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SECTION 1

INTRODUCTION

1.1 Introduction and Overview

Provision of Protective Services to adults presents considerations and challenges for the social worker that is unique to this population. While the Department is mandated by state law to assure the protection of vulnerable and incapacitated adults and facility residents, it is important to assure that the individual's rights, as guaranteed under the Fourteenth Amendment of the United States Constitution and the West Virginia Constitution, are not infringed upon unnecessarily. A client who has decision-making capacity, therefore, has the option of accepting or refusing certain intervention and services when offered. This right to refuse mainly relates to the case management component of Adult Protective Services and other supportive services. If it is clearly determined the client has mental capacity and does not reside in a facility and requests the alleged perpetrator not be interviewed, the worker will need to staff this with their supervisor to determine if an incomplete assessment may be appropriate.

Because of these varied and complex considerations, it is vital that the Department be able to proceed in a timely manner but also with sensitivity, understanding, and knowledge when intervening with adults. Whenever the Department becomes involved, the intervention provided must be at the least restrictive level possible and appropriate to meet the needs of the individual while assuring the highest degree of autonomy and self-determination possible. Meeting all these requirements frequently calls for maintaining a delicate and skillful balance by the social worker.

1.1.1 In general, the client's consent must be obtained before services are provided. However, there are times in which consent cannot be obtained. Examples include a client who:

a) Is in an emergency situation, appears to be incapacitated, and is unwilling to remove themselves from danger; or

b) Is in an emergency situation, appears to be incapacitated, and is unwilling to be removed by others.

If the social worker is unable to reduce the resistance in any of these situations, it may be necessary to pursue legal action in order to provide needed intervention.

The assignment of investigations/cases is done with service and continuity in mind. A reasonable attempt will be made to accommodate individuals with disabilities and examples of this include: Auxiliary aids for individuals with disabilities where necessary to ensure effective communication with individuals with hearing, vision or speech impairments will be arranged and provided. If further assistance is needed, the worker will contact the local Division of

Rehabilitation as well as the West Virginia Commission for Deaf and Hard of Hearing at 304-558-1675. The TTY toll free number is 1-866-461-3578.

Culturally competent practice is ensured by recognizing, respecting and responding to the culturally defined needs of individuals that we serve. If someone is in need of an interpreter, the worker must contact local resources to locate an interpreter. Examples include, but are not limited to, the Board of Education, local colleges and Division of Rehabilitation. If a local community resource cannot be located, the worker will seek other resources such as the Department of Justice Immigration and Naturalization Service at 304-347-5766, 210 Kanawha Boulevard, West, Charleston, WV 25302. If an interpreter is used, it is advisable to obtain a signed Confidentiality Statement. The worker will stress to the interpreter that confidentially must be discussed with this individual, reminding them that all information is confidential and must not be shared with anyone

Note: It is recommended that a Confidentiality Statement be signed by the interpreter. If this is not possible, the worker will need to document the reason in client contact.

1.2 Statutory Basis

1.2.1 Mandates for the Department

a) WV Code §9-6-2 - Establishes and continues within the Department of Human Services (now DHHR) the system of adult protective services heretofore existing. The secretary shall propose rules regarding the organization, duties and procedures which shall be used by the department to effectuate the purposes of this article, including the means by which the department shall cooperate with federal, state and other agencies to fulfill the goals outlined below. Those rules may be amended and supplemented from time to time;

b) The secretary shall design and arrange such rules to attain, or move toward the attainment of the following goals to the extent that the secretary believes feasible under the provisions of this article within the state appropriations and other funds available (**Note**: This policy constitutes the rules required by state statute);

c) WV Code §9-6-2(1) - Assisting adults who are abused, neglected or incapacitated in achieving or maintaining self sufficiency, and self support, and preventing, eliminating or reducing their dependency on the state;

d) WV Code §9-6-2(2) - Preventing, reducing and eliminating neglect and abuse of adults who are unable to protect their own interests;

e) WV Code §9-2-2(3) - Preventing and reducing institutional care of adults by providing less intensive forms of care, preferably in the home;

f) WV Code §9-6-2(4) - Referring and admitting abused, neglected or incapacitated adults to institutional care only where other available services are inappropriate;

g) WV Code §9-6-2(5) - Providing services and monitoring to adults in institutions designed to assist adults in returning to community settings;

h) WV Code §9-6-2(6) - Preventing, reducing and eliminating the exploitation of incapacitated adults and facility residents through the joint efforts of the various agencies of the Department of Health and Human Resources, the state and regional long-term care ombudsman, administrators of nursing homes or other residential facilities and county prosecutors;

i) WV Code §9-6-2(7) - Preventing, reducing and eliminating abuse and neglect of residents in nursing homes or facilities; and,

j) WV Code §9-6-2(8) - Coordinating investigation activities for complaints of abuse or neglect of incapacitated adults and facility residents among various agencies of the DHHR adult protective service system, the state and regional long-term care ombudsman, administrators of nursing homes or other residential facilities, county prosecutors, if necessary, and other state and federal agencies or officials, as appropriate.

k) WV Code §9-6-2(d) - No adult protective services caseworker may be held personally liable for any professional decision or action thereupon arrived at in the performance of his or her official duties as set forth in this section or agency rules promulgated thereupon Provided, That nothing in this subsection protects any adult protective services worker from any liability arising from the operation of a motor vehicle or for any loss caused by gross negligence, willful and wanton misconduct or intentional misconduct.

l) WV Code §44A-1-8 does not permit DHHR employees to serve as conservator for a client. If the court appoints DHHR as conservator for a client, a petition must be filed to name the Sheriff in the appropriate county as conservator, in consultation with the Regional Attorney.

Note: In addition, per policy, the Department cannot be appointed or named as representative payee and/or conservator for any Adult Service client, according to WV State Code §44A-1-8(i).

1.3 Definitions

1.3.1 Terms Defined by Law (WV Code §9-6-1)

Abuse: The infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident. (Similar definition is contained in §61-2-29 that addresses penalties for abuse or neglect of incapacitated adult or elder person).

Caregiver: Means a person or entity who cares for or shares in the responsibility for the care of an incapacitated adult on a full-time or temporary basis, regardless of whether such person or entity has been designated as a guardian or custodian of the incapacitated adult by any contract, agreement or legal procedures. Caregiver includes health care providers, family members, and any person who otherwise voluntarily accepts a supervisory role towards any incapacitated adult.

Emergency or Emergency Situation: A situation or set of circumstances which present a substantial and immediate risk of death or serious injury to an incapacitated adult.

Facility or Nursing Home: Any institution, residence, intermediate care facility for an individual with an intellectual disability, care home or any other adult residential facility, or any part or unit thereof, that is subject to the provisions of articles 5-C, 5-D, 5-E, or 5-H, Chapter 16 of the West Virginia State Code (nursing homes, assisted living [previously residential board and care and personal care homes], registered unlicensed homes that serve elderly and disabled adults).

Incapacitated Adult: Any person, who by reason of physical, mental or other infirmity, is unable to physically carry on the daily activities of life necessary to sustaining life and reasonable health. (**Note**: Incompetence of an adult is determined by a legal proceeding and is not the same as a determination of incapacity. Similar definition "incapacitated adult" is contained in §61-2-29 abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Legal Representative: A person lawfully invested with the power and charged with the duty of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, medical power of attorney, trustee or other duly appointed person.

Neglect: Means A) The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or B) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or facility resident. (Similar definition is contained in §61-2-29 abuse or neglect of incapacitated adult or elder person regarding criminal penalties).

Responsible Family Member: A member of a resident's family who has undertaken primary responsibility for the care of the resident and who has established a working relationship with the nursing home or other facility in which the resident resides. For the purpose of, a responsible family member may include someone other than the residents' legal representative.

1.3.2 Terms Not Specifically Defined in the Law But Defined for Casework Purposes

Adult Protective Services - Preventive Services: A range of supportive services provided to an adult who does not meet all four criteria to qualify as an Adult Protective Services client but for whom sufficient risk exists that it is likely that an Adult Protective Services situation will result without intervention.

Adult Protective Services: Specific intervention activities designed to protect mentally and/or physically incapacitated adults or facility residents from abuse, neglect or financial exploitation resulting in neglect by others and from self-neglect. The specific intervention activities utilized are investigation, client assessment, and time limited case management.

Basic Needs: The essential requirements necessary to sustain life, health and well-being such as food, clothing, shelter, and necessary medical care.

Domestic/Family Violence: Domestic violence is a pattern of coercive behaviors used by one person in order to maintain power and control in a relationship. The pattern of coercive behaviors include tactics of physical, sexual, verbal, emotional and economical abuse, threats, intimidation, isolation, minimizing, and using children.

Note: Domestic violence is not confined to spouse or significant other relationships.

Electronic Communication: Any communication sent or received electronically through one or more computers and/or electronic communication devices, which includes but is not limited to cell phones, I pads, fax machines, etc.

Emancipated Minor: A child over the age of sixteen (16) who has been emancipated by 1) order of the court based on a determination that the child can provide for his physical well-being and has the ability to make decisions for himself or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract. (Refer to WV State Code §49-7-27).

FACTS: Acronym for the Family and Children's Tracking System and is the automated client information system used by the West Virginia Department of Health and Human Resources, Bureau for Children and Families.

Fiduciary Duty: A special relation of trust, confidence, or responsibility exists. This duty legally obligates one entity/individual to act in the best interest of another and abide by the client's expressed wishes if possible. A guardian, conservator, Power of Attorney, etc. has a fiduciary relationship to a protected person.

Financial Exploitation: A type of neglect of an incapacitated adult involving the illegal, unethical and/or improper use of or willful dissipation of an individual's funds, property or other assets by a person, formal or informal caregiver, family member, or legal representative - either directly (i.e. as the perpetrator) or in-directly (i.e. by allowing or enabling the condition which permitted the financial exploitation).

Imminent Danger: Circumstances exist which indicate the presence or risk of death or serious physical injury.

Self-Neglect: The inability of an incapacitated adult to meet his/her own basic needs of daily living due to mental or physical incapacity.

Sexual Abuse: The coercion of an incapacitated adult or facility resident into having sexual contact with the perpetrator or another person with the incapacitated adult. A caregiver of the incapacitated person or facility resident must be involved either directly (i.e. as the perpetrator or sexual partner) or indirectly (by allowing or enabling the conditions which result in the sexual coercion).

Social Isolation: Controlling (denying, limiting, coercing): visits and/or conversations with friends, family and acquaintances; outside involvement; reading; spiritual beliefs, traditions and events; and access to others (i.e. transportation, phone use, electronic/assistive communication devices). Using verbal abuse and threats to keep others away: severing social relationships through manipulative tactics; and limiting access to friends/family through frequent moves and remote/rural housing.

Substantiation: A determination that an incapacitated adult or facility resident meets all four (4) of the Adult Protective Services eligibility criteria. The investigation and documentation of a situation in which an incapacitated adult has been abused or neglected or the investigation and documentation of a situation in which an incapacitated adult is at risk of probable harm from abuse or neglect.

Verbal Abuse: The threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident. The threat to inflict physical pain or injury includes, but is not limited to, threatening to withhold food, hydration and/or medical treatment. The threat to imprison includes, but is not limited to, isolation. The verbal threat(s) must be perceived by the client or others to be real. Non-malicious teasing does not constitute verbal abuse.

Verification of Allegations: Determination made that addresses the allegations reported and indicates if the alleged incident occurred or not. The allegation may be verified that it occurred, but may or may not meet the definition of neglect, abuse or financial exploitation in order to substantiate. Example: A reporter says an elderly person has no food in their home. We investigate and can verify no food is in the home due to the client goes out to eat their meals. We can verify this occurred but not substantiate it as abuse, neglect or financial exploitation.

SECTION 2

INTAKE

2.1 Procedures for Reporting Abuse/Neglect

The State Code of West Virginia §9-6-11, sets forth the details regarding reporting of abuse, neglect or emergency situations involving an incapacitated adult or facility resident. Specifically, any individual may report known or suspected cases of abuse, neglect or emergent situations involving an incapacitated adult or resident of a nursing home or residential facility. These reports may be made directly to the local Department of Health and Human Resources or to the twenty-four (24) hour Hotline (1-800-352-6513) provided for this purpose. In this way, reports may be received twenty-four (24) hours/day, seven (7) days/week. In addition, if the incapacitated adult or facility resident is willing and able, he/she may make a report on his/her own behalf.

In addition to the general provisions related to reporting of abuse, neglect or an emergency situation involving an incapacitated adult/facility resident, state statute also sets forth requirements related to mandatory reporting. These include:

a) Identification of various individuals who are mandatory reporters;

b) Statement of requirements regarding immediate reporting by mandatory reporters;

c) Statement of requirement to submit a written report within 48 hours;

d) Statement of requirement to use specified reporting form for the purpose of submission of the required written report;

e) Statement of requirement that mandatory reporters distribute copies of the completed written report to various parties; and,

f) Identification of the instances in which the Department of Health and Human Resources is required to report substantiated Adult Protective Services incidents to others such as the prosecuting attorney, law enforcement, medical examiner, etc..

2.2 Abrogation of Privileged Communications §9-6-13

The privileged status of communications between husband and wife and with any person identified as a mandatory reporter in the Code of West Virginia is nullified in circumstances involving suspected or known abuse or neglect of an incapacitated adult who is in a verified or suspected emergency situation. Therefore, in Adult Protective Services cases privileged communications do not apply between husband and wife, patient and doctor or with any mandated reporter. The only exclusion to this requirement is communication between an

attorney and their client which continues to be considered privileged communication.

2.3 Mandatory Reporting

In addition to the general provisions related to reporting of abuse, neglect or an emergency situation involving an incapacitated adult, state statute §9-6-9 also identifies various individuals who are mandatory reporters. This means that if any of these individuals believe, suspect or know that an incapacitated adult is being subjected to or has the potential to be subjected to abuse, neglect or an emergent situation, they must immediately report the circumstances to the local Department of Health and Human Resources. The following are identified as mandatory reporters:

a) Medical professionals;

b) Dental professionals;

c) Mental health professionals;

d) Christian Science practitioners;

e) Religious healers;

f) Social workers, including those employed by the DHHR;

g) Law enforcement officers;

h) Humane officer;

i) State or regional ombudsman; or,

j) Any employee of a nursing home or other residential facility.

The requirements, set forth in state statute regarding mandatory reporters, apply without regard to where the alleged victim resides (i.e. his/her own home, the home of another individual, or an institutional/facility setting). Individuals who are mandated to report suspected or known cases of abuse, neglect or emergent situations must follow their initial verbal report with a written report. This written report must be submitted to the local Department of Health and Human Resources within forty-eight (48) hours following the verbal report.

The form specified by the Department as the Adult Protective Services Reporting Form is to be used for this purpose. The original copy of the report is to be submitted within forty-eight (48) hours to the local DHHR office. In addition to submission of this report to the local DHHR, copies are to be distributed by the complainant to various parties, dependent on the circumstances of the allegations:

a) If alleged victim is a resident of a nursing home or other residential facility - submit a report to state/regional ombudsman, OHFLAC, and facility administrator;

b) In case of death of the alleged victim - submit a report to appropriate local medical examiner or coroner and if abuse or neglect is believed to have been a contributing factor to the death, report also to law enforcement; and,

c) When applicable (i.e. violent crime, sexual assault, domestic violence, death, etc.) - submit a report to law enforcement and prosecuting attorney.

As stated in West Virginia Code §9-6-14, failure to make such a report can be punishable by a fine of up to one hundred ($100.00) or imprisonment of up to ten (10) days in the county jail or both.

Under West Virginia Code §9-6-8, the Adult Protective Services supervisor/or their designee is required to provide notification to mandated reporters whether the referral has been accepted for investigation or screened out with no further action required. Under this same section of Code, APS is also to provide notification to mandatory reporters at the conclusion of the investigation on its completion. (Refer to Appendix T Notification Letter).

Note: The Notification Letter should only contain limited information in the Explanation and Remarks section. For example, if a referral was not assigned for investigation the supervisor and/or worker could say the client did not meet the eligibility criteria for an APS investigation and cite code. Another example could possibly be the client is no longer in danger or need of APS intervention. In the Remarks section an example would be why the investigation was not completed. Neither section should contain a detailed description of what was said or by whom during the investigation.

2.4 West Virginia State §9-6-8 Confidentiality of Records

Summaries concerning substantiated investigative reports of abuse, neglect or exploitation of adults may be made available to:

1. Any person who the Department has determined to have abused, neglected or exploited the victim.
2. Any appropriate official of the state or regional long-term care ombudsman investigating a report of known or suspected abuse, neglect or exploitation of a vulnerable adult.
3. Any person engaged in bona fide research or auditing, as defined by the department. However, information identifying the subjects of the report may not be made available to the researcher.
4. Employees or agents of an agency of another state that has jurisdiction to investigate known or suspected abuse, neglect or exploitation of vulnerable adults.
5. A professional person when the information is necessary for the diagnosis and treatment of, and service delivery to, a vulnerable adult.
6. A Department administrative hearing officer when the hearing officer determines the information is necessary for the determination of an issue before the officer.

The identity of any person reporting abuse, neglect or exploitation of a vulnerable adult may not be released, without that person's written consent, to any person other than employees of the department responsible for protective services or the appropriate prosecuting attorney or law-enforcement agency.

All reports of abuse, neglect or exploitation of vulnerable adults, including records generated as a result of such reports, may be made available to:

1. Employees or agents of the Department who need access to the records for official business.
2. Any law-enforcement agency investigating a report of known or suspected abuse, neglect or exploitation of a vulnerable adult.
3. The prosecuting attorney of the judicial circuit in which the vulnerable adult resides or in which the alleged abuse, neglect or exploitation occurred.
4. A circuit court or the Supreme Court of Appeals subpoenaing the records. The court shall, before permitting use of the records in connection with any court proceeding, review the records for relevancy and materiality to the issues in the proceeding. The court may issue an order to limit the examination and use of the records or any part of the record.
5. A grand jury, by subpoena, upon its determination that access to the records is necessary in the conduct of its official business.
6. The recognized protection and advocacy agency for the disabled of the State of West Virginia.
7. The victim.
8. The victim's legal representative, unless he or she is the subject of an investigation under this article.

The purpose is to allow for greater cooperation concerning reports of abuse, neglect or exploitation of vulnerable adults among different entities, the protected person, or persons having a fiduciary relationship to the protected person for the detection, prevention and correction of abuse, neglect and exploitation of disabled adults or elderly persons.

2.5 Reporting Suspected Animal Cruelty

The State Code of West Virginia §9-6-9a, sets forth the details regarding mandatory reporting by Adult Protective Services workers to the county humane officer. If the Adult Protective Services worker forms a reasonable suspicion that an animal is the victim of cruel or inhumane treatment, he or she shall report the suspicion and the basis therefore to the county humane officer within twenty-four (24) hours of the response to the report. This report must be documented in the Contact Screen in FACTS, with the date of the contact and the individual to whom the report was made.

2.6 Follow-up Reporting to the Medical Examiner

WV Code §9-6-10, specifies certain requirements involving abuse or neglect of an incapacitated adult or facility resident which resulted in death. Specifically, any person or official who is required to report cases of known or suspected abuse or neglect and who has reason to believe that an incapacitated adult or facility resident has died as a result of abuse or neglect, must report that fact to the appropriate local medical examiner or coroner. The medical examiner/coroner will then report their findings to the local law enforcement agency, the local prosecuting attorney, the local Department of Health and Human Resources, and if the institution making the report is a hospital, to the hospital administrator.

Generally, if there is a need to refer a case to the state medical examiner, this determination and the subsequent referral is to be made by the local coroner/medical examiner. The only instance when a referral might need to be made directly to the state medical examiner would be:

a) If there is no medical examiner or coroner responsible for the county where the death occurred, or:

b) The local medical examiner or coroner in the county where the death occurred cannot be reached/is unavailable. In these instances the referral would be made to the state medical examiner's Forensic Investigations Unit. (See Appendix P Contact Information).

Note: Even in the two (2) situations mentioned, a referral to the state medical examiner is generally not going to be made by the Department, but rather by the reporter/facility or local law enforcement.

2.7 Immunity from Liability

WV Code §9-6-12, specifies that any person who, in good faith, makes or causes to be made any report permitted or required by the statute cited, shall be immune from any civil or criminal liability which might otherwise arise solely as a result of making such a report. In addition, no facility may discharge or discriminate against a resident, family member, legal representative or employee because he/she filed a complaint or participated in a proceeding resulting from a report being made. Violation of the later provisions can result in suspension or revocation of the facility's license.

2.8 Cooperation Among Agencies

Whenever possible and appropriate, conducting investigations of alleged abuse and/or neglect should be coordinated between Adult Protective Services and other applicable state and federally authorized entities. Specifically, Adult Protective Service staff should coordinate investigations as appropriate with OHFLAC, Office of Behavioral Health and Health Facilities, Medicaid Fraud, State and Regional Long Term Care Ombudsman, law enforcement; patient

advocates in state operated behavioral health facilities, and the identified Protection and Advocacy Agency (WV Advocates). These and other state and federal agencies are required to cooperate with each other for the purposes of observing, reporting, investigating and acting on complaints of abuse or neglect of any incapacitated adult or facility resident.

In some instances, the medical examiner's office will contact local staff to see if a report of abuse or neglect has been made on one of their clients. Supervisor and staff are to work with the medical examiner's office and provide them with the necessary information. However, reporter information is never divulged.

2.9 Penalties for Caregiver, if Convicted

The Code of West Virginia §61-2-29, provides for criminal penalties for any person, caregiver, guardian or custodian who, directly or indirectly, abuses, neglects or financially exploits an incapacitated adult or elder person.

2.10 Eligibility Criteria

In order to be eligible to receive Adult Protective Services (APS) or Adult Protective Service Preventive Services (PAPS), the individual must meet certain criteria. These are set forth in the following sections.

2.10.1 Adult Protective/Preventive Services - Intake/Investigation

a) In order to be eligible to receive Adult Protective Services intake and investigation the individual need only meet the following three (3) criteria:

   1. Being eighteen (18) years of age or older, an emancipated minor;

   2. Incapacitated or a facility resident; and,

   3. Reported to be the victim of abuse, neglect (including self-neglect) or in an emergency situation.

b) In order to be eligible to receive Adult Preventive Services intake and investigation the individual need only meet the following three (3) criteria:

   1. Being eighteen (18) years of age or older, an emancipated minor;

   2. Incapacitated or a facility resident; and,

   3. Reported to be at risk of abuse or neglect (including self-neglect).

c) Clients generally live in the community, not a facility setting, in order to qualify for Adult Protective Preventive Services.

d) Whenever these criteria are met and the intake is assigned for investigation, an investigation is to commence and be completed within a specified period of time. (See policy sections titled Section 2.12 Response Times and Section 3.1 Risk Assessment for detailed information). The investigation of a report of abuse, neglect or

emergency situation involving an incapacitated adult or facility resident is not voluntary and must be brought to conclusion in all cases that are assigned for investigation. In the event a client has left the state, died, etc., an override or an incomplete assessment can be completed in consultation with the supervisor.

Note: Whenever a report is made that is suspected to be abuse/neglect or financial exploitation, the report is to be taken. This is true even in instances where the origin of the injury is not known by the reporter or when the identity of the perpetrator is not known by the reporter.

Adult Protective/Preventive Services – Ongoing

a) Adult Protective Services

1. In order to be eligible to open a case and receive ongoing Adult Protective Services, the individual must meet all four (4) of the following criteria simultaneously. (Section C contains two (2) questions. Question Number 1 must be answered yes in meeting the four (4) criteria outlined below. If Question C, Number 2 is answered yes, the four (4) criteria have not been met). The determination as to whether the criteria is met or not, is made based on the information gathered and the conclusions drawn during completion of the Adult Protective Service Risk Assessment. The four (4) criteria are:

   a. Being eighteen (18) years of age or older, an emancipated minor;

   b. Incapacitated or a facility resident; and,

   c. Questions:

      1.) According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.

      2.) The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).

   d. The client, excluding the perpetrator, 1) alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s), or 2) is in a care facility.

2. Whenever all four (4) of the criteria listed above are present, an Adult Protective Service situation is to be substantiated. Usually, whenever a report is substantiated a case will be opened. There are a few exceptional situations when a case may not be opened even though the report is substantiated. Examples: 1) all four (4) criteria are met but criteria “b” is met based on the adult’s physical

incapacity rather than mental incapacity. Mentally the client is able to make sound decisions and understand the consequences of those decisions and they choose to refuse intervention by the Department beyond the investigation and 2) the client is in a facility and the verified abuse/neglect was limited to a perpetrator who is no longer employed with the facility.

Note: Poor judgment does not necessarily indicate mental impairment (incapacity). Further, the social worker does not determine incapacity however if the client's decision-making capacity is in question, the social worker may request that an evaluation be completed to further assess the adult's decision making capacity. Refer to APS Guardianship Policy.

b) Adult Protective Preventive Services

1. Ongoing Adult Protective Preventive Services are intended to be used in situations where the client does not meet all four (4) criteria necessary to be eligible for Adult Protective Services but does meet the specified eligibility criteria for Adult Protective Preventive services and they are at risk of an Adult Protective Service situation developing without intervention. Adult Protective Preventive services are short-term, time limited services.

2. In order to be eligible to receive Adult Protective Preventive Services, the referral must come through the Adult Protective Services intake process and the individual must meet at least criteria "A," "B" and criteria "C", with Question Number 2 of C criteria answered yes. The determination as to whether the criteria is met or not, is made based on the information gathered and the conclusions drawn during completion of the Adult Protective Service investigation and Risk Assessment. The criteria are:

   a. The client must be eighteen (18) years of age or older or has been legally emancipated by marriage or by order of the court.

   b. The client is functionally disabled due to his/her physical and/or mental disabilities.

   c. 1.) According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.

      2.) The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).

   d. The client is, excluding the perpetrator, 1) alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s), or 2) is in a care facility.

3. Whenever three (3) of the criteria listed above are present, a Preventive Adult Protective Service situation can be verified and a case opened. **If the incapacitated adult has been abused or neglected and is at risk of probable harm from abuse or neglect you do not have to substantiate the whole report but can verify one or more of the allegations.**

Note: Clients generally live in the community, not a facility setting, in order to qualify for Adult Protective Preventive services. However, policy does not prevent a worker from opening an Adult Protective Preventive case for a client in a facility setting, if the client is going to benefit from this type of short term case management.

Other Department Social Services

a) Adults who are opened as an Adult Protective Services case may be eligible, without regard to income, for any adult social service program through the Bureau for Children and Families. These programs are designed to prevent, remedy, or abate the conditions of abuse, neglect, or exploitation resulting in neglect. When these services are indicated, they are to be reflected in the client's Service Plan and approved by the supervisor.

2.11 Required Information

During the intake process, information gathered must be as complete and thorough as possible. Whenever a report is received, if there is more than one allegation reported, all allegations are to be recorded separately within the intake on the allegations screen. The individual identified as the "alleged victim" in the intake process will become the "client" within FACTS and will be reflected as such in the investigation and in the case areas. (Refer to Appendix A Flow of Intake and Investigation). At a minimum, the following information must be gathered during the intake process and documented in FACTS:

2.11.1 In-Home Adult Protective Service Referral

Information that must be collected when an Adult Protective Services referral is received for an individual who is residing in their own home environment includes the following:

a) Name(s) of alleged victim;

b) County of incident;

c) Current location of the alleged victim;

d) Age/date of birth of alleged victim;

e) Address of the alleged victim's home;

f) Phone number for the alleged victim;

g) Directions to the home;

h) Name, age and relationship of alleged perpetrator (if applicable);

- Must be 18 years of age or an emancipated minor.
- If alleged perpetrator is under age 18 or not an emancipated minor the caregiver must be listed as the alleged perpetrator.
- If a minor, it may require a Child Protective Service and/or a Youth Services referral.

i) Other individuals involved in or who have knowledge of the incident;

j) Description of the alleged abuse/neglect incident(s) and any resulting injuries including type of alleged abuse/neglect, where incident occurred, when incident occurred, location(s) of injuries, etc.;

k) Physical and psychological description of the alleged victim;

l) Name of reporter or indication that referral was made anonymously if the reporter is unwilling to give their name. If the reporter indicates that their name is not to be shared with others, this needs to be documented; by checking the box in FACTS on the reporter screen that the reporter wishes to remain anonymous.

m) Relationship of the reporter to the alleged victim;

n) Identification of the reporter as a mandatory reporter, when applicable;

o) If a mandatory reporter, worker should request that a written report be submitted;

p) When receiving referrals from mandated referents, notification at the onset whether the referral has been accepted for investigation or screened with no further action taken, will be mailed to the mandated reporter; and,

q) When a non-mandated reporter indicates they want Adult Protective Services to follow-up after completion of the investigation, follow-up is limited to informing the reporter the information is not available.

Note: The name of the referent as well as any information that may identify the reporter to others is confidential and is not to be released except to certain parties such as the prosecuting attorney and law enforcement officials as authorized by state law**. But if the name of the reporter is requested, the worker will consult with their immediate supervisor who will consult with the Regional Attorney, per regional protocol prior to disclosure.**

In situations where the incident being reported involves self-neglect or self-abuse, the same person will be identified in FACTS as both the alleged victim and the alleged perpetrator. In situations where referrals are received involving more than one household member as an alleged victim (example: both a husband and his wife), each individual must be set up as a separate referral. The

two (2) referrals would then be associated in FACTS to show that there is a relationship between them.

At the conclusion of gathering the referral information, the intake worker may indicate if, in his/her opinion, the information reported constitutes imminent danger/emergency situation requiring prompt attention by the supervisor. Selection of this choice will trigger a response time of "within two (2) hours". This is the time frame within which a face to face contact with the alleged victim is to occur. If there is no imminent danger but there is a potential for danger, the intake worker can also indicate this, triggering a response time of "within seventy-two (72) hours". If there is no indication that either imminent danger or potential danger exists, FACTS will default to a seventy-two (72) hour response time. If the intake worker indicates that there is imminent danger or there is a potential for imminent danger, he/she must document the reason(s) for this determination. The final determination regarding assignment of the appropriate response time rests with the supervisor. (See Section 2.12 Response Times for additional information).

When all referral information is gathered and documented in FACTS, a search of the FACTS system must be completed to determine if there are other referrals/investigations/cases for the identified client. If so, the new referral is to be associated to the referral/investigation/case as appropriate and merge all duplicate client ID numbers for this individual. The referral is then to be forwarded to the appropriate Adult Services supervisor for further action.

2.11.2 Institutional/Out-of-Home Adult Protective Service Referral

The following information must be collected when a report is made alleging the abuse/neglect of an adult in an institutional setting, group living setting or other non-residential environment or service provider:

a) Name(s) of alleged victim(s);

b) County of incident;

c) Current location of the alleged victim(s);

d) Age/date of birth of alleged victim(s);

e) Phone number for the alleged victim(s);

f) Directions to the facility;

g) Name of alleged perpetrator(s) (if applicable);

h) Name, age and relationship of alleged perpetrator (if applicable);

- Must be 18 years of age or an emancipated minor.
- If alleged perpetrator is under age 18 or not an emancipated minor the caregiver must be listed as the alleged perpetrator.
- If a minor, it may require a Child Protective Service and/or a Youth Services referral.

i) Other individuals involved in or who have knowledge of the incident;

j) Name of the facility involved;

k) Type of facility;

l) Address of the facility;

m) Contact person at the facility;

n) Description of the alleged abuse/neglect incident and any resulting injuries including type of alleged abuse/neglect, where incident occurred, when incident occurred, location(s) of injuries, etc.;

o) Physical and psychological description of the alleged victim;

p) Name of reporter or indication that referral was made anonymously if the reporter is unwilling to give their name; by checking the box in FACTS on the reporter screen that the reporter wishes to remain anonymous;

r) Relationship of the reporter to the alleged victim;

s) Identification of the reporter as a mandatory reporter, when applicable;

t) If a mandatory reporter, worker should request that a written report be submitted;

u) When receiving referrals from mandated referents, notification at the onset whether the referral has been accepted for investigation or screened with no further action required, will be mailed to the mandated reporter; and,

v) When a non-mandated reporter indicates they want Adult Protective Services to follow-up after completion of the investigation, follow-up is limited to informing the reporter the information is not available.

In situations where referrals are received involving multiple clients, including those who are in institutional and other out-of-home residential settings, a separate referral must be taken for each alleged victim.

At the conclusion of gathering the referral information, the intake worker may indicate if, in his/her opinion, the information reported constitutes imminent danger or an emergency situation requiring prompt attention by the supervisor. If the intake worker indicates that there is imminent danger, he/she must document the reason(s) for this. This choice will also then trigger a response time of “within two (2) hours”. This is the time frame within which a face to face contact with the alleged victim is to occur. Similarly, if the intake worker indicates that there is a potential for imminent danger, he/she must document the reason(s) for this and the “within seventy-two (72) hours” response time will be triggered. If there is no indication that imminent danger or potential for imminent danger exists, FACTS will default to a seventy-two (72) hour response time. The final determination regarding assignment of the appropriate response time rests with the supervisor. (See Section 2.12 Response Times for additional information).

When all referral information is gathered and documented in FACTS, a search of the FACTS system must be completed to determine if there are other referrals/investigations/cases for the identified client. If so, the new referral is to be associated to the referral/investigation/case as appropriate and merge all duplicate client ID numbers for this individual. In addition, the worker must create a link between the referral and the provider record whenever the alleged abuse/neglect occurred in a setting other than the alleged victim's home. The referral is then to be forwarded to the appropriate Adult Services supervisor for further action.

2.12 Referral Triage/Disposition

The supervisor is the primary decision-maker at the intake stage of the Adult Protective Services casework process. This is consistent with other Department policy which recognizes the unique blend of experience, skill, and leadership which the supervisors provide. The supervisor's role includes 1) ensuring that all referrals are appropriately considered to determine if the referral is to be assigned for a Risk Assessment or screened out, and 2) for those assigned for assessment, determination of the required response time for the initial contact based on the degree of risk indicated in the referral information. Screening of the referral is to be done promptly, but in no instance is screening of the referral to exceed five (5) calendar days from the date of referral. Response times applicable to Adult Protective Services policy have been established. These are described in detail in the following sections:

2.12.1 Response Times

For all referrals that are accepted for investigation, the investigation must be initiated within a maximum of fourteen (14) days of the date the referral is received by the agency. Initiation of the investigation means, at a minimum, face-to-face contact with the alleged victim. This face to face contact is to occur in the adult's usual living environment whenever possible and is to be documented in FACTS by the end of the next working day. Depending on the degree of risk to the client's health, safety and well-being, contact with the victim may require a face-to-face contact in less than fourteen (14) days. No extension will be granted for the face to face contact beyond the assigned time frame. The policy rules for determining response time are as follow:

2.12.2 Response Time Options

Immediate Response - zero (0) to two (2) hours: This time frame will apply in cases where it is determined that, based on the referral information, an emergency situation exists. (Emergency is a situation or set of circumstances which presents a substantial and immediate risk of death or serious injury to an incapacitated adult). A face-to-face contact with the alleged victim must be made within two (2) hours.

Response - Within seventy-two (72) hours: This time frame will apply in cases where it is determined, based on the referral information, an emergency

situation does not currently exist but circumstances are severe enough that without prompt intervention, an emergency situation could result. A face-to-face contact with the alleged victim must be made within seventy-two (72) hours.

Response - Within fourteen (14) days: This time frame will apply in cases where it is determined that, based on the referral information, an emergency situation does not currently exist and/or is not expected to develop without immediate intervention. A face-to-face contact with the alleged victim must be made within fourteen (14) days.

Note: If "imminent danger" is selected by the intake worker, FACTS will trigger a response time of "0 - 2 hours". If the indication of imminent danger is not selected by the intake worker, the response time will default to the "within seventy-two (72) hours" response time. Regardless of the response time assigned based on the intake information the supervisor can over-ride and enter the response time they have assigned from among the three (3) possible options.

2.12.3 Considerations in Determining Response Time

To assist with the determination of the appropriate response time for initiation of an Adult Protective Service investigation, the supervisor should consider the following:

a) Whether the information reported contains an allegation that indicates the presence of imminent danger or the presence/risk of death or serious physical injury;

b) Whether the alleged victim has the physical, cognitive and emotional capacity to make decisions and independently act on them;

c) The location of the alleged victim at the time the intake is received (whether or not the victim is in a location that can assure their safety, or victims ability to remove themselves from danger if necessary);

d) The potential/likely effect of Adult Protective Service intervention in escalating the circumstances in the home/facility and the capacity of Adult Protective Services to remain with the situation once intervention is initiated;

e) Whether the nature of the alleged abuse/neglect indicates premeditation or bizarre behavior or circumstances;

f) Whether the alleged abuse/neglect is occurring at this moment;

g) Whether the alleged circumstances that exist could change rapidly;

h) Whether the alleged perpetrator's behavior is bizarre, out of control, or dangerous;

i) Whether the alleged victim or perpetrator will flee;

j) Whether the living arrangements are life threatening;

k) Whether the alleged victim requires medical attention;

l) Whether the caregiver is gone and the alleged victim is without needed assistance and supervision;

m) Whether the alleged victim is capable of self-preservation/protection;

n) Whether the alleged victim is isolated socially or geographically;

o) Whether there are indications of family violence;

p) Whether the family is transient or new to the community;

q) Whether the adult is currently connected to any formal support system;

r) Whether there are any family or friends available for support;

s) Whether the caregiver(s) are physically, cognitively and emotionally able to provide needed care to the adult;

t) Whether there is a past history of referrals or multiple current referrals;

u) Whether there are multiple injuries; and,

v) Whether the location of the injuries suggest more serious harm.

2.12.4 Once the supervisor has made a determination regarding the response time they will:

a) Document the decision in FACTS indicating the selected response time and the date of this decision;

b) Assign the referral to a social worker to initiate the investigation;

c) Ensure notification of acceptance or screening of the referral has been sent to mandated reporters;

d) Follow-up to assure that the assigned social worker adhered to the designated response time; and,

e) Ensure a follow-up notification letter has been sent to the mandated reporter that the assessment has been completed.

In the event extenuating circumstances exist, which prevent the social worker from conducting a face-to-face contact with the alleged victim he/she must document the reason(s) in FACTS why the face-to-face contact cannot be made within the assigned time frame. In these situations, the worker must consult with the supervisor prior to the date/time the face-to-face is due. As part of this, the social worker must document their efforts in the Contact screen to comply with the specified time frame and the reason(s) it was not met.

2.12.5 Supervisor's Role

The supervisor is the primary decision-maker at the intake stage of the Adult Protective Service process. This is consistent with other Department policy which recognizes the unique blend of experience, skill, and leadership which supervisors provide. The supervisor's role includes 1) ensuring that all referrals are appropriately considered to determine if the referral is to be assigned for an

Adult Protective Service investigation or screened out, and 2) for those assigned for investigation determination of the required response time for the initial contact based on the degree of risk indicated in the referral information.

The supervisor will:

a) Review the information collected at intake for thoroughness and completeness. If further clarification/information is required, the supervisor may contact the reporter.

b) Identify the type of Adult Protective Service referral - "in-home" (i.e. client's own home), "institutional" (i.e. nursing home, ICF/ID group home, Specialized Family Care homes, I/DD Waiver home, Assisted Living facilities, Adult Family Care, state operated mental health facilities, etc.); or "non-residential" (i.e. day treatment, adult day care, home-health agency, hospice, sheltered workshop, etc.).

c) If not previously completed by intake worker, conduct a search of the FACTS system to determine if other referrals/investigations/cases already exist for the identified client.

d) Create associations in FACTS between the current referral and other referrals/investigations/cases as appropriate, including creating a link between the referral and the provider record whenever the alleged abuse/neglect occurred in a setting other than the alleged victim's home

e) When an Adult Protective Service referral is received for a client in an institutional or other out-of-home residential setting, a file must be opened in FACTS, if one does not already exist on the institution/facility in addition to the client file and the two (2) files must be associated within FACTS (***Link provider/referral** on Referral Acceptance screen). When the provider/facility is set up it is important that it be marked as "unavailable" in FACTS unless it is a facility in which DHHR makes placements. For the purposes of Adult Protective Services, Adult Family Care homes, licensed assisted living settings, registered unlicensed homes, Waiver homes, Medley Homes, ICF/ID Group homes, etc. are considered to be facilities. (See Appendix P Contact Information).

f) Determine if the referral will be screened out and not accepted for an Adult Protective Service investigation. In determining whether to accept an Adult Protective Service referral or screen out the referral, the supervisor must consider:

1. The presence of factors which present a risk to the adult;
2. The information related to the alleged abuse and/or neglect, the alleged victim, and the alleged perpetrator;

3. Whether there are recent/current referrals under investigation with identical allegations;
4. Whether the information collected appears to meet the definition of Adult Protective Services; and,
5. The sufficiency of information in order to locate the individual/family.

g) Accept all referrals for an Adult Protective Service Risk Assessment that appear to meet the definition of Adult Protective Services or, based on the information provided, are at risk of being abused and/or neglected.

h) Ensure notification of acceptance or screening of the referral has been sent to mandated reporters.

i) Ensure a follow-up notification letter has been sent to the mandated reporter that the assessment has been completed.

Note: In reports involving facility/agency settings, the critical factor in determining whether to screen a referral are determined whether or not the allegations reported meet the definition of abuse/neglect. If they do, the report is to be investigated even if the injury's origin is not known, the perpetrator is not known, or the alleged perpetrator is no longer employed by the agency. **Example**: if the report is a minor bruise or skin tear with no indication that the injury occurred as a result of abuse/neglect the report may be screened out, if the same injury is reported but there is reason to believe it occurred as a result of a staff person not providing adequate care/supervision it would be accepted for investigation.

j) If the intake is "screened out", document the basis for that decision.

k) Ensure that referrals are made to other resources within and outside of the Department, if appropriate.

l) If the intake was not "screened out", determine the appropriate response time for the referral based on the information presented on the intake and assign the referral for investigation. Response time is to be determined from the time the referral is received by the Department. This includes referrals received by the Hotline who, under contract with the Department, acts as an extension of the Department by accepting reports of abuse/neglect twenty-four (24) hours/day, seven (7) days a week.

2.12.6 Recurrent Adult Protective Service Referrals

All referrals must be evaluated to determine whether or not an emergency situation exists. There may be times when recurrent referrals are received. Recurrent referrals mean identical referrals involving an active case or a client who is currently or was recently (within the past thirty (30) days) the subject of an Adult Protective Service investigation. Regardless of past contact with the client,

each referral must be considered separately to determine whether or not any additional action is required.

If recurrent referrals are received during a brief period of time that contains identical allegations, the decision may be made by the supervisor to screen the new referral out and associate it in FACTS with the previous referral or case. This option may only be considered if the allegations are identical. If there are differences in the allegations, a new referral is to be taken and, based on the details of the new referral, the supervisor is to make a decision regarding accepting or screening the referral out independent of any other referral(s).

2.13 Adult Protective Service Referrals Involving Specific Situations

There are certain situations where an APS referral is received that require additional action, a modified approach, or special considerations. These include APS referrals that involve the following situations:

a) Violent crime situations;

b) An active mental health client;

c) Financial exploitation;

1. Nursing home, assisted living, group home and residential settings;

d) Mental health and state operated long-term care facilities;

e) Nursing homes, assisted living facilities and other privately operated facilities;

f) A service agency (i.e. sheltered workshop, community mental health center, home health agency);

g) An acute primary care hospital;

h) Law enforcement agency;

i) Receiving Adult Family Care services; or,

j) Suspected Methamphetamine laboratories and/or use.

Specific requirements and/or actions required by the Department related to each of these situations are described in the following sections.

2.13.1 APS Referrals in Violent Crime Situations

Referrals that are received regarding a mentally and/or physically incapacitated adult or facility resident who is the victim of a violent crime, such as aggravated assault, sexual assault, attempted murder, domestic violence, etc., must be referred by DHHR to the appropriate law enforcement agency for investigation. Upon verbal and written notification to law enforcement the referral will be screened out. If law enforcement requests assistance then a new referral will be entered and assessed by the supervisor. The responsibility of the social worker in situations involving violent crime is to work in cooperation with law

enforcement to ensure the safety of the alleged victim while their investigation is being conducted. If it is known that a violent crime is alleged when the referral is received, the intake worker should first request that the reporter call law enforcement directly to report the situation. Whether or not the reporter refuses or agrees to call law enforcement, the referral is to be reported immediately by DHHR to law enforcement in either instance, the worker is to verbally notify law enforcement and follow this with written notification of the report to law enforcement. This written notification is to follow the verbal notification as soon as possible, not to exceed five (5) working days. If it is determined by law enforcement that they will not conduct an investigation, initiation of intervention by APS should not exceed fourteen (14) days from the date the referral was received.

If it is not known until after the APS investigation is initiated that a violent crime has occurred, the social worker is to immediately refer the matter to law enforcement. Again, close coordination between the worker and law enforcement is essential to ensure that appropriate intervention is initiated within a reasonable period of time and if it is determined by law enforcement that they will not conduct an investigation, initiation of intervention by APS should not exceed 14 days from the date the referral was received. If law enforcement is going to conduct an investigation and the alleged victim is an incapacitated adult, they may require assistance from APS to ensure safety of the client.

To do the written notification to law enforcement, the worker is to use the report titled “APS Notification Letter - Law Enforcement”. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the ‘Save to FACTS’ functionality. This functionality may be found in Microsoft Word under the ‘Add – Ins’ menu and then selecting ‘Save to FACTS’; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

Note: APS involvement in these types of cases is limited to those involving an incapacitated adult and residents of nursing homes or other residential facilities. APS staff involved in a situation that is under investigation by a law enforcement agency must proceed with caution. Any involvement by the social worker is not to interfere with or jeopardize the investigation by law enforcement and close coordination between the two (2) agencies is essential. The nature and scope of APS staff involvement should be determined by law enforcement and/or the prosecuting attorney if he/she is involved in the case.

2.13.2 APS Referrals Involving an Active Mental Health Client

Referrals involving active clients of a mental health/community behavioral health center who are endangering themselves or others should be referred to the center where they are receiving treatment. While these individuals may be in

need of protection, the involvement of the mental health/behavioral health center is essential to provision of appropriate services to this population. In some situations the center's involvement with the client may preclude the necessity of action taken by Adult Protective Services staff. However, if abuse/neglect is included in the report, APS is to respond, to address the abuse/neglect issues in addition to any intervention that may be offered by the behavioral health provider. (See also Section 2.13 APS Referrals Involving a Service Agency for the requirements if the alleged perpetrator is a staff member of the Mental Health agency).

2.13.3 APS Referrals Involving Financial Exploitation - (Refer to Appendix M Signs of Financial Exploitation)

Referrals of an incapacitated adult involving financial exploitation may be accepted for investigation if it appears it is presently occurring. However, the first responder should be law enforcement. If law enforcement declines to investigate or to conduct a joint investigation, then the supervisor may screen out the referral or assign for investigation. Due to the nature of these investigations and difficulty receiving information related to financial exploitation, these investigations will be limited to sixty (60) days with the option of an additional thirty (30) day extension approved by the supervisor.

The involvement of Adult Protective Services in financial exploitation situations will depend upon a variety of factors, such as the amount of information/documentation that the worker will be able to obtain from financial institutions, insurance companies, credit card companies, health care providers, etc. If the allegations involve transfer of property or other documents that are on file at the courthouse, the worker should be able to obtain information from the local county courthouse as this information is a matter of public record. If possible, the worker should obtain a Release of Information form from the client to obtain any necessary information. This form is available in the Reports section of FACTS. If unsuccessful in obtaining a Release of Information from the client, the worker must make every effort possible to obtain relevant/pertinent information. (Refer to Appendix L The Financial Services Modernization Act).

If unable to obtain relevant/pertinent information, all efforts to obtain information must be documented and the reason given by the holder of the information as to why the information was not produced. It may be necessary to consult with the regional attorney if the holder of the information refuses to comply with the request.

Under the West Virginia Code §39B the Uniform Power of Attorney Act if a person suspects an agent of abuse, neglect, financial exploitation a referral may be filed with Adult Protective Services. If the referral is accepted for investigation, APS can ask for an accounting of transactions made by the agent on behalf of the client.

The agent must provide APS within thirty (30) days the requested information or must provide in writing why they need an additional thirty (30) days. If the agent

fails to provide information within the allotted time frame, APS may file a petition with the court. APS workers should follow regional protocol to file this petition requesting the aforementioned documents.

Note: For information on legal usage of Social Security money as a representative payee, go to www.socialsecurity.gov

1. Nursing Home, Assisted Living, Group Home and Residential Settings

   For residents of any placement setting, discharge for non-payment of the resource amount is permissible. However, the facility is required to discharge to an appropriate setting that will meet the client's needs.

   Reports that deal solely with past due accounts do not meet the criteria as APS and generally will be screened out unless the referrals indicates the resident is currently being exploited. The social worker must not get involved in delinquent accounts and must focus on prevention of current and/or future financial exploitation. Whenever financial exploitation is substantiated that involves a nursing home, assisted living resident or a resident of a legally unlicensed home or a residential care community, the worker is to notify the long term care ombudsman (except Group Homes), OHFLAC, law enforcement, prosecuting attorney and Medicaid Fraud. (See Appendix P Contact Information).

   Whenever financial exploitation is substantiated that involves a resident of any other placement setting, the worker is to notify law enforcement, prosecuting attorney, Medicaid Fraud and the Office of Behavioral Health & Health Facilities, Bureau for Medical Services or the appropriate regulatory agency. (See Appendix P Contact Information.)

2.13.4 APS Referrals Involving State Operated Mental Health and Long-Term Care Facilities

The Department has established a mechanism for addressing APS complaints that involve state operated mental health facilities and state operated long-term care facilities. State operated Mental Health Facilities include Bateman and Sharpe hospitals and state operated long term care facilities include Lakin, Hopemont, Jackie Withrow, Welch Emergency Hospital, and John Manchin Sr. Health Care Center. A person(s) identified as a "Patient Advocate" is responsible for investigating all referrals received involving residents in state operated Mental Health facilities, regardless of the nature of the referral.

The following guidelines have been established to help determine the extent of involvement by APS staff in these state operated facilities:

a) Referrals that allege that a specific client has been the victim of neglect or abuse by a staff person, investigation by Adult Protective Services;

b) Upon receipt of a complaint by APS involving a specific client in one of these types of settings, the social worker must discuss the complaint with the facility administrator or their designee;

c) Referrals that indicate abuse of a patient/resident by another patient/resident in general are to be considered behavioral management issues within the institution and should be screened out and referred to the facility administrator or their designee. However, if there is a question as to whether or not neglect on the part of the facility was a contributing factor to the allegations of abuse, the referral may be accepted for investigation;

d) In any of the state operated facilities specified above, referrals that are general in nature and may concern the entire facility population should be referred to the facility administrator or their designee and forwarded, in writing, to the state Department of Health and Human Resources attention of the Commissioner of Bureau for Behavioral Health and Health Facilities. In addition, situations involving a long-term care facility are also to be referred to the Office of Health Facilities Licensure and Certification. (See Appendix P Contact Information).

Note: Use the form titled "APS Notification Letter - Within DHHR" to provide written notification to the Office of Behavioral Health and Health Facilities and/or OHFLAC. (See Appendix P Contact Information). This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

2.13.5 APS Referrals Involving Nursing Homes, Assisted Living Facilities and Other Privately Operated Facilities

Adult Protective Services referrals on adults who reside in nursing homes, assisted living facilities or other privately operated long term care facilities shall be handled as follows. All complaints and referrals shall be acted upon in one of the following ways:

a) Referrals that concern the general population of the facility rather than an individual (i.e. "food is not meeting dietary requirements") must be referred, in writing, to the Long-Term Care Unit in the Bureau of Medical Services, the Office of Health Facilities Licensure and Certification in the Department of Health and Human Resources, and the local Ombudsman. (See Appendix I Contact Information) Information about the reporter is not to be

shared as part of this notification. The reporter is to be encouraged to contact the appropriate agency to report the incident directly. If they refuse to make this report or it is unlikely or questionable as to whether or not the report will be made to the appropriate agency, the social worker must document the information reported and forward the information to the appropriate agency.

b) If the referral, however, indicates that the patients/residents in the facility may be in immediate danger, (i.e. it is 10 degrees outside and the facility's heating unit is broken), the Department should evaluate and may respond by conducting an APS investigation and making appropriate referrals as indicated previously;

c) Referrals that are received alleging abuse/neglect of a resident by a staff person or a visitor require an investigation by Adult Protective Services staff. If there are multiple victims named in the complaint, a separate referral must be taken for each alleged victim;

d) Referrals that allege client to client abuse generally are considered to be behavioral issues and therefore not considered to be appropriate for investigation by Adult Protective Services staff unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the facility. Rather, these should be referred to the facility administrator or their designee to be addressed. Further, if it is determined that there is/appears be a pattern of this type of allegation in a facility, a referral to the Office of Health Facilities Licensure and Certification or other applicable regulatory body and/or local Ombudsman should be made. (See Appendix P Contact Information).

Note: Use the form titled "APS Notification Letter - Within DHHR" or "APS Notification Letter - NON-DHHR, as applicable, to provide written notification to the appropriate regulatory or advocacy body. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

2.13.6 APS Referrals Involving a Service Agency

Adult Protective Services referrals alleging that abuse/neglect occurred at a service agency (i.e. sheltered workshop, community mental health center, home health provider, day treatment program, etc.) and the report alleges that the

perpetrator was a staff member of that service agency or a visitor, an investigation must be initiated. If more than one victim is named in the report, a separate referral must be completed for each individual.

Allegations of client to client abuse in this type of setting are generally not considered to be appropriate for an Adult Protective Service investigation unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the service agency. Rather, these situations are to be referred to the agency administrator and the appropriate licensing agency(s) for follow-up. (Examples of licensing agencies include OHFLAC-home health agencies; OBHS-day treatment, etc.).

Note: Use the form titled "APS Notification Letter - Within DHHR" or "APS Notification Letter - NON-DHHR, as applicable, to provide written notification to the appropriate regulatory body. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

2.13.7 APS Referrals Involving an Acute Primary Care Hospital

Referrals involving abuse or neglect by hospital personnel that occurred in an acute primary care hospital are not appropriate for an Adult Protective Service investigation. These are to be referred to the administrator of the hospital. Quality of Care issues are to be referred to West Virginia Medical Institute (WVMI), the Office of Health Facilities Licensure and Certification (OHFLAC) and/or the DHHR Medicaid Fraud Unit. (See Appendix P Contact Information). The reporter should be encouraged to contact these entities directly to make the referral. If the reporter is unwilling or unable to do so, the Department is to send a written referral after gathering all relevant intake information.

2.13.8 APS Referrals Involving a Law Enforcement Agency or Correctional Facility

Referrals involving a law enforcement agency are not appropriate for an Adult Protective Service investigation. These are to be referred to that agency's internal investigation office or the prosecuting attorney, who is the chief local law enforcement officer. The reporter should be encouraged to contact the agency's internal investigation office/prosecuting attorney directly to make the referral. If the reporter is unwilling or unable to do so, the Department is to send a written referral after gathering all relevant intake information.

2.13.9 APS Referrals Involving a Client that Receives Adult Family Care Services

Since AFC homes are certified by the Department, the Adult Protective Services worker must notify the appropriate Adult Service (AFC) Home Finder and Adult Service worker. Adult Protective Services referrals involving adults who reside in an Adult Family Care home shall be handled as follows:

a) To avoid a conflict of interest, it is recommended that the referral be assigned to another county rather than the resident county of AFC home for investigation. This is at the supervisor's discretion after consultation with their immediate supervisor and/or Community Service Manager following their regional protocol;

b) If that is not possible it is then recommended that the worker conducting the APS investigation NOT be the same worker who also carries an active Adult Services Request to Receive case (Adult Residential, Guardianship or Health Care Surrogate);

c) If the worker or supervisor is the reporter, the supervisor or an employee in that unit should not be assigned to the investigation and/or case. In these situations the referral and/or case should be assigned to another jurisdiction for investigation and case management after consultation with their immediate supervisor and/or Community Service Manager following their regional protocol;

d) If the referral indicates that one (1) or more residents of the AFC home may be in immediate danger, (i.e. it is 10 degrees outside and the heating unit is broken), the Department will evaluate and may respond by conducting an APS investigation and making appropriate referrals;

e) Referrals that are received alleging abuse/neglect of a resident by a provider or a visitor require an investigation by Adult Protective Services staff. If there are multiple individuals named in the complaint, a separate referral must be taken for each alleged victim; and,

f) Referrals that allege client to client abuse are considered to be behavioral issues and therefore not considered to be appropriate for investigation by Adult Protective Services staff. Rather, these should be referred to the Home Finding supervisor and the Adult Service supervisor to be addressed. These referrals would not be accepted for APS investigation unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the AFC provider.

2.13.10 APS Referrals Involving Suspected Methamphetamine Laboratories and/or Use

Referrals involving a suspected meth lab should be referred to law enforcement as they should be the first responder. Law enforcement may request placement assistance if there is a mentally and/or physically incapacitated adult. These may be accepted upon supervisory discretion. If worker discovers a meth lab or suspects that he/she has come across chemicals being used to make meth during a home visit or incapacitated adult abuse/neglect investigation, the worker will leave the house, depart the immediate area, and contact their supervisor and law enforcement. (For additional information regarding meth see Appendix C for appropriate protocol).

2.14 Investigation

2.14.1 Introduction

When the referral is received, if there is any missing information, such as name, last known address, birth date, etc. and the worker learns any of this information at any time, this information must be documented in FACTS.

It is extremely important that contact with and observation of the caregiver, alleged victim, alleged perpetrator, witnesses, collaterals, etc. in an Adult Protective Service investigation be accurately, carefully, and thoughtfully documented. In the event the perpetrator is prosecuted as a result of a substantiated Adult Protective Service complaint, the social worker will, in many cases, be the primary source of evidence for the court hearing. The information documented in the case record is critical since it may be used in the court's determination about the guilt/innocence of the perpetrator, whether the crime is a felony or a misdemeanor, and the severity of the sentence imposed.

Note: Caution must be exercised in assessing each new complaint. Each referral must be given serious consideration. If there are any doubts, they must be resolved in favor of protecting the alleged victim and the referral must be accepted for investigation.

2.14.2 Conducting the Investigation (Refer to Appendix B Worker Safety).

a) Client and Perpetrator Rights

There is a consensus among law makers and social workers as well as the community that clients have a right to be as educated and involved as possible in the decisions being made during an Adult Protective Service investigation.

The more knowledgeable and invested individuals are during an investigation the more willing they are to accept intervention. The worker is entrusted with the responsibility to share information with the individual during key points throughout the intervention process, not just those concerning the investigation. It is also important to keep in mind that the way in which information is disclosed is important. A

worker must balance the right of notification with concern for not compromising any criminal proceedings that may be initiated as a result of substantiated abuse/neglect.

b) **Client Rights:** The West Virginia Department of Health and Human Resources, Adult Protective Services is mandated by the State Code of West Virginia, §9-6-2 to conduct an investigation when a report of adult abuse, neglect or financial exploitation is received. When you are involved in an Adult Protective Services (APS) investigation or a case is open for APS services, there are certain rights you need to know about. Some of those rights include:

1. The right to object to someone coming into your home without your permission to conduct an investigation. If you refuse a face to face interview, law enforcement will be contacted for assistance and court intervention may be necessary to complete the investigation.
2. The right to have certain information about you that APS has in their records kept private and confidential.
3. The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted.
4. The right to refuse APS services, unless deemed incompetent by a court of law, and the right to know what may happen if you refuse; however, the APS worker is mandated by WV Code to conduct the investigation.
5. The right to have a decision made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs.
6. You may have the right to request certain help for you if you have disabilities as defined by the Americans with Disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process.
7. The right to know if there will be an open Adult Protective Services case.

c) **Alleged Perpetrator Rights:** The West Virginia Department of Health and Human Resources, Adult Protective Services is mandated by the State Code of West Virginia, §9-6-2 to conduct an investigation when a report of adult abuse, neglect or financial exploitation is received. When you are involved in an Adult Protective Services (APS) investigation, there are certain rights you need to know about. Some of those rights include:

1. The right to object to someone coming into your home without your permission to conduct an investigation.

2. The right to have certain information about you that APS has in their records kept private and confidential.
3. The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted.
4. The right to file a grievance if you disagree with a substantiated allegation.
5. The right to have fair and reasonable decisions made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs.
6. You may have the right to request certain help for you if you have disabilities as defined by the Americans with Disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process.
7. The right to have a representative present, such as a union steward if the alleged allegation occurred in a facility setting where the alleged perpetrator is employed.
8. The right to know if the allegations against you as an alleged perpetrator were substantiated, if you provide the Department of Health and Human Resources with a complete mailing address.

d) The duties of the Adult Protective Services worker during the investigation include:

1. Make a face-to-face contact with the alleged victim within the assigned time frame. If unable to do this, the worker must document the reasons in FACTS in the Contact screen;
2. Provide the alleged victim their rights using the handout 'Client Rights during the Adult Protective Service Process'. Briefly explain the content. In accordance with policy, the worker will clarify any questions that the client has during the assessment/investigation.
3. If the alleged victim has a decision maker that is a Guardian/Conservator or Uniform Power of Attorney that is in effect the worker must review or attempt to review the most recent document, and the worker will need to record their efforts in case contacts. The handout 'Client Rights during the Adult Protective Service Process' must be provided to them as well. If the client has a Health Care Surrogate or Medical Power of Attorney, the worker is not required to provide this to the Health Care Surrogate;
4. Never reveal the identity of the reporter, except: (a) when notifying the prosecuting attorney of a substantiated referral, (b) when notifying law enforcement of a substantiated referral unless the

reporter had requested to remain anonymous, or (c) under order of the court;

5. Involving relevant individuals/service providers as needed throughout the Adult Protective Service process;
6. Explaining the reasons behind actions taken by the worker;
7. Contact the alleged perpetrator(s) regarding the allegation(s) and all potential witnesses and collaterals;
8. Identify him/herself as a worker from the WV Department of Health and Human Resources. Display state employee identification to the alleged victim and any other individuals to be interviewed;
9. Give the alleged victim a brief verbal description of the abuse or neglect allegations. If permission to conduct the interview(s) is denied, the worker will explain to the alleged victim that the worker must discuss this situation with the Adult Protective Service supervisor. Once the supervisor has reviewed the situation, the supervisor or worker must contact the prosecuting attorney or regional attorney for consultation on how to gain access so that the alleged victim can be interviewed;
10. Provide the alleged perpetrator with the handout 'Alleged Perpetrator's Rights during the Adult Protective Service Process'. Briefly explain the content. If the alleged perpetrator has a Guardian/Conservator or Uniform Power of Attorney that is in effect, the handout 'Alleged Perpetrator's Rights during the Adult Protective Service Process' must be provided to them as well. If the client has a Health Care Surrogate/Medical Power of Attorney, the worker is not required to provide this to the HCS/MPOA;
11. If the alleged perpetrator refuses to be interviewed face to face, but opts for a telephone interview, the worker will request a mailing address so the Alleged Perpetrator's Rights can be mailed. If the alleged perpetrator refuses to provide a home mailing address, the worker will verbally explain the rights if the alleged perpetrator agrees;
12. In accordance with policy, the worker will clarify any questions the alleged perpetrator has about their rights;
13. Request a complete home mailing address from the alleged perpetrator explaining this is necessary for notification if the findings are substantiated. If the alleged perpetrator refuses to provide the worker with a complete home mailing address, the worker must explain that a notification letter will not be sent regarding the findings, if substantiated. The worker must explain to the alleged perpetrator that the findings may affect future employment. The worker must document in FACTS if the alleged

perpetrator refuses to provide a complete home mailing address. The worker must not mail the notification letter to the alleged perpetrator's place of employment, without written permission from the alleged perpetrator;

14. If the alleged perpetrator refuses to be interviewed, the worker must inform them that the findings will be completed without their input;

    Note: If the alleged perpetrator refuses to provide you any information the worker may want to send them a certified letter as a means of verifying attempts were made to get their information on record.

15. If it is known that the alleged perpetrator/victim has legal counsel, the worker must ask permission to continue the interview. If permission is granted, the worker will proceed with the interview. If permission is denied, the worker will discuss this with their supervisor. Once the supervisor has reviewed the situation, the supervisor or worker must contact the Regional Attorney and/or Prosecuting Attorney for advice on how to proceed; and,

16. Attempt to privately interview all relevant individuals.

    In a situation where the alleged abuse and/or neglect occurred in a county that is not the county of residence for the alleged victim, the investigation will be conducted in the county that the abuse and/or neglect occurred. In these instances, close coordination/cooperation will be required by workers from both counties.

    The order in which interviews are conducted is important to ensure that the information obtained is as factual as possible.

e) The recommended order for completing the interviews is as follows:

- Alleged victim - to obtain their account and to view injuries, if present;
- Witnesses who may be able to report about the incident;
- Other witnesses and/or collaterals;
- Alleged perpetrator(s); and,
- Reporter may be contacted if additional clarification/information is required at any time during the interview process.

At the conclusion of each interview by the worker, it is preferable to obtain a written summary of the individual's account of the incident and the events surrounding it. When the statement is completed, the individual should sign and date the statement after they have read it thoroughly, making and initialing any corrections they believe are needed to more accurately reflect their account of the incident.

Note: The worker must interview each individual themselves and are not to rely solely on the results of the investigation completed by the facility/agency. Information contained in this report is to be used to supplement the information obtained during the interviews conducted by the worker.

All interviews with the alleged victim, witnesses and the alleged perpetrator are to be conducted face-to-face. The interview with the alleged victim MUST be completed face to face and must be done within the assigned time frame. All other interviews are to be completed as quickly as possible, within the thirty (30) day period allowed for completion of the Risk Assessment (exception are Financial Exploitation investigations that are allowed sixty (60) days for completion). Every attempt must be made to conduct these interviews face to face (i.e. meeting individual at their place of employment at the end of their shift). If, after every possible attempt is made, a face to face interview with individuals, other than the alleged victim, is not possible, the interview(s) may be conducted by telephone. In the event it is not possible to complete a face to face interview with any one of the witnesses or the alleged perpetrator, the reason a face to face interview is not possible must be documented in the Contact screen in FACTS. Each contact with the alleged victim and others must be documented in FACTS as soon as possible.

Typically, the Adult Protective Service worker will not need to interview a child. However, if there is a need to interview a child under the age of eighteen (18) and the child is not an emancipated minor, the worker will need the permission of the parents or guardian to interview the child. If there is concern in regards to the safety of the child, the child may be evaluated for a referral to Child Protective Services/Youth Services.

If the alleged perpetrator refuses to be interviewed face to face, but opts for a telephone interview, the worker will request a mailing address so the Alleged Perpetrator's Rights can be mailed. If the alleged perpetrator refuses to provide a mailing address, the worker will verbally explain the Rights if the alleged perpetrator agrees.

On those occasions that interviews cannot be completed because the alleged victim is in another county, a courtesy interview may be appropriate. In these instances, the supervisor from the county requesting the courtesy interview will contact the supervisor in the county where the client is located to arrange the interview. Once the courtesy interview is completed, the worker must document the contact in FACTS, as well as notify the county requesting the interview that the interview has been completed. The worker must make an entry in the Audit Trail indicating why they accessed the investigation/case.

Note: The Audit Trail should be completed to document why the case was accessed by someone other than the assigned worker. The audit trail is to be used for case specific information only.

When interviewing the alleged perpetrator, the worker must request a complete mailing address from the alleged perpetrator explaining this is necessary for

notification of the findings of the investigation. If the alleged perpetrator refuses to provide the worker with a complete mailing address, the worker must explain that a notification letter will not be sent regarding the findings. The worker must explain to the alleged perpetrator that the findings may affect future employment. The worker must document in FACTS if the alleged perpetrator refuses to provide a complete mailing address.

Written documents/information sources are to be reviewed after all interviews are completed. This review will generally only apply when a facility/service provider agency is involved. The review of written documentation should include things such as the following, as applicable:

a) Client chart;
b) Care plan;
c) Flow books/daily observation log;
d) Nurses notes/social service notes;
e) Communication log;
f) Physician's orders;
g) Prescribed medications/medication log;
h) Photos;
i) Body audit;
j) Incident report(s);
k) Results of the provider's internal investigation of the incident; and,
l) Others as applicable.

The worker should request copies of all information relevant to completion of the Adult Protective Service investigation such as the incident report, internal investigation results, etc. All copies obtained are to be filed in the client's paper record and entered in Document Tracking in FACTS.

Finally, if the worker makes the initial contact and finds the alleged victim in an emergency situation requiring immediate action to ensure their safety, completion of the full investigation may need to be put on hold until the emergency situation is addressed. This may involve requesting either an Order of Attachment permitting the Department to do an emergency removal or an Order for Injunctive Relief in order to gain access to the alleged victim if access is being denied by the caregiver or others thereby preventing assessment of the condition of the alleged victim. (Refer to Appendix A Flow of Intake and Investigation).

2.15 Corrective Action Planning – Facilities

When abuse/neglect in a facility involving staff of the facility or a visitor has been substantiated, a Corrective Action Plan is required to assure the safety of the resident. The social worker must provide written notification to the facility

administrator within seven (7) calendar days following the completion of the Risk Assessment. This is similar to service planning for clients. The Corrective Action Plan is to be completed by the facility and must address all the issues identified that are contributing factors to the abuse/neglect. It must clearly identify the specific actions that are to be taken to alleviate the problems. It should include who is responsible for carrying out each task, time frames for completion of each task and other relevant information. The facility must submit a Corrective Action Plan to the Department within fifteen (15) days following receipt of the Investigation Summary from the Department. The social worker is to review the Corrective Action Plan to determine whether or not the plan adequately addresses all problem areas identified. To ensure that the Corrective Action Plan submitted by a facility has been adhered to, the social worker will request notification from the facility when the plan has been implemented. In most instances the Corrective Action Plan should be fully implemented or completed within thirty (30) days following the date the Corrective Action Plan is approved. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented. See the following sections for details related to various types of settings.

Upon approval by the Department of the Corrective Action Plan, a copy of the approved plan is to be forwarded to the appropriate regulatory office (i.e. Office of Health Facilities Licensure and Certification [OHFLAC], Behavioral Health and Health Facilities [BHHF], etc). In the event the facility is unable or unwilling to submit a Corrective Action Plan that adequately addresses the identified problems, the prosecuting attorney and the appropriate regulatory body are to be advised of the facility's failure to provide an acceptable Corrective Action Plan.

Note: The Corrective Action Planning process is separate from the written notification that is required to be sent to the regulatory entities, prosecuting attorney, etc. whenever abuse or neglect has been substantiated in a facility setting. Sharing a copy of the Corrective Action Plan and other information related to implementation of this plan is separate from the initial notification of substantiation. (See Section 3.2 and Section 8.4 Required Notifications for information about the initial notification to the PA, Section 8.5 regulatory entities, etc.).

a) State Operated Mental Health Hospital and Long Term Care Facilities

The two (2) state operated mental health facilities of this type are William R. Sharpe Hospital and Mildred Mitchell Bateman Hospital. The long term care facilities of this type are Lakin Hospital, Pinecrest Hospital, Hopemont Hospital, Welch Emergency Hospital and John Manchin Sr. Health Care Center.

1. Abuse/Neglect Substantiated

   If an APS situation is substantiated, the social worker must provide written notification to the facility administrator within seven (7) calendar days following completion of the Risk Assessment. This notification is to include

allegations that were substantiated. A form letter titled “Corrective Action Letter” has been developed for this purpose and is available as a DDE document and may be accessed through the reports area of FACTS. This form is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by using the ‘Save to FACTS’ functionality. This functionality may be found in Microsoft Word under the ‘Add – Ins’ menu and then selecting ‘Save to FACTS’; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

The facility administrator is then responsible for developing a Corrective Action Plan to address the findings and requirements identified.

The Corrective Action Plan must be submitted to the Department within fifteen (15) calendar days from the date of the notification letter. Once the Corrective Action Plan is approved by the Department, it is to be filed in the paper record for the facility and the client, as well as recorded in Document Tracking. Finally, a copy of the approved plan is to be forwarded to the appropriate regulatory agency (OHFLAC, OBHS). Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If the social worker and his/her supervisor believe that the Corrective Action Plan submitted by the facility administrator fails to adequately address the problems, the social worker is to contact the facility administrator to resolve the issues in question. This contact must be documented in FACTS and written notification sent to the facility administrator identifying the additional areas that must be addressed in the Corrective Action Plan. The facility administrator has seven (7) days from the receipt of this follow-up notification to submit an acceptable Corrective Action Plan. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If efforts to obtain an acceptable Corrective Action Plan from the facility administrator are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney and the Bureau of Behavioral Health and Health Facilities and Office of Health Facilities Licensure and Certification. Further action should be at the discretion of the prosecuting attorney. In addition to this notification, if it is a long term care facility when the nature of the concerns identified during the investigation relate to resident rights within the facility, notification is to be sent to the local Ombudsman.

2. Abuse/Neglect Not Substantiated

   A Corrective Action Plan is not routinely required when the abuse/neglect has not been substantiated. In this instance the worker is to notify the facility of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the facility may be discovered. When this occurs the social worker is to provide the facility administrator with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the facility that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non-DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by manually entering the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet.

   In addition to this notification, if it is a long term care facility when the nature of the concerns identified during the investigation relate to resident rights within the facility, notification is to be sent to the local Ombudsman.

   If abuse/neglect has not been substantiated and an Adult Preventive Case is going to be opened, a Corrective Action Plan may be requested by the worker for appropriate follow-up to correct the situation.

   b) Nursing Homes, Assisted Living Facilities or Other Non-State Operated Residential Group Care Facilities

1. Abuse/Neglect Substantiated

   If an APS situation is substantiated, the social worker must provide written notification to the facility administrator/operator within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. Additionally, the cover letter is to advise the operator of the confidential nature of the information contained in it and any attachment(s) to the letter and that the information is only to be shared with appropriate staff within the facility. A form letter titled “Corrective Action Letter” is available as a DDE and may be added to the file cabinet and Document Tracking by using the ‘Save to FACTS’ functionality. This functionality may be found in Microsoft Word under the ‘Add – Ins’ menu and then selecting ‘Save to FACTS’; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

The facility operator is then responsible for developing a Corrective Action Plan to address the findings and requirements identified. The Corrective Action Plan must be based on the summary of the investigation findings which is provided by the social worker to the facility administrator/operator. The Corrective Action Plan must be submitted to the Department within fifteen (15) calendar days from the date of the notification letter.

Once the Corrective Action Plan is approved by the Department, it is to be filed in the paper record for the facility and the client and recorded in Document Tracking. Finally, a copy of the approved plan is to be forwarded as follows (See Appendix P Contact Information):

a. Nursing home - OHFLAC, Medicaid Fraud, Ombudsman, and Bureau for Medical Services;

b. Assisted living residences, and registered/unlicensed homes - OHFLAC, Ombudsman, and Medicaid Fraud;

c. I/DD Waiver homes - OHFLAC, Medicaid Fraud, and Office of Behavioral Health and Health Facilities;

d. ICF/ID Group homes - OHFLAC, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for Medical Services;

e. Specialized Family Care homes (Medley) - Bureau for Children and Families/ Medley Program manager and Medicaid Fraud; and

f. Adult Family Care home - Bureau for Children and Families regional AFC home finding supervisor.

Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If the social worker and their supervisor believe that the Corrective Action Plan submitted by the facility administrator/operator fails to adequately address the problems, the social worker is to contact the facility administrator/operator to resolve the issues in question. This contact must be documented in FACTS and written notification sent to the facility administrator identifying the additional areas that must be addressed in the Corrective Action Plan. The facility administrator has seven (7) days from the receipt of this second notification to submit an acceptable Corrective Action Plan. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If efforts to obtain an acceptable Corrective Action Plan from the facility administrator are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting

attorney and the appropriate regulatory bodies as indicated above. Further action should be at the discretion of the prosecuting attorney.

2. Abuse/Neglect Not Substantiated

A Corrective Action Plan is not routinely required when the abuse/neglect has not been substantiated. In this instance the worker is to notify the facility administrator/operator of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the facility may be discovered. When this occurs the social worker is to provide the facility administrator with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the facility/home that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non-DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by manually entering the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet.

Finally, in addition to this notification, when the nature of the concerns identified during the investigation relate to resident rights within a nursing home, assisted living facility or registered/unlicensed home, notification is to be sent to the local Ombudsman.

If abuse/neglect has not been substantiated and an Adult Preventive Case is going to be opened, a Corrective Action Plan may be requested by the worker for appropriate follow-up to correct the situation.

c) Adult Family Care Homes

Since the Department is responsible for recruitment and providing support and assistance to both AFC providers and the clients placed in these homes, it is essential that the APS worker coordinate closely with both the AFC Home Finding staff and the Adult Family Care staff involved with the home. Even so, it is important for the APS worker to focus their involvement in the home on the issues of alleged abuse/neglect rather than compliance issues. If there are issues related to compliance that are identified during the course of the investigation, these are to be referred to the AFC Home Finding and/or AFC staff to address. (See Section 2.13 to review APS Referrals Involving a Client that Receives Adult Family Care Services and See Section 5.5 to review Conflict of Interest).

1. Abuse/Neglect Substantiated

If an APS situation is substantiated, and the perpetrator is the provider or a household member that is going to remain in the home, the APS worker is to notify the AFC worker and home finder to assist in evaluating whether or not closure of the home and/or removal of the clients is necessary. If

the substantiated abuse/neglect is minor and correctable, the APS worker must provide written notification to the provider within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. Additionally, the cover letter is to advise the provider of the confidential nature of the information contained in it and any attachment(s) to the letter. A form letter titled "Corrective Action Letter" is available as a DDE and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality. Finally, a copy of the notification letter is also to be sent to the regional AFC home finding supervisor.

The AFC provider is then responsible for developing a Corrective Action Plan to address the findings and requirements identified. The Corrective Action Plan must be based on the summary of the investigation findings which is provided by the APS worker to the provider. The Corrective Action Plan must be submitted to the Department within fifteen (15) calendar days from the date of the notification letter. Once the Corrective Action Plan is approved by the Department, it is to be filed in the paper record for the home and the client and recorded in Document Tracking. Finally, a copy of the approved plan is to be forwarded to the regional Adult Family Care home finding supervisor. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If the APS worker and their supervisor believe that the Corrective Action Plan submitted by the AFC provider fails to adequately address the problems, the APS worker is to contact the provider to resolve the issues in question and document this contact in FACTS. Written notification is to be sent to the provider identifying the areas that must be addressed in the Corrective Action Plan. The provider has seven (7) days from receipt of this second notification to submit an acceptable Corrective Action Plan. Upon receipt of notification that implementation has been completed, the social worker will conduct a home visit to verify that the plan was implemented.

If these efforts are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney and the home finding supervisor. Further action related to potential prosecution should be at the discretion of the prosecuting

attorney while action related to the continued status as an AFC provider should be at the discretion of the home finding supervisor.

2. Abuse/Neglect Not Substantiated

A Corrective Action Plan is not routinely required when the abuse/neglect has not been substantiated. In this instance the APS worker is to notify the provider of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the provider may be discovered. When this occurs the APS worker is to furnish the provider and the regional AFC home finding supervisor with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the provider that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non-DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by manually entering the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet.

*Though AFC homes act as an extension of the Department in their provision of services to residents, this letter is the most appropriate option to use in this instance.

If abuse/neglect has not been substantiated and an Adult Preventive Case is going to be opened, a Corrective Action Plan may be requested by the worker for appropriate follow-up to correct the situation.

d) APS Referrals Involving a Service Agency

Adult Protective Services referrals alleging that abuse/neglect occurred at a service agency (i.e. sheltered workshop, community mental health center, day treatment program, etc.) and reporting that the perpetrator was a staff member of that service agency may be investigated.

1. Abuse/Neglect Substantiated

If an APS situation is substantiated, the social worker must provide written notification to the administrative official within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. A form letter titled "Corrective Action Letter" has been developed for this purpose is available as a DDE document and may be added to the file cabinet and Document Tracking by using the 'Save to FACTS' functionality. This functionality may be found in Microsoft Word under the 'Add – Ins' menu and then selecting 'Save to FACTS'; then FACTS will automatically add this document to the file cabinet and the Document Tracking screen. If this automatic functionality is not used you may manually enter the report into the

FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet by using the import functionality.

The administrative official is then responsible for developing a Corrective Action Plan to address the findings and requirements identified. Additionally, the cover letter is to advise the recipient of the confidential nature of the information contained in it and any attachment(s) to the letter and that the information is only to be shared with appropriate staff within the facility.

The Corrective Action Plan must be submitted to the Department within fifteen (15) calendar days from the date of the notification letter. Once the Corrective Action Plan is approved by the Department, it is to be filed in the paper record for the facility and the client and recorded in Document Tracking. Finally, a copy of the approved plan is to be forwarded to the appropriate regulatory agency that presides over that service agency. If the worker is unclear as to who is the regulatory agency, the worker should confer with their supervisor for direction. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If the social worker and his/her supervisor believe that the Corrective Action Plan submitted by the administrative official fails to adequately address the problems, the social worker is to contact the administrative official to resolve the issues in question. This contact must be documented in FACTS and written notification sent to the administrative official identifying the additional areas that must be addressed in the Corrective Action Plan. The administrative official has seven (7) days from the receipt of this follow-up notification to submit an acceptable Corrective Action Plan. Upon receipt of notification that implementation has been completed, the social worker will conduct a site visit to verify that the plan was implemented.

If efforts to obtain an acceptable Corrective Action Plan from the administrative official are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney and the appropriate regulatory agency(s). If the worker is unclear as to who is the regulatory agency, the worker should confer with their supervisor for direction. Further action should be at the discretion of the prosecuting attorney.

2. Abuse/Neglect Not Substantiated

A Corrective Action Plan is not routinely required when the abuse/neglect has not been substantiated. In this instance the worker is to notify the administrative official of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the program may be discovered. When this occurs the social worker is to provide the administrative official with a copy

of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the program that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non-DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS as a DDE and may be added to the file cabinet and Document Tracking by manually entering the report into the FACTS Document Tracking screen and saving a copy of the letter into the Investigation filing cabinet.

If abuse/neglect has not been substantiated and an Adult Preventive case is going to be opened, a Corrective Action Plan may be requested by the worker for appropriate follow-up to correct the situation

2.16 Legal Processes

There are various legal remedies that may be appropriate for use in Adult Protective Service cases. These are summarized in the following sections.

2.16.1 Order of Attachment

An Order of Attachment is a legal remedy available through the circuit court. Its use permits the removal of an incapacitated adult from an emergency situation and movement of the adult to a location where their safety can be assured, such as a hospital, nursing home, or other safe place. The purpose of this action is to alleviate the emergency situation that was found to exist, to provide necessary treatment, and to reduce or avoid the risk of death or serious injury to the incapacitated adult. Specifically, an Order of Attachment may be used when there is probable cause to believe that an incapacitated adult is in an emergency situation and that the person(s) responsible for their care refuses or is unable to take the necessary steps to alleviate the emergency situation or the incapacitated adult is without a responsible person to provide for their care. Once an Order of Attachment is granted, the incapacitated adult will be delivered to a safe place such as a hospital or other safe place except a jail. Removal must be done by a law enforcement officer. An employee of the Department may accompany the law enforcement officer if requested or upon order of the court. The statutory basis for this action is contained in §9-6-5 of the West Virginia Code. For assistance, the worker may consult with their supervisor who may request additional assistance from their regional attorney.

2.16.2 Injunctive Relief

Injunctive Relief is a judicial remedy used for the purpose of requiring a party to refrain from doing or continuing to do a particular act or activity. Injunctive Relief differs from an Order of Attachment in that it is directed at a client's caretaker rather than directly at the client. Typically it causes a caretaker to give the worker access to the client for the purposes of continuing the investigation. State statute §9-6-4 set forth the circumstances under which Injunctive Relief may be granted by the court. Specifically, Injunctive Relief may be used to restrain and

abate the abuse/neglect of an incapacitated person or to alleviate an emergency situation by allowing access to the client.

2.16.3 Writ of Mandamus

A Writ of Mandamus is an action taken by the court to compel the performance of specific duties by a governmental agency or court which has a statutory mandate to do a certain activity but which is refusing to fulfill their statutory obligation. This applies to duties which the agency could reasonably be expected to perform. The applicable requirements are set forth in §53-1-1 et. seq. of the West Virginia Code. (Examples include: 1) an order requiring a Sheriff as conservator to pay necessary expenses for the adult's cost of care or 2) court refuses to accept a guardianship petition or Order of Attachment).

2.16.4 Appointment of Guardian

Appointment of a guardian is a legal process whereby a person(s) is appointed for the purpose of managing the personal affairs of another individual who has been deemed by the court to be incompetent. The appointment of a guardian is to be done through the circuit court in order to assure the protection of the constitutional rights of the protected person. The court also determines the type of guardianship needed and the specific areas of protection and assistance that are to be provided. Guardianship is usually a long-term arrangement. The requirements related to the appointment of a guardian are contained in §44A of the West Virginia Code, also known as the West Virginia Guardianship and Conservatorship Act.

Appointment of a guardian is a mechanism for assuring the protection of incapacitated adults. State law requires that the court select the individual or entity that is best qualified to act in the best interest of the protected person. Other considerations are to include, ability of the guardian to carry out the fiduciary duties and responsibilities of the office, and commitment to promoting the protected person's welfare. A guardian appointed under the provisions of §44A must be the least restrictive type of appointment possible and the powers granted shall not extend beyond what is necessary to assure the protection of the individual. The Department may be appointed to serve as guardian of last resort. Appointment of a guardian severely limits the rights of the protected person to act on his/her own behalf so seeking appointment of a guardian should not be pursued without careful consideration.

There are different types of guardianship, which are as follows:

a) Temporary Guardian: A person appointed by the circuit court who has only those responsibilities for the personal affairs of a protected person, as specified in the order of appointment. A Temporary Guardian may be appointed upon finding that an immediate need exists, that adherence to the procedures otherwise set forth in Chapter 44A for the appointment of a guardian may result in significant harm to the person and that no other individual or entity appears to have the authority to act on behalf of the person, or that the individual or entity

with authority to act is unwilling, unable or has ineffectively or improperly exercised the authority. A Temporary Guardian is time limited to six (6) months unless terminated or extended by the circuit upon good cause following a hearing.

b) Limited Guardian: A person appointed by the circuit court who has only those responsibilities for the personal affairs of a protected person, as specified in the order of appointment.

c) Full Guardian: A person appointed by the circuit court who is responsible for the personal affairs of a protected person.

WV State Code §44A-1-8

Any adult individual may be appointed to serve as a guardian, a conservator or both upon a showing by the individual of the necessary education, ability and background to perform the duties of guardian or conservator and upon a determination by the court that the individual is capable of providing an active and suitable program of guardianship or conservatorship for the protected person. The individual may not be employed by or affiliated with any public agency, entity or facility that is providing substantial services or financial assistance to the protected person.

WV State Code §44A-1-15

Eligibility of guardians or conservators employed pursuant to a Department of Health and Human Resources waiver program.

(a) A person employed pursuant to a written contract or other employment arrangement with a licensed provider of behavioral health services for the purpose of providing services to a protected person, may be appointed by a court as the guardian or conservator of the protected person if;

(1) Payment for services provided under the contract or employment agreement is made pursuant to a waiver program;

(2) The person is related to the protected person by blood, marriage or adoption;

(3) The contract or arrangement is disclosed in writing to the court, and,

(4) The court finds that the appointment is in the best interests of the protected person.

WV State Code §39B

The Uniform Power of Attorney Act dictates that if the client is incapacitated and does not have a guardian, conservator, co-agent or successor agent and the agent resigns as the power of attorney, they must notify the client's caregiver, or another person reasonably believed to have sufficient interest in the client's welfare or to notify APS of a need for guardianship of incapacitated client.

Refer to APS Guardianship Policy.

2.16.5 Appointment of Conservator

Appointment of a conservator is a legal process whereby a person(s) is appointed for the purpose of managing the financial affairs of another individual who has been deemed by the court to be incompetent, or a missing person. The appointment of a conservator is to be done through the circuit court in order to assure the protection of the constitutional rights of the protected person. The court also determines the type of conservatorship needed and the specific areas of management and assistance that are to be provided. Conservatorship is usually a long-term arrangement. The requirements related to the appointment of a conservator are contained in §44A of the West Virginia Code, also known as the West Virginia Guardianship and Conservatorship Act.

There are different types of conservatorship, which are as follows:

a) Temporary Conservator: A person appointed by the circuit court who has only those responsibilities for managing the estate and financial affairs of a protected person, as specified in the order of appointment. A Temporary Conservator is time limited to six (6) months unless terminated or extended by the circuit upon good cause following a hearing.

b) Limited Conservator: A person appointed by the circuit court who has only those responsibilities for managing the estate and financial affairs of a protected person, as specified in the order of appointment.

c) Full Conservator: A person appointed by the circuit court who is responsible for managing the estate and financial affairs of a protected person.

Appointment of a conservator is a mechanism for assuring the protection of incapacitated adults. State statutes require that the court select the individual or entity that is best qualified to act in the best interest of the protected person, ability of the conservator to carry out the financial duties and responsibilities of the office, and commitment to promoting the protected person's welfare. A conservator appointed under the provisions of §44A must be the least restrictive possible and the powers granted shall not extend beyond what is necessary to assure the protection of the individual. Appointment of a conservator severely limits the rights of the protected person to act on their own behalf. The local Sheriff may be appointed as conservator of last resort. In no instance is the Department to be appointed conservator. Should this occur, the social worker must advise his/her supervisor immediately and forward the matter to the Assistant Attorney General (regional attorney) for review and possible legal action.

2.16.6 Mental Hygiene/Involuntary Commitment Hearing

Involuntary commitment is a legal procedure whereby an individual who appears to be mentally ill or addicted to such a degree that the individual is a danger to him/herself or others is taken into custody and placed in a hospital for evaluation

and/or treatment after a hearing before a Mental Hygiene Commissioner. Two (2) facts must be present for individuals to be involuntarily committed:

a) They are mentally ill or addicted to drugs or alcohol; and,

b) They are dangerous to themselves or others. Mental illness or addiction alone is not grounds for involuntary commitment. The statutory basis is contained in West Virginia Code §27-5-1 et. seq.

Note: The person who observes the client's behavior is the individual who should be filing the Mental Hygiene Petition.

APS workers cannot commit an individual to a mental health facility. Only a Mental Hygiene Commissioner can make the commitment.

2.16.7 Transportation of Involuntary Commitments

a) West Virginia Code §27-5-1-d Duties of the Sheriff: Upon written order of the circuit court, mental hygiene commissioner or magistrate in the county where the individual formally accused of being mentally ill or addicted is a resident or is found, the sheriff of that county shall take said individual into custody and transport him or her to and from the place of hearing and the mental health facility. The sheriff shall also maintain custody and control of the accused individual during the period of time in which the individual is waiting for the involuntary commitment hearing to be convened and while such hearing is being conducted.

For additional information refer to West Virginia Code §27-5-1-d.

b) West Virginia Code §27-5-1-e: Duty of sheriff upon presentment to mental health care facility. Where a person is brought to a mental health care facility for purposes of evaluation for commitment under the provisions of this article, if he or she is violent or combative, the sheriff or his or her designee shall maintain custody of the person in the facility until the evaluation is completed or the county commission shall reimburse the mental health care facility at a reasonable rate for security services provided by the mental health care facility for the period of time the person is at the hospital prior to the determination of mental competence or incompetence.

2.16.8 West Virginia Code §27-5-10 Transportation for the mentally ill or substance abuser

a) Whenever transportation of an individual is required under the provisions of article four or five of this chapter, it shall be the duty of the sheriff to provide immediate transportation to or from the appropriate mental health facility or state hospital: Provided, that, where hospitalization occurs pursuant to article four of this chapter, the sheriff may permit, upon the written request of a person having proper interest in the individual's hospitalization, for the interested person to arrange

for the individual's transportation to the mental health facility or state hospital if the sheriff determines that such means are suitable given the individual's condition. (For additional information refer to West Virginia Code §27-5-10).

SECTION 3

ASSESSMENT

3.1 Client Assessment Processes

3.1.1 Risk Assessment

Once the referral is assigned to a social worker, the Risk Assessment is to be initiated within the assigned time frame. Completion of the Risk Assessment involves gathering a variety of information about the client, his/her current status, whether or not the allegations of abuse/neglect can be verified, and if so, the details of the abuse/neglect. Information is to be gathered by conducting a series of interviews with the client, caregiver (if applicable), alleged perpetrator, others having knowledge of the situation, and family members or other significant individuals. When interviewing the alleged perpetrator in a facility setting and if the individual is still employed they must cooperate with the investigation. If the alleged perpetrator has been terminated by the facility the worker must make every attempt to conduct the interview. In this instance, the alleged perpetrator, may or may not agree to be interviewed. If they refuse to be interviewed, this is to be documented in FACTS. This is the investigation phase of Adult Protective Services. (See the Section 2.14 titled Conducting the Investigation for detailed information).

3.1.2 Information To Be Collected

a) Identifying Information

Demographic information about the client, his/her family and his/her unique circumstances is to be documented. This includes information such as: (not an all inclusive list)

1. Name;
2. Address (mailing and residence);
3. Date of birth/age;
4. Household members;
5. Other significant individuals;
6. Legal representatives/substitute decision-makers (if applicable);
7. Identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);
8. Gender/ethnicity;
9. Marital status;
10. Advance directives in effect, if applicable; and,
11. Directions to the current residence.

3.1.3 Living Arrangements

Documenting information about the client's current living arrangements should include information about where the client currently resides, such as the following:

a) Client's current location (own home, relative's home, hospital, etc.);

b) Is this setting considered permanent/temporary;

c) Type of setting (private home/residential facility);

d) Household/family composition;

e) Physical description of residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);

f) Interior condition of the residence;

g) Exterior condition of the residence;

h) Type of geographic area (rural, urban, suburban, etc.); and,

i) Access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational, religious affiliations, etc.

3.1.4 Client Functioning

Documenting information about the client's personal characteristics should include information about how the client's personal needs are currently met, including an assessment of their strengths, needs and supports in areas such as:

a) Activities of daily living (ADL);

b) Whether or not his/her needs are currently being met and by whom;

c) Caregiver functioning, if applicable;

d) Ability to manage finances;

e) Ability to manage personal affairs;

f) Ability to make and understand medical decisions; and,

g) Assessment of decision-making capacity.

3.1.5 Physical/Medical Health

Documenting information about the client's current physical and medical conditions should include information about the physical condition and description of the client as observed by the worker during face-to-face contact, as well as information about his/her diagnosed health status. Included are areas such as:

a) Observed/reported physical conditions of the client;

b) Primary care physician;

c) Diagnosed health conditions;

d) Current medications;

e) Durable medical equipment and supplies used/needed; and,

f) Nutritional status.

3.1.6 Mental/Emotional Health

Documenting information about the client's current and past mental health status should include information about how the client is currently functioning, his/her current needs and supports, and his/her past history of mental health treatment involvement, if applicable. Included are areas such as:

a) Current treatment status;

b) Current mental health provider, if applicable;

c) Mental health services currently receiving;

d) Medication prescribed for treatment of a mental health condition;

e) Observed/reported mental health/behavioral conditions; and,

f) Mental health treatment history.

3.1.7 Financial Information

Documenting information about the client's current financial status should include information about the client's resources and their ability to manage these independently or with assistance. Included are areas such as:

a) Financial resources - type and amount;

b) Other resources available to the client - non-financial;

c) Assets available to the client;

d) Health insurance coverage;

e) Life insurance coverage;

f) Pre-need burial agreements/burial arrangements in effect, if applicable;

g) Information about client's ability to manage his/her own finances;

h) Outstanding debts/expenses;

i) Court ordered obligation for child support/alimony; and,

j) Whoever manages the client's finances or who has access to client's accounts.

3.1.8 Educational/Vocational Information

Document information about the educational/vocational training the client has received or is currently receiving. This should include information such as:

a) Last grade completed;

b) Field of study;

c) History of college attendance/graduation;

d) History of special licensure/training; and,

e) Current educational/training needs.

3.1.9 Employment Information

Document information about the client's past and present employment, such as:

a) Current employment status;

b) Current employer;

c) Prior employment history; and,

d) Current employment needs.

3.1.10 Military Information

Documenting information about the client's military history, if applicable should include information such as:

a) Branch of service/dates of service;

b) Type of discharge received;

c) Service related disability, if applicable; and,

d) Veteran's eligibility for benefits (contact local veteran representative).

3.1.11 Legal Information

Documenting information about the client's current legal status should include information about all known legal representatives, and the specific nature/scope of that relationship. This should include information such as:

a) Assessment of client's decision-making capacity by the social worker;

b) Information about legal determination of competence, if applicable;

c) Information about efforts to have client's decision-making capacity formally evaluated;

d) Identification of name and decision-making capacity of individuals who assist the client with decision-making; and,

e) Court/hearing information.

In addition to gathering the above information, several critical questions must be considered when completing the Risk Assessment and determining whether a case is to be opened for Adult Protective Services or the investigation closed at its conclusion. These include the following:

a) Is the alleged victim safe or can his/her safety be arranged/assured through resources available to him/her? (Resources include financial, social, familial, etc.)

b) Can any of the allegations presented in the referral, or identified during the investigation process, be verified?

c) Does the alleged victim meet all four (4) APS eligibility criteria?

d) If they do not meet all four (4) APS criteria, do they meet the criteria to be considered for APS Preventive Services?

e) If the alleged victim has decision-making capacity, is he/she willing to accept services?

f) If APS or APS Preventive Services will not be provided, are referrals to other resources needed?

Note: It is not required for the social worker to obtain the permission of the alleged victim or his/her legal representative, if applicable, to complete the Investigation/Risk Assessment component of Adult Protective Services if the client appears to be mentally or physically incapacitated or resides in an assisted living facility. If the social worker meets with resistance that cannot be resolved, it may be necessary to pursue legal action to proceed with the Investigation/Risk Assessment. Also, if at any time during the Investigation/Risk Assessment process doubt arises regarding the emergent nature of the situation (emergent vs. non-emergent) the social worker shall resolve the doubt in favor of the client's safety and immediately initiate face-to-face contact with the alleged victim. If the allegations are of a violent nature and the perpetrator is likely to be present, the social worker may want to have a conference with their supervisor to request that law enforcement accompany them to the home to complete the initial face-to-face contact. (**See Appendix B Worker Safety for more information).**

3.1.12 Time Frames

Time frames for initiation of the Risk Assessment are determined by the supervisor. It is critical that the social worker complete a face-to-face contact within the assigned time frame. The options are "within zero (0) - two (2) hours", "within seventy-two (72) hours", and "within fourteen (14) days". Initiation of the Risk Assessment means, at a minimum, face-to-face contact with the alleged victim. This contact is to be documented in FACTS within twenty-four (24) hours of completion of the contact. Documentation is to be pertinent and relevant to activities necessary to complete the Risk Assessment.

The Investigation/Risk Assessment process, including all applicable documentation in FACTS, must be completed and approved by the supervisor within thirty (30) calendar days from the day the referral is received. In order to complete the investigation process, in addition to the alleged victim, the caregiver (if applicable), the alleged perpetrator, witnesses, and all other relevant parties must also be interviewed.

3.1.13 Extension Beyond Allowed Time Frames

a) Face-to-face Contact

Because of the critical nature of Adult Protective Services, it is essential that face-to-face contact with the alleged victim be made by the social worker within the response time assigned by the supervisor. No extensions will be granted for the face to face contact beyond the assigned time frame. In very unique situations, extenuating circumstances may exist that prevent the social worker from meeting the applicable time frames for completion of the initial contact. When this occurs the worker must document the reason the time frame for the face to face contact could not be met.

b) Completion of Risk Assessment

The Risk Assessment is to be completed within thirty (30) days (exception is an investigation into Financial Exploitation which is sixty (60) days). In the rare situations when it is not possible to complete the full Risk Assessment within this time frame, the social worker must request an extension. To request an extension, the social worker must submit a request to the supervisor prior to expiration of the assigned response time. At a minimum, this request must clearly state the following:

1. Explanation of why the assigned time frame cannot be met;
2. Statement of the extenuating circumstances that exist;
3. Estimation of the amount of additional time required; and,
4. Other relevant information.

Based on the information provided, the supervisor may approve or deny the extension request. If approved, the maximum period of time allowed shall not exceed the maximum of fourteen (14) days.

3.2 Assessing Eligibility

3.2.1 Adult Protective Services

In order for a case to be eligible to receive Adult Protective Services, all four (4) of the following criteria must be met. If all four (4) criteria are met, the allegations must be substantiated. (Section C contains two (2) questions. Question Number 1 must be answered 'Yes' in meeting the four (4) criteria outlined below. If Question C, Number 2 is answered 'Yes', the four (4) criteria are not met). In addition, if the client appears to be capable of making informed, independent decisions on his/her own behalf, they must be willing to accept the case management services offered.

a) The client must be eighteen (18) years of age or older or, if under the age of eighteen (18) must be legally emancipated.

b) The client must be functionally disabled (unable to provide for the basic necessities of life) due to his/her physical or mental disabilities.

c) 1. According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.

2.The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).

d) The client is, excluding the perpetrator;

Alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s) or, is in a care/service facility.

3.2.2 APS Preventive Services

In order for the client to be eligible to receive APS Preventive Services, the referral must come through the Adult Protective Services Intake process and at least criteria A, B and C must be met with Question Number 2 of C criteria answered 'Yes'. In addition, the client must be willing to accept case management services offered.

a) **The client must be eighteen (18) years of age older or, if under the age of eighteen (18) must be legally emancipated**.

b) The client must be functionally disabled (unable to provide for the basic necessities of life) due to his/her physical or mental disabilities.

c) 1. According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.

2. The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).

d) The client is, excluding the perpetrator;

Alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s) or, is in a care/service facility.

Note: Clients generally live in the community, not a facility setting, in order to qualify for APS Preventive services. However, policy does not prevent a worker from opening an APS Preventive case for a client in a facility setting. If the client is going to benefit from this type of short term case management, the worker is still required to make all required referrals/notifications to the regulatory agency, the Ombudsman, Medicaid Fraud, etc. as appropriate).

3.2.3 Decision-Making Capacity

Based on the information gathered during the Risk Assessment, the social worker is to make a determination as to whether or not the client appears to have the capacity to make independent decisions on his/her own behalf and to act on these decisions to meet his/her needs. The determination of the client's decision-making capacity is to be documented in FACTS. If the social worker believes that the client lacks decision making capacity, the reason(s) for this conclusion must also be documented. Documentation must include information regarding a determination of incapacity, if applicable, or worker observations leading to this conclusion if there is no indication that there has been a determination. Observations may include but are not limited to physical/medical/emotional conditions as well as orientation to time, place, person, etc.

3.2.4 Assessment of Risk

A critical component of the Risk Assessment process is determining whether or not the alleged victim is at risk of injury or harm. This determination is made based on the client's circumstances, reported on the referral and/or observed during the investigation and the availability/accessibility of potential supports and resources that could alleviate the risk. Examples of circumstances that may exist which could be an indicator of risk include the following:

1. No established residence;
2. Inadequate/substandard housing;
3. Suicidal gestures/statements;
4. Self destructive behavior;
5. Violent/physically aggressive:
6. Misuse/abuse of alcohol and/or drugs;
7. Behaviors that provoke a serious reaction from others (incontinence, wandering, excessive talking, repetitive speech, etc.);
8. Peer relationships reinforce/promote problematic behaviors;
9. Client's behavior is a threat to self or others;
10. Family members are violent to each other; and,
11. Lack of support system (formal and/or informal).

Note: This is not intended to be an all inclusive list. Further, the presence of any one or combination of these in and of itself would not mean that risk is present in every case. It is essential to consider all of the client's circumstances in making a determination about the presence or lack of risk to the client. Example: the allegation may be verified but the circumstances do not meet the definition of abuse or neglect, i.e. "no food in the house" but adult goes out for meals. In this case the investigation would be verified; however there is no abuse or neglect.

3.2.5 Short-Term Service Planning

As the final part of the Risk Assessment, the social worker is to develop a short-term Service Plan in most situations. The short-term Service Plan documents intervention the worker will be providing during the investigative phase of the case and does not require signatures/agreement of the client or others. A short-term Service Plan must be completed if 1) the case will be opened for any social service or 2) the case will not be opened for any social service but there is some additional follow-up that is required in order to bring the investigation to resolution. Investigations that are to be closed with no case being opened typically would not require the full thirty (30) days. In development of the short term Service Plan, consideration is to be given to both the short and long term planning, including planning for eventual closure of the APS intervention, as appropriate.

a) Department Will Provide Social Services Beyond Risk Assessment

   In this situation, the short-term Service Plan is to briefly document the tasks that are to be accomplished in the immediate future. The plan should be of very limited duration, and should in no instance exceed thirty (30) days. This plan will be in effect until the Comprehensive Assessment and regular Service Plan are completed.

b) Department Will NOT Provide Social Services Beyond Risk Assessment

   In this situation the short-term Service Plan is to document the tasks that will be accomplished prior to conclusion of the investigation. A brief statement of each task is to be documented on the plan (i.e. referral for in-home services, referral for home delivered meals, etc.). Specific information regarding (a) who was contacted, (b) when contact was made, and (c) the result of the contact(s) are to be recorded on the contact screens in FACTS. In this situation, the short-term Service Plan will end at the point the assessment is approved by the supervisor and the investigation closed.

Note: The short-term Service Plan is primarily intended to be a way for the worker to document the tasks the Department has implemented/is going to implement until the Risk Assessment is completed or prior to completion of the regular Service Plan. It is part of the Risk Assessment and does not require signatures.

3.2.6 Conclusion of Risk Assessment

The final step in the investigation process is to determine, based on the information gathered, whether or not the allegations of abuse/neglect have been substantiated and if an APS/APS Preventive Services case is to be opened. The following requirements apply regarding disposition of APS investigations:

a) Consider each allegation individually and determine whether or not, based on the information gathered, the allegation can be substantiated, according to the legal definition of abuse or neglect;

b) If at least one (1) allegation of abuse/neglect has been substantiated according to the legal definition of abuse or neglect and the other three (3) criteria are met, the referral must be substantiated;

c) If abuse or neglect has not been substantiated and the client is at risk of being abused or neglected, and at least criteria A, B and C-2 are met, a Preventive case should be opened;

d) Generally, if the client meets all the eligibility criteria, the case generally will be opened for APS services. Refer to Adult Protective /Preventive Services – Ongoing for further information. Two (2) instances where all four (4) eligibility criteria are met that an APS case may not be opened include:

1. The client is in a facility, the verified abuse/neglect was limited to a perpetrator who is no longer employed with the facility and
2. The client has not been deemed to be incompetent by a court of law and is not willing to accept services;

Note: However if the client appears to be in immediate risk, court intervention may be necessary.

e) Even though the case is not opened, if the allegations are substantiated and it is not self neglect, required notifications are to be sent – (See Section 3.2 Required Notifications for detailed information);

f) Any time an individual is open in the FACTS system for multiple case types, one of which is APS (i.e. APS and AFC or APS and Guardianship), the APS case must be set up separate from any other case type. If there is an APS/Preventive investigation/case and the client is in need of guardianship, health care surrogate or adult residential placement, a Request to Receive Intake must be entered in FACTS for the appropriate service needed and an Initial Assessment must be completed. If it is determined that services will be provided, the appropriate case must be opened. Guardianship, health care surrogate or adult residential services cannot be added or opened in the APS/Preventive case in FACTS;

g) When follow-up is requested by a reporter, the social worker must follow-up with the reporter regarding the investigation within fourteen (14) days following completion of the Risk Assessment. The only information the worker can give the reporter is to advise that appropriate action is being taken and that all information obtained during the investigation is considered confidential and may not be shared; and,

h) Whenever the social worker identifies a need that can be met through community resources, the social worker must make appropriate referrals.

Note: The Summary Box should only be a narrative of the investigation. It should not include detailed information as to who was interviewed or the contents of the interview. A good example of what should be included in the Summary Box would be "Based on interviews, observation, etc. gathered during the investigation, the allegations have been (substantiated, verified, unsubstantiated, and/or unverified)."

3.2.7 Investigation Disposition Options

When the Risk Assessment is completed, all the information and findings are to be documented in FACTS. At the conclusion of the investigation and completion of the Risk Assessment, the social worker will then submit the Risk Assessment, along with their recommendation about disposition of the investigation, to the supervisor for approval. The possible dispositions available to the social worker are:

a) Close the investigation and open an APS case;

b) Close the investigation and open an APS Preventive Services case;

c) Close the investigation and refer to other resources (internal/external to Department);

d) Close the investigation with no additional action needed; or,

e) Incomplete - in some instances it will not be possible to complete an investigation (death of alleged victim, alleged victim moved to another state, after all possible attempts the worker is unable to locate alleged victim, etc.).

The disposition shall be based on all the information gathered during the investigation and completion of the Risk Assessment. From this information, the social worker will determine if the referral was "substantiated" or "unsubstantiated". This determination shall be based on whether or not the applicable eligibility criteria have been met according to West Virginia Code Chapter 9. The Code of West Virginia, §61-2-29, provides for criminal penalties for caregivers who, directly or indirectly, abuse, neglect or create an emergency situation for an incapacitated adult. Because of this it is extremely important that contact with and observations of the caregiver in an APS investigation be accurately, carefully, and thoughtfully documented. In the event the perpetrator is prosecuted as a result of a substantiated APS complaint, the social worker will, in many cases, be the primary source of evidence for the court hearing. The information documented in the case record is critical since it may be used in the court's determination about the guilt/innocence of the perpetrator, whether the crime is a felony or a misdemeanor, and the severity of the sentence imposed.

Note: When an APS case is opened for a client in an institutional or other out-of-home residential setting, a file must be opened in FACTS if one does not already exist, on the institution/facility in addition to the client file and the two (2) files must be associated within FACTS (on Referral Acceptance screen). When the provider/facility is set up it is important that it be marked as "unavailable" in FACTS unless it is a facility in which DHHR makes placements. For the purposes of APS, Adult Family Care homes, licensed assisted living settings, registered unlicensed homes, Specialized Family Care homes, I/DD Waiver homes, Medley Homes, ICF/ID Group homes, etc. are considered to be facilities. (See Appendix P Contact Information). Refer to Adult Family Care Request to Provide Policy.

3.2.8 Required Notifications

Notification letters must not be sent without the supervisor's approval of the investigation findings.

When an investigation is substantiated and the worker sends the letter in the Reports section to entities inside the Department, Notification Letter to Prosecuting Attorney or Notification Letter to Law Enforcement, a summary is to be included in the letter. This letter is to include: the client's name, address and birth date, the perpetrator's name and address, (if the abuse occurred in a facility, the perpetrator's title is to be included, i.e., CNA, RN, dietician, etc.) the name of the facility, as well as a summary of the investigation, which includes and is populated from the Allegation Findings Screen, Summary Tab, Client Response Text Box, Caretaker Perpetrator Response Text Box and Summary Comments Text Box. Information in these boxes should only be a narrative of the investigation. It should not include detailed information as to who was interviewed or the contents of the interview. Information that is not populated to this report must be completed by the worker prior to sending the letter. The Reporter's name must not be revealed in this letter.

In the investigation of Adult Protective Service referrals, there are certain circumstances where notification to parties inside and outside of the Department is required. These are:

a) Any time a referral for Adult Protective Services involving a known perpetrator is substantiated, the social worker MUST provide written notification to the prosecuting attorney (self-neglect is excluded);

   1. Use the form letter titled "Notification to the Prosecuting Attorney" for this purpose;
   2. Include in the body of the notification letter a description of the allegation(s) and investigation findings, potential witnesses, and action being requested of the court or the prosecuting attorney;
   3. The perpetrator's name and address, (if the abuse occurred in a facility, the perpetrator's title is to be included, i.e., CNA, RN, dietician, etc.) the name of the facility, as well as a summary of the investigation. In addition the worker must include the following:

a. Condition of the home;

b. Condition of the client;

c. What intervention has been attempted and the results;

d. What further intervention is needed to ensure the client's safety (if removal from the home is being recommended, where the adult will be taken to, how they are to be transported, any applicable precautions, etc.); and,

e. Any other pertinent information.

b) Any time a referral for Adult Protective Services involving a known perpetrator is substantiated, a letter will be automatically distributed by IS&C (self-neglect is excluded) to the perpetrator if complete information is entered in FACTS.

1. To accomplish this, the supervisor must approve the Allegation Findings Screen,
2. Then this information will be forwarded to IS&C automatically,
3. Complete demographic information must be entered in FACTS for the client,
4. Also, the Personnel Screen must be complete for the worker and supervisor,
5. The letter will state that the findings can be used in the future when the individual is seeking employment as a Foster Parent, Child Care Provider, Adult Family Care Provider or other professions that work with children, adults and families within and outside of DHHR
6. The letter will also notify the alleged perpetrator of their right to appeal and the process to request a grievance,
7. A pre-hearing conference must be offered to the individual to attempt to come to a resolution,
8. If a resolution cannot be achieved and the individual wants to continue with the grievance, the appropriate grievance forms must be completed and forwarded to the appropriate Hearings Office in accordance with the grievance procedure outlined in Common Chapters, Chapter 700. Refer to Personnel Common Chapters Policy

If the letter cannot be sent by IS&C with the information entered in FACTS, an Exception Report will be generated in FREDI for follow-up by the worker. If possible, the worker must resolve the issues on the Exception Report and send a manual letter. The worker and/or supervisor must check the FREDI report weekly, at a minimum.

Due to the legal nature of this letter, the content of the body of the letter must not be altered. This letter contains required information and has been approved by the Department's legal counsel. As such, FACTS will only allow the worker to make changes to the client's name and address. No other information can be altered.

Notification to the alleged perpetrator that allegations have not been substantiated may be sent to the alleged perpetrator, upon request from the alleged perpetrator. The alleged perpetrator must provide a complete name and mailing address and this information must be entered in FACTS. This letter will not be automatically distributed by IS&C, but must be manually sent by the worker upon supervisory approval. This letter is available as a DDE Report in the Reports Section of FACTS. The worker should not routinely send a letter to the alleged perpetrator when allegations have not been substantiated, but only upon request from the alleged perpetrator. The contact with the alleged perpetrator must be documented in FACTS and a copy of the letter must be recorded in Document Tracking and saved in the Filing Cabinet, with a hard copy filed in the case record.

Due to the legal nature of this letter, the content of the body of the letter must not be altered. This letter contains required information and has been approved by the Department's legal counsel. As such, FACTS will only allow the worker to make changes to the client's name and address. No other information can be altered.

c) When the substantiated abuse/neglect occurred in a facility, the appropriate written notification must be provided to the entity(s) as applicable (See Appendix P Contact Information):

1. Nursing home - OHFLAC, Medicaid Fraud, Ombudsman, and Bureau for Medical Services (Long Term Care unit);
2. Assisted living facilities, and registered/unlicensed homes - OHFLAC, Ombudsman and Medicaid Fraud;
3. I/DD Waiver homes - OHFLAC, Medicaid Fraud, and Office of Behavioral Health and Health Facilities;
4. ICF/ID Group homes - OHFLAC, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for (Long Term Care unit);
5. State Operated Mental Health or State Operated Long-Term Care Facilities - OHFLAC, Ombudsman, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for Medical Services (Long Term Care unit);
6. Specialized Family Care homes (Medley) - Bureau for Children and Families/ Medley Program Manager and Medicaid Fraud;

7. Adult Family Care home - Bureau for Children and Families regional home finding supervisor, Ombudsman, and Medicaid Fraud; and,
8. Non-residential Service providers (home health, homemaker agencies, behavioral health centers, sheltered workshop, etc.) – OHFLAC or the regulatory agency that licenses that entity, and Medicaid Fraud;
9. In addition, if it is determined that there is/appears be a pattern of allegations involving resident rights issues in a facility, a referral to the applicable regulatory agency and/or local Ombudsman should be made; and,
10. When an investigation is substantiated and the decision is reversed written notification must be sent to all individuals/entities that were previously notified of the substantiation and a copy filed in the client's record.

d) Follow-up with the reporter is permitted:

1. Only when a reporter requests that the Department provides feedback.
2. In this instance the information provided is limited to advising the reporter that the Department is taking appropriate action in the matter.
3. Details about the investigation and investigation findings are not to be shared with the reporter.
4. If the reporter is mandated to report, then a follow-up letter is required which indicates the assessment was completed and if the allegations were substantiated or not substantiated.

Note: It is not necessary to report substantiated allegations of self-abuse or self-neglect to the prosecutor, law enforcement, etc. since there is no perpetrator involved. Also, the information that may be shared with various parties may differ depending on who the notification is being sent to. (See Section 8.4 Notification to Prosecuting Attorney and Section 8.5 Notification to Entities Other than the PA for detailed information about required notifications).

e) APS Referrals That Have Been Substantiated and a Subsequent Record Check is Completed

Prior to May 18, 2006 under the "Other" Icon, Associated Referrals, and also in the Search area of FACTS on the Demo Screen, Referral Tab, verified or unverified is displayed in the Disposition Column. The user could not rely on this information to determine if the allegations were substantiated or unsubstantiated; therefore, a review of the record was required to make this determination. All referrals prior to May 18, 2006, still require a review of the record to determine if the

allegations were substantiated or unsubstantiated. Some of the screens the user would review to determine if the allegations were substantiated could be the Summary Tab on the Allegation Findings Screen; comments on the Case connect Screen, etc. However, if there is any doubt, consulting with the local Adult Services staff is recommended.

With the change of May 18, 2006 a new column was added titled "Substantiated" which displays the outcome of the referral. After May 18, 2006, if the user substantiated the allegations and entered the information correctly on the Allegation Findings Screen in FACTS, accurate information will be displayed in the "Substantiated" Column under "Other", Associated Referrals as well as in the Search Area of FACTS for all referrals received after May18, 2006. The Disposition Column is still displayed with Verified or Unverified. The user must not rely on the Disposition Column to determine if a referral has been substantiated or unsubstantiated.

SECTION 4

CASE PLAN

4.1 Service Planning

When a case is opened for a client in an institutional or other out-of-home residential setting, a file must be opened in FACTS if one does not already exist, on the institution/facility in addition to the client file and the two (2) files must be associated within FACTS (on Referral Acceptance screen). When the provider/facility is set up it is important that it be marked as "unavailable" in FACTS unless it is a facility in which DHHR makes placements. For the purposes of APS, Adult Family Care homes, Specialized Family Care homes, licensed assisted living settings, registered unlicensed homes, I/DD Waiver homes, Medley homes, ICF/ID Group homes, etc. are considered to be facilities. (See Appendix P Contact Information).

Following completion of the Comprehensive Assessment process, a Service Plan shall be developed to guide the provision of services in the ongoing stage of the case. Service Planning must be primarily directed toward remedy of the identified abuse/neglect and/or alleviating the risk of abuse/neglect to the adult. In developing a Service Plan, consideration should be given to the conditions that exist as well as the strengths/capabilities of the client and their family/significant others. Based on the circumstances that exist, it may also be appropriate to develop a plan to reduce risk and assure safety of the adult. In addition to addressing the immediate issues, consideration is also to be given to the long term planning, including preparing for eventual closure of the APS intervention, as appropriate. Service needs are to be addressed in priority order, beginning with the most urgent issues.

Development of the Service Plan is to be based on the findings and information collected during the assessment processes (i.e. Investigation, Risk Assessment, Comprehensive Assessment, and Case Review) as well as any specific requirements set forth by order of the court. Based on the information gathered, goals must be identified and set forth in the Service Plan. These will provide the milestones for assessing progress and success in the implementation of the plan. The Service Plan provides a written statement of the goals and desired outcomes related to the conditions identified through the assessment processes. Each problem area included in the Service Plan for an APS/Preventive case must directly relate to the APS/Preventive situation that exists. Problems not related to the APS/Preventive situation are not to be included.

Development of the Service Plan is to be a collaborative process between the social worker, the client, and others such as providers or legal guardian. In addition, the principle of self-determination, which is critical in intervention with adults, extends to the client's right to decide with whom they associate and who should be included in service planning for them. Those individuals who were

involved in the development of the Service Plan should also be involved in making changes/modifications to the plan.

Document the details of the Service Plan in FACTS, clearly and specifically delineating the plan components. When completed, forward to the appropriate supervisor for approval. After approval by the supervisor, a copy of the Service Plan is to be printed and required signatures obtained. Required signatures include the client or his/her legal representative and all other responsible parties identified in the Service Plan. The signed copy is then to be filed in the client record and its location documented in FACTS. A copy of the completed Service Plan is to be provided to all of the signatories.

Note: The Service Plan is available as a DDE in the reports area of FACTS and may be saved in the Filing Cabinet in FACTS and to Document Tracking.

4.1.1 Inclusion of the Incapacitated Adult in Service Planning

Inclusion of incapacitated adults in the service planning process presents the social worker with some unique challenges. Although legally determined to lack decision-making capacity, the client may have the capacity to participate in the development of the Service Plan and should be permitted and encouraged to participate in its development as well as signing of the completed document. Some special considerations for the social worker include the following:

a) When there has been a legal determination that the client lacks decision-making capacity and has a court appointed representative, the representative must be respected as the spokesperson for the client and the representative's consent must be obtained in completion of the Service Plan. If the court appointed representative is the perpetrator in the Adult Protective Services case, and is unwilling or unable to take/permit the action(s) necessary to carry out the Service Plan, that individual shall not participate in development of the Service Plan nor shall they sign the completed document. In this situation, the Service Plan must address seeking a change in the client's legal representative;

b) When the client has an informal representative (i.e. close relative or other long-term caregiver), this individual should be included in the service planning process and may sign the Service Plan. The relationship of the informal representative is to be documented in the client record;

c) When the client appears to lack decision-making capacity, but does not have a court appointed or informal representative, the social worker may complete the Service Plan without the client's consent and involvement if the primary goal in the plan is to obtain appropriate legal representation; and,

d) When a client appears to have decision-making capacity and could benefit from intervention but is resistant, it is appropriate for the social worker to try to overcome some of this resistance. Ultimately, however,

a client with decision-making capacity has the right to refuse case management services. In this situation, a Service Plan would not be developed and the APS/Preventive case is to be closed.

The situations listed above are the most likely to occur and require consideration by the social worker. Variations, however, may occur and could require consultation between the social worker and his/her supervisor to determine the most appropriate approach.

4.1.2 Determining the Least Intrusive Level of Intervention

In the provision of services to adults, the principle is well established both in law and policy that the least intrusive means of intervention should always be used. When applying this principle to individual situations there is some discretion in determining the appropriateness of the manner in which the Department intervenes in the life of the client and the level of care/assistance required in order to meet the client's needs. Intervention is to begin with the least intrusive approach that is appropriate to meet the client's needs. Intervention is to move from the least intrusive to the most intrusive option(s).

Dedication to the principle of least intrusive intervention requires a commitment to the maximum level of self-determination by the client. The client and/or their court appointed representative need to be presented with options, educated about the benefits and consequences of each, and then permitted to make decisions. The Service Plan is used to document these choices and to ensure the integrity of the decision-making process.

It is important to clearly document the efforts made to assure the least intrusive level of intervention. In the event these efforts are unsuccessful, this fact and the reason(s) they were not successful must also be clearly documented in the case record. This becomes increasingly important if legal intervention becomes necessary.

4.1.3 Required Elements – General

a) The Service Plan must contain all the following components in order to assure a clear understanding of the plan and to provide a means for assessing progress:

   1. Specific criteria which can be applied to measure accomplishment of the goals;
   2. Specific, realistic goals for every area identified as a problem, including but not limited to those identified through the Risk Assessment process. This will include identification of the person(s) for whom the goal is established, person(s)/agency responsible for carrying out the associated task(s), identification of services, and frequency/duration of services;
   3. Specific tasks which will be required in order to accomplish the goal. These are tasks or activities that are designed to help the

client progress toward achieving a particular goal and should be very specific and stated in behavioral terms (specifically stating what action is to occur i.e. Mary Samples will bathe at least once daily, Susie Provider will transport client to medical appointments as scheduled, or Kathie Harvey will attend AA meetings at least once weekly). These tasks are typically short-term and should be monitored frequently; and,

4. Identification of the estimated date for goal attainment. This is a projection of the date that the worker and the client expect that all applicable tasks will be achieved, that minimal standards associated with change will have been attained.

b) Other important considerations for the service planning process are:

1. The client's real and potential strengths;
2. Attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the Service Plan;
3. The circumstances precipitating involvement by the APS system; and,
4. Levels of motivation.

4.1.4 Developing a Plan to Reduce Risk/Assure Safety

When it is determined through the assessment process that risk factors exist which compromise the safety of the adult, the identified problem areas must be addressed in the Service Plan. When developing a plan to assure safety of the client, it is important to involve them in the discussion of the behaviors which are problematic, options for managing the behaviors and, the formalization of a plan to address the behaviors and their cause(s). In situations where it is necessary to remove the adult from their home in order to assure their safety, the following should occur:

a) Identify the conditions that establish/support the need for out-of-home placement;

b) Identify the recommended placement arrangement;

c) Describe arrangements for visitation with family and friends, including any restrictions, if applicable; and,

d) Describe the efforts that have been made to prevent out-of-home placement and the results of these efforts.

SECTION 5

CASE MANAGEMENT

5.1 Introduction

Case management is the primary service provided by the Department for clients who have been opened for Adult Protective Services or APS Preventive Services. It consists of identification of problem areas/needs, identification of appropriate services and resources to address the identified problems/needs, referral of the client to appropriate service agencies, and coordination of service delivery. It is important to note that APS case management is voluntary on the part of the client, or on the part of their legally appointed representative. Case management cannot be forced upon an unwilling client who has not been determined to be incapacitated. Case management in all Adult Protective Services is to be time-limited. APS cases are not to exceed twelve (12) months and APS Preventive Services are not to exceed six (6) months. The end goal of case management for these cases is to link clients with appropriate supportive services. Once this is accomplished, the case is to be closed for Adult Protective Services. This case management should only continue long enough for the social worker to determine that the arranged services and supports are adequate to address the client's needs and to ensure that the abuse/neglect situation has been adequately remedied.

5.2 Comprehensive Assessment

A Comprehensive Assessment must (this is documented on the Comprehensive Assessment screen) be completed for each individual whose case has been opened for Adult Protective Services/Preventive Services. In order to develop a detailed understanding of the client and their needs, the social worker must conduct a face-to-face contact with the client and complete an assessment, in addition to gathering information for the Comprehensive Assessment screen. Each individual contact is to be documented by the end of the next working day following completion of the contact. Information gathered on the Risk Assessment screen will populate forward to the Comprehensive Assessment screen in FACTS if it has been approved before the Case Connect (or information will not populate), as well as information in the Client screens. Any information that was not gathered during the Risk Assessment phase or information that has changed since the Risk Assessment was completed must be gathered in the Case Focus and documented on the appropriate screens in FACTS. (For a complete listing of information to be gathered, refer to Section 3.1 titled Information to Be Gathered in the Risk Assessment section of this policy). Completion of the Comprehensive Assessment involves interviews with the client and other significant individuals. This information will then be used as the basis for the client's Service Plan.

Note: The Comprehensive Assessment form, when printed, will reflect information from other areas of FACTS, in addition to what is documented on the Comprehensive Assessment screen in FACTS.

5.2.1 Time Frames

A Comprehensive Assessment, including the development of the Service Plan, must be completed for each individual who is opened for Adult Protective/Preventive Services. This assessment must be completed within thirty (30) calendar days following the date the case is opened. If changes in the client's circumstances occur that would impact the information documented on the Comprehensive Assessment after it has been completed in the case, these changes are to be documented within forty-eight (48) as a modification to the existing Comprehensive Assessment.

5.2.2 Conclusion of Comprehensive Assessment

When the Comprehensive Assessment is completed, all the information and findings are to be documented in FACTS. This, along with the Service Plan that was developed as a result of the assessment findings, is then to be submitted by the social worker and approved by the supervisor within thirty (30) calendar days after the case is opened. Areas that were identified as problem areas on the Risk Assessment that have not been completely resolved are to be addressed on the Service Plan.

5.3 Out-of-Home Placement Considerations

Due to physical and/or mental incapacities, some clients may be unable to reside in their own home, even with provision of a variety of supportive services. When this occurs the social worker must evaluate the client's circumstances and needs to assist in arranging the most appropriate, least restrictive placement alternative. Options to consider, in the order of least to most restrictive, include the following:

a) Placement with a relative, friend, or other interested party (with or without supportive services);

b) Adult Family Care; Refer to Adult Family Care Request to Receive Policy;

c) Adult Emergency Shelter Care Home (if placement needed on short-term, emergency basis);

d) Specialized Family Care Home;

e) Assisted Living facility;

f) I/DD Waiver Home;

g) ICF/ID Group Home;

h) Nursing Home; or

i) State Operated Behavioral Health Facility.

5.4 Administrative Processes

5.4.1 Do Not Resuscitate (DNR) Order

A do not resuscitate order (DNR) is a physician's order, issued by a physician licensed and authorized to practice in the state of West Virginia. The order specifically states that cardiopulmonary resuscitation should not be administered to a certain person. The requirements related to issuing a do not resuscitate order are contained in West Virginia Code §16-30C-1 et. seq..

In situations where the Department has been legally appointed to act as guardian for the protected person, or has been appointed to serve as health care surrogate, the decision of whether to sign a DNR should not be taken lightly. The decision to sign a DNR must be made on a case by case basis and staffed with the supervisor. Careful consideration should be given to the guardian's/health care surrogate's knowledge of the client and their expressed wishes. In addition, if the client has been placed with a care provider, particular attention should be given to the provider's input. **In no instance is the Department to routinely sign DNR orders.**

When a DNR is being considered or has been requested by the attending physician, the social worker must consult the medical professional(s) to gather applicable information about the client's medical/physical condition, prognosis for improvement, impact of health condition on quality of life, etc. Consultation should also include the care provider. Approval must be staffed with the supervisor prior to a DNR being signed by the social worker. Whenever the decision of whether or not to sign a DNR is in question, the social worker is strongly encouraged to consult with the Ethics Committee in the facility where the adult resides if applicable and/or the Social Services Ethics Committee of the Bureau for Children and Families. The Bureau for Children and Families Committee assists in resolving ethical problems in client care through the use of an Ethics Consultation Service (ECS) which is a sub-committee of the Social Services Ethics Committee.

Note: In certain instances, only one physician is required to do a DNR. These are:

a) When the individual has capacity and authorizes their attending physician to do a DNR, and

b) When the individual is incapacitated but has a legal representative or health care decision-maker who authorizes the attending physician to do a DNR.

The opinion of a second physician is required when:

a) The individual is incapacitated and there is no representative or health care decision maker available, or

b) The patient is a minor child under the age of sixteen (16).

5.4.1 Organ Donation

Organ Donation is an end-of-life decision that can be written in an Advanced Directive (i.e. Living Will), indicated on an individual's driver's license, through the Center for Organ Recovery and Education or simply made known by the individual's expressed wishes. It is essential that the worker discusses organ, tissue, and/or body donation with the client and family prior to the client becoming deceased. It is recommended that the worker make every attempt to obtain the client's wishes in writing. If the Department is guardian, the Adult Service worker will need to gain approval from the supervisor for an organ donation and then make an official request through the court for permission to proceed. If the wishes of the protected person are not known regarding organ, tissue, or body donation, donation will not be authorized by the Department. In this instance an Ethics Consult can always be requested if there are any questions that arise from family and/or interested parties concerning this decision.

There are hospitals in designated regions that serve CORE as a referral site for potential donors. Five of the hospitals also perform life-saving organ transplants. Of those listed they are Allegheny General Hospital, Charleston Area Medical Center, Children's Hospital of Pittsburgh, University of Pittsburgh Presbyterian Hospital and the Veteran's Administration Pittsburgh Health System. You may contact CORE at 1-800-DONORS-7. The lines are answered 24 hours a day.

5.4.2 Uniform Power of Attorney

A Uniform Power of Attorney is a power of attorney by which an individual (principal) designates another person to act as their representative (attorney in fact). The Uniform Power of Attorney specifies the areas in which the attorney in fact can exercise authority. In the event the principal becomes incapacitated, the Uniform Power of Attorney remains in effect. The requirements related to the creation of a Uniform Power of Attorney are contained in §39-4-1 et. seq. of the West Virginia Code.

Under this Uniform Power of Attorney Act, Adult Protective Services can ask for an accounting of transactions made by the agent on behalf of the client. The agent must provide the information within thirty (30) days or must provide in writing why they need an additional thirty (30) days. If the agent fails to provide the requested information within the allotted time frame, Adult Protective Services may file a petition with the court.

Under the Uniform Power of Attorney Act, if the client is incapacitated and does not have a guardian, conservator, co-agent or successor agent and the agent resigns as the Power of Attorney, they must notify the client's caregiver, and another person reasonably believed to have sufficient interest in the client's welfare or Adult Protective Services. For further information on the Uniform Power of Attorney Act refer to §39-4-1 et. seq. of the West Virginia Code.

5.4.3 Health Care Surrogate

A health care surrogate is a person selected by a qualified physician or advanced practice nurse to make health care decisions only, about and on behalf of the incapacitated person. A health care surrogate can be appointed without review by the court and can usurp a client's right to make health care decisions about him/her. The health care surrogate may make decisions regarding giving, withholding, or withdrawing informed consent to any type of health care, including, but not limited to, medical and surgical treatments, including life-prolonging interventions, psychiatric treatment, nursing care, hospitalization, treatment in a nursing home or other health care facility (Examples: Assisted Living Residence, ICF/ID), home health care, and organ or tissue donation. The authority of the health care surrogate shall cease upon a determination that the person is no longer incapacitated or the health care surrogate is no longer willing or able to serve.

West Virginia Code sets forth the provisions regarding the termination of a health care surrogate appointment in §16-30-5(d). In order to terminate a Health Care Surrogate appointment based on the fact that the individual has regained capacity requires a certification of this by one (1) of the following:

a) Two physicians, one of whom may be the attending physician;

b) One physician and a qualified psychologist; or

c) One physician and an advance nurse practitioner. (See §16-30-22(c))

d) Refer to Health Care Surrogate Policy for detailed information about appointment/termination of Health Care Surrogate appointments.

Decisions made by a health care surrogate, though made by a person other than the incapacitated adult, are intended to be in accordance with the expressed values and wishes of the incapacitated persons. If the values and wishes of the incapacitated adult are not known, the decisions made are to be in the person's best interest with the worker receiving input from the care provider or friends and family.

West Virginia Code sets forth the provisions regarding the appointment of a health care surrogate in §16-30-1 et seq., also referred to as the West Virginia Health Care Decisions Act. The intent of this law is to create a process by which health care decisions can be made for incapacitated adults without involvement of the court. The primary advantage of having a health care surrogate is that needed medical care and services for an Adult Services client can be obtained more quickly through this type of appointment than would be possible through 1) obtaining an Order of Attachment or 2) appointment of a guardian. The disadvantages are that 1) since a single physician or advance practice nurse can make the determination that a person is incapacitated and that a health care surrogate is needed, without review by a court or other body, medical treatment may be forced upon the individual, and 2) with the appointment of a health care

surrogate, there are no provisions specifically set forth regarding the appointment of a guardian ad litem to represent the interests of the incapacitated adult.

Note: If an individual is having a health care surrogate appointed in order to authorize provision of psychiatric treatment, two (2) physicians or a physician and a psychologist must evaluate the individual and determine that a health care surrogate is needed.

In situations where a court has ruled a client to be mentally incapable of standing trial for the crimes they have committed and remanded to the State Hospitals of Sharpe, Mildred Mitchell Bateman Hospital and State operated long term care facilities which include Jackie Withrow Hospital, Hopemont Hospital, Lakin Hospital, Marion Health Care Hospital, and Welch Emergency Hospital; and if all attempts with family/friends for possible HCS appointment have been explored and there is no one else, DHHR CANNOT deny HCS services to anyone in any of these facilities according to The West Virginia Health Care Decisions Act contained in Article 30, Chapter 16 of the West Virginia State Code. Our role is the same as with any other HCS client, we make medical decisions only. Refer to the Health Care Surrogate Policy.

5.4.4 Living Will

Any mentally competent adult may at any time execute a Living Will. This document is used for the purpose of stating, in advance, an individual's wishes regarding the withholding or withdrawal of life-prolonging intervention from him/her. Creation of a Living Will is an administrative procedure. Though an attorney may assist in preparing this document, this is not required. The requirements related to the creation of a Living Will are contained in §16-30-1 et. seq. of the West Virginia Code, the "West Virginia Health Care Decisions Act".

5.4.5 Medical Power of Attorney

A Medical Power of Attorney is a Uniform Power of Attorney by which any person (the principal) designates another person (the representative), in writing, to make health care decisions for them in the event they are unable to do so. In addition, the Medical Power of Attorney may be used to nominate a conservator or guardian to be considered by the court if protective proceedings are initiated after the Medical Power of Attorney becomes effective. Requirements related to the creation of a Medical Power of Attorney are contained in §16-30-1 et. seq. of the West Virginia Code.

5.4.6 Power of Attorney

A power of attorney is a document by which one person, as principal, appoints another person as his agent (attorney in fact) and confers upon him the authority to perform certain specified acts or kinds of acts on behalf of the principal. This type of power may or may not grant medical decision making authority to the agent. The statutory basis for this is contained in West Virginia Code §39-4-1.

5.4.7 Representative Payee

Appointment of a representative payee is an administrative action that may be voluntary but which can be obtained, if necessary, without the individual's consent. This is an individual designated by the Social Security Administration to manage Social Security and/or Supplemental Security Income benefits in instances where the beneficiary is physically and/or mentally incapable of managing these benefits. A representative payee is also required by law (1631 (a) (2) of the Social Security Act) for an individual who has been determined to be a drug addict or an alcoholic. While the appointment of a representative payee does not require court action, it does restrict the individual's rights.

The representative payee that is appointed has control over the Social Security and/or SSI benefit check and is responsible for receiving the payment and using the funds to meet the beneficiary's needs. There does not need to be a finding of incompetence by a court in order to establish a representative payee. Medical evidence from a physician may be used if the physician determines that the beneficiary is not capable of managing his/her benefits. The Social Security Administration can appoint anyone it chooses to be representative payee. This means that the Social Security Administration is not required to name court appointed guardians or conservators to serve as the payee.

The Social Security Administration may be unable to locate a person willing to serve as representative payee. If no relative, friend or neighbor is willing to accept this responsibility, the social worker may be able to assist in the recruitment of a payee, through the use of volunteer services or appropriate community resources such as local mental health facilities, service clubs, or church groups. In the event no representative payee can be found or the appointed payee can no longer serve, the Social Security Administration may hold the client's benefits. This may result in the client not having access to his/her resources for a period of time. When an adult is in a placement setting, the residential provider may be named to serve as the representative payee if there is no one else. **In no instance is the Department to be named as representative payee for any adult benefits.**

Since a judgment of incompetence by a court is not required for payee appointment, this procedure may appear to be a relatively simple solution in an Adult Service situation. However, it is important to remember that this does limit the client's rights without a review by the court. The beneficiary does have the right to protest the appointment of a representative payee and is entitled to an administrative hearing on the question.

Note: While typically representative payees are assigned for the management of Social Security benefits, the Veterans Administration also provides for the assignment of a representative payee to manage Veterans' benefits when this is needed.

5.5 Confidentiality

5.5.1 Confidential Nature of Adult Services Records

Refer to Personnel Common Chapters Policy Legal provisions concerning confidentiality have been established on both the state and federal levels. In federal law, provisions are contained in the Social Security Act and the federal regulations promulgated related to implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA See Appendix V). On the state level, provisions related to confidentiality related to Adult Protective Services cases are contained in §9-6-8 and Chapter 200 of the Department of Health and Human Resources, Common Chapters. Anonymous reporters will be encouraged to give their names to facilitate the investigation process. Requests for confidentiality of the reporter will be honored to the extent allowed by law.

5.5.2 Access by Adult Protective Services to Protected Health Information of Alleged Victims

Under the federal regulations related to implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), disclosure of protected health information is permitted, with or without the alleged victim's consent, if the sharing of this information is related to reporting of abuse/neglect, or is necessary to comply with state requirements related to conducting Adult Protective Service investigations (§45 CFR 164.512(c)(i). See Appendix V for more information.

5.5.3 When Confidential Information May be Released

All records of the Bureau For Children and Families concerning an Adult Protective Services client shall be kept confidential and may not be released except as follows:

a) A copy of any substantiated report of abuse, neglect, or emergency situation involving a perpetrator shall be provided in writing to the prosecuting attorney, and in the case of death, to the appropriate medical examiner or coroner's office. Substantiated cases of self abuse and/or neglect do not need to be reported to the prosecutor unless court action becomes necessary;

b) All other reports of abuse and neglect shall be maintained by the Department and shall be made available, upon request, to the prosecuting attorney and any law enforcement agency; and in reports involving facilities, to the appropriate licensing body within the Department (See Section 3.1 Risk Assessment; Section 3.2 Required Notifications; Section 2.15 Corrective Action Planning - Facilities for specific information about what information is shared and with whom);

c) Specific information may be shared with other offices within the Department of Health and Human Resources who are also mandated to maintain client confidentiality (i.e. Medicaid Fraud, OBHS, and OHFLAC). When specific information is requested, the worker must

consult with the supervisor prior to releasing any information. If there is a question concerning the request, the supervisor will consult with the Adult Services Consultant and/or regional attorney per regional protocol;

d) According to state statute the Ombudsman is to receive a carbon copy of all Adult Protective Service Reporting Forms that are submitted by mandated reporters involving certain long-term care facilities (nursing homes, assisted living facilities, registered unlicensed homes). With the exception of reporter information which is only disclosed to Adult Protective Services, both the Department and the Ombudsman have received exactly the same information when this form is used. Discussion of the content of the report itself is not a breach of confidentiality. Beyond discussion of this information however, only certain information may be shared with the State and local Ombudsman. This information is limited to 1) the name of the facility where the abuse/neglect occurred, 2) general information about the nature of the allegations, and 3) whether or not abuse/neglect of an adult was substantiated. Specific information regarding the Adult Protective Service case is confidential and shall not be released, including but not limited to the name of the client and the name of the reporter. Please refer to Appendix X Memorandum of Understanding for further clarification regarding information that may be released. (See Section 3.1 titled Risk Assessment; Section 3.2 Required Notifications; and Section 2.15 Corrective Action Planning-Facilities for detailed information);

e) Information about developmentally disabled adults who are the subject of abuse/neglect may be shared with West Virginia Advocates (WVA) , the recognized protection and advocacy agency for West Virginia under federal law, §42 USCA 15043 under certain circumstances. They too must agree to keep all information shared confidential. For more information on §42 USCA 15043 see Appendix V;

f) In addition, a circuit court or the Supreme Court of Appeals subpoenaing the records. The court shall, before permitting use of the records in connection with any court proceeding, review the records for relevancy and materiality to the issues in the proceeding. The court may issue an order to limit the examination and use of the records or any part of the record;

g) A grand jury, by subpoena, upon its determination that access to the records is necessary in the conduct of its official business;

h) The victim; and,

i) The victim's legal representative, unless he or she is the subject of an investigation.

In addition, summaries concerning substantiated investigative reports of abuse, neglect or exploitation of adults may be made available to:

1. Any person who the Department has determined to have abused, neglected or exploited the victim.
2. Any appropriate official of the state or regional long-term care ombudsman investigating a report of known or suspected abuse, neglect or exploitation of a vulnerable adult.
3. Any person engaged in bona fide research or auditing, as defined by the Department. However, information identifying the subjects of the report may not be made available to the researcher.
4. Employees or agents of an agency of another state that has jurisdiction to investigate known or suspected abuse, neglect or exploitation of vulnerable adults.
5. A professional person when the information is necessary for the diagnosis and treatment of, and service delivery to, a vulnerable adult.
6. A Department administrative hearing officer when the hearing officer determines the information is necessary for the determination of an issue before the officer.

The identity of any person reporting abuse, neglect or exploitation of a vulnerable adult may not be released, without that person's written consent, to any person other than employees of the Department responsible for protective services or the appropriate prosecuting attorney or law-enforcement agency.

5.5.4 Conditions that apply when considering whether or not information may be shared with West Virginia Advocates are as follows:

a) WVA does have authority under federal law to investigate allegations of abuse/ neglect involving individuals with developmental disabilities if the incident is reported to WVA or if there is probable cause to believe that the incidence occurred;

b) WVA shall have access to all records within three (3) days for 1) any developmentally disabled individual who is a client of WVA if they or their legal representative has authorized WVA to have access, 2) any individual with developmental disability in a situation where the individual (a) is unable to authorize WVA to have access, (b) does not have a legal representative or the state is legal guardian and (c) a complaint has been received by WVA or WVA has probable cause to believe the individual has been subject to abuse/neglect;

c) When a request for access to the record is made based on probable cause, the basis for probable cause should be made known to DHHR prior to access of the record;

d) WVA shall have immediate access (within twenty-four (24) hours of request) without consent to the records of the developmentally disabled individuals who meet the above criteria if WVA determines there is probable cause to believe the health or safety of the individual is in serious and immediate jeopardy or in the case of death of the individual; and,

e) If the entire record is requested, relevant case information may be copied (with the exception of the reporter's identity) and a reasonable charge may be assessed by the local DHHR to cover the time and cost involved in the duplication and mailing of the material.

Note: The name of the reporter is considered to be confidential information and is not to be shared at any time except a) when notifying the prosecuting attorney of a substantiated referral, b) when notifying law enforcement of a substantiated referral unless the reporter had requested to remain anonymous, or c) under order of the court.

5.5.5 When Information is Released to the Courts

In many instances courts will seek information for use in their proceedings. The process by which a court commands a witness to appear and give testimony is typically referred to as a subpoena. The process by which the court commands a witness who has in his/her possession document(s) which are relevant to a pending controversy to produce the document(s) at trial is typically referred to as subpoena duces tecum.

Records shall be released to a court only upon receipt of a valid subpoena duces tecum or court order. Immediately upon receipt of a subpoena or subpoena duces tecum the social worker must consult with the supervisor. The supervisor will follow regional protocol to determine the appropriate action. Contact with the regional attorney may be necessary to determine if further assistance or review is necessary.

If there is insufficient time to consult the regional attorney, seek the advice of the local prosecuting attorney. If there is insufficient time to obtain legal advice from either the regional attorney or the local prosecutor prior to the hearing, the Department must comply with the subpoena or the subpoena duces tecum. Failure to do so may result in the social worker or the Department being held in contempt. Also, the Department should always comply with an order of the court unless that order is amended by the court or over-turned; and, the statutes further permit the circuit court or supreme court of appeals to subpoena the case record, but shall, before permitting their use in connection with any court proceeding, review them for relevancy to the issues being addressed in the proceeding and may, based upon that review, issue an order to limit the examination and use of the information contained in the case record.

Note: Consultation with the regional attorney and/or prosecuting attorney must not be documented in the FACTS case record/hard copy client file. However, if the regional attorney and/or prosecuting attorney represented Adult Protective

Services in court proceedings, only their attendance can be entered in the FACTS case record/hard copy client file.

5.5.6 Electronic Communication

Electronic communication regarding confidential client information is forbidden between DHHR staff and outside community agencies. Any agency within DHHR has access and it is acceptable to e-mail confidential client information. It is also forbidden to text confidential information or take client pictures utilizing a communication device that is not agency approved (this includes your own personal cell phone, camera, etc.).

Any agency/client information including general statements must not be posted on any social networking site such as Facebook, My Space, Twitter, Linked In, Blogs, etc.

Additionally, no videotaping/pictures of clients is permitted on social network sites, such as You Tube.

It is permissible to photograph clients using approved agency equipment in certain situations. Client and/or guardian permission is required prior to being photographed. Some examples may include:

- Documentation of physical injuries; and,
- Environmental conditions.

5.5.7 Conflict of Interest

To avoid any conflict of interest and ensuring optimal client services, the Adult Service staff should inform their supervisor immediately upon discovering that a friend, relative, or current/former co-worker, and anyone with close ties to the worker has been assigned to him/her for investigation or as an ongoing case. Upon this disclosure the supervisor has the discretion to transfer the case to another worker (and in some instances to another county) and restrict the case for limited access. The supervisor will then be responsible for informing their Social Service Coordinator and/or Community Service Manager of this issue per regional protocol.

In addition, Adult Service staff should not solicit or accept any monetary gain or gifts for their services to the client other than their salary and benefits paid by the Department.

5.5.8 Subpoenas, Subpoena duces tecum & Court Orders

The Department may be requested by the court or other parties to provide certain information regarding Adult Services cases with which we have/have had involvement. The various mechanisms that may be used are:

a) Subpoena,

b) Subpoena duces tecum,

c) Court order

Upon receipt of any of these, the Department MUST respond. Failure to comply is contempt of court and could result in penalties.

A subpoena commands a witness to appear to give testimony while a subpoena duces tecum commands a witness, who has in his/her possession document(s) that are relevant to a pending controversy, to produce the document(s) at trial. Subpoenas may be court ordered or administrative (ordered by a party other than the court). Though all subpoenas must be responded to, the manner in which this response occurs is somewhat different dependent on who issues the subpoena.

1. Court Ordered Subpoenas

   These include subpoenas issued by the circuit court, the magistrate court or the mental hygiene commissioner. There may be times when a questionable court order or a subpoena requesting that confidential information be provided is received. In this event, the social worker must advise his/her supervisor immediately and promptly refer the matter to the appropriate regional attorney for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the regional attorney. In the event there is not sufficient time for the regional attorney to become involved in the situation prior to the scheduled hearing, the Department should request a continuance until such time as legal representation can be arranged. If a continuance is not granted, the Department should comply with the subpoena or court order.

2. Administrative Subpoenas (not DHHR issued)

   These include subpoenas issued by an attorney or administrative law judge (other than a DHHR administrative law judge). These subpoenas generally request that the social worker appear to provide testimony and/or produce the case record. The social worker should advise his/her supervisor immediately and promptly refer the matter to the appropriate regional attorney for review and possible legal action, including filing a motion to quash. The locally established protocol is to be followed whenever a referral is being made to the regional attorney. The Department is to respond to the subpoena by certified mail advising the issuing party that the requested information is confidential and cannot be provided in accordance with §9-6-8 of the West Virginia Code. In the event the Department is ordered to appear even after being advised that information may not be released, the Department should comply with the subpoena and appear but testimony must be limited to advising those present that the requested information is confidential and cannot be provided in accordance with §9-6-8 of the West Virginia Code.

3. Administrative Subpoenas Issued by DHHR (Refer to Appendix Q).

   These subpoenas are issued by the Department in order to obtain information regarding the location of an adult who is the subject of an allegation of abuse or neglect. Prior to issuing this type of administrative subpoena, every attempt should have been made to obtain the needed information through other means. Should an administrative subpoena of this type be needed, the following steps are to be followed:

   a. Contact the Community Services Manager to initiate this process and arrange for service delivery by certified mail or service of process or both under the name of the Community Services Manager. Personal service should be done by a county sheriff or professional process server and should not be attempted by Department staff;

   b. If the information requested is provided, no further action is needed;

   c. If the entity/individual fails to respond or refuses to provide the requested information, the Community Services Manager is to contact the Secretary for DHHR, explain the circumstances in which the information is being sought and the response received, requesting to be designated with the authority to invoke the aid of the circuit court to require the production of the requested information;

   d. Once the Community Services Manager is designated, they should contact the county prosecutor and request that they file a petition before the appropriate circuit court to compel the provision of the information being sought; and,

   e. If the prosecutor is unable or unwilling to assist, contact the regional attorney as soon as possible.

5.6 Exceptions to Policy

In some circumstances exceptions to policy may be requested. Exceptions will be granted on an individual case by case basis and only in situations where client circumstances are sufficiently unusual to justify the exception. However, such exceptions are to be requested ONLY after other methods and/or resources have been exhausted. In that event, requests must be submitted as a policy exception in FACTS. The policy exception request is to be submitted by the social worker to the supervisor. Upon supervisory approval, the request will be forwarded to the appropriate individual for final approval/denial. Policy exception requests must include:

a) Explanation of why the exception is requested;

b) Alternate methods resources attempted;

c) Anticipated impact if the policy exception is not granted;

d) Efforts to resolve the situation;

e) Information supporting the request;

f) The time period for which the exception is being requested; and,

g) Other relevant information.

In an emergency situation, the request for a policy exception may be made to and approved by the Adult Services Consultant and/or Program Manager, or designee verbally. Once verbal approval is granted, the request for policy exception and all supporting information must be entered in FACTS.

5.7 Payment by the Bureau for Children and Families

Generally the Bureau for Children and Families does not pay for services provided as a result of an Adult Protective Services case. There are certain situations, however when the Department may consider authorization of payment in APS cases. The following sections detail the specific requirements related to authorization of payment.

5.7.1 Court Ordered Payments - General

There are certain instances when the Department is ordered by the court to make payment on behalf of an APS client. Whenever the Department is court ordered to pay for services or fees, the client's Service Plan must address the efforts being made to obtain/access resources for the client so he/she may assume this responsibility. Additionally, the worker **will** object when the Department is court ordered to pay for services so their objections are noted in the court order. Worker will consult with their supervisor and follow regional protocol in regard to contacting their Regional Attorney.

In cases where the Department has been court ordered to make payment, the Department should only be considered when the client does not have, will not use, or cannot use resources of his/her own to cover the costs. Whenever possible, the client is expected to use his/her resources when these exist or can be obtained. Additionally, part of the social worker's responsibility is to inform the court of resources available or potentially available to the client that may be used for this purpose. When appropriate, the social worker should also request that the court order address reimbursement to the Department by the client for the cost of services provided at such time as the client's resources become available (i.e. sale of real estate to generate funds to provide for the client's needs).

5.7.2 Court Ordered Payments - Required Procedures

Payment by the Department of guardian ad litem fees is limited to APS cases involving the Department seeking an Order of Attachment. In these instances, the Department may be court ordered to pay the associated fees. Whenever the client does have resources to pay these fees, the social worker is to request that the court require the client to assume financial responsibility for these costs.

If the Department is required by court order to pay guardian ad litem or other fees, the request for payment is to be submitted, in writing, to the appropriate Regional Adult Services Field Consultant for approval within six (6) months of occurrence. Specifically, the attorney is to submit an invoice and required documentation to the social worker. The social worker reviews the material submitted to verify accuracy and completeness and then, upon approval by the supervisor, forwards the request for payment to the appropriate Regional Adult Services Field Consultant. Once approved by the field consultant, the payment request is to be forwarded to the Bureau for Children and Families, Finance and Administration for processing of the payment. In addition to the written request, the following documentation must be provided by the worker:

a) Cover memo stating that the client is an active recipient of Adult Protective Services;

b) Court order which 1) has an embossed court seal, 2) has been signed by the judge, and 3) specifically states what costs the Bureau for Children and Families is required to pay; and,

c) Itemized invoice that meets the following requirements:

1. Is on the guardian ad litem/provider's letterhead;
2. Contains the FEIN or social security number of the guardian ad litem/provider;
3. The total amount invoiced is identified and matches the amount specified in the court order;
4. The specific amount(s) invoiced shall not exceed the current rates established by the public defender's office; and,
5. In order to request reimbursement for this type of expense, it should be completed within six (6) months after the hearing.

Note: In addition, worker may also open another case as a Request to Receive intake for other services, such as state approved Adult Residential placement, etc. (payment is to be made at the DHHR established rate).

A Guardianship case may at times result from APS intervention. Please note, a separate guardianship case must be opened and the Department **will** not pay for court appointed counsel to the protected person in guardianship proceedings. This payment, by statute is to be paid from the estate or by the state Supreme Court. See Appendix WV State Code §44A-1-13 for further information.

Fees related to the filing of a petition for guardianship may only be paid from a guardianship case. It cannot be paid out of an APS or Health Care Surrogate case. It can be paid if the primary case type is Adult Residential **IF** the secondary case type is Guardianship. A demand payment should be issued from the guardianship case within the six (6) months of occurrence within the time frame for all payments to be reimbursed.

5.7.3 Emergency Hospital/Nursing Home Placement for APS Clients

Occasionally, it becomes necessary to arrange for placement in a hospital or nursing home of an Adult Protective Services client for whom Medicaid eligibility has not yet been established. If the nursing home or hospital will not admit the client pending Medicaid approval and if there are no other available resources, the Bureau for Children and Families may authorize payment for the hospital or nursing home care for a brief period of time until Medicaid eligibility can be determined or other appropriate funds are obtained.

State Statute §9-6-6 permits payment by the Department in these instances. This option may be considered only under the following limited circumstances:

a) When abuse/neglect has been substantiated;

b) Prior to permanent placement, hospital admittance may be required to determine client's level of care. When it has been determined that the adult appears to meet nursing home eligibility criteria, worker will need to check to see if a Pre Admission Screening-2000 (PAS-2000) has been approved within the past sixty (60) days. If not, a PAS-2000 will have to be completed and approved prior to placement;

c) When there are no other available resources to assure the client's safety; and,

d) When it is determined by the social worker and their supervisor that this is the only way to ensure the victim's safety until permanent arrangements for their care can be made.

1. Approval for Emergency Hospital/Nursing Home Placement

   Placement of an active APS client in a hospital and/or nursing home at the Department's expense shall be considered only when all other options have been exhausted and this is being considered as a last resort to ensure the client's safety. Prior approval for payment of placement for an APS client must be obtained from the Regional Adult Services Field Consultant prior to placement. After verbal and/or written approval is obtained from the Adult Services Field Consultant, the social worker must submit a Policy Exception request in FACTS. All requests for payment by the Department for placement are to be time limited and, except in extraordinary circumstances, are not to exceed thirty (30) days. Any time payment by the Department beyond the initial approved thirty (30) day time frame is necessary, a second Policy Exception request for an additional thirty (30) days must be submitted with a detailed explanation of why an extension is needed. This request must be submitted prior to the expiration of the initial thirty (30) day time frame and payment should be requested within six (6) months of approval. During this time, the worker needs to assist client with acquiring Medicaid for the client.

The initial and subsequent policy exception requests must include the following information, at a minimum:

a. Client name;

b. Explanation of why hospital/nursing home placement is needed;

c. Amount of available financial resources;

d. Other options explored/considered and reason(s) each was ruled out;

e. Name of hospital/nursing home where client is to be placed;

f. Length of stay at Department expense being requested - except in very extraordinary circumstances, not to exceed thirty (30) days;

g. Plans for arranging for alternate placement/securing alternate funding for placement ;

h. Whether an application for other resources have been made such as Medicare, Medicaid, Social Security, Veteran's benefits, private funds/benefits, etc.; and,

i. Other relevant information.

There are two (2) situations where it may not be possible to submit a verbal and/or written request and obtain a response from the Regional Adult Services Field Consultant prior to placement. These are:

a. If the need occurs during non-work hours; and,

b. If the need occurs during normal work hours but the emergency situation is so serious that immediate action must be taken.

In the first instance listed, the supervisor/program manager may temporarily grant approval with a verbal and/or written request for approval to be submitted to the Regional Adult Services Field Consultant immediately upon return to the office. In the second instance listed, the supervisor may make a verbal request to the Regional Adult Services Field Consultant for payment of hospital/nursing home placement. If granted, the written request, including a description of the emergency situation that prompted the verbal approval, in addition to the information listed above, must be submitted to the Regional Adult Services Field Consultant upon the social worker's return to the office.

If approval for the policy exception is granted, the worker must diligently seek an alternate payment source for the client's cost of care. Examples of this include, but are not limited to, facilitating a Medicaid application, determining the client's monthly income and assets and who is the appropriate individual to authorize payment to the hospital/nursing home. Depending on the circumstances, the worker may need to request change of payee to the nursing home or file a petition for the Sheriff to be appointed as Conservator in order to access client's

income and/or assets. Also, during this thirty (30) day time period, the worker must make getting an approved PAS-2000 a priority.

Note: The role of the Regional Adult Services Field Consultant in these instances is for authorization of short-term payment for the emergency placement of an adult in the hospital/nursing home as a result of an Adult Protective Services investigation. Invoices from the hospital/nursing home for these placements will not be submitted by the Regional Adult Services Field Consultant to the Finance and Administration for reimbursement until written documentation to support the invoice has been received by the Regional Adult Services Field Consultant.

2. Invoicing for APS Hospital/Nursing Home Placement

   To receive reimbursement for emergency hospital/nursing home placement of an APS client, the hospital/nursing home must submit an original invoice. The invoice must contain the following information, at a minimum:

   a. Client name;

   b. Name of facility;

   c. Signature of individual authorized by the facility to submit invoices;

   d. Statement of daily rate for room and board (not to exceed the approved Medicaid rate);

   e. Date(s) of service (except in extraordinary situations, should not exceed thirty (30) days, dates of service on the invoice should match the dates reflected in the approved request for payment); and,

   f. Total amount due.

Invoices are to be submitted through the social worker and his/her supervisor to the Regional Adult Services Field Consultant for approval and processing within six (6) months of service. As part of this submission the social worker is to prepare a cover memo that indicates the date that the Regional Adult Services Field Consultant approval was granted and the period of time that was covered by the approval.

Note: WV-DHHR is to be invoiced for the payment amount, not the individual DHHR worker or county office.

5.7.4 Special Medical Authorization

Most adults who are served through Adult Protective Services will have or be eligible for some type of medical insurance coverage. If the client does not have coverage for necessary medical care, (prescriptions and limited doctor visits) the social worker must thoroughly explore all potential options for securing appropriate medical coverage. (Examples include, but are not limited to, DHHR

Income Maintenance Services, Social Security, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc.). If, after this exploration, an active Adult Protective Services client requires medical services for limited doctor services, prescriptions, chuxs and disposable briefs and does not have the resources available to obtain them, a Special Medical Authorization may be requested to cover the cost of eligible services at a rate not to exceed the current Medicaid rate. For clients that are sixty-five (65) years of age or older, the Special Medical card will not cover any prescriptions that are covered under Medicare Part D, regardless of whether the client is enrolled in or receiving Medicare Part D; therefore, the Special Medical Card must not be issued for any prescriptions covered by Medicare Part D.

Eligibility for Medicare Part D is based upon the following:

a) The individual must be receiving either Medicare Part A or B. To be eligible for either Medicare Part A or B, the individual must be sixty-five (65) years of age OR, if under sixty-five (65) years of age, the individual must be receiving disability Social Security benefits and must have been receiving disability Social Security benefits for two (2) years.

b) Lack of resources means that:

    1. The client does not have funds to pay for medical care;
    2. Is not eligible for any type of medical coverage; or,
    3. Is eligible for medical coverage but benefits are not currently available (recent application is not yet approved for coverage), with the exclusion of Medicare Part D.

The Special Medical Authorization may be used to cover certain medical costs. However, all Medicaid eligible services are not necessarily covered by this authorization. The Special Medical Authorization is to be used to provide for limited doctor visits and prescriptions needed to treat an emergency or to prevent a medical emergency from occurring. Examples of costs that are typically covered are medication and limited doctor visits, chuxs and disposable briefs. **Examples of costs not covered include emergency room, hospitalization, nursing home placement, psychiatric/behavioral health services/treatment, dental work, corrective eye glasses, outpatient surgery, diagnostic testing, etc.**

To request the Special Medical Authorization, the worker must prepare the request in FACTS and submit it to the supervisor for review and approval. When requesting a Special Medical Authorization, the following information must be documented in FACTS:

a) Client's goal related to providing the requested services;

b) List the specific service(s) payment is being requested for and the associated cost(s) (cannot exceed current Medicaid rate);

c) Statement of verification that all potential resources have been explored and there are no other resources available to meet the cost;

d) Anticipated duration of request (not to exceed thirty (30) days);

e) Name of provider;

f) Client income amount and source; and,

g) Any other relevant information.

Ideally this information should be documented in summary form as a contact, "other" type, in addition to documentation, as appropriate, in other areas of FACTS (i.e. income information would also be recorded on Income screens; information related to goals would be documented on the Service Plan screens, etc.).

Note: In a situation where a client needs services from more than one vendor (i.e. an office visit with a physician and prescriptions from a pharmacy) a separate Special Medical Authorization request will be required for each vendor.

h) If Approved

Once approved by the supervisor, the worker will print a copy of the Authorization letter and review it to ensure the information is complete and accurate. Upon completion of this review by the worker, the authorization is to be saved in the FACTS File Cabinet for the case and recorded in Document Tracking. Finally, the worker will furnish the Authorization letter to the vendor(s) who will be providing the service.

Vendors need to be made aware there is generally a delay of about five (5) working days between when the Special Medical Authorization is generated by the Bureau for Children and Families and when this information is received by the Bureau for Medical Services. Therefore, if the Special Medical Authorization is used immediately upon issuance, the vendor may need to wait a few days to submit the request for reimbursement otherwise, Medicaid may not have received verification that the service has been authorized.

i) If Denied

If request is denied, the social worker may provide additional information and re-submit the request if the denial was based upon insufficient information, otherwise the social worker must seek alternate resources to cover the services requested.

Note: If the Adult Protective Services case is closed and the Special Medical Authorization is still in effect, the worker must send written notification to the vendor, the client or their legal representative, and the Bureau for Medical Services advising them that the authorization is no longer in effect and the date on which coverage ends. (See Appendix P Contact Information).

Note: Clozaril, or an equivalent, is covered by Medicare Part D. If the client is not eligible for Medicare Part D, Medicaid covers this for recipients of Medicaid. If the client is not currently receiving Medicaid and is not eligible for Medicare Part D, an application for Medicaid must be made through Income Maintenance as a potential resource. There is a Special Pharmacy Program for persons who cannot meet a Medicaid spend down and who meet certain other criteria.

5.7.5 Other Payments

Other payments that may be considered emergent in nature may include, but are not limited to food, identification card, birth certificate, etc. Prior supervisory approval must be verbal and/or written. A policy exception must be requested by the worker to the Regional Adult Services Field Consultant/Program Manager. If granted, the written request, including a description of the emergency situation that prompted the verbal approval, must be submitted to the Regional Adult Services Field Consultant.

If approval for the policy exception is granted, the worker must diligently seek an alternate payment source for future client needs.

If a birth certificate is out of state, the worker can request their Financial Officer to pay by check and reimbursement will be made by worker entering a demand payment.

5.8 Transfer of Cases between Counties

Though the need for transfer of an Adult Protective Services case will be rare, there may be situations when an Adult Protective Service case must be transferred from one county to another. (Example: nursing home placement & payment has been authorized under Adult Protective Services and this payment by the Department is anticipated to go on for an extended period of time while benefits are applied for/approved. The nursing home is in a different county from where the Adult Protective Service report was received. After the original county has arranged for the placement and received initial authorization for payment of the nursing home placement, the Adult Protective Service case may be transferred to the county in which the nursing home is located). Whenever it is necessary to transfer a case from one county to another, this is to be a planned effort with close coordination between the sending county and the receiving county.

Note: The Adult Protective Service case is not to be transferred if the placement is a temporary arrangement (substance abuse treatment, inpatient psychiatric care, acute care hospital admission, etc.). In these instances the originating county is to continue to carry the case. If there are times when it is a hardship for the county responsible for the case to maintain contact with the client as required, the supervisor may arrange with the Adult Services supervisor in the county where the facility is located to do a courtesy visit.

5.8.1 Timing of Transfers

It is recommended that case transfers be planned for the beginning or end of a month in order to minimize confusion related to payment, if applicable.

5.8.2 Sending County Responsibilities

When it is necessary to transfer an Adult Protective Service case from one county to another, the sending county is responsible for completing the following tasks:

a) Prior to arranging or actually completing a transfer to a provider in another county, the sending supervisor must contact the supervisor in the receiving county to notify them that a client is being transferred to their county (if placement in the receiving county will be in an AFC, or an Assisted Living Residence an Adult Residential Services case should be opened and carried by the receiving county while the Adult Protective Service case remains with the sending county until the Adult Protective Service issues are resolved and the Adult Protective Service case may be closed);

b) Provide a summary about the client's needs (i.e. reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable);

c) Complete all applicable case documentation prior to case transfer;

d) Immediately upon transfer of the client to the receiving county, send the updated client record (paper and FACTS) to the receiving county; and,

e) Notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the client's change of address.

5.8.3 Receiving County Responsibilities

The receiving county is responsible for completing the following tasks in preparation for the transfer:

a) Notify the DHHR Family Support staff of the client's arrival when the transfer is complete;

b) Complete all applicable documentation; and,

c) Assist with arranging or initiating any needed community resources.

When an Adult Protective Service case is transferred from one county to another, problems that arise during the first thirty (30) day period following the transfer are to be addressed jointly between the counties. When this occurs, the receiving county may request assistance from the sending county. If such a request is received, the sending county is to work cooperatively with the receiving county to resolve the problem(s). The social worker should maintain frequent contact

during this initial adjustment period to ensure a smooth transition. This will permit timely resolution of problems that may occur during this time.

SECTION 6

CASE REVIEW

6.1 Introduction

Evaluation and monitoring of the Adult Protective Services case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For APS and APS Preventive cases, frequent monitoring is essential since both APS and APS Preventive services are short-term services. Specifically, an APS case may be open for a period not to exceed twelve (12) months and an APS Preventive case may be open for a maximum of six (6) months. In unique situations it may not be possible to complete all necessary tasks to resolve the abuse/neglect or risk within these time frames. Should this occur, an extension must be requested by the worker to exceed the allowed time. (See Section 6.4 Extension Beyond Allowed Time Frames for detailed information).

6.2 Purpose

The purpose of Case Review is to consider and evaluate progress made toward resolution of the abuse and/or neglect. Re-examination of the Service Plan is a primary component of the review process. The social worker must consider issues such as progress made, problems/barriers encountered, effectiveness of the current plan in addressing the identified problem areas, and whether or not modifications/changes are indicated.

6.3 Time Frames

6.3.1 Adult Protective Services

Formalized case review must occur at three (3) month intervals following opening of the APS case, and prior to case closure at twelve (12) months. (Example: if a case is open for five (5) months it would be reviewed two times - at three (3) months and again prior to case closure. If a case is open seven (7) months it would be reviewed three times - at three (3) months, at six (6) months and again prior to case closure). While this is the minimum standard, the social worker must have a face-to-face contact with the client at least once monthly and a case review may be completed if circumstances warrant. A review can and should be completed any time there is a significant change in the client's circumstances. In the event the abuse/neglect cannot be resolved within the allowed twelve (12) month period, the social worker must request an extension. This extension request must be submitted to the supervisor according to the established protocol, prior to the end of the allowed twelve (12) months. (See Section 6.4 Extension Beyond Allowed Time Frames for detailed information).

6.3.2 APS Preventive Services

APS Preventive services are generally used in situations where a client resides in their own home and meets the three (3) specified eligibility criteria for APS Preventive services and they are at risk of an APS situation developing without intervention (See Section 2.9 Eligibility Criteria for detailed information). APS Preventive services are short-term time limited services that may be provided for a maximum of six (6) months. Due to the short-term nature of APS Preventive services, case review must occur on an ongoing basis. At a minimum, a formal review is to be completed at three (3) months and prior to case closure.

In the event the risk of abuse/neglect cannot be resolved within the initial six (6) month period, the social worker must consult with the supervisor to evaluate the need for additional time. A maximum of an additional thirty (30) days are available. (See Section 6.4 Extension Beyond Allowed Time Frames for detailed information).

6.4 Extension Beyond Allowed Time Frames

6.4.1 APS Cases

In extenuating circumstances, it may be necessary to keep the APS case open beyond the maximum of twelve (12) months in order to resolve the abuse/neglect. Should an extension become necessary, the social worker must request a policy exception to go beyond the maximum allowed time frames. To do so, the social worker, will make a request for a policy exception to the supervisor who will request an extension according to regional protocol. This request must be submitted prior to the end of the twelve (12) months deadline for case closure. If approved, the extension must be time-limited. Policy exceptions will not exceed thirty (30) days per request. If more time is needed, a second policy exception must be requested prior to the expiration of the original policy exception that was granted. Policy exceptions cannot exceed thirty (30) days at a time. A policy exception request must include the following, at a minimum:

a) Explanation of why extension is being requested;

b) Explanation of why required time frames cannot be met;

c) Efforts to date to resolve the risk;

d) Barriers encountered preventing completion of the plan within the allowed time frame;

e) Duration of extension being requested;

f) Plans to resolve the outstanding issues during the extension period, if granted;

g) Anticipated impact if the policy exception is not granted; and,

h) Other relevant information.

In no instance shall a policy exception approval exceed thirty (30) days at a time. If the request for a policy exception is denied, the social worker must proceed to case closure.

6.4.2 APS Preventive Service Cases

If a policy exception is to be requested to go beyond six (6) months, the social worker must prepare and submit a request for a policy exception to their supervisor who will request an extension according to regional protocol, prior to the end of the six (6) months period. If approved, the extension must be time-limited. Policy exceptions will not exceed thirty (30) days per request. If more time is needed, a second policy exception must be requested prior to the expiration of the original policy exception that was granted. Policy exceptions cannot exceed thirty (30) days at a time. A policy exception request must include the following, at a minimum:

a) Explanation of why an additional extension is being requested;

b) Describe efforts to date to resolve the risk;

c) Barriers encountered preventing completion of the plan within the initial six (6) months;

d) Duration of extension being requested;

e) Plans to resolve the outstanding issues during the extension period, if granted;

f) Impact if policy exception is not granted; and,

g) Other relevant information.

In addition, if the case has been opened for six (6) months and an extension is granted and if additional extensions are necessary in order to resolve the issues presenting potential risk to the client, the same process is to be followed. In no instance shall a policy exception approval exceed thirty (30) days at a time.

If the request for a policy exception is denied, the social worker must proceed to case closure.

6.5 Conducting the Review

A formal review of the APS case must be completed within applicable time frames and just prior to case closure (See Section 6.3 Case Review - Time frames for applicable time frames). The review process consists of evaluating progress toward the goals identified in the current Service Plan. This requires the social worker to review the Service Plan and have a face-to-face contact with the client and caregiver. Follow-up with other individuals and agencies involved in implementing the Service Plan, such as service providers, must also be completed. During the review process, the social worker is to determine the following:

a) Extent of progress made toward goal achievement;

b) Whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are needed;

c) Barriers to achieving the identified goals; and,

d) Other relevant factors.

6.6 Documentation of Review

At the conclusion of the review process the social worker must document the findings in FACTS. This includes reviewing the Service Plan in FACTS and end dating any goals that have been achieved or are to be discontinued or modified for some other reason(s). Goals that have not been end dated must be continued on the new Service Plan and additional goals may be added as appropriate. Documentation of each contact made in completion of the review is to be recorded as soon as possible.

When completed, the social worker must submit the review and new Service Plan to the supervisor for approval. Once approved, the social worker must print a copy of the revised Service Plan, save it to the FACTS File Cabinet for the case which will record it in Document Tracking, and secure all required signatures. Finally, they must provide a copy of the Service Plan to the client and to all signatories. The original signed Service Plan is to be filed in the client's case record (paper file).

SECTION 7

CASE CLOSURE

7.1 Assessment Prior to Case Closure

A final assessment must be completed as part of the case review process prior to closure of the case. When completing the final assessment, the elements that led to opening of the APS or APS Preventive case should again be considered and evaluated based upon current information.

Upon completion, the social worker must document the results of this assessment in FACTS and submit to the supervisor for approval of recommendation for case closure. Upon supervisory approval, the case is to be closed for APS/PAPS. When the need for aftercare is identified, the worker and the client will work together to develop an aftercare plan, if requested by the client.

7.2 Case Closure

The decision to close the Adult Protective Services/Preventative Adult Protective Services case is to be determined through the case review process. At the point in time the client is no longer at risk of abuse/neglect, the client appears to have capacity and requests closure, or upon death of the client, the social worker is to recommend closure of the APS/PAPS case. Other services will continue as necessary, if appropriate. The review and the reason(s) for case closure are to be documented in FACTS. Upon completion of the review, it and the social worker's recommendation to close the case are to be forwarded to the supervisor for approval. Upon approval by the supervisor, the case is to be closed in FACTS.

7.3 Purging of Adult Protective Service Records (Change per 2003 law) Statutory Basis

The State Code of West Virginia §9-6-8 requires that case records of individuals who have received Adult Protective Services be destroyed thirty (30) years following their preparation.

SECTION 8

OTHER

8.1 Risk Assessment

The Risk Assessment is completed in the investigation phase of the APS process. This form is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a Word document, and will be populated with information that has been entered in FACTS. The social worker then has the ability to make modifications and corrections, as appropriate, before printing the document. The completed document must then be saved to the FACTS File Cabinet for the case. Finally, creation of this form must be documented in the Document Tracking area of FACTS.

8.2 Comprehensive Assessment

The Comprehensive Assessment is completed in the assessment phase of the APS process. It is a compilation of elements from several areas of the system and is available as a DDE in FACTS, accessible through the report area. This report may be opened as a Word document, and will be populated with information that has been entered in FACTS. The social worker then has the ability to make modifications and corrections, as appropriate, before printing the document. The completed document must then be saved to the FACTS File Cabinet for the case. Finally, creation of this form must be documented in the Document Tracking area of FACTS.

8.3 Service Plan

The Service Plan is completed in the case management phase of the APS process. This form is available as a DDE in FACTS and may be accessed through the report area. It may be opened as a Word document, and will be populated with information that has been entered in FACTS. The social worker then has the ability to make modifications and corrections, as appropriate, before printing the document. The completed document must then be saved to the FACTS File Cabinet for the case. Creation of this form must be documented in the Document Tracking area of FACTS. Finally, after printing the Service Plan the worker must secure all required signatures, provide the client and all signatories with a copy, file the original signed document in the client case record (paper record), and record in Document Tracking where the original signed document is located.

8.4 Notification to Prosecuting Attorney

Notification to the prosecuting attorney is to be prepared at the end of the investigation phase of the APS process in cases where abuse/neglect or financial exploitation has been substantiated and there is an identified perpetrator. A form

letter titled “APS Notification Letter - PA” has been developed for this purpose is available as a DDE and may be accessed through the reports area of FACTS.

After the social worker enters the appropriate information, the completed document is ready for printing. In addition to the notification letter to the prosecutor, the social worker is to forward a copy of the Risk Assessment containing a summary of the investigation findings. The Risk Assessment is available as a DDE and may be accessed through the reports area of FACTS. Finally, the completed document(s) must be saved to the FACTS File Cabinet for the case and creation of this notification must be documented in the Document Tracking area of FACTS.

8.5 Notification to Persons/Entities Other than PA

Information to be shared with entities other than the prosecuting attorney is quite limited in order to ensure that Adult Protective Services case information is maintained in a confidential manner in accordance with the West Virginia Code. Generally, the reporter’s name shall not be shared in any instance. Persons/entities with whom the Department may need to provide notification fall into one (1) of three (3) categories. These are: 1) law enforcement, 2) other offices/entities within the Department of Health and Human Resources, and 3) entities outside the Department of Health and Human Resources. There are some slight differences regarding the information that may be shared between these categories. The requirements for each are as follows:

1. Law Enforcement

Generally, notification to law enforcement will occur prior to or early in the APS investigation process. As a result, information available to the Department may be limited. Notification to law enforcement by the Department is to include all relevant information that is available at the time notification is sent, including the reporter’s name unless the reporter has specifically stated that he/she wishes to remain anonymous. A form letter titled “APS Notification Letter - Law Enforcement” has been developed for this purpose. It is available as a DDE and may be accessed through the reports area of FACTS. In addition to the notification letter to law enforcement, the social worker is to forward a summary of any contact/information the Department has obtained regarding the situation. Finally, the completed document must be saved to the FACTS File Cabinet for the case and creation of this notification must be documented in the Document Tracking area of FACTS. (See Section3.1 Risk Assessment; Section 3.2 Required Notifications; and Section 2.15 Corrective Action Planning-Facilities for detailed information about which notification(s) are required for each setting).

2. Offices/Entities within the Department of Health and Human Resources

Various notifications to parties other than the prosecuting attorney are required depending on the type of setting where the abuse/neglect occurred and other unique circumstances of the case. Notification to entities within the Department of Health and Human Resources, such as OHFLAC, Medicaid Fraud and the

Long-Term Care unit within the Bureau for Medical Services, is to be prepared at the end of the investigation phase of the APS process. Notification is to be sent to the appropriate regulatory entity in each case where abuse/neglect has been substantiated. These entities within the Department of Health and Human Resources are bound by the same requirements regarding confidentiality of individual case records as is the Bureau for Children and Families.

A form letter titled "APS Notification Letter - within DHHR" has been developed for the purpose of providing this notification and is available as a DDE. This form is accessible through the reports area of FACTS. After the social worker enters the appropriate information, the completed document is ready for printing. The notification letter is to include a summary of the investigation, including the client's name, address and birth date, the perpetrator's name and address, (if the abuse occurred in a facility, the perpetrator's title is to be included, i.e., CNA, RN, dietician, etc.) the name of the facility, as well as a summary of the investigation, which includes and is populated from the Allegation Findings Screen, Summary Tab, Client Response Text Box, Caretaker Perpetrator Response Text Box and Summary Comments Text Box. Information that is not populated to this report must be completed by the worker prior to sending the letter. The reporter's name must not be revealed in this letter.

Finally, the completed document must be saved to the FACTS File Cabinet for the case and creation of this notification must be documented in the Document Tracking area of FACTS. (See Section 3.1 Risk Assessment; Section 3.2 Required Notifications; and Section 2.15 Corrective Action Planning-Facilities for detailed information about which notification(s) are required for each setting).

3. Offices/entities Outside of the Department of Health and Human Resources

Various notifications to parties other than the prosecuting attorney are required depending on the type of setting where the abuse/neglect occurred and other unique circumstances of the case. Limited information may be shared with entities outside the Department of Health and Human Resources in certain situations. These would include notification to the Long-Term Care Ombudsman. Notification to the Ombudsman is to be provided whenever allegations of abuse/neglect have been substantiated in a long-term care setting or when abuse/neglect is not substantiated but the APS investigation revealed areas of concern or patterns of practice within the setting related to resident rights.

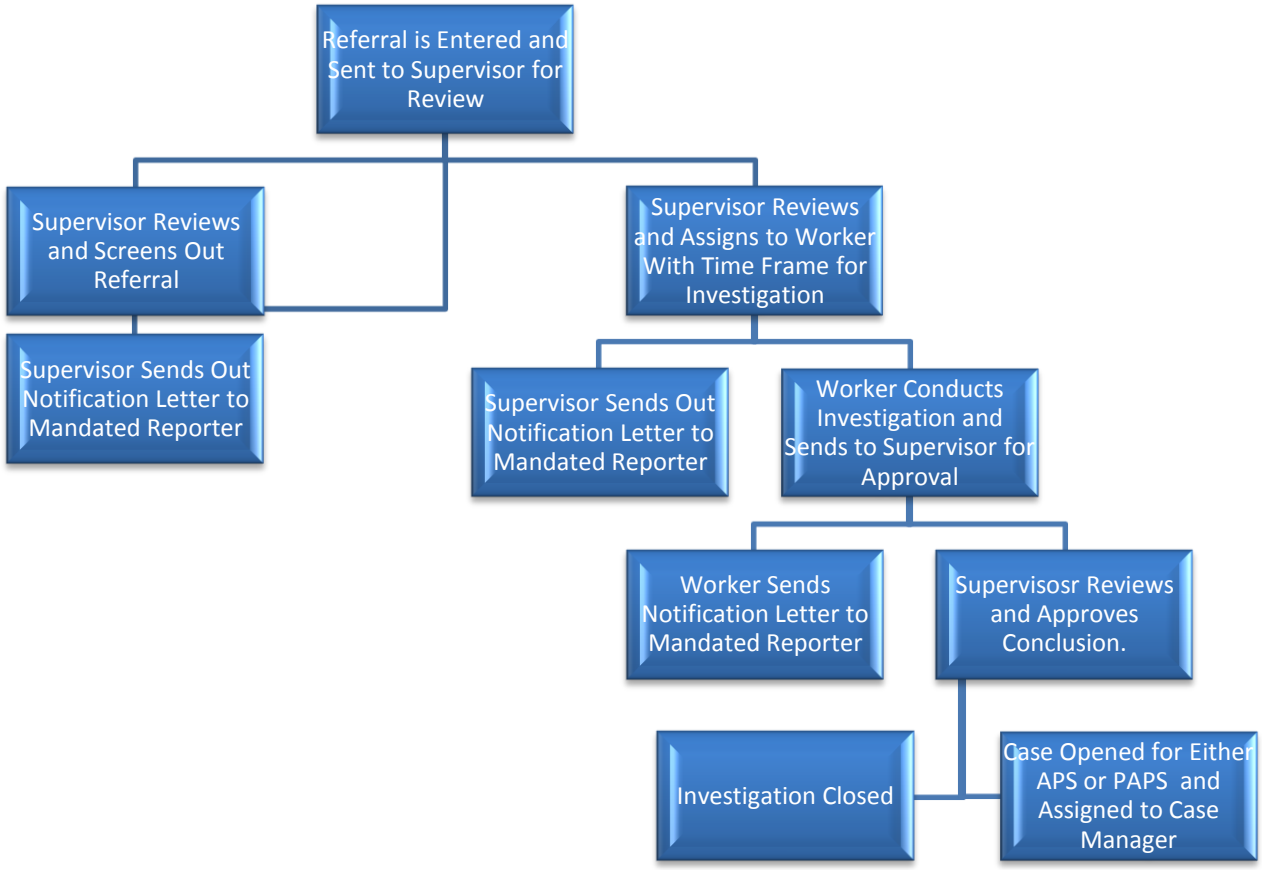
Information that may be shared with the entities outside of the Department of Health and Human Resources is limited to 1) the name of the facility involved in the Adult Protective Service referral, 2) whether or not the allegation(s) of abuse/neglect was/were substantiated, 3) the general nature of the allegation(s) received, and 4) the date on which the report of abuse/neglect was received. The name of the client and the name of the reporter are confidential and are not to be shared. A form letter titled "APS Notification Letter - Non- DHHR" has been developed for this purpose. It is available as a DDE and may be accessed through the reports area of FACTS. The social worker enters the appropriate

information and the completed document is then ready for printing. (See Section 3.1 Risk Assessment; Section 3.2 Required Notifications; and Section 2.15 Corrective Action Planning-Facilities for detailed information about which notification(s) are required for each setting). Finally, the completed document must be saved to the FACTS File Cabinet for the case and creation of this form must be documented in the Document Tracking area of FACTS.

APPENDIX A

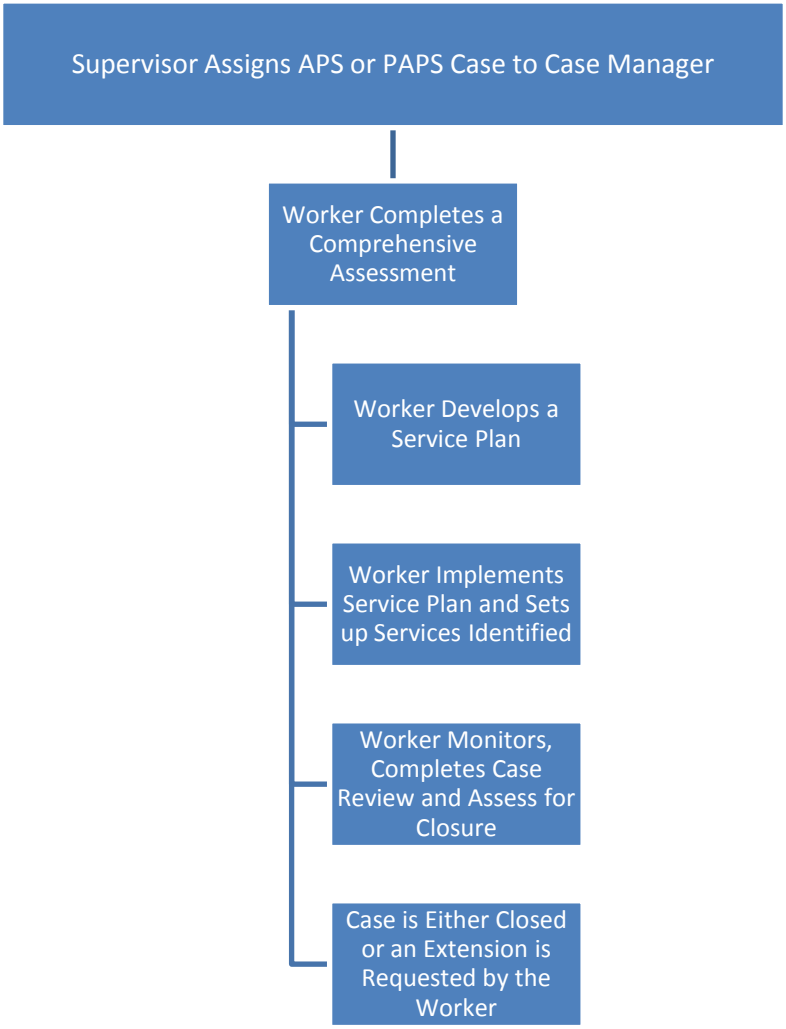
Flowchart

Intake and Investigation Flow 1



Flowchart

Case Management Flow 2



APPENDIX B

Worker Safety

It is more prevalent than ever before for the social worker, who is conducting an investigation into the safety and well being of vulnerable adults, are safe. The following are some steps but are not all inclusive of safety awareness the worker should utilize:

a) Once an investigation is assigned to you, research the case. Check with different units within your organization (i.e. WV Works, Youth Services, etc.) to see if there have been previous problems and what those problems consisted of.

b) If there is the potential for danger, take someone with you or contact the police to accompany you to the home. Discuss this with your supervisor for the best solution.

c) Are the directions sufficient in the referral so you will have no difficulty locating the home? If not, check with others who may have been to the home previously and co-workers who may know of the general area. Make sure you have plenty of gas.

d) Develop a buddy system or adhere to the local district protocol. Let other co-workers, supervisor know where you are going and have a code word for if you are in danger. Utilize the sign in and out sheet in your office to indicate what client you will be seeing, the address or telephone number and if there are any changes deviating from your planned visits, to inform your supervisor of that change.

e) Once you have arrived at your destination, it is best practice to park by backing in, but be sure to give yourself room for an easy exit and not allow yourself to be blocked in.

f) Before exiting your car, look around and observe if there are any animals, broken glass, creeks, etc. that may be hazardous or harmful if you are trying to exit. It is also wise to check out the porch environment for safety issues.

g) When you knock, be polite. Don't bang on the door. Then step back and to the side so the person can see you.

h) Once the door is answered ask if anyone else is home. Then scan the home environment.

i) When sitting, sit two (2) to three (3) inches in your seat. This will enable you to stand up quickly if needed.

j) Watch for any behavior changes in the client. If the client begins ranting, don't sit and take notes! If the client stands to rant, you stand. If the client leaves to get something, go to the door and

stand to be prepared to leave quickly if needed. If at any time you feel unsafe, leave!

k) Clients become upset due to a loss of power and helplessness. Find a common area of agreement by providing them with options. By doing this you are essentially giving the client back some of their power. You are also de-escalating the situation.

l) When leaving, remember to thank them for their time as you are walking to the door. When getting in your car remember to look in your rear view mirror to ensure you are not being followed.

By following these simple precautions you are better prepared to protect your safety and well being.

APPENDIX C

Protocol for Methamphetamine Investigations

The following policy is designed to outline the process for response to methamphetamine laboratories and homes suspected of meth use when incapacitated adults are involved. While the dangerous nature of responding to methamphetamine laboratories requires some very different responses by APS, and may seem contrary to the usual practices, many of the usual policies and procedures that apply across Adult Services will remain the same. In the following policy, special attention will focus on the unusual requirements in methamphetamine laboratory situations, while referring back to existing policy when appropriate.

a) Protocol for Methamphetamine Investigations

Those who make methamphetamine often use methamphetamine, making them prone to violence. It is a powerful stimulant and produces physiological changes similar to the fight or flight response. Methamphetamine use can cause aggression, paranoia, depression and irritability, making the user's behavior unpredictable. Methamphetamine users will often use weapons, explosive traps and surveillance equipment to protect and keep their operations secret. The term "methamphetamine laboratory" is used as a broad term in this policy to define any type of set-up and combination of chemical used to make methamphetamine. The lab can be very professional using professional chemistry equipment (very rare) or it can be composed of twenty (20) ounce soda pop bottles, gas cans, Mason jars, plastic tubing and milk jugs (more common in this area).

If the referral comes from law enforcement it should be considered a confirmed methamphetamine laboratory. It would be rare that a referral with these allegations would not be accepted for investigation. The intake worker will gather the following information specific to the plans of the reporting law enforcement officer;

1. Is the officer currently at the home and needing immediate assistance from APS?
2. If the police are anticipating a visit to the home in which they will be arresting individuals and dismantling a lab, at what time do they anticipate needing assistance from APS?
3. Where is the incapacitated adult now? Does the law enforcement officer anticipate that incapacitated adults will be in the home at the time of the planned police visit, if police are not already at the home?
4. Is there a briefing meeting planned prior to the police visit where they are requesting that an APS worker be present: If so, when and where?

5. Has there been prior law enforcement involved with this family?

Law enforcement should contact other appropriate law enforcement investigators as necessary. If the report only alleges exposure to a methamphetamine laboratory and there are no other allegations, the report will generally be accepted for assessment if there are incapacitated adults in the home.

If APS receives a report from someone other than law enforcement of incapacitated adults living in or present where the methamphetamine laboratory was located or were otherwise endangered by exposure to the drug, its' ingredients, its' by-products or waste, a report will generally be accepted if there are incapacitated adults in the home.

The social worker will follow the same rules and procedures for intake as other reports of suspected adult abuse, neglect or financial exploitation.

The social worker shall also gather other specific information relating to methamphetamine laboratories that includes but is not limited to;

1. Specific description of condition of the house fires: Safety hazards?
2. Proximity of the lab to the home, in the home, in a shed in the back yard?
3. Are incapacitated adults present when the drug is being cooked?
4. High frequency of visitors to the home?
5. Drug paraphernalia?
6. Chemicals?
7. Surveillance equipment?
8. Booby traps?
9. Description of adult substance abuser (paranoia, abnormal patterns, aggression, tweaked);
10. Have the police ever been to the home?
11. Where are the incapacitated adults at time of report?
12. Any other relevant information.

Whether the report is screened out or accepted for assessment, APS must make an immediate oral and subsequent written report of that information to the appropriate local law enforcement agency within forty-eight (48) hours after receipt of the information.

When deciding whether the report is accepted for assessment of abuse and/or neglect, the supervisor will consider the following:

1. Where is the laboratory in relation to the incapacitated adult?
2. Are individuals, including the incapacitated adult smoking/using methamphetamine in the home?
3. Is the product being brought into the home?
4. Are chemicals accessible to the incapacitated adult?
5. Has the incapacitated adult been injured by the chemicals?
6. Is the reporter aware of the incapacitated adult being present during a "cook"?
7. Is the reporter doubtful or certain of the presence of a methamphetamine laboratory?
8. Are there any other allegations of abuse and/or neglect?

Upon acceptance of an APS report which includes a methamphetamine laboratory, APS must cooperate with the law enforcement agency or agencies in planning any initial contact if contact has not already been made with the family by law enforcement. Social workers should not respond to a suspected laboratory site without the presence of law enforcement. All methamphetamine laboratory reports require contact with law enforcement for assistance regardless of whether they are suspected or confirmed. When advance notice is possible, the social worker responding to the scene must attend the law enforcement briefing held prior to responding to the suspected or confirmed laboratory site. The social worker must document any reasons for delay in initiating the investigation. If the worker cannot obtain law enforcement assistance (due to refusal by local law enforcement agency) for the initial home visit, the worker will not go alone to the home but will consult with their supervisor for the appropriate protocol.

Please be aware that one social worker alone may not be able to do everything that need to be completed at the initial contact in an APS investigation regarding incapacitated adults who have been exposed to methamphetamine. While one social worker may be assigned to the referral, it is recommended that the supervisor enlist other workers and support staff to assist with the initial response, so someone is available to assist with finding a placement for the incapacitated adult or evaluating the need to file an Order of Attachment if the incapacitated adult is not willing to go to a safe place.

APS Policy states that face to face contact must be made within zero (0) to two (2) hours when imminent danger exists, potential for imminent danger within seventy-two (72) hours and fourteen (14) days if no danger exists. If APS workers are not able to meet mandated time frames for initiation because of coordinating with law enforcement, it must be documented in the record. Documentation must reflect who the social worker spoke with from law enforcement and the reason for the delay in initiating the referral. Documentation

must reflect that the social worker spoke with his/her supervisor regarding the delay in initiating the investigation.

The assigned social worker shall meet or arrive with law enforcement at the suspected laboratory site, if possible. The social worker shall identify him or herself to all agencies that have responded to the scene. The local law enforcement agency should take the lead at the laboratory site. At no time should APS staff enter a methamphetamine laboratory location during the time that law enforcement is processing the site. Preferably, the worker will not enter the location at all. The worker should assess/interview the incapacitated adult after the incapacitated adult has left the enclosed physical structure of the laboratory area and are outside the physical structure. Privacy for the assessment/interview must be maintained to the extent possible. The worker must ask the law enforcement officer for copies of the pictures that are taken at the site to be used in the abuse/neglect case, if necessary for evidentiary purposes. Of particular interest, are pictures of chemicals next to food items that incapacitated adults usually eat such as cereal, granola bars, candy, fruit, etc. and chemicals in the refrigerator next to juice, soda, milk, fresh vegetables, etc. Also of interest are pictures of chemicals that are within reach or in close proximity of the incapacitated adult or are in the incapacitated adult's room or sleeping area.

Law enforcement should be responsible for securing the area, gathering physical evidence and removing the incapacitated adult to outside the home if they are in the home at the time of the initial contact. The social worker shall obtain information concerning the general conditions of the home from law enforcement's photos and observations. Law enforcement should be responsible for documenting what chemicals were found in the home. At this point, the information obtained from law enforcement and others at the scene would be used to complete the Risk Assessment along with other information the social worker has gathered. The main focus for the social worker is the safety of the incapacitated adult and removal to a safe place, or evaluating the need to file an Order of Attachment if the incapacitated adult is not willing to go to a safe place.

If Behavioral Health/Substance Abuse responds to the scene, they should be responsible for assessing the incapacitated adult's current state of mind and assessing for substance abuse regarding the caretaker and others in the home. The APS social worker must coordinate with Behavioral Health to obtain the results of their assessments. This information must also be included in the Risk Assessment or the Contact Screen.

b) Incapacitated Adult(s) in the Home at the Time of the First Contact

If there is a confirmed laboratory with incapacitated adults present, the incapacitated adult may need to go through a decontamination process facilitated by law enforcement/EMS or other public health agency staff, as assessed by the on scene

responders. If the incapacitated adult is decontaminated at the scene, the worker must advocate for the incapacitated adult to receive the least invasive, but most effective decontamination process with special attention being paid that the incapacitated adult is not humiliated or frightened further by the decontamination process. If EMS is present as a first responder team member, EMS should be available to evaluate the incapacitated adult's immediate medical needs and transport the incapacitated adult to the hospital for emergency medical treatment, if needed. If possible the incapacitated adult should be decontaminated before leaving the scene. Guidelines for decontamination are posted on www.nationaldec.org which currently is done by giving the incapacitated adult a fresh change of clothing (not the incapacitated adult's clothes that came out of the house where the methamphetamine was being manufactured) and having the incapacitated adult shower using soap and water (no baths). This must be done as soon as possible after removing the incapacitated adult from the laboratory site with respect to the incapacitated adult's sense of modesty and without alarming the incapacitated adult. If the incapacitated adult appears to be in medical distress (breathing problems, unconsciousness, etc.), the worker must call 911 and have the incapacitated adult transported to the hospital for emergency medical treatment as soon as possible, or the social worker will evaluate the need to file an Order of Attachment if the incapacitated adult is not willing to go for medical treatment (EMS personnel will usually make the decision for the incapacitated adult if they are not willing to go for medical attention and are in medical distress). The worker should assess the need to accompany the incapacitated adult to the hospital to ensure that the necessary medical treatment is received.

The APS worker shall assume the primary role for transfer of the incapacitated adult at the scene to a safe place once law enforcement has removed them from the home. If the incapacitated adult refuses the social worker's assistance with transfer to a safe place, the worker must evaluate the need for an Order of Attachment and document all attempts to get the incapacitated adult to a safe place. Once the incapacitated adult is in the appropriate placement, the APS worker must fully apprise the incapacitated adult(s) or caretaker of the need for any follow-up medical treatment recommended at the medical assessment. The APS worker must further emphasize the importance of obtaining the correct follow-up treatment for the incapacitated adult.

Facilitating an immediate medical assessment may include gathering the incapacitated adult's medical history, and arranging transportation by ambulance or other means. Please be aware that

this medical examination may take several hours and the client may need to be fed.

If deemed necessary, the adult shall be assessed by a physician for any immediate health or safety concerns. The physician shall screen the adult for drug and chemical exposure to receive any necessary treatment and gather evidence. This screening may include, but is not limited to obtaining a urine sample within twelve (12) hours of removal from laboratory site, taking the incapacitated adult's vital signs, liver and kidney functioning tests, baseline electrolytes, CBC, physical exam, etc. If worker takes the incapacitated adult to a hospital that is unaccustomed to treating and assessing incapacitated adults removed from methamphetamine laboratories, the worker can suggest that medical staff follow the national medical protocol found at www.nationaldec.org. it fully outlines recommended tests and evaluations. Any test run for forensic purposes must follow the chain of evidence procedures required by law enforcement. The worker should request laboratory results, as well as any other medical documentation for the client's case record. Industrial levels should not be used in evaluating incapacitated adult's exposure to methamphetamine.

Be aware that if APS is not the Guardian or Health Care Surrogate, the social worker cannot give permission or sign for medical treatment for the incapacitated adult. In West Virginia, physicians have the authority to treat adults without permission in certain extreme emergency situations. The method of payment is limited to any medical coverage the client has at the time of treatment, or if the medical facility is willing to treat this as an emergency/indigent situation.

When the incapacitated adult is removed from the contaminated site, none of their belongings may be removed from the home and taken with them to their new placement. An exception to this may be necessary medication or medical equipment that may be decontaminated by wiping off with soap and water. APS may consider having items or having access to such items as toothbrushes, hair brushes, pajamas and other necessary clothing, etc. available to replace some of the incapacitated adult's belongings. APS may also consider having latex gloves and disposable wipes available for the social workers' safety. If the media arrives at the scene, please be mindful of the incapacitated adult and their exposure to the cameras and reporters. If at all possible, the incapacitated adult should be protected from media exposure to the extent possible.

The APS worker(s) shall also be responsible for initiating an assessment for risk and attempting to locate safe housing/placement for the incapacitated adult, if needed. At this time, no decontamination standards for re-occupancy of former methamphetamine laboratories exist in West Virginia.

The APS worker(s) must provide the person assuming care of the incapacitated adult with a description of what the incapacitated adult has been exposed to, any medical treatment the incapacitated adult has received, any follow-up appointments the incapacitated adult has by observing the incapacitated adult for symptoms that requires medical care and the name and number of the APS worker and supervisor to call if the caregiver has concerns.

Whether there is a confirmed laboratory in the home or not, the social worker(s) shall continue with the investigation based on any other allegations of abuse, neglect or dependency that may have been alleged in the referral.

c) Incapacitated Adult)s) Not in the Home at the Time of the First Contact

If an incapacitated adult is not in the home at the time of the initial contact, the APS worker(s) must attempt to locate them and assess their health, safety and well being. All attempts at locating the incapacitated adult must be documented. The incapacitated adult may not need to be decontaminated if they have been out of the home for seventy-two (72) hours, but they should be examined by their physician. If the incapacitated adult is at a day treatment program, etc., the risk is minimal that they may have contaminated other adults or day treatment personnel because most of the chemicals dissipate in the air once the incapacitated adult is out of the area where the laboratory is located.

d) Ongoing Investigation

If law enforcement and their County Prosecuting Attorney's Office make a decision regarding any charges to be filed, APS shall cooperate with this process to the extent allowed by West Virginia Code by sharing information and testifying in court, if necessary.

The APS worker(s) shall make contact within forty-eight (48) hours with the incapacitated adult and caregiver to determine how the incapacitated adult is doing and if there are any medical follow-up needs. This time frame is necessary because of assuring any medical needs are met and because at this time the effects of long term exposure to methamphetamine are unknown. Any necessary evaluations need to be scheduled as quickly as possible to ascertain and obtain the appropriate services needed for the incapacitated adult.

The APS worker(s) shall coordinate a joint interview of the incapacitated adult and law enforcement within forty-eight (48) hours, if not completed at the initial contact and if necessary. The incapacitated adult must be interviewed using a general protocol that screens for all types of abuse and neglect. Incapacitated adults who live in a home where methamphetamine is used are often subjected to neglect, physical abuse and/or sexual abuse. At the initial contact, the incapacitated adult's medical evaluation, safety and needs take priority. This time frame is necessary to assure that the incapacitated adult is interviewed quickly and to gather as much information as is needed to make an informed decision regarding safety, abuse, neglect or dependency.

e) Social Worker Safety

Methamphetamine laboratories are most dangerous when they are operational. Please be advised, if the APS worker enters a home for any reason and discovers strong indications of a methamphetamine laboratory, the worker must leave immediately and report to their supervisor and local law enforcement by phone while at a safe distance from the home. All allegations, whether contained in the original report or uncovered during the course of the investigation, shall be documented in the case record. Worker must not confront the caretaker or others in the home about their suspicions. Most people who manufacture methamphetamine use it. Methamphetamine is a powerful stimulant and can cause aggression, paranoia, depression and irritability. Methamphetamine users' behaviors are unpredictable. They often have access to weapons. They also may use booby traps and explosives to protect their laboratories. The APS worker will return with appropriate law enforcement officers to address the allegations of the methamphetamine laboratory with the caretakers and others in the home. It is also important to understand that a "cook" that is interrupted is extremely dangerous and volatile. The process needs to be completed in order to avoid an explosion or fire. The worker must find an excuse to get out of the home as quickly as possible, such as "I just stopped by for a minute to see how you were doing because I was in the area for another appointment." The social worker must never use sense of touch or smell to try to identify chemicals or unknown substances.

If after being in the home or laboratory site, the APS worker begins to have headaches, burning eyes, difficulty breathing, et. Medical attention should be sought immediately. The APS worker may also have come into contact with chemicals or toxins that could contaminate others. This contamination may not be obvious, so some precautions are necessary. Place any clothes worn at the lab

site into a paper bag until they can be washed. The clothes should be washed separately on the hottest setting. Rewash a second time and air dry outside the home, not in the dryer. Run the washer once empty to clean it thoroughly. Shoes should be washed with the clothes if possible or wiped clean with soap and hot water. The social worker should shower in very warm, but not hot water and use lots of soap. Clean the tub/shower thoroughly afterwards.

f) Placement Provider Preparation and Safety

It is imperative that the placement providers are given as much information concerning what the incapacitated adult has been exposed to, what medical treatment the incapacitated adult has received and any follow-up appointments the incapacitated adult will need to attend. The social worker will need to provide the placement provider with the incapacitated adult's known health status at the time of placement. The placement provider also needs to be given instructions for decontamination to reassure themselves regarding their risk of contamination and what symptoms to look for in the incapacitated adult. Some contamination may not be obvious, so some precautions may be necessary. Place any clothes worn by the incapacitated adult into a paper bag until they can be washed. The clothes should be washed separately on the hottest setting. Rewash a second time and air dry outside the home, not in the dryer. Run the washer once empty to clean it thoroughly. Shoes should be washed with the clothes if possible or wiped off with soap and hot water. The incapacitated adult should shower in very warm, but not hot water and use lots of soap. Clean the tub/shower thoroughly afterwards. The social worker must reassure the placement provider that their risk of exposure is minimal since the incapacitated adult has either been decontaminated or assessed to not need decontamination prior to placement.

Because some effects of chemical exposure can develop slowly, the placement provider must seek immediate medical attention if they notice the incapacitated adult experiencing:

1. Headache;
2. Drowsiness;
3. Unusual movements like tremors, shaking, jumpiness, agitation or seizures;
4. Difficulty breathing, wheezing, coughing or poor color;
5. Fever;
6. Hallucinations or mental confusion; and,

7. Any other unusual symptom that seems severe.

It is also likely that the circumstances of the discovery of the illegal methamphetamine laboratory and removal have been traumatic for the incapacitated adult. In addition the incapacitated adult may have been subjected to neglect, physical and/or sexual abuse. It is important for the placement provider to ensure that the incapacitated adult has a warm, stable environment and to understand the emotional reactions that may follow.

g) Protocol for APS Investigations Involving Meth

1. If worker discovers a meth lab or suspects that he/she has come across chemicals being used to make meth during a home visit or incapacitated adult abuse/neglect investigation, the worker will leave the house, depart the immediate area and contact their supervisor and law enforcement;
2. The worker will remain away from the home until after law enforcement has responded to the worker's call and secured the home and the people inside;
3. The worker will return to the scene and accompany law enforcement as appropriate;
4. The worker will facilitate appropriate, safe placement of the incapacitated adult, or evaluate the need to file an Order of Attachment if the incapacitated adult is not willing to go to a safe place.
5. The worker will arrange for decontamination of the incapacitated adult at the site, if possible. Worker will provide clean clothing and wipes for the incapacitated adult to use, if possible. If this is not possible on-site, worker will arrange for this as soon as possible after leaving site if not taking incapacitated adult straight to a hospital;
6. The worker will arrange for transportation of the incapacitated adult to a safe place or nearest hospital emergency department (please call ahead to the hospital);
    a) Items from the drug site are left on site and not taken with the incapacitated adult, with the exception of necessary medication or medical equipment, which must be decontaminated;
    b) Transport vehicle should have protective gear for occupants. Examples include blankets or plastic to cover the seat. If the incapacitated adult cannot be decontaminated on site, wrap a blanket around the individual prior to placing them in the transport vehicle.

The transport vehicle will need to be decontaminated after transporting the incapacitated adult.

7. Advise placement provider of immediate needs of incapacitated adult as a result of meth contamination;

    a) The incapacitated adult is not allowed to bring anything with them from the contaminated site (clothing, personal belongings, food, etc.). An exception to this may be necessary medication or medical equipment that may be decontaminated by wiping off with soap and hot water. Medication that is in an enclosed container may be taken with the incapacitated adult; and,

    b) Follow-up medical care needs to be scheduled and completed.

APPENDIX D

Examples of Domestic Violence

The adult victim must be approached as an individual who needs to have his/her own experience validated, to be supported and empowered to act, and to make his/her own choices from a range of available options. Many victims of domestic violence appear hostile or distrustful when asked to talk about their situation. This may be due to many factors such as fear of retaliation, previous negative experiences with authorities, and/or not viewing their partners as abusive. When conducting an interview, it is important to remember that victims are often afraid that APS may tell their partner. The worker will need to explain the limits of confidentiality to the victim.

Victims of domestic violence are often threatened by the alleged perpetrator. It is best practice to NOT ask a suspected adult victim about domestic violence in the presence of a suspected alleged perpetrator. This may be achieved by two (2) workers going together and separating the client and alleged perpetrator to interview each alone. Another example would be for the worker to obtain information of when the alleged perpetrator is away from the home.

For additional information refer to Appendix E "Power and Control Wheel".

a) An adult who consistently describes and addresses their partner in derogatory terms.

b) An adult who is overly condescending or solicitous toward his/her partner.

c) An adult who admits to acts of domestic violence but minimizes the frequency or severity, blames the partner for provoking it, or refuses to accept responsibility for his/her actions.

d) One adult who speaks for the other partner when the parties are together.

e) Adults who are fearful about another adult becoming angry if their rules, decisions or plans are not followed.

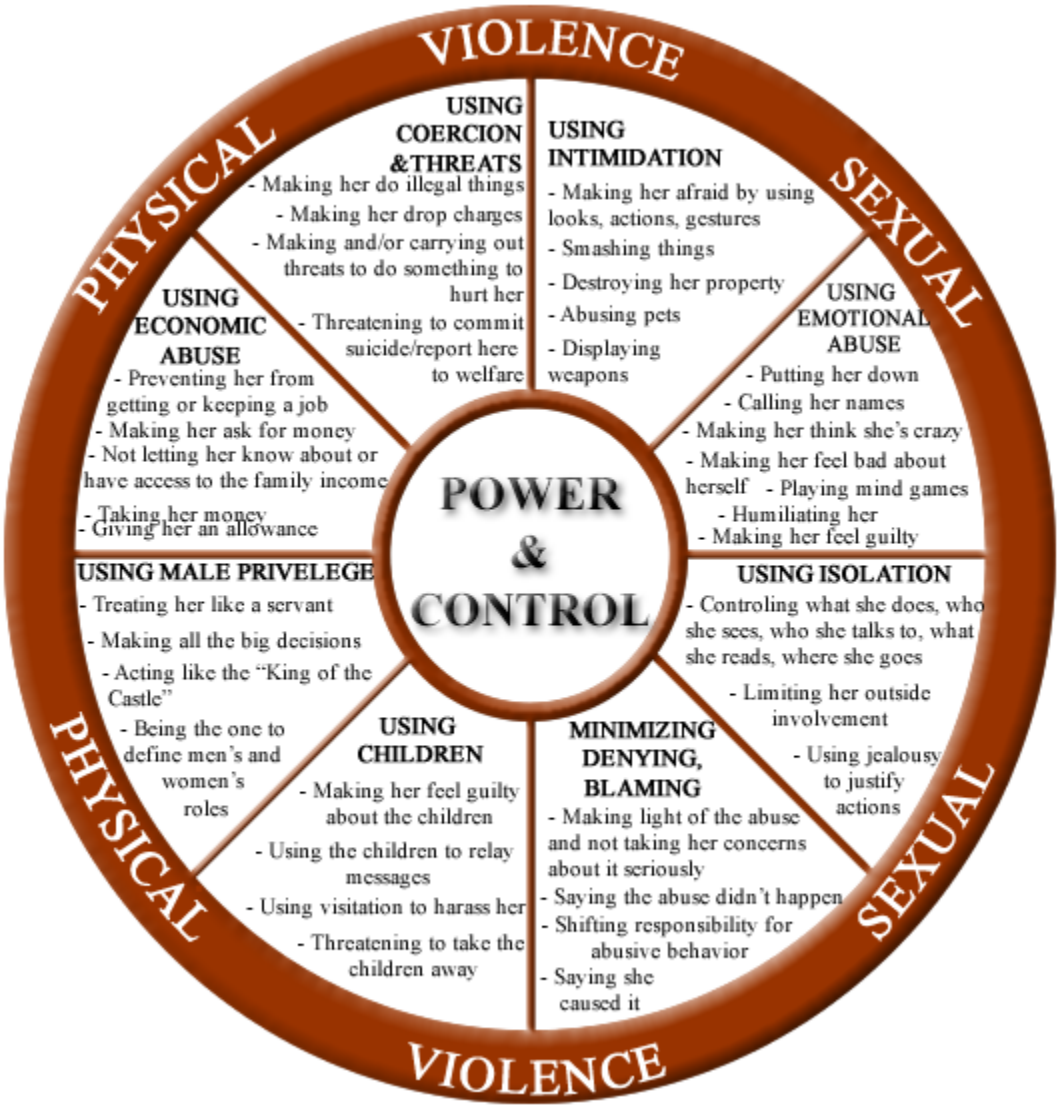
f) An adult who is controlling of other family members.

g) The inability of a partner to meet alone with the worker may also be suggestive of domestic violence.

Please note that the indicators listed are only meant as a tool to let the workers recognize the signs of domestic violence. It is not always an accurate indication of domestic violence. Please refer to the "Power and Control Wheel" Appendix E.

APPENDIX E

Power and Control Wheel



Power and Control Wheel 1

APPENDIX F

Terms Defined by Law (West Virginia Code §48-27-202 & §48-27-204)

Domestic Violence-Legal Definition: Means the occurrence of one or more of the following acts between family or household members: (1) attempting to cause or intentionally, knowingly or recklessly causing physical harm to another with or without dangerous or deadly weapons; (2) placing another in reasonable apprehension of physical harm; (3) creating fear of physical harm by harassment, psychological abuse or threatening acts; (4) committing either sexual assault or sexual abuse as those terms are defined in articles eight-b and eight-d, chapter sixty-one of this code; and (5) holding, confining, detaining or abducting another person against that person's will (§48-27-202).

Family or Household Member: Current or former spouses, persons living as spouses, persons who formerly resided as spouses, parents, children and stepchildren, current or former sexual or intimate partners, other persons related by blood or marriage, persons who are presently or in the past have resided or cohabitated together or a person with whom the victim has a child in common (§48-27-204).

APPENDIX G

Court Rules for Domestic Violence Proceedings

Rule 23a. Children and incapacitated family or household members as parties.

(a) Individuals filing on behalf of a person in need of protection. If an adult family or household member is filing on behalf of a child or physically or mentally incapacitated family or household member and not requesting protection for himself or herself, then the petitioner shall be the child or physically or mentally incapacitated family or household member in need of protection. The adult family or household member shall be recognized on the petition as the parent/guardian or next friend. The adult family or household member shall attend any hearing scheduled to protect the interest of the child or physically or mentally incapacitated family or household member.

(See Rules of Practice and Procedure for Domestic Violence - West Virginia Judiciary for further details).

APPENDIX H

Resources for Victims of Domestic Violence

a) Domestic Violence Hotline 1-800-799-SAFE (7233)

b) Domestic Violence Hotline for the Deaf TTY 1-800-787-3224

c) West Virginia Coalition Against Domestic Violence 304-965-3552 Voice/TTY

d) Crime Victim's Compensation Fund 304-347-4850 or toll free 1-877-562-6878

e) Branches Domestic Violence Shelter (Huntington) 304-529-2382 or 1-888-538-9838 Voice/TTY (Counties served: Cabell, Lincoln, Mason, Putnam and Wayne)

f) Family Crisis Center (Keyser) 304-788-6061 Voice/TTY or 1-800-698-1240 Voice (Counties served: Grant, Hampshire, Hardy, Mineral and Pendleton)

g) Family Crisis Intervention Center (Parkersburg) 1-800-794-2335 Voice/TTY (Counties served: Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt and Wood)

h) Family Refuge Center (Lewisburg) 304-645-6334 Voice/TTY or 1-866-645-6334 Voice (Counties served: Greenbrier, Monroe and Pocahontas)

i) Hope, Inc. (Fairmont) 304-367-1100 Voice (Counties served: Doddridge, Gilmer, Harrison, Lewis and Marion)

j) Lighthouse (Weirton) 304-797-7233 (Counties served: Brooke and Hancock)

k) Rape and Domestic Violence Information Center (Morgantown) 304-292-5100 Voice/TTY (Counties served: Monongalia, Preston and Taylor)

l) S.A.F.E. (Welch) 304-436-8117 Voice/TTY or 1-800-688-6157 Voice (Counties served: McDowell, Mercer and Wyoming)

m) Shenandoah Women's Center (Martinsburg) 304-263-8292 Voice/TTY (Counties served: Berkeley, Jefferson and Morgan)

n) Tug Valley Recovery Center (Williamson) 304-235-6121 Voice/TTY or 1-800-340-0639 Voice (Counties served: Mingo and Logan)

o) Women's Aid in Crisis (Elkins) 304-636-8433 or 1-800-339-1185 Voice/TTY (Counties served: Barbour, Braxton, Tucker, Randolph, Upshur and Webster)

p) Women's Resource Center (Beckley) 304-255-2559 Voice/TTY or 1-888-825-7836 Voice (Counties served: Fayette, Nicholas, Raleigh and Summers)

q) YWCA - Family Violence Prevention Program (Wheeling) 304-232-2748 or 1-800-698-1247 Voice/TTY (Counties served: Brooke, Hancock, Marshall, Ohio and Wetzel)

r) YWCA - Resolve Family Abuse Program (Charleston) 304-340-3549 Voice or 1-800-681-8663 Voice/TTY (Counties served: Boone, Clay and Kanawha)

APPENDIX I

Sexual Assault and Abuse:

Sexual abuse occurs when a person subjects another person to sexual contact without their consent, and that lack of consent is due to physical force, threat or intimidation. According to West Virginia law, there are three (3) levels of sexual abuse:

- ***1st Degree:*** Sexual contact without the victim's consent due to forcible compulsion, the victim is physically helpless, or the victim is younger than age 12 and the perpetrator is age 14 or older.
- ***2nd Degree:*** Sexual contact with someone who is mentally defective or mentally incapacitated.
- ***3rd Degree:*** Sexual contact with a victim under age 16 without their consent.

Sexual assault is sexual intercourse or sexual intrusion without consent. According to West Virginia law, there are three (3) levels of sexual assault:

- ***1st Degree:*** The perpetrator inflicts serious bodily injury, uses a deadly weapon, or the perpetrator is over age 14 and the victim is younger than twelve years old and is not married to that person.
- ***2nd Degree:*** Sexual intercourse or intrusion without consent and lack of consent is due to forcible compulsion or physical helplessness.
- ***3rd Degree:*** Sexual intercourse or intrusion with someone who is mentally defective or mentally incapacitated, or when someone age 16 or older assaults someone less than 16 who is at least 4 years younger than the perpetrator and not married to him/her.

FYI—A statute of limitations is a law that sets forth the maximum period of time, after certain events, that legal proceedings based on those events may be initiated.[4] There is no statute of limitations for felonies in the West Virginia Code, with the exception of the felony offense of perjury which has a three-year statute of limitations and some felony tax offenses which have statute of limitations. Felonies, with these exceptions, can be charged at any time. There is a one-year statute of limitation for misdemeanors, so 2nd and 3rd degree sexual abuse must be charged within a year after the offense was committed (WV Code §61-11-9).

FYI—There may be many reasons why victims may be reluctant to report sex offenses to law enforcement. Some of the most common are self-blame, fear of retaliation by perpetrators, fear of rejection by family/friends, and unwillingness to deal

with the humiliation, loss of privacy and negativity they perceive would accompany criminal justice system involvement.[5] Victims with disabilities may also be concerned that reporting may lead to a loss of independence or, in cases of caregiver abuse, loss of someone to assist them with their daily needs. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) Regardless of their decision about reporting, victims need to be aware of any available non-legal assistance to help them recover. Whether or not there are criminal charges filed, civil legal remedies may also be available to sexual assault victims. In civil lawsuits, victims typically seek monetary compensation for damages. (WV FRIS, 2006)

APPENDIX J

WV Sexual Abuse and Sexual Assault Laws Terms Defined by Law Drawn From (WV Code §61-8B-2)

- **Forcible compulsion:** (a) physical force that overcomes such earnest resistance as might reasonably be expected, under the circumstances; (b) threat or intimidation, expressed or implied, placing a person in fear of immediate death or bodily injury to him/herself or another person or in fear that he/she or another person will be kidnapped; or (c) fear by a person under 16 years of age caused by intimidation, expressed or implied, by another person who is at least four (4) years older than the victim. For the purpose of this definition, "**resistance**" includes physical resistance or any clear communication of the victim's lack of consent.

- **Married:** for the purpose of this article, in addition to its legal meaning, includes persons living together as husband and wife regardless of the legal status of their relationship.

- **Mentally defective:** a person suffers from a mental disease or defect which renders that person incapable of appraising the nature of his/her conduct.

- **Mentally incapacitated:** a person is rendered temporarily incapable of appraising or controlling his/her conduct, as a result of the influence of a controlled or intoxicating substance administered to that person without his/her consent or a result of any other act committed upon that person without his/her consent.

- **Physically helpless:** a person is unconscious or for any reason is physically unable to communicate unwillingness to an act.

- **Sexual contact:** intentional touching, either directly or through clothing, of the anus/any part of the sex organs of another person, or the breast of a female or intentional touching of any part of another person's body by the actor's sex organs, where the victim is not married to the actor and the touching is done to gratify the sexual desire of either party.

- **Sexual intercourse:** any act between persons not married to each other involving penetration, however slight, of the female sex organ by the male sex organ or involving contact between the sex organs of one person and the mouth or anus of another person.

- **Sexual intrusion:** any act between persons not married to each other involving penetration, however slight, of the female sex organ or of the anus of any person by an object for the purpose of degrading or humiliating the person so penetrated

or for gratifying the sexual desire of either party.

- **Bodily injury:** substantial physical pain, illness or any impairment of physical condition.

- **Serious bodily injury:** bodily injury which creates a substantial risk of death, which causes serious or prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

- **Deadly weapon:** any instrument, device or thing capable of inflicting death or serious bodily injury and designed or adapted for use as a weapon or possessed, carried or used as a weapon.

Sexual abuse and sexual assault are the main categories of sex offenses in the *West Virginia Code*. Additional offenses, including incest, are described in other sections of the *West Virginia Code* (www.legis.state.wv.us) and in the Sex Crimes section of the *West Virginia Protocol for Responding to Victims of Sexual Assault* (www.fris.org). (WV FRIS, 2006)

APPENDIX K

Resources for Victims of Sexual Assault

a) National Sexual Assault Hotline 1-800-656-HOPE (4673)

b) Crime Victim's Compensation Fund 304-347-4850 or toll free 1-877-562-6878

c) Women's Resource Center 304-255-2559 TTY or 1-888-825-7835

(Counties served: Fayette, Nicholas, Raleigh and Summers)

d) The Family Refuge Center 1-800-645-6334 or 304-645-6334 (Counties served: Greenbrier, Monroe and Pocahontas)

e) REACH (Rape Education, Advocacy, counseling and Healing) 304-340-3676 (Counties served: Kanawha and Putnam)

f) Contact Rape Crisis Center 304-399-1111 or toll free 1-866-399-RAPE (7273) (Counties served: Cabell, Lincoln, Mason and Wayne)

g) Women's Aid in Crisis, Inc. 304-636-8433 or 1-800-339-1185 (Counties served: Barbour, Braxton, Randolph, Tucker, Upshur and Webster)

h) Shenandoah Women's Center 304-263-8292 or 304-725-7080 or 304-258-1078 (Counties served: Berkeley, Jefferson and Morgan)

i) Rape and Domestic Violence Information Center, Inc. 304-292-5100 (Counties served: Monongalia, Preston and Taylor)

j) Hope, Inc. - A Task Force on Domestic Violence 304-367-1100 (Counties served: Doddridge, Gilmer, Harrison, Lewis and Marion)

k) Sexual Assault Help Center 304-234-8519 or toll free 1-800-884-7242 (Counties served: Brooke, Hancock, Marshall, Ohio and Wetzel)

APPENDIX L

Financial Services Modernization Act

The Financial Services Modernization Act passed in 1999 (often known as the Gramm-Leach-Bliley Act or GLBA). The GLBA contains strong privacy protection. It requires notification to customers before disclosures of their records and an opportunity to disapprove the proposed disclosure. However, Section 502(e) of the GLBA contains exceptions to this privacy protection. Three are relevant to state reporting programs:

a) (e)(3)(B) permits disclosure "to protect against or prevent actual or potential fraud, unauthorized transactions, claims, or other liability."

b) (e)(5) permits disclosure, "to the extent specifically permitted or required under other prevision of law…to law enforcement agencies…or for an investigation on a matter related to public safety".

c) (e)(8) permits disclosure "to comply with Federal, State or local laws, rules, and other applicable legal requirements.[.]"

APPENDIX M

Signs of Financial Exploitation

The signs of financial exploitation may not be subtle or blatantly obvious: (i.e., not all inclusive):

a) Numerous cash withdrawals from an incapacitated adult's checking account in a short period of time, especially if inconsistent with previous spending habits;

b) Signatures on checks, wills, powers of attorney or other documents that look forged, unusual or suspicious;

c) Several checks that are used out of numerical order;

d) Reports by the incapacitated adult or collaterals (i.e. friends, neighbors, relatives Senior Citizens Center, banks, etc.) that funds are missing from his or her account;

e) Someone forcing, pressuring, or coercing the incapacitated adult into withdrawing large sums of cash from checking or savings accounts;

f) An incapacitated adult applying for several new credit cards;

g) An unexpected increase in ATM or credit card usage by an incapacitated adult;

h) An incapacitated adult failing to understand recently completed financial transactions;

i) An incapacitated adult making unusual changes to bank accounts;

j) Having credit card statement sent to someone other than the incapacitated adult who is named on the account;

k) Unexpected or unexplained changes by an incapacitated adult in account beneficiaries, property titles, deeds or other ownership documents;

l) An incapacitated adult refinancing a mortgage;

m) Abrupt and unexpected changes in a will, trust, power of attorney, or other legal document;

n) An incapacitated adult who is unexpectedly and uncharacteristically unkempt, forgetful, disoriented;

o) An incapacitated adult who is unexpectedly not meeting their financial obligations such as food, utilities, rent, mortgage payments, and/or medical expenses (health care or long term care expenses, etc.);

p) Substandard care being provided or bills unpaid despite the availability of adequate financial resources;

q) Sudden appearance of previously uninvolved relatives claiming their rights to an incapacitated individual's affairs and possessions; and,

r) Provision of services that are not necessary.

APPENDIX N

Terms Defined by Law (WV Code §61-2-29(2))

Caregiver: An adult who has or shares actual physical possession or care of an incapacitated adult or elder person on a full-time or temporary basis, regardless of whether such person has been designated as guardian of such adult by any contract, agreement or legal proceeding. Caregiver includes health care providers, family members, and any person who otherwise voluntarily accepts a supervisory role toward an incapacitated adult or elder person.

Custodian: A person over the age of eighteen years who has or shares actual physical possession of care and custody of an elder person on a full-time or temporary basis, regardless of whether the person has been granted custody of the elder person by any contract, agreement or legal proceeding.

Elder: A person age sixty-five or older.

APPENDIX O

Article 2. Crimes Against the Person.

§61-2-29b. Financial exploitation of an elderly person, protected person or incapacitated adult; penalties; definitions.

(a) Financial exploitation occurs when a person intentionally misappropriates or misuses the funds or assets of an elderly person, protected person or incapacitated adult. Any person who violates this section is guilty of larceny and shall be ordered to pay restitution.
(b) In determining the value of the money, goods, property or services referred to in subsection (a) of the section, it shall be permissible to cumulate amounts or values where such money, goods, property or services were fraudulently obtained as part of a common scheme or plan.
(c) Financial institutions and their employees, as defined by section one, article two-a, chapter thirty-one-a of this code and as permitted by section four, subsection thirteen of that article, others engaged in financially related activities as defined by section one, article eight-c, chapter thirty-one-a of this code, caregivers, relatives and other concerned persons are permitted to report suspected cases of financial exploitation to state or federal law enforcement authorities, the county prosecuting attorney and to the Department of Health and Human Resources, Adult Protective Services Division or Medicaid Fraud Division, as appropriate. Public officers and employees are required to report suspected cases of financial exploitation to the appropriate entities as stated above. The requisite agencies shall investigate or cause the investigation of the allegations.
(d) When financial exploitation is suspected and to the extent permitted by federal law, financial institutions and their employees or other business entities required by federal law or regulation to file suspicious activity reports and currency transaction reports shall also be permitted to disclose suspicious activity reports or currency transaction reports to the prosecuting attorney of any county in which the transactions underlying the suspicious activity reports or currency transaction reports occurred.
(e) Any person or entity that in good faith reports a suspected case of financial exploitation pursuant to this section is immune from civil liability founded upon making that report.
(f) For the purposes of this section:
(1) "Incapacitated adult" means a person as defined by section twenty-nine of this article;
(2) "Elderly person" means a person who is sixty-five years
or older; and
(3) "Protected person" means any person who is defined as a "protected person" in subsection thirteen, section four, article one, chapter forty-four-a of this code and who is subject to the protections of chapter forty-four-a or forty-four-c of this code.

APPENDIX P

Contact Information

- **Office of Health Facilities Licensure and Certification (OHFLAC)**

  408 Leon Sullivan Way

  Charleston, West Virginia 25301-1713

  (304) 558-0050

- **Office of Behavioral Health Services (OBHS)**

  350 Capitol Street, Room 350

  Charleston, West Virginia 25301-3702

  (304) 558-0627

- **State Long-Term Care Ombudsman Bureau for Senior Services**

  1900 Kanawha Blvd., East

  Charleston, West Virginia 25305-0160

  (304) 558-3317

- **Legal Aid of West Virginia (Regional Ombudsmen)**

  922 Quarrier Street, 4th floor

  Charleston, West Virginia 25301

  (304) 343-4481

- **State Medical Examiner**

  619 Virginia Street, West

  Charleston, West Virginia 25302

  (304) 558-6920 (main number) (304) 558- 2573 (Forensic Investigations Unit)

- **Medicaid Fraud**

  408 Leon Sullivan Way

  Charleston, West Virginia 25301-1713

  (304) 558-1858

- **Bureau for Medical Services (Medicaid)**

  350 Capitol Street, Room 251

  Charleston, West Virginia 25301

  (304) 558-1700

- **Specialized Family Care Program (Medley)**
  350 Capitol Street, Room 691
  Charleston, West Virginia 25301-3704
  (304) 558-7980
- **West Virginia Advocates**
  1207 Quarrier Street
  Charleston, West Virginia 25301
  (304) 346-0847/1-800-950-5250
- **West Virginia Prescription Drug Abuse Quitline**
  1 Medical Center Drive
  P.O. Box 9190
  WVU School of Medicine
  Morgantown, WV 26506-9190
  1-866-WV-QUITT (1-866-987-8488)
  www.wvrxabuse.org
- **WVEMS Technical Support Network of Elkview (EMS/TSN)**
  P.O. Box 100
  Elkview, West Virginia 25071
  (304) 965-0573
- **WV Medical Institute (WVMI)**
  3001 Chesterfield Place
  Charleston, WV 25304
  304-346-9864 or toll free 800-293-3009 Fax 304-346-8949

APPENDIX Q

Administrative Subpoena

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Address Inserted Here

Rocco S. Fucillo
Cabinet Secretary

Subpoena

ADMINISTRATIVE SUBPOENA DUCES TECUM
Adult Protective Services Division

TO: (Individual's name or name of records custodian of company)
(Address)

Pursuant to the authority by § 9-6-16 of the West Virginia Code, the Secretary of his/her designee for the West Virginia Department of Health and Human Resources commands that you provide any and all information which will lead to the location of (Protected Person's Name).

The information must be provided within twenty-four (24) hours of being served with this subpoena. All information leading to the location of the above named individual shall be provided to _____, Community Service Manager for the West Virginia Department of Health and Human Resources located at _____ Telephone number: _____-_____.

Upon receipt of this subpoena, please contact _____, Community Service Manager at _____- _____.

Note: In accordance with §49-6A-9 et seq., failure to provide such information may result in circuit court proceedings.

APPENDIX R

Client Rights During the APS Process

The West Virginia Department of Health and Human Resources, Adult Protective Services is mandated by the State Code of West Virginia §9-6-2 to conduct an investigation when a report of adult abuse, neglect or financial exploitation is received. When you are involved in an Adult Protective Services (APS) investigation or a case is open for APS services, there are certain rights you need to know about.

Some of those rights include:

- The right to object to someone coming into your home without your permission to conduct an investigation. If you refuse a face to face interview, law enforcement will be contacted for assistance and court intervention may be necessary to complete the investigation.
- The right to have certain information about you that APS has in their records kept private and confidential.
- The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted.
- The right to refuse APS services, unless deemed incompetent by a court of law, and the right to know what may happen if you refuse; however, the APS worker is mandated by WV Code to conduct the investigation.
- The right to have a decision made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs.
- You may have the right to request certain help for you if you have disabilities as defined by the Americans with Disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process.
- The right to know if there will be an open Adult Protective Services case.

Please keep this list in a safe place where you can find it. If you have any questions in regard to your rights, you may contact your worker or the Adult Services Supervisor. They are available to clarify any questions about your rights.

Worker's Name/Telephone Number: _____

Supervisor's Name/Telephone Number: _____

Date: _____

APPENDIX S

Alleged Perpetrator's Rights During the APS Process

The West Virginia Department of Health and Human Resources, Adult Protective Services is mandated by the State Code of West Virginia §9-6-2 to conduct an investigation when a report of adult abuse, neglect or financial exploitation is received. When you are involved in an Adult Protective Services (APS) investigation, there are certain rights you need to know about.

Some of those rights include:

- The right to object to someone coming into your home without your permission to conduct an investigation.
- The right to have certain information about you that APS has in their records kept private and confidential.
- The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted.
- The right to file a grievance if you disagree with a substantiated allegation.
- The right to have fair and reasonable decisions made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs.
- You have the right to request certain help for you if you have disabilities as defined by the Americans with disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process.
- The right to have a representative present, such as a union steward if the alleged allegation occurred in a facility setting where the alleged perpetrator is employed.
- The right to know if the allegations against you as an alleged perpetrator were substantiated, if you provide the Department of Health and Human Resources with a complete mailing address.

Please keep this list in a safe place where you can find it. If you have any questions in regard to your rights, you may contact your worker or the Adult Services Supervisor. They are available to clarify any questions about your rights.

Worker's Name/Telephone Number: _____

Supervisor's Name/Telephone Number: _____

Date: _____

APPENDIX T

Notification Letter

West Virginia Department of Human Services
Bureau for Children and Families

DISPOSITION OF REFERRAL/INVESTIGATION REPORT

Disposition of Referral

Name of Client Referred: _____ Date Received: _____

Address: _____
_____

Action taken: _____ Referral Assigned for Investigation
_____ Referral Not Assigned for Investigation

Worker Assigned, if applicable: _____

Explanation (if not assigned):
_____
_____
_____
_____

Disposition of Investigation

_____ Investigation Completed on _____
_____ Investigation Not Completed due to Extenuating Circumstances

Remarks:
_____
_____
_____

Worker: _____
Date: _____

This information is confidential. It is provided to persons mandated to report by 9-6-8 of the West Virginia Code

APPENDIX U

§44A-1-13. Compensation

(c) Attorneys appointed to represent individuals under this article shall be paid a reasonable rate of compensation from the estate, as approved by the circuit court, or, in the event the court determines that the estate is devoid of funds for the payment of such fees, the attorney shall be paid at a rate prescribed by and from funds allocated by the supreme court of appeals.

APPENDIX V

Terms Defined by Law (Federal Code §45 CFR 164.512 (c)(i)

TITLE 45--PUBLIC WELFARE

SUBTITLE A--DEPARTMENT OF HEALTH AND HUMAN SERVICES

PART 164_SECURITY AND PRIVACY--Table of Contents

Subpart E_Privacy of Individually Identifiable Health Information

Sec. 164.512 Uses and disclosures for which an authorization or opportunity to agree or object is not required.

A covered entity may use or disclose protected health information without the written authorization of the individual, as described in Sec. 164.508, or the opportunity for the individual to agree or object as described in Sec. 164.510, in the situations covered by this section, subject to the applicable requirements of this section. When the covered entity is required by this section to inform the individual of, or when the individual may agree to, a use or disclosure permitted by this section, the covered entity's information and the individual's agreement may be given orally.

(a) Standard: Uses and disclosures required by law. (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

(2) A covered entity must meet the requirements described in paragraph (c), (e), or (f) of this section for uses or disclosures required by law.

(b) Standard: uses and disclosures for public health activities--(1) Permitted disclosures. A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to:

(i) A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority;

(ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

(iii) A person subject to the jurisdiction of the Food and Drug Administration (FDA) with respect to an FDA-regulated product or activity for which that person has responsibility, for the purpose of activities related to the quality, safety or effectiveness of such FDA-regulated product or activity. Such purposes include:

(A) To collect or report adverse events (or similar activities with

respect to food or dietary supplements), product defects or problems (including problems with the use or labeling of a product), or biological product deviations;

(B) To track FDA-regulated products;

(C) To enable product recalls, repairs, or replacement, or lookback (including locating and notifying individuals who have received products that have been recalled, withdrawn, or are the subject of lookback); or

(D) To conduct post marketing surveillance;

(iv) A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such person as necessary in the conduct of a public health intervention or investigation; or

(v) An employer, about an individual who is a member of the workforce of the employer, if:

(A) The covered entity is a covered health care provider who is a member of the workforce of such employer or who provides health care to the individual at the request of the employer:

(1) To conduct an evaluation relating to medical surveillance of the workplace; or

(2) To evaluate whether the individual has a work-related illness or injury;

(B) The protected health information that is disclosed consists of findings concerning a work-related illness or injury or a workplace-related medical surveillance;

(C) The employer needs such findings in order to comply with its obligations, under 29 CFR parts 1904 through 1928, 30 CFR parts 50 through 90, or under state law having a similar purpose, to record such illness or injury or to carry out responsibilities for workplace medical surveillance; and

(D) The covered health care provider provides written notice to the individual that protected health information relating to the medical surveillance of the workplace and work-related illnesses and injuries is disclosed to the employer:

(1) By giving a copy of the notice to the individual at the time the health care is provided; or

(2) If the health care is provided on the work site of the employer, by posting the notice in a prominent place at the location where the health care is provided.

(2) Permitted uses. If the covered entity also is a public health authority, the covered entity is permitted to use protected health information in all cases in which it is permitted to disclose such information for public health activities under paragraph (b)(1) of this section.

(c) Standard: Disclosures about victims of abuse, neglect or domestic violence--(1) Permitted disclosures. Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:

(i) To the extent the disclosure is required by law and the

disclosure complies with and is limited to the relevant requirements of such law;

(ii) If the individual agrees to the disclosure; or

(iii) To the extent the disclosure is expressly authorized by statute or regulation and:

(A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or

(B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

(2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:

(i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(d) Standard: Uses and disclosures for health oversight activities--(1) Permitted disclosures. A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of:

(i) The health care system;

(ii) Government benefit programs for which health information is relevant to beneficiary eligibility;

(iii) Entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards; or

(iv) Entities subject to civil rights laws for which health information is necessary for determining compliance.

(2) Exception to health oversight activities. For the purpose of the disclosures permitted by paragraph (d)(1) of this section, a health oversight activity does not include an investigation or other activity in which the individual is the subject of the investigation or activity and such investigation or other activity does not arise out of and is not directly related to:

(i) The receipt of health care;

(ii) A claim for public benefits related to health; or

(iii) Qualification for, or receipt of, public benefits or services when a patient's health is integral to the claim for public benefits or services.

(3) Joint activities or investigations. Nothwithstanding paragraph (d)(2) of this section, if a health oversight activity or investigation is conducted in conjunction with an oversight activity or investigation relating to a claim for public benefits not related to health, the joint activity or investigation is considered a health oversight activity for purposes of paragraph (d) of this section.

(4) Permitted uses. If a covered entity also is a health oversight agency, the covered entity may use protected health information for health oversight activities as permitted by paragraph (d) of this section.

(e) Standard: Disclosures for judicial and administrative proceedings--(1) Permitted disclosures. A covered entity may disclose protected health information in the course of any judicial or administrative proceeding:

(i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or

(ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if:

(A) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iii) of this section, from the party seeking the information that reasonable efforts have been made by such party to ensure that the individual who is the subject of the protected health information that has been requested has been given notice of the request; or

(B) The covered entity receives satisfactory assurance, as described in paragraph (e)(1)(iv) of this section, from the party seeking the information that reasonable efforts have been made by such party to secure a qualified protective order that meets the requirements of paragraph (e)(1)(v) of this section.

(iii) For the purposes of paragraph (e)(1)(ii)(A) of this section, a covered entity receives satisfactory assurances from a party seeking protecting health information if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The party requesting such information has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);

(B) The notice included sufficient information about the litigation or proceeding in which the protected health information is requested to permit the individual to raise an objection to the court or administrative tribunal; and

(C) The time for the individual to raise objections to the court or administrative tribunal has elapsed, and:

(1) No objections were filed; or

(2) All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.

(iv) For the purposes of paragraph (e)(1)(ii)(B) of this section, a covered entity receives satisfactory assurances from a party seeking protected health information, if the covered entity receives from such party a written statement and accompanying documentation demonstrating that:

(A) The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or

(B) The party seeking the protected health information has requested a qualified protective order from such court or administrative tribunal.

(v) For purposes of paragraph (e)(1) of this section, a qualified protective order means, with respect to protected health information requested under paragraph (e)(1)(ii) of this section, an order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that:

(A) Prohibits the parties from using or disclosing the protected health information for any purpose other than the litigation or proceeding for which such information was requested; and

(B) Requires the return to the covered entity or destruction of the protected health information (including all copies made) at the end of the litigation or proceeding.

(vi) Nothwithstanding paragraph (e)(1)(ii) of this section, a covered entity may disclose protected health information in response to lawful process described in paragraph (e)(1)(ii) of this section without receiving satisfactory assurance under paragraph (e)(1)(ii)(A) or (B) of this section, if the covered entity makes reasonable efforts to provide notice to the individual sufficient to meet the requirements of paragraph (e)(1)(iii) of this section or to seek a qualified protective order sufficient to meet the requirements of paragraph (e)(1)(iv) of this section.

(2) Other uses and disclosures under this section. The provisions of this paragraph do not supersede other provisions of this section that otherwise permit or restrict uses or disclosures of protected health information.

(f) Standard: Disclosures for law enforcement purposes. A covered entity may disclose protected health information for a law enforcement purpose to a law enforcement official if the conditions in paragraphs (f)(1) through (f)(6) of this section are met, as applicable.

(1) Permitted disclosures: Pursuant to process and as otherwise required by law. A covered entity may disclose protected health information:

(i) As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section; or

(ii) In compliance with and as limited by the relevant requirements of:

(A) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;

(B) A grand jury subpoena; or

(C) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:

(1) The information sought is relevant and material to a legitimate law enforcement inquiry;

(2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and

(3) De-identified information could not reasonably be used.

(2) Permitted disclosures: Limited information for identification and location purposes. Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that:

(i) The covered entity may disclose only the following information:

(A) Name and address;

(B) Date and place of birth;

(C) Social security number;

(D) ABO blood type and rh factor;

(E) Type of injury;

(F) Date and time of treatment;

(G) Date and time of death, if applicable; and

(H) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

(ii) Except as permitted by paragraph (f)(2)(i) of this section, the covered entity may not disclose for the purposes of identification or location under paragraph (f)(2) of this section any protected health information related to the individual's DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue.

(3) Permitted disclosure: Victims of a crime. Except for disclosures required by law as permitted by paragraph (f)(1) of this section, a covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(i) The individual agrees to the disclosure; or

(ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;

(B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and

(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

(4) Permitted disclosure: Decedents. A covered entity may disclose protected health information about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death of the individual if the covered entity has a suspicion that such death may have resulted from criminal conduct.

(5) Permitted disclosure: Crime on premises. A covered entity may disclose to a law enforcement official protected health information that the covered entity believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the covered entity.

(6) Permitted disclosure: Reporting crime in emergencies. (i) A covered health care provider providing emergency health care in response to a medical emergency, other than such emergency on the premises of the covered health care provider, may disclose protected health information to a law enforcement official if such disclosure appears necessary to alert law enforcement to:

(A) The commission and nature of a crime;

(B) The location of such crime or of the victim(s) of such crime; and

(C) The identity, description, and location of the perpetrator of such crime.

(ii) If a covered health care provider believes that the medical emergency described in paragraph (f)(6)(i) of this section is the result of abuse, neglect, or domestic violence of the individual in need of emergency health care, paragraph (f)(6)(i) of this section does not apply and any disclosure to a law enforcement official for law enforcement purposes is subject to paragraph (c) of this section.

(g) Standard: Uses and disclosures about decedents--(1) Coroners and medical examiners. A covered entity may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. A covered entity that also performs the duties of a coroner or medical examiner may use protected health information for the purposes described in this paragraph.

(2) Funeral directors. A covered entity may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the covered entity may disclose the protected health information prior to, and in reasonable anticipation of, the individual's death.

(h) Standard: Uses and disclosures for cadaveric organ, eye or tissue donation purposes. A covered entity may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

(i) Standard: Uses and disclosures for research purposes--(1) Permitted uses and disclosures. A covered entity may use or disclose protected health information for research, regardless of the source of funding of the research, provided that:

(i) Board approval of a waiver of authorization. The covered entity obtains documentation that an alteration to or waiver, in whole or in part, of the individual authorization required by Sec. 164.508 for use or disclosure of protected health information has been approved by either:

(A) An Institutional Review Board (IRB), established in accordance with 7 CFR lc.107, 10 CFR 745.107, 14 CFR 1230.107, 15 CFR 27.107, 16 CFR 1028.107, 21 CFR 56.107, 22 CFR 225.107, 24 CFR 60.107, 28 CFR 46.107, 32 CFR 219.107, 34 CFR 97.107, 38 CFR 16.107, 40 CFR 26.107, 45 CFR 46.107, 45 CFR 690.107, or 49 CFR 11.107; or

(B) A privacy board that:

(1) Has members with varying backgrounds and appropriate professional competency as necessary to review the effect of the research protocol on the individual's privacy rights and related

interests;

(2) Includes at least one member who is not affiliated with the covered entity, not affiliated with any entity conducting or sponsoring the research, and not related to any person who is affiliated with any of such entities; and

(3) Does not have any member participating in a review of any project in which the member has a conflict of interest.

(ii) Reviews preparatory to research. The covered entity obtains from the researcher representations that:

(A) Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research;

(B) No protected health information is to be removed from the covered entity by the researcher in the course of the review; and

(C) The protected health information for which use or access is sought is necessary for the research purposes.

(iii) Research on decedent's information. The covered entity obtains from the researcher:

(A) Representation that the use or disclosure sought is solely for research on the protected health information of decedents;

(B) Documentation, at the request of the covered entity, of the death of such individuals; and

(C) Representation that the protected health information for which use or disclosure is sought is necessary for the research purposes.

(2) Documentation of waiver approval. For a use or disclosure to be permitted based on documentation of approval of an alteration or waiver, under paragraph (i)(1)(i) of this section, the documentation must include all of the following:

(i) Identification and date of action. A statement identifying the IRB or privacy board and the date on which the alteration or waiver of authorization was approved;

(ii) Waiver criteria. A statement that the IRB or privacy board has determined that the alteration or waiver, in whole or in part, of authorization satisfies the following criteria:

(A) The use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements;

(1) An adequate plan to protect the identifiers from improper use and disclosure;

(2) An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and

(3) Adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of protected health information would be permitted by this subpart;

(B) The research could not practicably be conducted without the waiver or alteration; and

(C) The research could not practicably be conducted without access to and use of the protected health information.

(iii) Protected health information needed. A brief description of the protected health information for which use or access has been

determined to be necessary by the IRB or privacy board has determined, pursuant to paragraph (i)(2)(ii)(C) of this section;

(iv) Review and approval procedures. A statement that the alteration or waiver of authorization has been reviewed and approved under either normal or expedited review procedures, as follows:

(A) An IRB must follow the requirements of the Common Rule, including the normal review procedures (7 CFR 1c.108(b), 10 CFR 745.108(b), 14 CFR 1230.108(b), 15 CFR 27.108(b), 16 CFR 1028.108(b), 21 CFR 56.108(b), 22 CFR 225.108(b), 24 CFR 60.108(b), 28 CFR 46.108(b), 32 CFR 219.108(b), 34 CFR 97.108(b), 38 CFR 16.108(b), 40 CFR 26.108(b), 45 CFR 46.108(b), 45 CFR 690.108(b), or 49 CFR 11.108(b)) or the expedited review procedures (7 CFR 1c.110, 10 CFR 745.110, 14 CFR 1230.110, 15 CFR 27.110, 16 CFR 1028.110, 21 CFR 56.110, 22 CFR 225.110, 24 CFR 60.110, 28 CFR 46.110, 32 CFR 219.110, 34 CFR 97.110, 38 CFR 16.110, 40 CFR 26.110, 45 CFR 46.110, 45 CFR 690.110, or 49 CFR 11.110);

(B) A privacy board must review the proposed research at convened meetings at which a majority of the privacy board members are present, including at least one member who satisfies the criterion stated in paragraph (i)(1)(i)(B)(2) of this section, and the alteration or waiver of authorization must be approved by the majority of the privacy board members present at the meeting, unless the privacy board elects to use an expedited review procedure in accordance with paragraph (i)(2)(iv)(C) of this section;

(C) A privacy board may use an expedited review procedure if the research involves no more than minimal risk to the privacy of the individuals who are the subject of the protected health information for which use or disclosure is being sought. If the privacy board elects to use an expedited review procedure, the review and approval of the alteration or waiver of authorization may be carried out by the chair of the privacy board, or by one or more members of the privacy board as designated by the chair; and

(v) Required signature. The documentation of the alteration or waiver of authorization must be signed by the chair or other member, as designated by the chair, of the IRB or the privacy board, as applicable.

(j) Standard: Uses and disclosures to avert a serious threat to health or safety--(1) Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:

(i)(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat; or

(ii) Is necessary for law enforcement authorities to identify or apprehend an individual:

(A) Because of a statement by an individual admitting participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to the victim; or

(B) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody, as those terms are defined in Sec. 164.501.

(2) Use or disclosure not permitted. A use or disclosure pursuant to paragraph (j)(1)(ii)(A) of this section may not be made if the information described in paragraph (j)(1)(ii)(A) of this section is

learned by the covered entity:

(i) In the course of treatment to affect the propensity to commit the criminal conduct that is the basis for the disclosure under paragraph (j)(1)(ii)(A) of this section, or counseling or therapy; or

(ii) Through a request by the individual to initiate or to be referred for the treatment, counseling, or therapy described in paragraph (j)(2)(i) of this section.

(3) Limit on information that may be disclosed. A disclosure made pursuant to paragraph (j)(1)(ii)(A) of this section shall contain only the statement described in paragraph (j)(1)(ii)(A) of this section and the protected health information described in paragraph (f)(2)(i) of this section.

(4) Presumption of good faith belief. A covered entity that uses or discloses protected health information pursuant to paragraph (j)(1) of this section is presumed to have acted in good faith with regard to a belief described in paragraph (j)(1)(i) or (ii) of this section, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

(k) Standard: Uses and disclosures for specialized government functions--(1) Military and veterans activities--(i) Armed Forces personnel. A covered entity may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the Federal Register the following information:

(A) Appropriate military command authorities; and

(B) The purposes for which the protected health information may be used or disclosed.

(ii) Separation or discharge from military service. A covered entity that is a component of the Departments of Defense or Transportation may disclose to the Department of Veterans Affairs (DVA) the protected health information of an individual who is a member of the Armed Forces upon the separation or discharge of the individual from military service for the purpose of a determination by DVA of the individual's eligibility for or entitlement to benefits under laws administered by the Secretary of Veterans Affairs.

(iii) Veterans. A covered entity that is a component of the Department of Veterans Affairs may use and disclose protected health information to components of the Department that determine eligibility for or entitlement to, or that provide, benefits under the laws administered by the Secretary of Veterans Affairs.

(iv) Foreign military personnel. A covered entity may use and disclose the protected health information of individuals who are foreign military personnel to their appropriate foreign military authority for the same purposes for which uses and disclosures are permitted for Armed Forces personnel under the notice published in the Federal Register pursuant to paragraph (k)(1)(i) of this section.

(2) National security and intelligence activities. A covered entity may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act (50 U.S.C. 401, et seq.) and implementing authority (e.g.,

Executive Order 12333).

(3) Protective services for the President and others. A covered entity may disclose protected health information to authorized federal officials for the provision of protective services to the President or other persons authorized by 18 U.S.C. 3056, or to foreign heads of state or other persons authorized by 22 U.S.C. 2709(a)(3),or to for the conduct of investigations authorized by 18 U.S.C. 871 and 879.

(4) Medical suitability determinations. A covered entity that is a component of the Department of State may use protected health information to make medical suitability determinations and may disclose whether or not the individual was determined to be medically suitable to the officials in the Department of State who need access to such information for the following purposes:

(i) For the purpose of a required security clearance conducted pursuant to Executive Orders 10450 and 12698;

(ii) As necessary to determine worldwide availability or availability for mandatory service abroad under sections 101(a)(4) and 504 of the Foreign Service Act; or

(iii) For a family to accompany a Foreign Service member abroad, consistent with section 101(b)(5) and 904 of the Foreign Service Act.

(5) Correctional institutions and other law enforcement custodial situations. (i) Permitted disclosures. A covered entity may disclose to a correctional institution or a law enforcement official having lawful custody of an inmate or other individual protected health information about such inmate or individual, if the correctional institution or such law enforcement official represents that such protected health information is necessary for:

(A) The provision of health care to such individuals;

(B) The health and safety of such individual or other inmates;

(C) The health and safety of the officers or employees of or others at the correctional institution;

(D) The health and safety of such individuals and officers or other persons responsible for the transporting of inmates or their transfer from one institution, facility, or setting to another;

(E) Law enforcement on the premises of the correctional institution; and

(F) The administration and maintenance of the safety, security, and good order of the correctional institution.

(ii) Permitted uses. A covered entity that is a correctional institution may use protected health information of individuals who are inmates for any purpose for which such protected health information may be disclosed.

(iii) No application after release. For the purposes of this provision, an individual is no longer an inmate when released on parole, probation, supervised release, or otherwise is no longer in lawful custody.

(6) Covered entities that are government programs providing public benefits. (i) A health plan that is a government program providing public benefits may disclose protected health information relating to eligibility for or enrollment in the health plan to another agency administering a government program providing public benefits if the sharing of eligibility or enrollment information among such government agencies or the maintenance of such information in a single or combined data system accessible to all such government agencies is required or

expressly authorized by statute or regulation.

(ii) A covered entity that is a government agency administering a government program providing public benefits may disclose protected health information relating to the program to another covered entity that is a government agency administering a government program providing public benefits if the programs serve the same or similar populations and the disclosure of protected health information is necessary to coordinate the covered functions of such programs or to improve administration and management relating to the covered functions of such programs.

(l) Standard: Disclosures for workers' compensation. A covered entity may disclose protected health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

[65 FR 82802, Dec. 28, 2000, as amended at 67 FR 53270, Aug. 14, 2002]

APPENDIX W

Terms Defined by Law (Federal Code §42 USCA 15043)

42 USC Sec. ***15043*** 02/01/2010

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 144 - DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS

SUBCHAPTER I - PROGRAMS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Part C - Protection and Advocacy of Individual Rights

Sec. 15043. System required

(a) System required

In order for a State to receive an allotment under part B of this subchapter or this part -

(1) the State shall have in effect a system to protect and advocate the rights of individuals with developmental disabilities;

(2) such system shall -

(A) have the authority to -

(i) pursue legal, administrative, and other appropriate remedies or approaches to ensure the protection of, and advocacy for, the rights of such individuals within the State

who are or who may be eligible for treatment, services, or habilitation, or who are being considered for a change in living arrangements, with particular attention to members of ethnic and racial minority groups; and

(ii) provide information on and referral to programs and services addressing the needs of individuals with developmental disabilities;

(B) have the authority to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred;

(C) on an annual basis, develop, submit to the Secretary, and take action with regard to goals (each of which is related to 1 or more areas of emphasis) and priorities, developed through data driven strategic planning, for the system's activities;

(D) on an annual basis, provide to the public, including individuals with developmental disabilities attributable to either physical impairment, mental impairment, or a combination of physical and mental impairment, and their representatives, and as appropriate, non-State agency representatives of the State Councils on Developmental Disabilities, and Centers, in the State, an opportunity to comment on -

(i) the goals and priorities established by the system and the rationale for the establishment of such goals; and

(ii) the activities of the system, including the

coordination of services with the entities carrying out advocacy programs under the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.), and the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (!1) (42 U.S.C. 10801 et seq.), and with entities carrying out other related programs, including the parent training and information centers funded under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), and activities authorized under section 3003 or 3004 of title 29;

(E) establish a grievance procedure for clients or prospective clients of the system to ensure that individuals with developmental disabilities have full access to services of the system;

(F) not be administered by the State Council on Developmental Disabilities;

(G) be independent of any agency that provides treatment, services, or habilitation to individuals with developmental disabilities;

(H) have access at reasonable times to any individual with a developmental disability in a location in which services, supports, and other assistance are provided to such an individual, in order to carry out the purpose of this part;

(I) have access to all records of -

(i) any individual with a developmental disability who is a

client of the system if such individual, or the legal guardian, conservator, or other legal representative of such individual, has authorized the system to have such access;

(ii) any individual with a developmental disability, in a situation in which -

(I) the individual, by reason of such individual's mental or physical condition, is unable to authorize the system to have such access;

(II) the individual does not have a legal guardian, conservator, or other legal representative, or the legal guardian of the individual is the State; and

(III) a complaint has been received by the system about the individual with regard to the status or treatment of the individual or, as a result of monitoring or other activities, there is probable cause to believe that such individual has been subject to abuse or neglect; and

(iii) any individual with a developmental disability, in a situation in which -

(I) the individual has a legal guardian, conservator, or other legal representative;

(II) a complaint has been received by the system about the individual with regard to the status or treatment of the individual or, as a result of monitoring or other activities, there is probable cause to believe that such individual has been subject to abuse or neglect;

(III) such representative has been contacted by such system, upon receipt of the name and address of such representative;

(IV) such system has offered assistance to such representative to resolve the situation; and

(V) such representative has failed or refused to act on behalf of the individual;

(J)(i) have access to the records of individuals described in subparagraphs (B) and (I), and other records that are relevant to conducting an investigation, under the circumstances described in those subparagraphs, not later than 3 business days after the system makes a written request for the records involved; and

(ii) have immediate access, not later than 24 hours after the system makes such a request, to the records without consent from another party, in a situation in which services, supports, and other assistance are provided to an individual with a developmental disability -

(I) if the system determines there is probable cause to believe that the health or safety of the individual is in serious and immediate jeopardy; or

(II) in any case of death of an individual with a developmental disability;

(K) hire and maintain sufficient numbers and types of staff (qualified by training and experience) to carry out such

system's functions, except that the State involved shall not apply hiring freezes, reductions in force, prohibitions on travel, or other policies to the staff of the system, to the extent that such policies would impact the staff or functions of the system funded with Federal funds or would prevent the system from carrying out the functions of the system under this part;

(L) have the authority to educate policymakers; and

(M) provide assurances to the Secretary that funds allotted to the State under section 15042 of this title will be used to supplement, and not supplant, the non-Federal funds that would otherwise be made available for the purposes for which the allotted funds are provided;

(3) to the extent that information is available, the State shall provide to the system -

(A) a copy of each independent review, pursuant to section 1396a(a)(30)(C) of this title, of an Intermediate Care Facility (Mental Retardation) within the State, not later than 30 days after the availability of such a review; and

(B) information about the adequacy of health care and other services, supports, and assistance that individuals with developmental disabilities who are served through home and community-based waivers (authorized under section 1396n(c) of this title) receive; and

(4) the agency implementing the system shall not be

redesignated unless -

(A) there is good cause for the redesignation;

(B) the State has given the agency notice of the intention to make such redesignation, including notice regarding the good cause for such redesignation, and given the agency an opportunity to respond to the assertion that good cause has been shown;

(C) the State has given timely notice and an opportunity for public comment in an accessible format to individuals with developmental disabilities or their representatives; and

(D) the system has an opportunity to appeal the redesignation to the Secretary, on the basis that the redesignation was not for good cause.

(b) American Indian consortium

Upon application to the Secretary, an American Indian consortium established to provide protection and advocacy services under this part, shall receive funding pursuant to section 15042(a)(6) of this title to provide the services. Such consortium shall be considered to be a system for purposes of this part and shall coordinate the services with other systems serving the same geographic area. The tribal council that designates the consortium shall carry out the responsibilities and exercise the authorities specified for a State in this part, with regard to the consortium.

(c) Record

In this section, the term "record" includes -

(1) a report prepared or received by any staff at any location at which services, supports, or other assistance is provided to individuals with developmental disabilities;

(2) a report prepared by an agency or staff person charged with investigating reports of incidents of abuse or neglect, injury, or death occurring at such location, that describes such incidents and the steps taken to investigate such incidents; and

(3) a discharge planning record.

-SOURCE-

(Pub. L. 106-402, title I, Sec. 143, Oct. 30, 2000, 114 Stat. 1714; Pub. L. 108-364, Sec. 3(a)(3), Oct. 25, 2004, 118 Stat. 1736.)\

REFERENCES IN TEXT

The Rehabilitation Act of 1973, referred to in subsec. (a)(2)(D)(ii), is Pub. L. 93-112, Sept. 26, 1973, 87 Stat. 355, as amended, which is classified generally to chapter 16 (Sec. 701 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 701 of Title 29 and Tables.

The Older Americans Act of 1965, referred to in subsec. (a)(2)(D)(ii), is Pub. L. 89-73, July 14, 1965, 79 Stat. 218, as amended, which is classified generally to chapter 35 (Sec. 3001 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 3001 of this title

and Tables.

The Protection and Advocacy for Mentally Ill Individuals Act of 1986, referred to in subsec. (a)(2)(D)(ii), was Pub. L. 99-319, May 23, 1986, 100 Stat. 478, as amended. Pub. L. 99-319 was renamed the Protection and Advocacy for Individuals with Mental Illness Act by Pub. L. 106-310, div. B, title XXXII, Sec. 3206(a), Oct. 17, 2000, 114 Stat. 1193, and is classified generally to chapter 114 (Sec. 10801 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 10801 of this title and Tables.

The Individuals with Disabilities Education Act, referred to in subsec. (a)(2)(D)(ii), is title VI of Pub. L. 91-230, Apr. 13, 1970, 84 Stat. 175, as amended, which is classified generally to chapter 33 (Sec. 1400 et seq.) of Title 20, Education. For complete classification of this Act to the Code, see section 1400 of Title 20 and Tables.

AMENDMENTS

2004 - Subsec. (a)(2)(D)(ii). Pub. L. 108-364 substituted "section 3003 or 3004 of title 29" for "section 3011 or 3012 of title 29".

-FOOTNOTE-

(!1) See References in Text note below

APPENDIX X

Memorandum of Understanding

DATE: **December 8, 2011**

TO: **Regional Directors**
Community Services Managers
Regional Program Managers
Adult Services Consultants
Adult Services Supervisors
Long-Term Care Ombudsman Personnel

FROM: **Jane McCallister, Director, Children & Adult Services**
Suzanne Messenger, State Long-Term Care Ombudsman

SUBJECT: **Best Practice Guidelines for Bureau for Children and Families, Adult Services staff and Long-Term Care Ombudsmen**

Memorandum of Understanding

The guidelines outlined below were developed during a series of meetings in 2004 between the Department of Health and Human Resources, Bureau for Children and Families (BCF) Adult Services policy staff and Adult Services Consultants, the State Long-Term Care Ombudsman, the Regional Ombudsman Supervisor and the Ombudsman Attorney. In addition, it has been reviewed by the Bureau for Children and Families legal staff. The purpose of these guidelines is to enhance communication and cooperation between BCF Adult Services staff and the Long-Term Care Regional Ombudsman as we carry out our respective duties/mandates. It has recently been updated, December 8, 2011, to reflect changes in responsibilities of the Ombudsmen.

Role/Responsibilities – Generally

Adult Protective Services

The Department of Health and Human Resources (DHHR) is the designated agency responsible for accepting and handling reports of abuse/neglect involving incapacitated adults and/or residents of certain facilities. As such, DHHR Bureau for Children and Families is the "lead" agency in responding to all reports received alleging abuse/neglect of incapacitated adults and/or facility residents, as defined by West Virginia State Code. The Bureau for Children and Families accepts reports 24 hours/day, seven days/week. In situations involving alleged abuse/neglect of residents of long-term care facilities, the Regional Long-Term Care Ombudsman is also to receive notification of all reports made by a mandatory reporter. This notification is to be sent directly to the Regional Ombudsman by the reporter, in addition to the original report which is submitted to the local DHHR office. Each report received is reviewed by a supervisor and either accepted for investigation or screened out. Assigned investigations must be initiated within a specified timeframe (within 2 hours, 72 hours, 14 days) based on the information contained in the report/seriousness of the situation reported.

Long-Term Care Ombudsman

The Federal Older Americans Act, which is administered by the Administration on Aging, requires that the state agency on aging (Bureau of Senior Services in WV) be responsible for establishing the Office of the State Long-Term Care Ombudsman and ensuring that the program operates according to provisions of the Act. The Bureau in turn, contracts with Legal Aid of West Virginia to administer the day-to-day operation of the program. The specific duties of the Ombudsman Program enumerated by the Act and reinforced in WV State Statue are the following:

1. Make unannounced visits to long-term care facilities on a regular basis. [1]

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[1] Note: Under the Administration on Aging interpretation "the ombudsman program is both authorized and required under federal law to cover nursing homes, board and care homes, adult residential care facilities, assisted living facilities and any other type of congregate adult care home, the majority of whose residents are age 60 and above." *Frequently Asked Questions and Answers About the Long-Term Care Ombudsman Program Under the Older Americans Act, as Amended in 2000, U. S. Dept. of Health and Human Services, Administration on Aging, Office of Elder Rights Protection, Discussion Draft June, 28, 2001, Question #6.* State Statute in WV has expanded the definition to allow ombudsman to serve residents in all such homes, including AFC homes, regardless of age.

2. Receive, investigate and attempt to resolve complaints made by, or on behalf of, long- term care residents.
3. Represent residents' interests to government agencies and seek administrative, legal and other remedies to protect residents.
4. Provide information and assistance about long-term care.
5. Educate community members and promote awareness about long-term care issues.
6. Conduct in-service training for facility residents and staff on residents' rights.
7. Provide technical assistance on the development of resident and family councils.
8. Identify issues affecting the quality of life for long-term care facility residents.
9. Coordinate efforts with other agencies and organizations concerned about long-term care.
10. Document complaint resolution and other activities through the uniform statewide reporting system.

The Ombudsmen receive and investigate complaints made by, or on behalf of, residents of the following types of facilities:

- Nursing home:
- Long-term care units situated in an acute care hospital;
- Assisted Living facilities (previously Personal Care Homes and Residential Board & Care Homes); and,
- Registered Unlicensed Homes.

The Long-Term Care Ombudsmen DO NOT investigates complaints in Intermediate Care Facility for the Individually Disabled (ICF/ID) facilities since these are served by other advocacy groups.

Confidentiality Requirements

Adult Protective Services

The state statute governing the delivery of protective services to adults is quite restrictive in regard to the information released from these records. Information generally cannot be released except under order of the court. Since sharing of information with certain parties by mandatory reporters is not only permitted but is required by statute (§9-6-11) during the reporting process, discussing the contents of the reports received with other recipients of the report is not a violation of the confidentiality requirements that generally apply to these records. Other recipients may include the following, based on the circumstances of the report:

- Original report - Department of Health and Human Resources;
- Copy to the appropriate law-enforcement agency and the prosecuting attorney, if criminal matter involved;
- In case of a death, copy to the appropriate medical examiner or coroner's office;

- In case the alleged victim is a resident of a nursing home or other residential facility, a copy to the state or regional ombudsman and the administrator of the nursing home or facility.

Long-Term Care Ombudsman

Both the federal and state laws that govern the Ombudsman Program provide that all identity information, *i.e.,* any information which would reasonably allow someone to determine the identity of a long-term care resident or person providing information about a resident, obtained or maintained by the Long-Term Ombudsman in the course of carrying out their official duties as a Long-Term Care Ombudsman, is confidential and shall not be disclosed or released by the Ombudsman unless the resident or his or her legal representative consents. All information, records and reports received by or developed by a Long-Term Ombudsman which relate to a resident of a facility, including written material identifying a resident, are confidential and shall not be disclosed or released by the Ombudsman.

Abuse reports, and their contents, are reports received by Ombudsman that relate to a resident of a facility and must be kept confidential by the Ombudsman. However, the Ombudsman is only one of a number of entities that receive a copy of the abuse report. Because an Ombudsman is not disclosing any information by discussing the contents of the report with a representative of these specific entities (WVDHHR and law enforcement and/or coroner if criminal matter and/or death) the Ombudsman can discuss the contents of these reports and coordinate a response to these reports with these entities without violating confidentiality.

Ongoing Communication

In order to facilitate a cooperative working relationship between BCF Adult Services staff and the State and Regional Ombudsman, as called for in the West Virginia State Code (§9-6-2), ongoing and frequent contact between Adult Services staff and the Regional Ombudsman is essential. To establish and strengthen the relationship between Adult Services staff and the Regional Ombudsman, the following guidelines are suggested:

- Initially, contact should be made by the Regional Ombudsman with the Adult Services supervisor to determine the protocol to be followed for ongoing contact with both supervisors and workers (frequency of contact, primary contact person in BCF, coordination of joint investigations, etc.);
- Once the protocol is established, ongoing contact should be initiated by the Regional Ombudsman – recommended on a monthly basis (phone or face-to-face);
- Face to face contact recommended at least quarterly.

The intent of maintaining ongoing contact and communication is two-fold. First, to strengthen a cooperative working relationship and second; to provide a forum for discussion and resolution of issues as they arise. Topics might include general procedural issues, clarification about roles and responsibilities, issues/concerns identified involving specific facilities, identification of APS reports that were screened out, etc.

Collaboration on Adult Protective Services (APS) Reports Received Involving Long-Term Care Facility Resident

According to §9-6-11, both DHHR and the Ombudsman are required to receive a copy of all reports involving abuse/neglect of residents of long-term care facilities, it is not a breach of confidentiality for the two entities to discuss the reports received in these settings for the purpose of determining the most appropriate respondent and for coordination of site visits, whenever possible.

Screened Out Reports

Since BCF is the lead agency with regard to reports of abuse/neglect in these settings, the assumption will be that Adult Protective Services staff will take appropriate action on each report received. Some reports are clearly within the scope of APS. Whenever this is not clear, and clarification/confirmation is desired about whether a report will be assigned for investigation by APS staff or screened out, the Regional Ombudsman may contact the Adult Services supervisor or the Adult Services worker identified in the established protocol. If a report is screened out by the AS supervisor which indicates a pressing need requiring prompt attention (i.e. pending discharge due to non-payment, resident rights issues such as not permitted to vote, refusal of family visitation by out of town relatives, etc.) the supervisor should contact the Regional Ombudsman promptly so they may proceed with an investigation.

Referrals/Notification to Ombudsman by DHHR

Whenever abuse/neglect is substantiated in a long-term care facility where the Ombudsman has authority, the APS worker is to send written notification of the substantiation following completion of the investigation. In addition, if during the course of the investigation the worker becomes aware of situations that negatively impact the rights of the facility resident they are to be reported to the Regional Ombudsman for additional follow-up.

Referrals to APS by Ombudsman

The Long-Term Care Ombudsman may receive complaints involving various issues (see Appendix Y titled “Ombudsman Complaint Categories”). At times, these may include disclosure of alleged abuse/neglect either at the time the complaint is made or

during the Ombudsman's investigation of the complaint. Federal statute which authorizes the Ombudsman Program prohibits disclosure of any information without the consent of the identified client. Therefore the following guidelines will apply:

1) Allegations of abuse/neglect disclosed when the complaint is made to the Ombudsman:
    - The complainant will be encouraged to report the abuse/neglect to Adult Protective Services;
    - If the complainant is unwilling or unable to report to APS, the Ombudsman will proceed with their investigation.
2) Allegations of abuse/neglect disclosed during the Ombudsman's investigation of a complaint:
    - If the allegations are specific to the resident who is the subject of the complaint being investigated by the Ombudsman, the Ombudsman will request permission from the resident/legal guardian to make the report to APS.
    - If the allegations are not specific to the resident who is the subject of the complaint being investigated by the Ombudsman, but rather, impact multiple facility residents the Ombudsman will make the report to APS, not singling out the resident they are involved with.
3) Abuse/neglect witnessed by the Ombudsman during a site visit, whether or not the site visit is for the purpose of complaint investigation of routine facility monitoring:
    - Ombudsman will report abuse/neglect to APS.
4) Perpetrator of abuse or neglect admits to the allegations to the Ombudsman:
    - Ombudsman will report abuse/neglect to APS.

Coordination of Investigation Site Visits

Whenever both APS and the Regional Ombudsman will be conducting an investigation focused on a specific resident/report, coordination of site visits is strongly encouraged. Doing so serves to minimize disruption for both residents and facility staff. Though the visit is coordinated, the investigations are to be conducted separately since the focus of an APS and Ombudsman complaint investigation are not the same.

In order to schedule a joint site visit, the Regional Ombudsman is to contact the Adult Services supervisor. As a result of the short response time in some cases, it is important that this contact be made promptly (APS response times: within 2 hours, 72 hours, 14 days based on the information reported). Conversely, when APS wishes to arrange a joint site visit, the Adult Services supervisor is to contact the Regional Ombudsman.

Facility Closures

Closure of a facility can have a significant impact on both residents and staff and as a result, ideally will be handled in a planned and organized fashion. While the facility has primary responsibility for ensuring that residents are discharged to other settings which are appropriate to meet their needs, both Adult Services staff and the Regional Ombudsman can, and often do, play a role in helping to facilitate as smooth a transition as possible for the residents. Whenever either the Regional Ombudsman or Adult Services staff learns of a facility closure, they are to notify the other. The Department will generally be actively involved in planning for transfer of residents for whom BCF is the guardian/health care surrogate or for whom BCF is making a supplemental payment. In situations involving facilities that appear to be willing to cooperate and the residents are not at risk, the Ombudsman may assist in the following ways:

- Participate in monitoring homes during the closure period;
- Help to identify other appropriate facilities that may have a vacancy;
- Help with assessment of resident preferences about where they would like to live; and,
- Follow-up after residents have been moved to ensure that the new placement is appropriate.

During the transfer process, efforts should be coordinated between the Adult Services staff and the Ombudsman whenever possible.

Adult Family Care/Adult Emergency Shelter Care Homes

Adult Family Care (AFC) homes are one of the placement settings the Regional Ombudsman has authority to monitor and provide assistance to residents. Since these homes are recruited and certified by BCF and are required to have regular, ongoing contact with Home Finding and Adult Services staff, the Ombudsman does not typically do scheduled monitoring visits in these homes. A list of the active AFC homes will be provided by the BCF state office to the State Ombudsman on a quarterly basis, for informational purposes only, so the Ombudsman is able to distinguish these homes from registered-unlicensed homes.

Complaints are accepted by the Ombudsman from/on behalf of residents of AFC and the Regional Ombudsman has authority to conduct investigations in these homes. A unique consideration related to the Ombudsman's involvement in these homes is that since these homes are certified by BCF, unless the allegation is against the Adult Services case worker, the Ombudsman is to contact the Regional Home Finding supervisor to inform that a complaint has been received and to arrange a joint visit if this is possible. If a joint visit cannot be arranged, the Ombudsman is to notify the Home Finding supervisor of the outcome of the investigation, if the client has granted permission to share this information.

DHHR is Guardian for Resident who is the Subject of an Ombudsman Complaint Investigation

Whenever a complaint is received by the Ombudsman involving a resident for whom DHHR is the legal guardian, the Regional Ombudsman must request permission to investigate the complaint and, if necessary, to review the resident's record maintained by the facility. To request permission, the Ombudsman must contact the Adult Services supervisor/worker in accordance with the established protocol and specify if they want permission to investigate a complaint and/or gain access to the resident's facility record. If the request is determined to be in the protected person's best interest, access may be granted.

In the event the guardian refuses to grant access, the Regional Ombudsman may request a waiver from the State Long-Term Care Ombudsman to proceed with the investigation and gain access to the resident's record. If the waiver is granted, the Ombudsman may proceed with their investigation and/or gain access to the resident's record maintained by the facility.

DHHR is Health Care Surrogate for Resident who is the Subject of an Ombudsman Complaint Investigation

The scope of a Health Care Surrogate's authority is limited to health care matters. As a result, whether or not the Health Care Surrogate can authorize access to a resident's medical records in the facility providing their care is dependent on the nature of the complaint being investigated. If the complaint directly relates to the residents health care, the Health Care Surrogate can grant the Ombudsman access to the resident's medical record for the purpose of completing their investigation. The Health Care Surrogate is not empowered to grant access to the resident's medical record if the complaint being investigated is not related to their health care. This assumes that the resident lacks capacity to make health care decisions. This would have to be determined on a case by case basis. Examples of issues requiring HCS authorization would include complaints related to quality of health care provided, Medicaid eligibility, etc., while decisions which would not require HCS authorizations might include complaints related to visitation issues, quality of food, missing personal items, etc.

Whenever a complaint related to health care issues is received by the Ombudsman involving a resident for whom DHHR is the Health Care Surrogate, the Regional Ombudsman must request permission to investigate the complaint and, if necessary, to review the resident's medical record. To request permission, the Ombudsman must contact the Adult Services supervisor/worker in accordance with the established protocol and specify if they want permission to investigate a complaint and/or gain access to the resident's facility record. If the request is determined to be in the resident's best interest, access may be granted.

In the event the Health Care Surrogate refuses to grant access, the Regional Ombudsman may request a waiver from the State Long-Term Care Ombudsman to proceed with the investigation and gain access to the resident's record. If the waiver is granted, the Ombudsman may proceed with their investigation and/or gain access to the resident's facility record.

If the nature of the complaint is outside the scope of authority for the Health Care Surrogate AND the resident is incapacitated and unable to grant access themselves, the Ombudsman may proceed with their investigation and access the resident's facility record.

APPENDIX Y

LTC Ombudsman Complaint Categories

LTC Ombudsman Complaint Categories	
ID	**Description**
A1	Abuse, physical (including corporal punishment)
A2	Abuse, sexual
A3	Abuse, verbal/mental (including punishment/seclusion)
A4	Financial exploitation (use categories in Section E for less severe forms of financial complaints)
A5	Gross neglect (use categories under Care, Sections F & G for non-willful forms of neglect)
A6	Resident-to-resident physical, verbal or sexual abuse
A7	Not Used
B10	Access to facility survey/staffing reports/license
B11	Information regarding advance directive(s)
B12	Information regarding medical condition, treatment and any changes
B13	Information regarding rights, benefits, services, the resident's right to complain
B14	Information communicated in understandable language
B15	Not Used
B8	Access to Own records
B9	Access by or to Ombudsman/Visitors
C16	Admission contract and/or procedure
C17	Appeal process-absent, not followed
C18	Bed hold-written notice, refusal to readmit
C19	Discharge/eviction-planning, notice, procedure, implementation, including abandonment
C20	Discrimination in admission due to condition disability
C21	Discrimination in admission due to Medicaid status
C22	Room assignment/room change/intra-facility transfer
C23	Not Used
D24	Choose personal physician/pharmacy/hospice/other health care provider
D25	Confinement of facility against will (illegally)
D26	Dignity, respect-staff attitudes
D27	Exercise preference/choice and/or civil/religious rights, individual's right to smoke
D28	Exercise right to refuse care/treatment
D29	Language barrier in daily routine

LTC Ombudsman Complaint Categories	
ID	**Description**
D30	Participate in care planning by resident and/or designated surrogate
D31	Privacy-telephone, visitors, couples, mail
D32	Privacy in treatment, confidentiality
D33	Response to complaints
D34	Reprisal, retaliation
D35	Not Used
E36	Billing/charges-notice, approval, questionable, accounting wrong or denied
E37	Personal funds-mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
E38	Personal property lost, stolen, used by others, destroyed, withheld from resident
E39	Not Used
F40	Accidental or injury of unknown origin, falls, improper handling
F41	Failure to respond to requests for assistance
F42	Care plan/resident assessment-inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D.30)
F43	Contracture
F44	Medications-administration, organization
F45	Personal hygiene (includes nail care & oral hygiene) and adequacy of dress dining
F46	Physician services, including podiatrist
F47	Pressure sores, not turned
F48	Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition
F49	Toileting, incontinent care
F50	Tubes-neglect of catheter, gastric, NG tube (use D28 for inappropriate, forced use
F51	Wandering, failure to accommodate/monitor exit seeking behavior
F52	Not Used
G53	Assistive devices or equipment
G54	Bowel and bladder training
G55	Dental services
G56	Mental health, psychosocial services
G57	Range of motion/ambulation/exercise
G58	Therapies, physical, occupational, speech
G59	Vision and hearing

LTC Ombudsman Complaint Categories	
ID	**Description**
G60	Not Used
H61	Physical restraint-assessment, use, monitoring
H62	Psychoactive Drugs - Assessment, use, Evaluation
H63	Not Used
I64	Activities-choice and appropriateness
I65	Community interaction, transportation
I66	Resident conflict, including roommates
I67	Social Services-availability/appropriateness (use G.56 for mental health, psychosocial counseling/service)
I68	Not Used
J69	Assistance in eating or assistive devices
J70	Fluid availability/hydration
J71	Food service - quantity, quality, variation, choice, condiments, utensils, menu
J72	Snacks, time span between meals, late/missed meals
J73	Temperature
J74	Therapeutic diet
J75	Weight loss due to inadequate nutrition
J76	Not Used
K77	Air/environment: temperature and quality (heating, cooling, ventilation, water, noise)
K78	Cleanliness, pests, general housekeeping
K79	Equipment/Buildings-disrepair, hazard, poor lighting, fire safety, not secure
K80	Furnishing, storage for residents
K81	Infection control
K82	Laundry-lost, condition
K83	Odors
K84	Space for activities, dining
K85	Supplies and linens
K86	American with Disabilities Act (ADA) accessibility
L87	Abuse investigation/reporting, including failure to report
L88	Administrator(s) unresponsive, unavailable
L89	Grievance procedure (use C categories for transfer, discharge appeals
L90	Inappropriate or illegal policies, practices, record keeping
L91	Insufficient fund to operate
L92	Operator inadequately trained

LTC Ombudsman Complaint Categories	
ID	**Description**
L93	Offering inappropriate level of care (for B&C/similar)
L94	Resident or family council/committee interfered with, not supported
L95	Not Used
M100	Staff unresponsive, unavailable
M101	Supervision
M102	Eating Assistants
M96	Communication, language barrier
M97	Shortage of staff
M98	Staff training
M99	Staff turn-over, over-use of nursing pools
N103	Access to information (including survey)
N104	Complaint, response to
N105	Decertification/closure
N106	Sanction, including Intermediate
N107	Survey process
N108	Survey process-Ombudsman participation
N109	Transfer or eviction hearing
N110	Not Used
O111	Access to information, application
O112	Denial of eligibility
O113	Non-covered services
O114	Personal Needs Allowance
O115	Services
O116	Not Used
P117	Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person
P118	Bed shortage-placement
P119	Facilities operating without a license
P120	Family conflict; interference
P121	Financial exploitation or financial neglect by family or other affiliated with facility
P122	Legal-guardianship, conservator ship, power of attorney, wills
P123	Medicare
P124	Mental health, development disabilities, including PASARR
P125	Problems with resident's physician/assistant
P126	Protective service agency

LTC Ombudsman Complaint Categories	
ID	**Description**
P127	SSA, SSI, VA, other benefits/agencies
P128	Request for less restrictive placement
Q129	Home care
Q130	Hospital or hospice
Q131	Public or other congregate housing not providing personal care
Q132	Services from outside provider
Q133	Not Used

APPENDIX Z

Acknowledgement

WV FRIS. (2006). *Sexual Violence 101.* Fairmont: Office on Violence Against Women, U.S. Department of Justice.