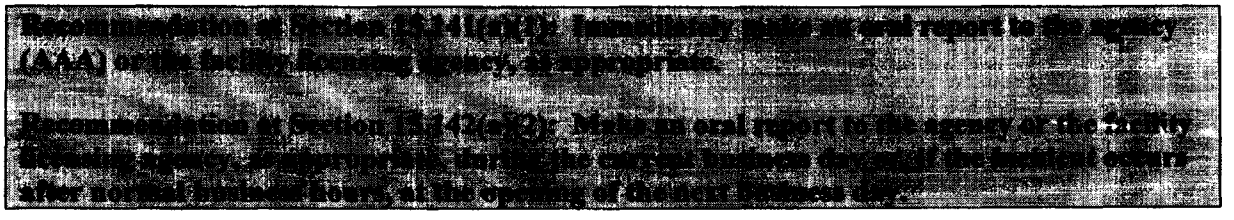
Our first comment addresses the general issue regarding the applicability of these regulations to mental retardation service providers and their employees. As noted above, PAR members provide services to people of all ages who have mental retardation; however, the statements of scope and authority at Section 15.1 continue to emphasize the application of these provisions to older adults even though the training that has been provided by the Department of Aging regarding the applicability of the related statutes have included mental retardation providers of services to individuals age 21 and over. If the proposed rulemaking and this chapter are to apply to adults under age sixty (60), additional statements should be inserted to clarify their application. Otherwise, there will be confusion regarding the applicability of these regulations beyond older adults.

By making this recommendation, we are not suggesting that the proposed regulations need to be applied to facilities and employees that provide services to people with mental retardation in order to insure appropriate protections. Mental retardation service providers already are required to report not only allegations of abuse, but any unusual incidents encountered by facility residents to the Office of Mental Retardation ("OMR") of the Department of Public Welfare, among others, depending upon the location of the facility and the placement of the individual. For that reason, to apply the requirements to report suspected abuse at Section 15.141 through 15.145 to mental retardation service providers largely duplicates existing reporting requirements.



REPORTING SUSPECTED ABUSE
Sections 15.141-15.149

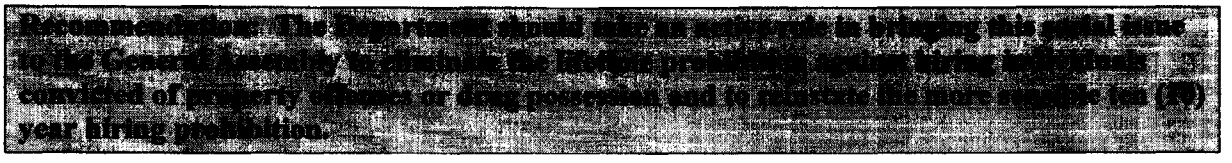
In addition, the requirement to make an immediate oral report to the local area agency on aging, or its designee that provides protective services for older adults in its service area, unfortunately serves to delay and confuse the system of reporting. Such incidents, and more, are already reported to OMR. While we intend to do all we can to protect the individuals who live in community mental retardation facilities, we do not believe their best interests are served through mandating immediate reporting to an agency that is neither trained or equipped to cope with the report. We believe the local AAAs will refer that report to OMR or the county MH/MR to whom PAR members also report, and in fact, in the absence of regulations, this has been occurring. We suggest that this suspected abuse reporting system will duplicate efforts and cause confusion that will slow the response by the appropriate agency. Instead of creating that confusion and delay, we suggest that the reporting system be revised by allowing designation of OMR by all of the local AAA's for reports by mental retardation services facility employees to help achieve the goals of uncovering and preventing any suspected abuse.



CRIMINAL HISTORY RECORD INFORMATION REPORTS
Sections 15.131-15.137

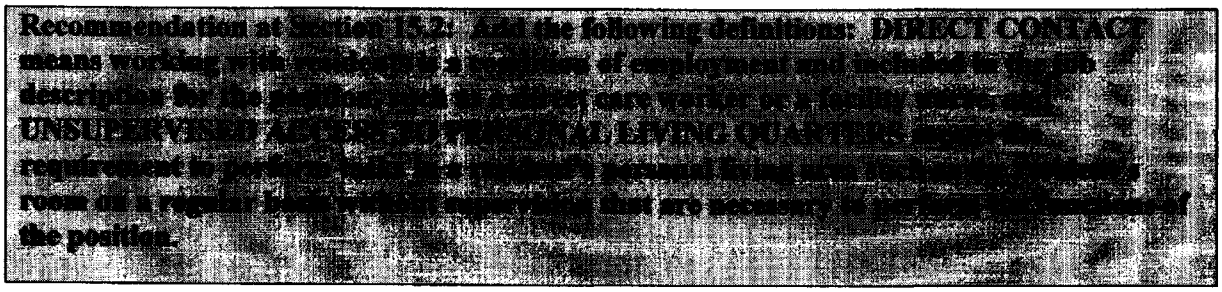
Our comments regarding criminal background checks do not question the wisdom of conducting criminal background checks of job applicants or employees who have direct contact with individuals who receive services at mental retardation facilities. Our initial concern focuses upon the requirements of Act 13 of 1997 and reiterated in the proposed regulations at Section 15.133 to implement a lifetime ban for an individual convicted of one of the listed offenses. While we agree that the life-time ban from employment for individuals convicted of offenses against people such as homicide, aggravated assault, kidnapping, rape and indecent assault may be appropriate, we do not believe that a lifetime ban should be imposed against individuals convicted of property offenses such as theft, forgery and securing execution of documents by deception or against individuals convicted of possession of illegal drugs.

We believe people convicted of any offense are capable of rehabilitation and that individuals convicted of these types of offenses should have the opportunity to seek and obtain employment at a facility as defined by the regulations. We believe the ten (10) year ban from employment for individuals convicted of offenses against property or under the Drug Device and Cosmetic Act contained in the law before the enactment of Act 13 of 1997, finds the right balance between protecting the interests of individuals served at facilities and promoting opportunity for rehabilitated individuals to obtain employment. There simply is no good reason to deny employment to a person who was convicted of two (2) misdemeanor counts of theft forty (40) years ago. The hiring discretion of the facility provider should not be so restricted to require that otherwise caring and competent individuals who made mistakes and paid for those mistakes decades ago may not help provide services today.



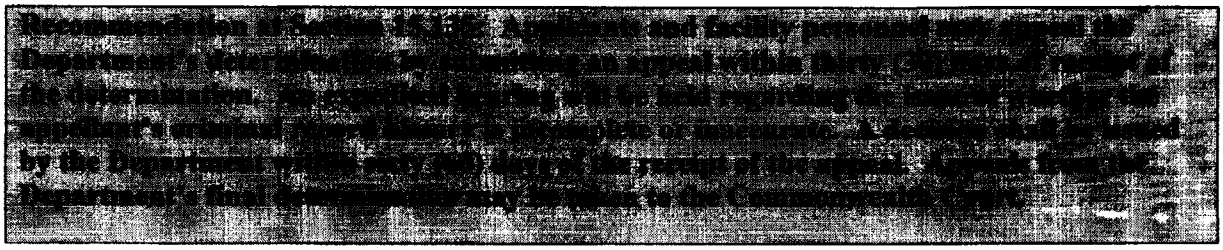
As regards the mechanics of the criminal background check procedure, mental retardation providers' main concern is the time required by the state police or FBI to process criminal record information requests. We are very pleased to see that Section 15.137(d) extends the period of provisional employment if processing by the state police or FBI is not achieved within the mandated time frames to address this concern. This will be of tremendous practical assistance to PAR members in conducting hiring and orientation.

We also ask for additional clarification regarding what constitutes "direct contact" with residents or clients and what constitutes "unsupervised access to their personal living quarters" in order to better determine to whom these regulations are to be applied. For example, do those qualifications apply only to administrators, operators and contract employees or do they also apply to a custodian worker who may need to repair plumbing in a bathroom used by facility residents on occasion or a person employed in an administrative capacity or office of a facility provider who may on occasion have contact with facility residents, although that is not the purpose of either position.



We also request clarification of the provision regarding the applicant's and facility personnel's opportunity to question the Department's determination at Section 15.134(g). Is requesting this review the same as appealing the accuracy of the criminal history record information? What is the purpose of this provision if it is not an appeal provision?

We favor the establishment of an appeal right that will permit applicants and facility personnel a prompt and inexpensive procedure to resolve their questions and correct errors. Otherwise, if an employee has been terminated to comply with these provisions and that position is filed, how can facility providers comply with the requirement to reinstate the employee to the employee's former position or an equivalent one as required at Section 15.136(b). We believe employees in those circumstances should have redress against the agencies that made the error, not the facility providers who had to implement it or violate the proposed rules.



I thank you for the opportunity to comment upon the proposed rulemaking and hope these comments will be helpful in those areas we have addressed, particularly with regard to clarifying the applications of these provisions to mental retardation services facilities and the individuals who receive their services.

Sincerely,

Shirley A. Walker

Shirley A. Walker
Executive Director

cc: John R. McGinley, Chairman
Independent Regulatory Review Commission

The Honorable Feather O. Houstoun, Secretary
Department of Public Welfare

Senator Timothy Murphy, Chair
Senate Committee on Aging and Youth

Senator Christine Tartaglione, Democratic Chair
Senate Committee on Aging and Youth

Representative Jere Schuler, Chair
House Committee on Aging and Youth

Representative Frank Pistella, Democratic Chair
House Committee on Aging and Youth

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DEPARTMENT OF HUMAN SERVICES

JOHN R. MEHLER
Director

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December 21, 1999

Mr. Robert Hussar
Chief
Division of Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, 5th Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:

Protective Services staff of the Northampton County Area Agency on Aging have had the opportunity to review the Draft Protective Services For Older Adults regulations. We have the following comments/questions/concerns:

1) The Department of Aging is applauded for its' work in collating the various statutory and policy changes that have occurred over the past twelve or so years, and combining them into one document.

2) 15.2, Definitions, Facility (p.7): Please clarify whether MH/MR community homes, Community Residential Rehabilitation Facilities, group homes, etc., are included in this definition.

3) 15.20(b) Handling of complaints, (p.31): We might want to re-think the routing of completed Report forms to State licensing agencies prior to investigation of the report. The proposed requirement may result in the dissemination of uninvestigated (and unsubstantiated) allegations that may unfairly color the reputation of individuals/facilities in the eyes of the licensing agency.

4) 15.42 (c) Standards for initiating and conducting investigations (p.34) Strictly an editorial comment - please clarify the meaning of (c) as opposed to the last sentence of (b). If "interference" is occurring, how can the investigation be "fully objective"? Maybe (c) is unnecessary.

5) 15.146 (b) Restrictions on Employees (p.63) Please clarify, is the "agency" the AAA, (or contracted protective services for older adults provider)? And, if the "facility" is a home health agency, which AAA has jurisdiction over the plan of supervision-the one where the facility is located, (office), or where the victim/recipient is located? It would be very problematic for such agencies if their plans are subject to review/approval by multiple AAAs/protective service provider agencies. Please clarify how that AAA to have jurisdiction will be determined for home health agencies.

6) 15.147 (a) (10) Confidentiality of and access to confidential report (p.64):

(10) - A phrase appears to have been left out here - A mandated reporter under ???.

Also, it may be appropriate to clarify that, if the mandated reporter is a facility administrator, for example, the administrator may receive information relating to the final status of the report following the investigation, and services provided or to be provided, on behalf of the facility, but the AAA/protective services provider is not required to share such information with each and every facility staff member who might inquire, even though each such employee is considered a "mandated reporter".

(7) 15.147 (d) (p.65) - we continued to believe that this type of requirement vis a vis alleged perpetrators may lead to increased risk for older adults and increased liability to AAAs and to the Commonwealth. We will await the implementation of newly-designed Protective Services training before commenting further in this regard.

(8) 15.147 (3) (p.65): Our reading of this provision indicates that the identities of persons making reports will now be shared with law enforcement. Is this a correct interpretation?

(9) 15.148 (c) (p.66): Please clarify when the AAA must notify the police when reporting requirements are not carried out by mandatory reporters: Any time, or only when the violation appears willful and defiant? Locally, we have not experienced the latter, we have had situations where facility staff were uncertain of their responsibilities or were fearful of taking unwarranted action. We believe training and internal facility policy development is a better response here the making a police report.

Thank you again for all of the Department's thought and effort regarding this Draft. Please don't hesitate to contact me if you wish to discuss any of these comments further.

Very truly yours,

John R. Mehler
Director

JRM:jem
Enclosure
Cc: PAAAA
Robert Martin
1417/MEH23

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JOHN F. BAUER
DIRECTOR

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December 17, 1999

Mr. Robert Hussar
Division of Regulatory Coordination
Pennsylvania Department of Aging
Forum Place
555 Walnut St., 5th Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:

Thank you for allowing us to make comments regarding the proposed Protective Service regulations. Overall, we agree with the revisions offered in the proposal. However, we would like to see the following issues addressed:

1. 15.2.Definitions:
   a. We would like to see a definition of perpetrator. Who is considered a perpetrator and who gets the perpetrator notification?
   b. We would like to see that each type of facility is named rather than referring the reader to a specific Act. It is unclear whether the definition of Facility includes CLA's, CRR's, or SNF units.
2. 15.144. Reports to Department and Coroner by Agencies:
   A victim/recipient, who is under 60 years of age, living in the community,(and is not involved with any agency, MR or MH department) may not have any entity investigate the allegations or offer assistance. This gap should be addressed and authority given to deal with these situations.

Sincerely,

Jack Bauer

John F. Bauer, Director
Delaware County Services
For the Aging

BLAIR SENIOR SERVICES
INCORPORATED

A Nonprofit Agency Helping to Meet the Needs of the County's Older Residents.

1320 TWELFTH AVENUE
ALTOONA, PA 16601
814-946-1235

TOLL FREE TO CLIENTS:
1-800-245-3282

FOR TRANSPORTATION CALL:
814-695-3500

OR TOLL FREE:
1-800-458-5552

AREA AGENCY ON AGING

Original: 2077
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Markham
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Wyatte

December 21, 1999

Mr. Bob Hussar
Division of Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street, Fifth Floor
Harrisburg, PA 17101-1919

Dear Mr. Hussar:

The following are comments in response to the proposed rulemaking for Chapter 15 Protective Services for Older Adults.

15.91 (a) Protective Services are activities...provided under the act "subsequent to an investigation"...

Question: "subsequent" to what? Subsequent to the initiation, or completion of the investigation? I would suppose that this must mean subsequent to the initiation since, on a practical level, many services must be provided prior to the conclusion of the investigation. Please clarify this.

15.146 Restrictions on Employees Re:

(a).....facilities shall develop and submit to the agency and the Commonwealth agency with regulatory authority...a copy of their facility supervision/suspension plan

(b) Following written approval of plans by the agency and the Commonwealth agency with regulatory authority...

(c) Changes to plans shall be approved...

Comment:

The issue of this Agency's approval of a facility's supervision/ suspension plan is somewhat confusing. Could you please provide technical assistance as to the development of such plans?

Thank you for the opportunity to comment on this proposed rulemaking. If you have any questions, please contact Mike Seymour, Protective Services Supervisor, at 814-946-1235.

Sincerely,

David M. Slat
Executive Director

DMS:llh

AREA AGENCY ON AGING OF SOMERSET COUNTY

Original: 2077
Mizner
Copies: Harris
Jewett
Markham
Nanorta
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Wyatte

December 17, 1999

Mr. Robert Hussar
Division of Regulatory Coordination
Pennsylvania Department of Aging
555 Walnut Street- Fifth Floor
Harrisburg, PA 17101-1919

Subject: Protective Services Regulations

Dear Bob:

Thank you for the opportunity to review and comment on the above-specified regulations. It is our belief that one of the strengths of our aging network is the use of a communication process that allows for the voicing of all issues prior to the enactment of new policy or regulation. Our history would clearly show that this dialogue results in decision-making that is most responsive to consumer need.

Upon evaluating the proposed protective services regulations internally, we have conclude that the included revisions or additions would create no significant hardship for our organization or our service delivery system.

Again, we appreciate the chance of review and look forward to cooperatively maintaining our system's high standard of service to our community's consumers.

Most sincerely yours,

Arthur N. DiLoreto,
Administrator

1338 SOUTH EDGEWOOD AVENUE
SOMERSET PENNSYLVANIA 15501
TELEPHONE (814) 443-2681 or 1-800-452-0825
Fax - (814) 445-4398

Original: 2077

Pennsylvania Association of Resources
for People with Mental Retardation

1007 North Front Street
Harrisburg, Pennsylvania 17102
Phone • 717-236-2374
Fax • 717-236-5625

September 26, 2000

Mr. Bob Derr
Office of Mental Retardation
P.O. Box 2675
Room 512 Health and Welfare Building
Harrisburg, PA 17105-2675

Dear Mr. Derr:

On behalf of the Pennsylvania Association of Resources for People with Mental Retardation (PAR), thank you for meeting with us on September 18, 2000 to discuss the Draft Incident Management Bulletin. We hope our comments and recommendations will assist the Department in its efforts to improve safety and protections for individuals with mental retardation.

While many relevant details were discussed during the meeting, most of our comments can be grouped under four major recommendations related to: inconsistency with existing laws and regulations (the Older Adult Protective Services Act – OAPSA); the need to separate "incidents" from routine occurrences; the cost of implementing the bulletin on an ongoing basis; and the institutional bias.

On the basis of the bulletin's inconsistency with OAPSA alone, PAR requests that the Department issue another draft of the Incident Management Bulletin for public review and comment. As we discussed with you, our attorney, who is working with us regarding Act 13/OAPSA implementation, has advised us that providers cannot comply with this bulletin, as currently drafted, in that it violates existing laws and regulations.

We have noted the confusion that has surrounded Act 13/OAPSA in past comments and we continue to urge the Department to resolve the inconsistencies and impracticalities of Act 13/OAPSA by working with the Department of Aging to develop clarifying amendments or a Memorandum of Understanding (MOU) which works out the details for satisfactory reporting of incidents that do not add complexity without adding value.

During our meeting, we frequently discussed the issue of separating "incidents" from routine occurrences that are common to people's everyday lives and medical needs. This is a critical issue for providers, who already report a large amount of data to multiple entities. The Department's decision to define routine occurrences such as visits to the doctor as "incidents" will lead to excessive reporting and spoil the data that is needed for

tracking and analyzing real incidents. By addressing this issue, the Department can eliminate unnecessary paperwork and preserve the quality of the data it seeks to collect. PAR trusts you understood the gravity of our concerns related to this issue, and that the Department will carefully consider our comments and recommendations.

The costs associated with the incident management system described above were also discussed in the meeting. The current funding within the system is insufficient to carry out the mandates of the bulletin. There are numerous examples we could give, but we will remind you of two that we discussed with you. The requirement that staff be recertified every two years is a significant expense to providers. Our recommendation that staff only be recertified if he/she has not conducted a proper investigation within two years of initial certification would reduce the financial burden of this requirement without reducing competence to conduct proper investigations. Another example of a cost-related issue is the requirement that providers submit quarterly reports to the County. Again, our recommendation that providers submit semi-annual reports instead of quarterly reports would cut this paperwork and its related costs in half without negatively affecting the system's ability to analyze the data. We also recommended the submission of Program Revision Requests (PRRs) to obtain adequate funding for these proposed new mandates.

The fourth major area of the bulletin we covered in our meeting concerns the institutional bias we found in the draft. Several aspects of the bulletin appear to be inconsistent with the Department's self-determination principles and movement toward choice. For example, the requirement that providers report refusal of prescribed treatment does not reflect the Department's purported movement toward consumer choice. An individual has the right to refuse treatment, especially if the refusal does not place him or her in physical danger. Requiring providers to report such occurrences as "incidents" reflects an institutional bias.

Another requirement that seems institutional has to do with reporting inappropriate public behavior which does not rise to the level of criminality. We have experienced situations in which the police were called for behavior that was not actually "inappropriate," but rather behavior that the public is not used to seeing. As we continue to integrate individuals into the community, "different" behaviors will be seen more often by the public, and sometimes reported. Requiring providers to report behavior that is not "inappropriate" but just "different" reflects an institutional bias and sends the wrong message when it has to be reported as an "incident."

Again, because of these and other substantive issues discussed during our meeting with you, we urge the Department to issue another draft of the Incident Management Bulletin. We are available to discuss our recommendations further with the Department.

Thank you again for taking the time to meet with us and for being receptive to our comments and recommendations.

Sincerely,

Shirley A. Walker

Shirley A. Walker
Executive Director

cc: Mel Knowlton, Chief
Division of Policy Development and Program Support
Office of Mental Retardation

Nancy Thaler, Deputy Secretary
Office of Mental Retardation

cc w/ enclosure:

Robert Hussar, Chief
Department of Aging

Jeffrey Wood, Chief Counsel
Department of Aging

John R. McGinley, Chairman
Independent Regulatory Review Commission

Original: 2077

Pennsylvania Association of Resources
for People with Mental Retardation

1007 North Front Street
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September 15, 2000

Mr. Mel Knowlton
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

Re: Comments by the Pennsylvania Association of Resources for People with Mental Retardation (PAR) on the Draft Mental Retardation Bulletin Incident Management Issued by the Department of Public Welfare on July 11, 2000

Dear Mr. Knowlton:

The Pennsylvania Association of Resources for People with Mental Retardation (PAR) thanks the Department of Public Welfare for requesting comments to the above-referenced draft bulletin. PAR is a statewide association whose members provide the full range of supports and services to individuals with mental retardation in over 2200 locations in the Commonwealth in addition to numerous non-residential and in-home supports.

This bulletin proposes significant new requirements and adds to the many complex reporting procedures already in place. Our comments are provided to aid the department in improving health and safety and quality of supports and services to individuals with mental retardation in cost-effective ways that add value.

Following are our comments and recommendations. Each section that we have commented on is referenced with the specific language used in the bulletin, followed by a discussion section, followed by our recommendations.

COMMENTS:

Prior to implementation of this bulletin, please insure that the forms and protocols referred to in the bulletin are in place:

- All standardized reporting forms
- County policies and procedures
- Electronic Data Management System
- Coordination of overlapping areas with other State agencies
- A standardized protocol for conduct of investigations

~ ~ ~ ~

SCOPE (pg. 1)

OMR's Draft Proposal: *"All individuals who are registered with a County Mental Retardation program and/or who receive supports and services from licensed facilities are covered under this bulletin."*

Discussion: Would this include individuals receiving only case management services? Also, please provide additional clarification noted below in the recommendation.

Recommendation: Clarify whether or not this includes individuals receiving only case management.

Recommendation: Add *"mental retardation"* after *"who receive."*

OMR's Draft Proposal: *"Anyone who receives (services) funds from the mental retardation system to provide or secure supports or services for individuals registered in the county mental retardation program; and employees of facilities licensed by the Department of Public Welfare, Office of Mental Retardation are obligated to report incidents as defined within this bulletin."*

Discussion: Facilities licensed by DPW/OMR may also serve individuals whose primary diagnosis is not MR. Does OMR intend that individuals who do not receive funding through the MR system and who are not diagnosed as having mental retardation, be subjected to the mandates of this bulletin?

Recommendation: Specifically exclude individuals who are not diagnosed as having MR, but are being served in licensed DPW/OMR facilities, from the mandates of this bulletin.

PURPOSE (pg. 2)

OMR's Draft Proposal: *"This bulletin will establish standards to protect health and safety, and enhance the dignity and protect the rights of individuals receiving supports and services. These standards will include uniform requirements for: timely and appropriate action in response to incidents; reporting of incidents; investigation of incidents; corrective action in response to incidents; analysis of individual and aggregate data and making necessary changes to reduce risk of reoccurrence."*

Discussion: The bulletin describes the use of incident information and analyses of incident information in a way that focuses on change and remediation. However, much of the required data to be reported are not "incidents" which could benefit from change or remediation planning and really need to be separated from this "incident management" bulletin and included in a general databank of information that OMR wants to have for tracking purposes.

Also, it is important to know how the information will be used so that information is gathered in ways that can result in meaningful analyses. For example, the bulletin infers that the information will flow over the Internet (references are made to "links") and there has been discussion by OMR that incident information may be available to the public via the Internet. Data must be gathered, then presented, in ways that accurately inform rather than mislead the public. Data which is not clean presents a false picture and is useless rather than useful to the public and damages relationships without reason. Our comments are intended to encourage the department to gather and analyze the data for optimal use.

Recommendation: Any data to be reported that does not represent a trend of incidents that can benefit from remediation planning needs to be separated from this bulletin and included in a general databank of information that OMR wants to have for tracking purposes.

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DISCUSSION (pg. 4)

OMR's Draft Proposal: *"The incident management system, described in this bulletin is more than a standardized reporting system. The primary goal of an incident management system is to assure that when an incident occurs the response will be adequate to protect health and safety of the individual. This bulletin establishes clear and specific responsibilities at provider, county and state levels. It requires continuous review and analysis of reported incidents at provider, county and state levels aimed at uncovering trends and formulating action to prevent recurrence. The standardization of reporting format, the time frames for reporting, investigation and follow-up are key to conducting county-wide and state-wide analysis of incidents.*

The incident management system described in this bulletin requires the investigations at provider, county and state levels to be conducted by certified investigators. This will help assure that all incidents which require investigation receive a thorough investigation that meets accepted standards and are conducted by a certified investigator. The certification process will be established by the Commonwealth."

Discussion: The Commonwealth continues to add mandates with significant costs to the mental retardation system without funding the mandates. Annual cost of living adjustments have been woefully inadequate, creating the most serious challenges to health and safety. The current system is characterized by staff shortages and high turnover rates. Providers do not have sufficient funding to carry out the mandates of this bulletin, which impose additional costs that are not insignificant. Now another set of processes is being put in place without any recognition or provision of funding that will be necessary to implement these additional mandates.

Where is the time and money going to come from to support the staff who will be doing the investigations, writing the reports and reporting to several different bodies?

The cost of the incident management infrastructure will be added to providers' administrative costs. This is complicated by the fact that the state and county are often reluctant or unwilling to pay for additional administrative costs or simply do not have the money. Providers, who are already under tremendous stress, are unable to pay staff, who are the key to health, safety and quality, adequate wages and providers cannot afford further administrative costs.

On another point, sufficient time frames need to be established to ensure staff members have time to become certified as investigators.

Recommendation: Provide a responsible estimate of cost and submit a Program Revision Request (PRR) to obtain the necessary funding for counties so that counties can include funding in their contracts with providers so the financial impact of these mandates will not take money away from current funding of existing services.

Recommendation: Establish sufficient time frames for the certification of staff members.

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INCIDENT MANAGEMENT STANDARDS & EXPECTATIONS (pg. 4)

OMR's Draft Proposal: *Providers are responsible to: develop provider-specific procedures; insure that staff and others associated with the provider have proper orientation and training; take prompt action to protect the person's health and safety;*

notify the responsible person; assign trained people (point people); conduct investigations; create an incident management review process; identify immediate and long-term effects; conduct cumulative reviews; conduct periodic trend analyses; track significant events related to health and safety; translate learning from individual events or trends into training and systemic changes; periodically assess the effectiveness of the incident management process and monitor quality and responsiveness of all ancillary services and act to change vendors, offer training or file official complaints to secure appropriate services.

Discussion: Refer to the discussion above regarding the costs associated with the incident management infrastructure.

Recommendation: Submit a Program Revision Request (PRR) to obtain the necessary funding so counties can fund this mandate through their contracts with providers.

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Provider Responsibilities (pgs. 4-5)

OMR's Draft Proposal: *"Providers are responsible to: Take prompt action to protect the person's health and safety, including separation of the alleged perpetrator while an investigation is conducted."*

Discussion: Separation could be interpreted as termination or suspension, which may be necessary in some cases, but not all.

Recommendation: For the purposes of this bulletin, it is recommended that separation be defined as *"not working with the individual or living in the individual's unit."*

OMR's Draft Proposal: *"Providers are responsible to: Create an incident management review process which: Identifies immediate and long-term effects to the individual resulting from an incident or multiple incidents;"*

Discussion: It is difficult, if not impossible, to determine the immediate and long-term effects to an individual resulting from an incident. It is also unclear what the purpose of this provision is, since the responsibility of the provider should be to investigate the facts and take appropriate action.

Recommendation: Delete this sentence.

OMR's Draft Proposal: *"Monitors quality and responsiveness of all ancillary services and act to change vendors, offer training or file official complaints to secure appropriate services."*

Discussion: This statement is too broad. If the incident is something the ancillary services were responsible for, then this requirement should apply.

Recommendation: After *"ancillary services,"* add the following sentence: *"if the incident is related to ancillary services."*

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County responsibilities (pg. 5)

OMR's Draft Proposal: *"The County is responsible to: Develop county policy and procedures necessary to implement this bulletin."*

Discussion: There is currently a lack of continuity and consistency among county policies and procedures. If the 46 counties and county joinders develop their own various versions of policies and procedures necessary to implement the bulletin, it will be extremely time consuming and confusing for providers and cost the entire system.

Recommendation: Require the counties to develop one set of policies and procedures necessary to implement this bulletin statewide.

OMR's Draft Proposal: *"The County is responsible to: Have an administrative structure to meet mandates of this bulletin; Supports providers with appropriate training and resources to meet the mandate of the bulletin."*

Discussion: One of our major concerns relates to the costs associated with the mandates of the bulletin. Counties already tell us they lack funding to meet current needs. Although this requirement places funding responsibilities on the county, the fact is that funding comes from state and federal sources and without adding state or federal money to meet the mandates, the money will come directly out of existing MR services.

Recommendation: Submit a PRR as recommended in our preceding comments.

OMR's Draft Proposal: *"The County is responsible to: Create an incident management review process which is responsible to: Assess "quality" of provider's management process."*

Discussion: This provision has already been covered in the requirement to have an incident management procedure that has been approved by the counties. Therefore, this provision is duplicative.

Recommendation: Delete this provision. If this provision is not deleted, add *"incident"* after *"quality of provider's management process."*

OMR's Draft Proposal: *"The County is responsible to: Conduct or assure independent or joint investigations as necessary."*

Discussion: Providers are subject to laws and regulations that hold them criminally liable for various things that may result from not investigating incidents which occur in their agency. Providers cannot afford to wait for authorization from an external entity before responding to an incident occurring in their agency. Thus, we are adamantly opposed to any limitation on providers' ability to conduct investigations so they can begin improvements. In the bulletin, it needs to be made clear that there is nothing in this bulletin which prevents providers from responding to incidents occurring in their agency.

Requiring certain investigations to include the county case managers will require additional scheduling. Scheduling interviews for all of the parties involved in an investigation is difficult. Currently, if the county or regional office has additional questions, they call and become involved at that time. From our experience, that has only happened on rare occasions. Providers should be encouraged and given the opportunity to conduct their internal investigations before regulatory agencies are involved.

On another note, it would be helpful if the chart on page 20 of the bulletin was referenced here.

Recommendation: Add the following language: *"This does not supplant the provider's responsibility to conduct their own internal investigations."*

Recommendation: Reference the chart on page 20 of the bulletin.

OMR's Draft Proposal: *"The County is responsible to:*
Coordinate with other county social service agencies and Health Care Coordinating Units [HCCU on incident reporting and investigations]."

Discussion: See our recommendations below regarding coordinating with triple AAA's in relation to the Older Adults Protective Services Act; Act 13 of 1997 (OAPSA) requirements.

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Commonwealth Responsibilities (pgs. 5-6)

OMR's Draft Proposal: *"The Commonwealth is responsible to: Develop electronic data management system with links to counties and providers."*

The data management system should be Windows-based to minimize additional costs.

Recommendation: Use a Window-based data management system.

OMR's Draft Proposal: *"The Commonwealth is responsible to: Provide necessary training on the bulletin requirements."*

Several training dates need to be available within each region because of staff coverage issues.

Recommendation: Schedule several training dates within each region on the bulletin requirements.

OMR's Draft Proposal: *"The Commonwealth is responsible to: Work with other state agencies to coordinate overlapping areas of the bulletin [aging - health - children and youth - law enforcement]."*

Discussion: Several actions taken over the last couple of years have multiplied reporting requirements and have resulted in overlapping, duplicative reporting. With that in mind, we appreciate this policy statement to ensure that overlapping areas are coordinated and to eliminate duplicate reporting.

Recommendation: Coordinate the overlapping areas of the bulletin so that providers do not have to make multiple reports for each incident. (For an example, refer to the OAPSA comments throughout this document.)

OMR's Draft Proposal: *"The Commonwealth is responsible to: Provide historic incident information for individuals transitioning from state-operated facilities."*

Recommendation: PAR supports this requirement.

OMR's Draft Proposal: *"The Commonwealth is responsible to: Respond to requests from individuals/family and others for involvement or investigation of significant events."*

Discussion: The Commonwealth should respond to requests from individuals and family members and others involved in the support of the individual. However, the Commonwealth needs to be careful to not honor requests for involvement in investigations by persons who may have potential conflict of interests.

Recommendation: Ensure that requests for involvement or investigation of significant events are not honored for those who may have a potential conflict of interest.

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REPORTABLE INCIDENTS DEFINED (pgs. 7-10)

OMR's Draft Proposal: ***Emergency Closure*** *- "any unplanned situation which forces the relocation of an individual from his home overnight. Any unplanned situation other than ice or snow which forces the closure of a program facility for one or more days. This category does not apply to individuals who reside in the home of a family member."*

Discussion: Not all unplanned overnight relocations of individuals are emergency closures. For example, if a behavioral incident occurred and the individual needed to be moved elsewhere, it should be considered an administrative issue and not subject to reporting. Otherwise, the amount of reporting becomes excessive without worthwhile value added.

Recommendation: Revise the language to read as follows: ***"any unplanned situation other than weather-related closures which forces the closure of a program facility for one or more days. This category does not apply to individuals who reside in the home of a family member or to situations where an individual is temporarily moved to another location due to behavioral issues."***

OMR's Draft Proposal: ***Emergency Room Visit*** *- "any use of a Hospital Emergency Room. This includes situations that are clearly "emergencies" as well as those when an*

individual is directed to an Emergency Room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. For coding purposes, the reason for the Emergency Room visit must be specified as either illness, accidental injury, unexplained injury, injury resulting from a person to person interaction, injury resulting from a staff to person interaction, injury resulting from or sustained during the application of a restraint, self-inflicted injury, for the treatment of suspected drug toxicity, for the assessment or treatment of a behavioral / psychiatric crisis, or "Other."

Discussion: Requiring providers to report "any use of a hospital emergency room" would lead to a large amount of paperwork and unnecessary reporting. However, if serious bodily injury occurs, then it should be reportable as an emergency room visit and, for the sake of consistency, "serious bodily injury" should be defined as it is in the OAPSA (Act 13 of 1997): *"Injury which creates a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a body member or organ."*

Recommendation: Revise the language to read as follows: *"any use of a hospital emergency room for the treatment of serious bodily injury or acute serious illness. This includes visits to the PCP only in situations of serious bodily injury or acute serious illness."*

Recommendation: Define "serious bodily injury" to be consistent with the OAPSA.

OMR's Draft Proposal: *Fire -" any fire or other situation that requires the active involvement of fire personnel, i.e., extinguishing a fire, clearing smoke from the premises, etc. Situations which require the evacuation of a facility in response to suspected or actual gas leaks and/or carbon monoxide alarms are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. The involvement of safety personnel (police or fire) in the identification or location of a malfunctioning alarm is not considered "active" involvement and is not reportable. "False alarms" and automatic alarms that are triggered by steam, water vapor, cooking smoke, etc. do not have to be reported even if safety personnel respond."*

Discussion: With regard to situations in which staff extinguish small fires without the involvement of fire personnel, such a situation should be reported on an administrative level, but it should not rise to the level of a reportable incident within the requirements of this bulletin.

Recommendation: Delete the requirement *"situations in which staff extinguish small fires without the involvement of fire personnel are reportable."* If this provision is not deleted, revise the language to read as follows: *situations in which staff extinguish small fires without the involvement of fire personnel are reportable to the provider agency for their review."*

OMR's Draft Proposal: ***Law Enforcement Activity*** *- "- the involvement of law enforcement personnel is reportable in the following situations:*
- An individual is charged with a crime or is the subject of a police investigation which may lead to criminal charges;
- An individual is the victim of a crime, including crimes against the person or their property [vandalism, break-ins, harassment, etc];
- Police / law enforcement action involves an on-duty employee or caregiver at the site;
- Crisis Intervention involving police / law enforcement personnel. This includes instances of inappropriate public behavior by an individual which does not rise to the level of criminality.
Minor traffic accidents that result in no injury to anyone are not reportable unless otherwise covered (i.e., the passengers are evaluated at an Emergency Room)."

Discussion: We acknowledge that crisis intervention involving the police/law enforcement personnel should be reported. However, the sentence following this provision, *"this includes instances of inappropriate public behavior by an individual which does not rise to the level of criminality,"* should be handled administratively. As we have continued to integrate individuals into the community, we have experienced calls to the police for behaviors that were not actually for "inappropriate" behavior, but rather behavior that the public is not used to seeing. Therefore, this is another area in which it makes sense to have such situations handled on an administrative level.

Recommendation: Delete the sentence *"this includes instances of inappropriate public behavior by an individual which does not rise to the level of criminality."*

OMR's Draft Proposal: ***Medical Condition requiring treatment beyond first aid*** *- "any injury or condition that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a band-aid, etc. Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR or use of the Heimlich Maneuver, visits to a physician, x-rays, suturing, wound care provided by a medical or health care professional, limits on participation ordered by a physician (i.e., "bed rest"), casting or otherwise immobilizing a limb, prescription of medication, etc. Treatment of an acute or chronic illness by a medical or health professional is not reportable unless otherwise covered (i.e. the treatment is provided in an Emergency Room) except in those instances where the acute illness being treated is one of those contained on the list of Reportable Diseases published by the PA Department of Health. Diseases is attached as Addendum __. An incident report is required only when the "reportable disease" is initially diagnosed. Incident reports are not required when an individual receives follow-up treatment of this illness unless the event is otherwise covered (i.e., the treatment is provided on an in-patient basis in a hospital.) Assessment of a condition without*

treatment by a medical or health professional is not reportable unless otherwise covered (i.e. the assessment is completed in an Emergency Room). For coding purposes, the reason for the medical treatment must be specified as either accidental injury, unexplained injury, injury resulting from a person to person interaction, injury resulting from a staff to person interaction, injury resulting from or sustained during the application of a restraint, self-inflicted injury, for the treatment of suspected drug toxicity, for the assessment or treatment of a behavioral / psychiatric crisis, or "Other." Evaluation/assessment of an individual by emergency personnel in response to a "911" call is reportable even if the individual is not transported to an Emergency Room."

Discussion: This bulletin includes reporting requirements for routine procedures and common occurrences. There needs to be a separation between what should be included as "incidents" for "trend analyses" as distinct from routine medical visits and routine issues for individuals common to the non-MR population. A routine visit to a physician, for example, is not an incident, and should not be reported as such. Why does the state need to know about routine bed rest? If a physician prescribes bed rest for an individual with a cold for a day, how does that rise to the level of a reportable incident? Why would an X-ray, which is considered relatively routine for people without mental retardation, be considered an incident for an individual with mental retardation?

Also, there is concern that providers who support more complex individuals will show more "incidents" which has a negative connotation.

Recommendation: Revise the language to read as follows: *"Treatment beyond first aid includes but is not limited to lifesaving interventions such as CPR, Heimlich Maneuver, suturing, and casting."*

Recommendation: Delete the following: *"wound care; visits to a physician; X-rays; limits on participation ordered by a physician (i.e. "bed rest"); otherwise immobilizing a limb; prescription of medication, etc."*

Recommendation: Replace *"immobilizing a limb,"* with *"immobilizing a fracture."* If "bed rest" is not deleted, at least clarify the length of time one would remain in bed before it would need to be reported.

Recommendation: Revise the bulletin's definition of an 'incident' so that routine, ordinary occurrences are not included in the definition.

Discussion: What is the purpose of this provision? Just because something is treated in the ER does not mean it is serious enough to report, or that it is serious at all. Just because an assessment is completed in the ER does not mean it rises to the level of unusual. Again, the bulletin mixes routine medical issues which don't need to be "analyzed" with unusual incidents which should be analyzed and may require

intervention. There is clearly a difference between the two types of data. Mixing the two is confusing and actually spoils the data the bulletin seeks to collect.

Recommendation: Separate "incident" data from the other reportable data required by this bulletin so that the trend analyses can be useful.

Recommendation: Delete *"the assessment is completed in the ER."*

Discussion: Why should calling 911 be a reportable incident? For example, if 911 is called during a false fire alarm, the bulletin mandates that it be reported. As discussed previously, requiring providers to report such routine events leads to unnecessary over-reporting.

Recommendation: Delete 911 reporting requirements.

OMR's Draft Proposal: ***Medication Error -"*** *reportable medication errors include the following:*

- *When an individual receives the wrong medication (including medication intended for another individual, medication which had been discontinued, improperly packaged or labeled medication, etc.);*
- *When an individual receives the wrong dosage of a prescribed medication;*
- *When a dose of a prescribed medication is omitted without the approval of a physician (including instances when a medication is not available to be given because a continuing prescription has not been refilled or a new prescription has not been filled and initiated in a timely manner as directed by the individual's physician*
- *When a dose of a prescribed medication is given at the wrong time;*
- *When a dose of a prescribed medication is given via the wrong route.*

Serious or repeated errors may be treated as neglect. Errors in the documentation of medication administration are not reportable incidents, however, the agency must take corrective action when documentation errors occur, in accordance with OMR's established Medication Administration Guidelines."

Discussion: There are general rules for determining the significance of medication errors in the ICF/MR Regulations. It is recommended that the bulletin's references to serious or repeated errors be replaced with language from the ICF/MR regulations: "significant" and "nonsignificant" errors since that language is better defined and more easily understood.

An alternative to reporting all medication errors is to report trends. For instance, the provider could report (semi-annually) 3 repeated, serious errors leading to medical attention. Such information would establish a trend, thus providing valuable information to the agency, county and state.

Recommendation: Add *"resulting in serious bodily injury requiring medical attention"* to the title.

Recommendation: Replace *"serious or repeated errors"* with *"significant or nonsignificant errors"* (the language from the ICF/MR Regulations).

Discussion: Providers have to wait for MCO approval prior to administering medication. When an error occurs as a result of not having the medications approved by the MCO, and there are delays, how should it be reported? These are not medication errors as such; they are system errors. If the state wants this to be reported, this requirement should be put under a separate category in a general databank for the entire system outside the bulletin where it specifically defines any delays by MCO's following doctor's orders. This could be valuable information and a way to monitor trends, especially when new MCO's are involved or there have been delays in filling prescriptions due to the MCO being slow to approve prescriptions. These delays occur prior to medications being administered.

If the bulletin continues to include such information as reportable incidents, again, it will spoil the "incidents" data it seeks to collect. There is a difference between general medical data and the data that should be included in incident reporting. These two types of data are mixed throughout the bulletin, and it is confusing.

Recommendation: When a medication error occurs due to delay by the MCO, put it under a separate category in a general databank for the entire system.

OMR's Draft Proposal: ***Misuse of Funds*** *- "any act or course of conduct which results in the loss or misuse of an individual's money or personal property or the loss or misuse of agency money or property intended for the benefit of an individual or group of individuals. Requiring an individual to pay for an item or service that should be provided as part of the individual's plan of support is considered financial exploitation and is reportable. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other- individuals of items that benefit the household."*

Discussion: Part of coordination with other departments and laws involves the use of similar definitions, policies, and procedures. This will help to assure consistent application of the definition, improve training, and eliminate confusion associated with different definitions in similar regulations and policies. It is recommended that OAPSA's (Act 13 of 1997) definition of exploitation, which is broader in scope, be used.

In addition to the concerns discussed above, further clarification is needed for instances such as the following: If someone loses their wallet or if $10 is missing, does that rise to the level of a reportable incident? It is certainly not financial exploitation if it is replaced. A situation like this can be handled administratively; anything that is made whole administratively should not be considered a reportable incident.

Recommendation: Replace the bulletin's definition and use of the phrase *"misuse of funds"* with the language in OAPSA, replacing "older adult or adult" with "individual":

Revise the language to read as follows: *"Exploitation: an act or course of conduct by a caretaker or other person against an individual ~~older adult~~ or an individual's ~~older adult's~~ resources, without the informed consent of the individual ~~older adult~~ or with consent obtained through misrepresentation, coercion or threats of force, that results in monetary, personal or other benefit, gain or profit for the perpetrator or monetary or personal loss to the individual ~~older adult~~."* **

**** Underlined language indicates our additions. Language which is stricken out indicates language which we have deleted.**

OMR's Draft Proposal: *Neglect - - "the failure to obtain and/or provide the services and supports defined as necessary in the individual's plan or otherwise required by law or regulation. Acts which place an individual in harm's way, such as leaving a person unattended when they lack necessary self-preservation skills, locking an individual in an unattended vehicle, etc., are included whether actual harm occurs or not."*

Discussion: The definition of neglect should be consistent with other definitions of neglect. Refer to the preceding discussion regarding consistency among definitions, policies and procedures.

Recommendation: Use the OAPSA's definition of "neglect."

Revise the language to read as follows: *"The failure ~~to provide for oneself or~~ of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health. An individual ~~No older adult~~ who does not consent to the provision of protective services will not be found to be neglected solely on the grounds of environmental factors which are beyond the control of the caretaker, such as inadequate housing (for example, when providing in-home supports), furnishings, income, clothing or medical care."*

OMR's Draft Proposal: ***Physical Abuse*** *- "an act which causes or may cause physical injury to an individual, such as striking or kicking, threatening physical violence, applying noxious or potentially harmful substances or conditions to an individual."*

Discussion: This definition does not mention intent. It is important to include intent in this definition as a reasonable protective measure.

Recommendation: Revise the language to read: ***"any act which is intended to cause or may cause..."***

OMR's Draft Proposal: ***Psychiatric Hospitalization*** *- "any inpatient admission to a psychiatric facility, including respite or crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation and/or treatment, whether voluntary or involuntary. This includes admissions for "23 - hour" observation and those for the review and/or adjustment of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors. For coding purposes the report must specify whether the hospitalization was voluntary or involuntary."*

Discussion: If the purpose of the data collection is to track certain medical statistics to see what is happening within the MR population, then including routine psychiatric hospitalizations is appropriate, but not within the context of "incident" reporting. If the purpose of the data collection is to track incidents for the purpose of correction, how can a provider correct a routine psychiatric hospitalization?

It is unclear why several of these definitions are included under incident management. As discussed previously, there should be a clear separation between what constitutes an incident and what is simply a routine occurrence common to people's everyday lives and medical needs. Providers can include such occurrences in trend reports without reporting them to the state as incidents. Why should events that don't rise to the level of an incident be subject to state reporting and investigation requirements? It should also be noted that the amount of incidents requiring investigation under this bulletin may result in less effective investigations.

Recommendation: Remove routine medical reporting from incident reporting and include necessary medical reporting in another data collection process.

Recommendation: Revise the language to read as follows: ***"any emergency admission..."***

OMR's Draft Proposal: ***Refusal of Prescribed Treatment*** **-**

Discussion: Why is refusal of prescribed treatment considered a reportable incident? Providers document refusal, but people have the right to refuse. This requirement feels very institutional. The implications of refusal should be documented but shouldn't have to be reported as an incident. For example, if an individual refuses therapy that is prescribed, that would be reportable under this bulletin. Situations such as this occur frequently, and when they do, at the individual's request, we try to honor the individual's request, as we have been encouraged to do so by OMR's philosophy and self-determination principles.

Clients have the right to choose whether or not they want to accept or refuse prescribed treatment. The definition should only require reporting when refusal results in serious bodily injury. Otherwise, the Department is not being consistent with its movement toward choice. We encourage the department to ensure that the provisions throughout the bulletin are made consistent with consumer choice.

Recommendation: Change title to *"Refusal of Prescribed Medical Treatment."*

Recommendation: Add the following language: *"refusal of medical services that result in a threat of or actual loss of life, or actual serious bodily injury."*

OMR's Draft Proposal: *Verbal Abuse - "verbal behavior which is intended to inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual. Included are acts such as yelling, the use of profane language directed at an individual, name-calling or the use of negative stereotypes and labels, threats, etc."*

Discussion: The definition of 'abuse' is significantly expanded in this bulletin. Our recommendations focus on two things: families and the use of the word "yelling."

Families may yell or use profanity routinely; providers do not have control over the behavior of families. We suggest that including the requirement to report yelling is unnecessary since the other parts of the definition cover "verbal abuse" sufficiently.

Recommendation: Remove the word *"yelling"* from this definition, which is difficult to define and easy to misinterpret. The other parts of the definition sufficiently cover "verbal abuse."

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OVERVIEW OF REPORTABLE INCIDENTS (pg. 11)

Thank you for including this useful chart.

REPORTING REQUIREMENTS (pgs. 12-13)

Discussion: The reporting requirements section enumerates multiple entities to whom reports are to be given. The amount of reporting required is burdensome and duplicative (e.g. to the county, OMR, DPW, law enforcement, family/guardian/next of kin, Department of Health, and particularly to Department of Aging, etc.). Problems with OAPSA (Act 13 of 1997) reporting have already demonstrated the difficulty of reporting to every entity who may have some interest and/or regulatory connection with an incident, unusual or routine.

For example, the bulletin suggests separate reporting for persons under age 18 to Child Protective Services. This in direct contradiction with the mandate in OAPSA, which requires incidents involving not just persons over the age of 18, but any recipients of care, to be reported to the local AAA. As defined by OAPSA, a recipient is "an individual who receives care, services or treatment in or from a facility." It is recommended that OMR not be suggesting to providers that they have the option of not reporting incidents involving individuals under the age of 18 to the local AAA. Refer to the Department of Aging's revised proposed rulemaking for clarification.

As we have discussed before, reporting to various agencies is duplicative, and we commend the OMR for attempting to coordinate with the agencies. However, the OMR cannot coordinate overlapping areas of this bulletin in ways that are in violation of the law. As we have recommended in our comments on OAPSA, we request that the departments work out a way to make sense out of the overlapping requirements which might include the departments proposing a clarifying amendment to OAPSA that will coordinate these duplications effectively or develop a Memorandum of Understanding (MOU) among the departments that would effectively allow some of the language in this draft bulletin to be implemented as it relates to OAPSA.

Recommendation: Work with the departments to establish a clarifying amendment to OAPSA or a Memorandum of Understanding (MOU) if allowed by law, to eliminate the duplicate reporting and encourage effective coordination of reporting requirements.

OMR's Draft Proposal: *"All reportable incidents must be reported to:"*

This statement needs to be clarified so providers understand that the requirements apply to them.

Recommendation: Add, *"by the provider"* after *"must be reported."*

OMR's Draft Proposal: *"In Addition: "Reportable incidents involving individuals who reside in facilities licensed as ICF/MRs (both state- and privately-operated) must be reported to the appropriate Regional Field Office of the PA Department of Health, Division of Intermediate Care Facilities;..."*

Discussion: In this section, the OAPSA is summarized. We suggest that the bulletin quote or reference the OAPSA so the bulletin does not have to be changed any time the OAPSA is amended. Also, we have noted in our comments that the bulletin misinterprets or misquotes OAPSA. This is further reason to reference OAPSA.

Recommendation: Reference OAPSA in this section.

Discussion: The Commonwealth needs to eliminate dual or multiple reporting required by providers. Providers should make a report on an incident to a county or state agency which then has the responsibility for reporting and coordinating with other agencies which have a need to know the information.

Recommendation: Develop a clear reporting algorithm that outlines the reporting procedure before the bulletin is issued in final form.

Recommendation: Formalize coordination procedures through Memorandums of Understanding (MOU) or other effective methods.

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REPORTING REQUIREMENTS MATRIX (pg. 14)

Discussion: Having a matrix is helpful. Is everything in the matrix reportable by the provider (e.g., who does the reporting in the last two columns? The matrix does not comply with OAPSA. Refer to earlier comments regarding the definition of "recipient" and reports that OAPSA requires to be made to the local AAA.

Recommendation: Clarify whether or not the provider is expected to report everything in the matrix.

Recommendation: The reporting requirements matrix needs to be in compliance with the OAPSA. As an example of a change that needs to be made to be in compliance with OAPSA, the "Report to AAA" column which references 18 years of age should be changed to "x".

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REPORTING PROCESS (pg. 15)

OMR's Draft Proposal: *"Providers, Counties and the Commonwealth will follow a standard procedure for reporting and receiving incidents covered under this bulletin."*

Discussion: Time frames for the reporting process need to be coordinated with time frames required in all regulations that pertain to the entities covered by this bulletin.

Recommendation: Coordinate time frames for the reporting process with time frames required in all regulations that pertain to the entities covered by this bulletin.

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POINT PERSON (pg. 15)

OMR's Draft Proposal: *"When an incident is reported, the provider point person must..."*

Discussion: Was it OMR's expectation that the point person notify the family/guardian?

Recommendation: Clarify who notifies the family/guardian.

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STANDARDIZED INCIDENT REPORT FORMAT (pgs. 15-16)

OMR's Draft Proposal: *"All Incident Reports must be submitted on a form designed by the Office of Mental Retardation..."*

Discussion: We appreciate OMR's plan to standardize. There are forms, many of which are automated, which are used for reporting. The development of forms and/or adaptation of reporting forms need to be done with providers' involvement.

Recommendation: Ensure that the standardized incident report form is developed or adapted with provider involvement since many reporting forms are already in place.

OMR's Draft Proposal: *"Initial Notification: Due within 24 hours of the incident or within 24 hours of when the provider learns of the incident."*

Discussion: Is initial notification verbal or written? It is now usually done by phone. If it is written, it is another expansion beyond the current bulletin. In the past, providers were able to fax reports to the DPW. Will this continue? If so, all counties and regional offices should increase the number of available fax numbers because the reporting load will increase markedly. If not, there may be a problem getting reports submitted on time.

Recommendation: Clarify that initial notification may be written or verbal.

Recommendation: Increase the number of available fax numbers for reporting.

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INITIAL NOTIFICATION (pg. 16)

OMR's Draft Proposal: *"The Initial Notification which is due within 24 hours of the incident or within 24 hours of when the provider learns of the incident will include the following: name and telephone number of the staff (or other) person making the initial notification."*

Discussion: Does this mean initial reporter?

Recommendation: Change the language from *"person making the initial notification"* to *"person making the initial report."*

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FINAL REPORT (pg. 18)

OMR's Draft Proposal: *"The Final Report is due when the incident is closed by the provider, with an outside limit of thirty (days) from the date of the incident or of the date the provider learns of the incident unless an extension has been granted will retain all of the preceding information from the Initial Notification and Written Report and will add: if the individual was hospitalized, the Final Report must include the Hospital Discharge Summary and a description of any plans for subsequent medical follow-up. If the written Hospital Discharge Summary is not available at the end of 30 days, a summary of the hospitalization may be provided but the Discharge Summary must be forwarded to the appropriate parties as soon as it becomes available; the date on which the incident was*

considered "closed" by the provider and the name and title of the provider representative who made the closure determination. An incident is "closed" when the report is complete, investigation is complete, and any designated follow-up has been authorized. This should normally happen within 30 days of the incident or first knowledge of the incident by the provider."

Discussion: Thirty (30) days is much too short if there is a complex investigation and multiple reporting requirements.

Recommendation: Revise the language to read: *" within 60 days."*

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FILING OF REPORTS (pg. 19)

"The completed incident report form must be filed in the individual's record. An investigation file must be maintained by the provider and the County."

Discussion: Previously, only founded reports were required to be in the actual record and founded reports are the only pertinent data that should be used in trend analyses.

Recommendation: Clarify that only founded reports are required to be in the actual record.

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INCIDENTS REQUIRING INVESTIGATION (pg. 20)

OMR's Draft Proposal: *"Accidental injury requiring hospitalization or emergency room treatment"*

Discussion: Only serious medical incidents should be reportable. Refer to our earlier discussion regarding the distinction between routine medical occurrences and unusual incidents. Also refer to our earlier discussion regarding consistency among regulations and policies, specifically in the application of definitions.

Recommendation: Delete *"requiring hospitalization or emergency room treatment."* After "injury," add *"resulting in serious bodily injury,"* which is referred to in OAPSA.

OMR's Draft Proposal: *"Unexplained injury requiring hospitalization or emergency room treatment."*

Discussion: Refer to the discussion above.

Recommendation: Delete *"requiring hospitalization or emergency room treatment."* After "injury," add *"resulting in serious bodily injury"* which is referred to in OAPSA.

OMR's Draft Proposal: *"Allegation or finding of abuse/neglect involving physical, sexual, verbal, or psychological abuse/neglect."*

Discussion: Should only providers be listed here; won't regional, county and local law enforcement also investigate sexual abuse, for instance? OAPSA requires local law enforcement to investigate incidents such as sexual abuse that the bulletin does not specify.

Recommendation: Clarify if the OMR intends to leave out investigations by law enforcement.

Recommendation: Ensure that the chart on page 20 of the bulletin is in compliance with OAPSA.

REQUIREMENTS FOR CERTIFICATION (pg. 21)

OMR's Draft Proposal: *"Certified investigators are people who have been trained according to Commonwealth specifications and received a certificate in investigation from the Commonwealth. Providers, Counties and the Commonwealth must have certified investigators available to conduct required investigations. To be a certified investigator a person must: Be a high school graduate; Be over the age of 21 years; Meet the criminal background requirements of the Older Adults Protected Services Act; Present a letter of recommendation; and Successfully complete the training. Training and testing will be required for certification as an investigator. Persons who are trained at the time of the issuance of this bulletin and who have conducted investigations may take a test to become certified. Only those who pass the test will be certified. Certification is good for two years. At least once every two years, certified investigators must participate in a refresher class to be recertified. Certification may be withdrawn by the Commonwealth for cause."*

Discussion: Certification is a good idea and provides an appropriate safeguard. The recommendations we have concern the recertification requirements. Requiring

recertification every two years is time consuming, costly, and may not add value enough to offset cost.

We suggest that after an individual has been certified, if the individual does not conduct an investigation within two years, that individual should be recertified. However, if an individual has conducted a proper investigation during those two years, we suggest that the investigation count as on-the-job training and experience which would meet the requirements of recertification. Experience and feedback is the best training after initial recertification. Additional seat-time is seen as adding little value even though it would add significant costs.

On another note, who does the letter of recommendation come from?

Recommendation: Revise the language to read as follows: *"At least once every two years, certified investigators who have not conducted a proper investigation within two years of certification must participate in a refresher class to be recertified."*

Recommendation: Add *"from their employer"* after *"present a letter of recommendation."*

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INVESTIGATION REQUIREMENTS (pg. 21)

OMR's Draft Proposal: *"The investigation record includes the incident report, evidence, witness statements, and the investigator's report. A copy of the investigation report must be sent to the County. When the investigation is conducted by the County, the record must be sent to the Commonwealth. The investigation record must be secured and separate from the individual's record."*

Discussion: For adequate follow-up, providers must receive all information related to investigations of incidents which originated with the provider.

Recommendation: After *"sent to the Commonwealth,"* add *"and to the provider involved."*

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DATA AND INFORMATION ANALYSIS REQUIREMENTS (pgs. 22-24)

OMR's Draft Proposal: *"Provider Responsibilities: Trend analysis is one means of making sense out of the data which accumulates when incidents and unusual incidents are reported and documented in a data base. Trend analyses provide the agency, the*

county and the Commonwealth with insights into specific issues that cannot be gained from the review of individual reports. As part of an ongoing risk management/quality improvement process, the provider may choose to examine a different question and/or analyze a specific trend at regular intervals. Some suggested areas for trend analysis are listed below. This is not an all-inclusive list.

- *The same thing happening to the same person/people over a period of time*
- *Different things happening to the same person over time*
- *Same things happening across groups over time.*
- *Cluster of incidents that are outside the norm*
- *Variations from the norm over time*
- *Outside variables which impact on incidents*
- *Impact of place, time, etc.*
- *High occurrence by type (locked in vans, left at site unattended by para transit, etc.)*
- *Absence of things reported*
- *Typical risk or atypical risk*
- *Process analysis/time needed to bring closure*
- *Causes of hospitalization (including psychiatric diagnoses0*
- *Causes of death (especially those that are sudden and unexpected)*
- *Percent of positive findings after allegations*
- *Impact of changes on subsequent rate of events*
- *Comparison of staff vacancy rate with rate/type of incidents*
- *Comparison of variables (turnover rate, use of overtime...)*
- *Average number of incidents per person supported (changes over time, locales,...)*
- *Changes in rate of incidents as models of support change*
- *Agency issues (increase in medication errors since..., etc.)*
- *As part of the provider review process, a provider management group, designated in provider policy, shall review all incident reports and investigations as required.*

Provider Responsibilities

- *Trend analysis is one means of making sense out of the data which accumulates when incidents and unusual incidents are reported and documented in a data base. Trend analyses provide the agency, the county and the Commonwealth with insights into specific issues that cannot be gained from the review of individual reports. As part of an ongoing risk management/quality improvement process, the provider may choose to examine a different question and/or analyze a specific trend at regular intervals. Some suggested areas for trend analysis are listed below. This is not an all-inclusive list.*
- *The same thing happening to the same person/people over a period of time*
- *Different things happening to the same person over time*
- *Same things happening across groups over time.*
- *Cluster of incidents that are outside the norm*
- *Variations from the norm over time*

- *Outside variables which impact on incidents*
- *Impact of place, time, etc.*
- *High occurrence by type (locked in vans, left at site unattended by para transit, etc.)*
- *Absence of things reported*
- *Typical risk or atypical risk*
- *Process analysis/time needed to bring closure*
- *Causes of hospitalization (including psychiatric diagnoses0*
- *Causes of death (especially those that are sudden and unexpected)*
- *Percent of positive findings after allegations*
- *Impact of changes on subsequent rate of events*
- *Comparison of staff vacancy rate with rate/type of incidents*
- *Comparison of variables (turnover rate, use of overtime...)*
- *Average number of incidents per person supported (changes over time, locales, ...)*
- *Changes in rate of incidents as models of support change*
- *Agency issues (increase in medication errors since..., etc.)*
- *As part of the provider review process, a provider management group, designated in provider policy, shall review all incident reports and investigations as required reports with the County that include:*
- *per month by individual and site;*
- *summary comparisons to prior four quarters*
- *incidents requiring investigation by individual and site*
- *results of investigations (confirmed, unconfirmed and inconclusive)*
- *actions to be taken in response to the conclusion/determination*
- *analysis of increases/decreases in numbers and types of incidents from*
- *previous quarter and previous year by person, by location*
- *analysis of individuals with three or more incidents during the reporting period*
- *analysis of significant factors which may influence the data*
- *analysis of the implementation of corrective actions during the reporting period discussion of special areas of concerns identified in the review process*

County responsibilities

- *The County must have procedures for the review and analysis of data on all*
- *reported incidents. Those procedures must include at least quarterly reviews to determine what trends may be developing and to take appropriate administrative actions to intervene. The county provider must report on incident data to the Commonwealth at least semi-annually. The report to the Commonwealth must include at a minimum:*
- *incidents by provider by quarter for the reporting period*
- *summary comparisons of provider data for the past four quarters*
- *incidents requiring investigation by provider*
- *incidents requiring investigation by the county*

- *analysis of increases/decreases in numbers and types of incidents from previous reporting period.*
- *analysis of individuals with six or more incidents during the reporting period*
- *analysis of data by site*
- *analysis of significant factors which may influence the data*
- *analysis of the implementation of corrective actions during the reporting period*
- *discussion of special areas of concerns identified in the review process*
- *discussion of joint actions between the county and the provider.*

Health Care Coordination Unit responsibilities:
The HCCU shall have access to incident data on at no less than a monthly basis. The HCCU shall review data: related to medication errors, ER and in-patient hospitalizations, deaths and other health related matters to determine where trends suggest training, a change in procedures or medical supports are needed.

Commonwealth responsibilities:
The Commonwealth will review data on all reported incidents at least semi-annually to determine what trends may be developing statewide or regionally and take appropriate administrative steps to intervene. The Commonwealth will issue an annual report reviewing statewide incident trends."

Discussion: Will all reportable incidents be placed on the web? See our earlier comments regarding significant vs. non-significant errors and reporting trends vs. reporting each incident. Corrective actions that agencies take along with trends are more accurate representations of agencies than presenting the public with the number of 'incidents' occurring in an agency. Also see our discussion of what constitutes an 'incident.' The bulletin needs to narrow the definition of what is considered an "incident" so reporting is focused and useful.

Regarding the phrase "absence of things reported," what does that phrase mean?

Recommendation: Separate "incidents" from other data to be reported.

Recommendation: Provide clarification regarding the phrase "absence of things reported" so that we can offer recommendations if necessary.

Discussion: Trends don't show up in 3-4 months, which is another good reason to reduce the frequency of reporting from quarterly to semi-annually.

Recommendation: Change *"quarterly"* to *"semi-annually"* and make the change consistent throughout the bulletin.

Discussion: The following discussion pertains to the requirement that providers analyze individuals with three or more incidents during the reporting period. Because of the way "incidents" have been defined, many individuals will have three or more incidents during any quarter, many of which are nothing "unusual" – like doctor's visits. This is another reason that it makes sense to separate incidents from routine occurrences. However, if the bulletin remains as proposed, it is recommended that repeat incidents occurring three or more times in the reporting period be reported.

Recommendation: Separate reporting of "incidents" from reporting of routine occurrences.

Recommendation: If the bulletin remains as proposed, revise the language to read as follows: *"analysis of individual with three or more repeat incidents during the reporting period."*

Discussion: With regard to the reporting requirements for counties, it is important that providers receive copies of all reports which pertain to them.

Recommendation: Revise the language to read as follows: *"the county must report on incident data at least semi-annually. A copy of this report must be submitted to the provider agency in which the incident occurred."*

Discussion: With regard to analysis of data by site, which is already done by the provider, use the county's expertise by having them analyze the trends in their county using the providers' analyses. Counties don't have knowledge of all of the variables and would therefore be unable to develop a complete report. They would always have the option, however, to provide additional information if they felt a providers' analysis was inadequate or incomplete.

Recommendation: Instead of having the county conduct an analysis of data by site, which is already done by the provider, use the county's expertise by having them analyze the trends in their county using the provider's analyses.

Recommendation: Use the following language: *"review the providers analysis of data by site, providing additional analysis if deemed necessary or if the analysis is inadequate or incomplete."*

Recommendation: All of the references to analysis in this section should read "provider's analysis."

Discussion: With regard to HCCU's responsibilities, who is responsible for giving the HCCU access to incident data? How will they obtain access?

Recommendation: Clarify that the county will provide the analyses to HCCU's on any founded incident which is health-related.

Discussion: Will providers receive a copy of the annual report issued by the Commonwealth? It is essential that providers receive all information and analyses generated by others which pertain to any provider-related incidents. If the information is to be useful, the annual report should also include corrective actions taken in addition to trends.

Recommendation: Revise the language to read as follows: *"the Commonwealth will issue an annual report reviewing statewide incident trends and corrective actions agencies have taken. A copy of the annual report will also be given to provider agencies."*

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ADDENDUM I
FOR FAMILIES (pgs. 25-26)

Family Notification
OMR's Draft Proposal: *"Family members of individuals residing in licensed settings need to have information regarding their relative's health and safety. If your family member resides in a licensed setting or receives services and supports in a licensed setting: You will be notified of the findings of an investigation within 30 days of the occurrence or when the circumstances became known;"*

Discussion: Families should be entitled to information about the outcome of an investigation. It must be recognized that notifying families of the specific findings of an investigation is problematic because of confidentiality and liability issues. If the provider is forced to disclose certain information related to the investigation (e.g. names, details), and the results of the investigation are inconclusive, the provider is placed in a compromised position. Confidentiality issues arise during investigations, and a provider who discloses confidential information may risk going to court on a regular basis. For example, whereas providers regularly terminate the employment of a staff person if the provider's investigation warrants, if they are required to disclose such information related to a staff person, when presented in a court of law where different standards are used, this requirement may actually damage the provider's ability to respond effectively and increase the risk to individuals.

Therefore, while it is a good thing to inform families of the outcome, providing details of the findings is not advisable.

We also repeat our request to change the 30 day timeframe to 60 days.

We also suggest that the option of notifying families verbally or in writing be maintained.

Recommendation: Revise the language to read as follows: *"You will be notified, verbally or in writing, of the outcome of the investigation within 60 days of the occurrence or when the circumstance became known."*

Reportable Incidents Which Occur in the Home

OMR's Draft Proposal: *"An increasing number of people are supported to live in their own homes or the homes of their families. When a provider is contracted with to provide services and supports within the home, they are obligated to report all incidents identified in this bulletin. This includes incidents which they become aware of, but may not have occurred during the time they are providing supports. It is always the family's option to contact the case manager to initiate any incident report."*

Discussion: What exactly are the obligations of families? Are families to report incidents that occur within the family? Are families to report errors they made or only errors that outside caregivers made? If so, families will find this to be intrusive.

The role of the provider with the family in a family's own home is unclear. The proposal seems to suggest setting up providers over families as watchdogs and investigators. Is that what the department intends?

Recommendation: Further clarify the role of the family in the investigation and reporting process.

Recommendation: Ensure that providers only have to file an incident report when they are providing services.

Recommendation: It is recommended that providers provide services to families but not be responsible for being a watchdog or investigator of families and incidents which occur within families.

Special Requirements for Families who Manage Supports and Services Directly

OMR's Draft Proposal: *"Some family members take on the role of managing funds to purchase services from a variety of vendors. The vendors are not licensed or otherwise regulated by the Office of Mental Retardation and have no contractual relationship with the County and as a result, the vendor does not fall within the scope of this bulletin for purposes of reporting. The family member managing the funds, however, is included within the scope of the bulletin."*

Discussion: Vendor/family and vendor/provider relationships need further clarification, especially with regard to the reporting of incidents. A vendor doesn't provide services other than managing funds. If the provider is a vendor, directly receiving money from the family, a contractual relationship does not exist. Thus, the provider would not fall within the scope of this bulletin. If the provider is being paid by the county/state, then the provider is a watchdog over the family. Is there any assumption being made that a vendor is or is not potentially a provider of that family's services?

An individual who needs personal assistance may hire an assistant not licensed by OMR. The assistant would not fall within the scope of the bulletin. In this situation, is the bulletin assuming that the family takes on a quasi-provider role and it is the family's responsibility to tell the vendor the rules?

Recommendation: Further clarify the vendor/family and vendor/provider relationships, specifically regarding the reporting of incidents.

Discussion: With regard to the family's responsibility to report information about incidents, there should be a clear, simple written document that families can use for this purpose.

Recommendation: Provide families with a simple document for reporting information.

Discussion: With regard to investigations in the family section, the bulletin needs to be clarified. The investigation process should be the same for an individual living with his/her own family as it is for any individual living with anyone else or by themselves.

In the investigation section, there is no recognition of potential conflict of interest and there needs to be.

No class of individuals should be excluded from being investigators (e.g. all providers; all family members; all case managers). Each investigation should stand on its own as to who would be excluded from being an investigator. Choices of investigators should be made among people who would not have any conflict of interest, rather than be based on class distinctions.

Also, it would be helpful to have a list of certified investigators available on the web.

Recommendation: Clarify that the investigation process is the same for families, providers, and anyone else providing care.

Recommendation: Include a conflict of interest section.

Recommendation: Clarify that no class of individuals are excluded from being an investigator.

Recommendation: Put a list of certified investigators on the web.

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ADDENDUM II
Related Statutes, Regulations and Policies
OMR's Draft Proposal: *"The related laws include: Neglect of Care-Dependent Persons [18 Pa. C.S.A. § 2713]; The Child Protective Services Law [23 Pa. C.S.A. Chapter 63]; The Older Adults Protective Services Act [35 Pa. C.S.A. § 10225]. [Note: The Older Adults Protective Services Act applies in its entirety to persons aged 60 or above. Chapter 7 of this act (Reporting Suspected Abuse By Employees) applies to any care-dependent adult (a person age 18 or above) receiving services from a covered facility.]*

Discussion: As discussed previously, OAPSA defines recipient as any individual receiving care, not as a person 18 or above. Since OAPSA clearly states that it applies to persons of any age, the language of this bulletin does not accurately reflect the statute.

Recommendation: Delete the sentence "*[Note: The Older Adults Protective Services Act applies in its entirety to persons aged 60 or above. Chapter 7 of this act (Reporting Suspected Abuse By Employees) applies to any care-dependent adult (a person age 18 or above) receiving services from a covered facility.]*"

OMR's Draft Proposal: *"The Older Adults Protective Services Act [35 Pa. C.S.A. § 10225] The Older Adults Protective Services Act (OAPSA) establishes specific*

requirements and procedures for the mandatory reporting of alleged abuse and the provision of protective services when needed for adults over age 60. Chapter 7 of the OAPSA (often referred to as Act 13) extends the mandatory reporting requirements of the Act to all care-dependent adults (those over the age of 18) who reside or receive services in specified facilities, including home health agencies. Employees or administrators of a covered facility who have reasonable cause to suspect that an individual receiving care, services or treatment from the facility is a victim of abuse shall immediately make a report in compliance with the requirements detailed in the Act. All adults covered within the scope of this Mental Retardation Bulletin who are receiving care or services in a facility as defined in the OAPSA are also covered by the Act. Individuals and agencies who provide facility-based supports and services within the scope of this Bulletin are required to follow the mandatory reporting requirements of the OAPSA when they have reasonable cause to suspect that a care-dependent adult is a victim of abuse or neglect as defined within the OAPSA. Compliance with the mandatory reporting requirements of the OAPSA is in addition to the reporting requirements established in this Bulletin. Greater detail on the reporting requirements of the Older Adults Protective Services Act is found in Department of Aging Regulations XXXXX."

Discussion: The above statements are misleading in that it suggests that OAPSA *only* applies to adults over the age of 60. OAPSA clearly states that its reporting requirements apply to recipients of any age. Providers may be mislead to believe that they would not have to report incidents involving individuals under the age of 60 to the local AAA if the bulletin does not revise language related to OAPSA.

Recommendation: Delete references to "older adults" and replace with "individuals" throughout the bulletin where OAPSA is discussed or referenced.

* * * * * * *

In the interest of working in partnership with the Office of Mental Retardation to improve the health, safety and quality of supports and services for individuals with mental retardation, we are looking forward to meeting with OMR to discuss our recommendations. Thank you for giving our comments and recommendations your thoughtful consideration.

Sincerely,

Shirley A. Walker
Executive Director

Original: 2077

P·A·N·P·H·A PENNSYLVANIA ASSOCIATION OF NON-PROFIT HOMES FOR THE AGING

MEMORANDUM

TO: Robert F. Hussar
Regulatory Coordinator
PA Department of Aging

FROM: Betty M. Simmonds
Public Policy Analyst

DATE: May 18, 2000

SUBJECT: Comments on second draft of the protective services regulations

Thank you for the opportunity to comment on this draft of 6 Pa. Code Chapter 15, Protective Services for Older Adults. PANPHA's Protective Service Regulation Review Task Force has reviewed the draft and has provided comment. This takes the form of narrative comments that are more substantive or are more broadly applicable, and annotations on the draft for the remaining comments that are more editorial in nature.

If you have any questions, please call me at (717) 763-5724, or e-mail betty@panpha.org.

cc: Jeffrey Wood
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Comments made by PANPHA regarding the second draft of the proposed Protective Services for Older Adults regulation, 6 Pa. Code Ch. 15

A commentary on current implementation of the criminal history record information requirements in long term care nursing facilities is that in some instances counties do not report all criminal history records to the state police. A criminal history record report obtained from the State Police would therefore, not contain information related to situations that occurred in a county, but were not reported. Facilities have had difficulty when the survey agency has some prior knowledge of an individual about activity in the county, that the nursing facility did not know about and had no information about the particular incident noted on the report obtained from the State Police.

A comment on current implementation of requirements for investigation and action regarding exploitation of older adults is that in some counties the issue of exploitation seems to be a low priority. In some cases the protective services agency does not take action.

One spelling of the term "employee" should be used consistently throughout the regulations.

References to criminal history record information reports should use consistent language throughout.

References to the Department should be consistent throughout.

§ 15.1. Scope and Authority.
p. 4. Since § 15.134 (e) regarding procedure indicates that the criminal history record information applies to those conducted by the Department of Education pursuant to Act 14 of 1997, related to nursing assistant training, that should be noted in the section which addresses scope and authority.

§ Definitions.
p. 5. Administrator. This should be the operator, the owner, officers, board, or other governing entity, or its designee.

p. 7. Employee. If a student doing an internship or clinical rotation is not paid, would he be considered an employee or a volunteer? If the student has no resident contact, would the criminal history record information report requirements apply? If the student is paid, but is supervised at all times during resident contact, would the criminal history record information requirements apply?

F.B.I. The abbreviation F.B.I. is defined to mean the Federal Bureau of Investigation, yet the abbreviation is not used in the regulation.

Home Health Care Agency. At the time when Act 169 was passed there was discussion about inclusion of unlicensed home health agencies and nurse registries in the

requirements for criminal history record information reports. Was this done and do the draft regulations reflect this?

p. 8. Several types of residential settings are listed as being included in the definition of Home Health Care Agency. Are they, in fact home health care, or are they facilities?

p. 9. Operator. See comment regarding definition of administrator.

§ 15.12 Administrative functions and responsibilities of area agencies on aging.
p. 14. (b) (3) Staff must be available in order to fill in on an as needed basis. Staff must also use the information that they have been taught regarding protective services with sufficient frequency to enable them to maintain an effective skill level. (See pp. 17, § 15.13 (e) and 23, § 15.41(c))

p. 15. (b)(4) Since there is no requirement for the AAA to obtain local funding for its protective services plan budget, why must this language be included in the regulation?

§ 15.13. Organization and structure of protective services functions.
p. 16. (c)(4) Reference is made to the Department's Long Term Care Assessment and Management Program (LAMP). This should be OPTIONS.

(c)(5) Language to ensure that protective services caseworkers can focus on protective services work should not be deleted.

§ 15.22 Safeguards for those who make or receive reports.
p. 18. (a) and (c). The terms triple and treble are used. Only one should be used.

§ 15.24. Receiving reports; agency intake process.
p. 20. (b) Anonymity for reporters. Although we realize that reporters may need the security of anonymity in order to make valid reports regarding the need for protective services, PANPHA members, and state survey agency staff, have experienced a tremendous waste of resources when complaints are made maliciously, only to cause trouble for the facility or an individual. Some method to minimize these malicious reports, but still protect older adults is needed.

§ 15.25. Report form and content.
p. 20. (a) Standardized forms. It is unclear whether intake workers, investigators, and facility reporters use a single form or multiple forms. This should be clarified.

§15.26. Screening and referral of reports received.
p. 21. The difference in action taken between the referral categories of Emergency and Priority is not very clear. The term "immediately" must be defined. The term "early intervention" must be defined.

p. 22. No need for protective services. An individual should not be placed in the category of "no need for protective services" merely because of age, not because of a lack of need for intervention. In some cases waiting until the next business day for the

protective services caseworker to review the case and make a referral to another community agency may be too late. (See also § 15.42(a)(4) on p. 25).

§ 15.42. Standards for initiating and conducting investigations.
p. 24. (a) Requirements by report category. The term "immediately" must be defined. What are "reasonable attempts" and "reasonable efforts"?

p. 25. (c) If the agency delays investigation, the Department should intervene in the investigation.

§ 15.43. Resolution of unsubstantiated reports.
p. 26. (c) In order to establish patterns in abuse, neglect, exploitation, or abandonment reports must be maintained for longer than 6 months. Unsubstantiated reports should be maintained for 1-2 years. How long are files maintained if they are reopened?

§15.46. Law enforcement agencies as available resources.
p. 30. (f) Simultaneous investigation. When investigations are being conducted by the police and the licensure agency, the agency shall coordinate the investigation with these entities. Although language is included in multiple sections regarding coordination of investigation and sharing necessary information, § 15.105 does not contain language to permit sharing of information with State Licensing Agencies.

§ 15.71. Involuntary intervention by emergency court order.
p. 32. (a) Suggested language for the first sentence is: "When there is clear and convincing evidence that, if protective services are not provided, the older adult to be protected is at imminent risk of death or serious physical harm, the agency shall take appropriate action to provide necessary services, up to and including a court order."

§ 15.96. Termination of protective services.
p. 42. See previous comment regarding determination of need for service based solely upon age.

§ 15.102. Maintenance of case records.
p. 43. (c) Relevant information from case records must be shared with the applicable licensing agency under § 15.105.

p. 44. (e) See previous comment regarding maintenance of unsubstantiated reports for 6 months to establish a pattern.

§15.105. Limited access to records and disclosure of information.
p. 45. Language must be added in this section to permit sharing of pertinent information with the State Licensing Agency.

§ 15.113. Time limitation on service purchases.
p. 48. (b) **Continued** need for services should be reviewed after 15 days. Neither 30-days or 15-days should be considered as standard time allotments for services.

§ 15.124. Protective services intake training curriculum.
p. 52. Clarification is needed regarding the report form(s) that are used by the persons involved in intake and investigation of reports of need for protective services.

§ 15.132. Facility personnel requirements.
p. 55. See previous comments regarding the definition of administrator.

(a)(5) Thank you for including PANPHA's request that staffing agencies must provide criminal history record information to the long-term care nursing facility for which they provide staff. We are concerned, however, that the requirement for the report to be provided to the nursing facility may be too stringent, for example, when agency staff are needed on the weekend or at night when an agency office would not be open to obtain the proper information. An agency could provide a statement attesting that the criminal history record information report was completed and on file at the agency.

§ 15.133. Facility responsibilities.
p. 56. (a) It is good to reinforce the level of offense that is needed in order to prohibit employment.

p. 58. Language should be used consistently to refer to the criminal history record information report.

(c)(3) Expungement of a criminal record should not be required, but it should be available as an option to permit some individuals who would otherwise be disqualified to be employed in the covered facilities.

(f) See previous comments regarding definition of administrator.

p. 59. (h)(II) See previous comments regarding definition of administrator. Posting notices regarding protections and obligations under the act should provide sufficient notice.

p. 61. It must be clear that the "facility personnel" identified in this section are employees that must obtain a criminal history record information report, not facility personnel that process the applications.

(e) Nursing assistants are not certified in Pennsylvania. The term "Certified" must be deleted.

§15.136. Facility personnel rights of review.
p. 62. (b) It is overly burdensome to a facility to require reinstatement when the facility acted in good faith on information provided through the State Police and FBI. There may be no comparable position available. Language regarding reinstatement should be deleted.

§ 15.137. Provisional hiring.
See previous comments regarding use of the term operator and consistent language for criminal history record information report.

(a)(5) Regular supervisory observation must be defined.

§ 15.138. Violations.
p. 64. Use operator instead of administrator or owner.

§ 15.141 General requirements.
p. 65. Reasonable cause and immediate must be defined. The term administrator should be replaced by the term operator or designee.

(b) Although it is required by the act, requiring employees to immediately notify the facility administrator when they make an oral or written report makes anonymous reporting impossible. The operator or designee should be notified, rather than the administrator. Must the employee notify the operator or designee in the middle of the night if that is when a report is made?

§ 15.142. Additional reporting requirements.
p. 65. Use the term operator instead of administrator. Does the Department have a 24-hour hotline for reporting purposes? On a holiday weekend it could be three days until the Department can receive an oral report.

§ 15.143. Contents of reports.
p. 66. Will facilities receive a supply of the forms, or will they make copies of the forms?

§ 15.145. Investigation.
p. 67. (a)(4) Department of Public Welfare should be changed to Department of Health.

(a)(6) Older adult daily living center is the regulatory term, not adult day care center.

p. 68. What does "mental retardation or mental health issues" mean? Is there a regulatory definition for this?

(b) The state licensing agency must be added to the list of entities that must coordinate investigations.

§ 15.146. Restrictions on employees.
p. 69. Immediately must be defined. Regulatory authority should read licensure authority. How long will approval of the plan of supervision take? This process must be very rapid. The agency and the Department must have sufficient resources to make rapid approval possible. The facility must have discretion and control in employee supervision.

p. 70. See previous comments regarding definition of administrator.

(a)(5) What is a medical institution?

§ 15.148. Penalties.
p.71. The terms owner and administrator should be replaced by operator.

§ 15.161. Waivers.
p. 72. If an area agency on agency wants to request a waiver from compliance with the chapter, then public notice is needed so that interested parties can provide comment to the Department regarding the request.

No further comment at this time.