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This redacted Investigative Report is being published solely because of its use before the Joint Public Hearing of the House Aging and Older Protective Services Committee and the Senate Aging and Youth Committee on April 29, 2019, to aid the committees in eliciting testimony and informing policy and legislative decision making on the issues of public concern identified in the Investigative Report.

# OFFICE OF STATE INSPECTOR GENERAL



## INVESTIGATIVE REPORT

OSIG-17-0151-I-PDA

September 27, 2018

*Confidential*



CONFIDENTIAL

COMMONWEALTH OF PENNSYLVANIA  
OFFICE OF INSPECTOR GENERAL

September 27, 2018

**TO:** The Honorable Teresa E. Osborne  
Secretary of Aging

**FROM:** Bruce R. Beemer  
State Inspector General

**RE:** **Older Adults Protective Services**  
Department of Aging  
OSIG-17-0151-I-PDA

Pursuant to Executive Order 1987-7 and 71 P.S. § 213, the Office of State Inspector General (OSIG) submits this *Investigative Report* for appropriate action.<sup>1</sup> Investigative Reports issued by the OSIG are PRIVILEGED and CONFIDENTIAL and may not be disseminated outside of your agency without the permission of the Governor's Office of General Counsel.

**SYNOPSIS**

In May 2017, the OSIG received a complaint and initiated an investigation to determine:

- (1) whether the Pennsylvania Department of Aging (PDA) is properly monitoring Pennsylvania's Area Agencies on Aging (AAAs) which are tasked with investigating allegations of abuse against older Pennsylvanians; and
- (2) whether PDA is enforcing its regulations which require AAAs to categorize reports of need and complete subsequent investigations within the applicable timeframes as required by Pennsylvania law and regulations.

The OSIG reviewed PDA's documentation from monitoring reviews conducted in Dauphin, Delaware, Lawrence, and Westmoreland Counties. The OSIG's review specifically focused on these counties based on allegations in the complaint that they particularly exemplified deficiencies in the AAAs' handling of protective services cases and PDA's oversight of the AAAs. The OSIG also interviewed 12 individuals with knowledge of the protective services program,

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<sup>1</sup> The OSIG started its investigation under the authority of Executive Order 1987-7, prior to the effective date (September 18, 2017) of Act 29 of 2017, which empowers the OSIG to conduct investigations and issue reports related to the operations of executive agencies (codified at 71 P.S. § 213 (a)(1)).



consisting of current and former PDA employees; [REDACTED]; [REDACTED]; Temple University employees who offer training to AAA staff; and former employees of AAA protective services departments.<sup>2</sup> Additionally, the OSIG reviewed PDA statewide database records of 18,275 Reports of Need (RON) received by all AAAs in fiscal year 2016/17.

During the course of the OSIG's investigation, PDA's Executive and Program staff were cooperative and accommodating. PDA made staff available for interviews and provided requested information, documentation, and data within a timely fashion and in a manner that was conducive to the OSIG's independent analysis.

### OSIG FINDINGS

Under Pennsylvania law, AAAs are required to (1) conduct face-to-face interviews of alleged abused or neglected victims within 72 hours after receiving the RON, and (2) complete investigations of the allegation(s) within 20 days after receiving the RON.<sup>3</sup> However, the OSIG found that:

- in 43% of the 18,275 cases (7,859), the AAAs did not complete investigations within the required 20 days (*See, pages 12 through 15 of this Investigative Report*);
- in another 6.2% of the 18,275 cases (1,151), the AAAs entered insufficient or incorrect data into the PDA database, preventing the OSIG (and PDA) from determining whether the investigation was completed within the required 20 days (*See, pages 12 through 15 of this Investigative Report*);
- in 20.4% of the 18,275 cases (3,724), the AAAs failed to conduct a face-to-face interview of the alleged neglected or abused older adult within the required 72 hours (*See, pages 9 through 12 of this Investigative Report*); and
- in another 4.8% percent of the 18,275 cases (875), the AAAs entered insufficient or incorrect data into the PDA database, preventing the OSIG (and PDA) from determining whether the face-to-face interview was completed within the required 72 hours (*See, pages 9 through 12 of this Investigative Report*).

PDA is responsible for directing the administration of the Older Adults Protective Services Program for the prevention and treatment of elder abuse, neglect, exploitation, and abandonment, and designs and implements a statewide reporting and investigative system to address the needs of older adults requiring protective services.<sup>4</sup> The OSIG's investigation found that:

- 1) PDA is neither requiring nor offering sufficient training to adequately prepare AAA staff to properly categorize and investigate RONs;

<sup>2</sup> Throughout this *Investigative Report*, the OSIG may not refer to these employees by name, but rather through a randomly-assigned "employee number."

<sup>3</sup> The OSIG *excluded* from this analysis any RONs where only financial exploitation was alleged, because investigations to substantiate those types of allegations generally require extensive review of financial records and therefore demand more than 20 days.

<sup>4</sup> <https://www.aging.pa.gov/organization/about-us/Pages/default.aspx>



- 2) PDA is not monitoring the AAAs as they categorize and investigate RONS;
- 3) PDA is not offering timely guidance to the AAAs on case management; and
- 4) PDA is not adequately staffing its own Protective Services Department.

## INVESTIGATION

### BACKGROUND

PDA contracts with 52 AAAs (that cover the Commonwealth's 67 counties) which are responsible for planning, developing, and implementing a system of services for older adults in their respective planning and service areas.<sup>5</sup> Of the 52 AAAs, 19 are non-profit entities and 33 are for-profit entities. PDA, through the AAAs and other partners within the aging network,<sup>6</sup> facilitates the provision of aging services, including caregiver support, employment, health and wellness, help at home, housing, insurance, legal assistance, meals, ombudsman programs, prescriptions, transportation, and protective services.<sup>7</sup>

The Older Adults Protective Services Act (OAPSA), 35 P.S. § 10225.101, *et seq.*, protects Pennsylvanians 60 years of age and older against physical, emotional, and financial abuse, as well as exploitation, neglect (including self-neglect), and abandonment. PDA is responsible for oversight of the protective services work of the local AAAs<sup>8</sup> and their implementation of OAPSA, as well as enforcement of Pennsylvania law and regulations relating to older adults.<sup>9</sup>

The AAAs receive RONS, conduct investigations, make case dispositions, and when determined necessary, provide protective services to older adults to reduce or eliminate the identified abuse. According to PDA's records, in fiscal year 2006/07, AAAs received 11,962 RONS for Adult Protective Services (18-59) and Older Adult Protective Services (60 and over); by fiscal year 2016/17, the number rose to 40,004 RONS, a 234% increase. In fiscal year 2016/17, AAAs received 23,984 RONS<sup>10</sup> regarding 20,750 older adults.

Pennsylvania law requires AAAs to initiate an investigation of each RON within 72 hours after receipt of the report.<sup>11</sup> AAAs must complete all investigations involving abuse and neglect within 20 days of receipt of the RON (all other investigations must be completed as soon as possible).<sup>12</sup> Upon receipt of a RON, AAA staff must screen the report and assign it to one of the

<sup>5</sup> Pennsylvania Department of Aging State Plan on Aging 2016-2020 (2016-2020 State Plan).

<sup>6</sup> According to its 2016-2020 State Plan, PDA describes the aging network as composed of senior community centers, adult daily living centers, and Aging and Disability Resource Centers (ADRCs).

<sup>7</sup> 2016-2020 State Plan.

<sup>8</sup> Under OAPSA, the AAAs are responsible to administer the older adult protective services program in their respective planning and service areas.

<sup>9</sup> 35 P.S. § 10225.101, *et seq.*; 6 Pa. Code § 15.1, *et seq.*

<sup>10</sup> The OSIG notes that of the 40,004 RONS received in 2016/17, 23,984 RONS related to older adults and 16,020 RONS related to adults (18-59).

<sup>11</sup> 35 P.S. § 10225.303(a).

<sup>12</sup> 6 Pa. Code § 15.42(d). PDA told the OSIG that due to the severity of the allegations in abuse and neglect cases, it elected to use a 20-day maximum investigative timeframe because such cases required a more immediate determination. The OSIG notes that

following categories for further investigation, if necessary:<sup>13</sup>

- *Emergency* – An investigation must be initiated immediately following the referral of the RON, and all reasonable attempts should be made to conduct a face-to-face visit within 24 hours after receipt of the RON;<sup>14</sup>
- *Priority* – An investigation must be initiated as soon as possible following the referral of the RON, and reasonable efforts should be made to initiate an investigation and attempt a face-to-face visit within 24 hours after receipt of the RON;<sup>15</sup>
- *Non-Priority* – An investigation must be initiated in a timely manner, but never more than 72 hours after receipt of the RON, and the investigation must include at least one face-to-face visit;<sup>16</sup> and
- *No Need* – An investigation must consist of the AAA protective services caseworker's review of the report categorization. If the caseworker agrees with the categorization, appropriate referrals, if any, should be made within 72 hours; if the caseworker does not agree with the categorization, the RON must be placed in another category and appropriate action initiated.<sup>17</sup>

All investigative activities must be documented and placed in the case record.<sup>18</sup>

PDA's Protective Services staff conduct periodic quality assurance reviews to ensure AAAs appropriately categorized and investigated RONs, and they provide technical assistance to AAAs, as needed. Additionally, PDA, through a contract with Temple University's Institute on Protective Services (Temple), provides protective services training to AAA staff.

#### **PDA IS NEITHER REQUIRING NOR OFFERING SUFFICIENT TRAINING TO ADEQUATELY PREPARE AAA STAFF TO PROPERLY CATEGORIZE AND INVESTIGATE REPORTS OF NEED**

PDA regulations identify three distinct job responsibilities within AAA's protective services unit: caseworkers, supervisors, and intake workers. The regulations require that AAAs designate at least one protective services caseworker who meets the minimum standards of training and experience,<sup>19</sup> and that the immediate supervisor of a protective services caseworker be trained in protective services.<sup>20</sup> Intake workers are permitted to conduct nonprotective services duties, in addition to any assigned protective services functions; and must receive appropriate training in protective services.<sup>21</sup>

the language in § 15.42(d) regarding 20 days was included in PDA's 1999 proposed regulations, and following comment by the public and legislature, the language remained unchanged.

<sup>13</sup> 6 Pa. Code § 15.26(a).

<sup>14</sup> 6 Pa. Code § 15.42(a)(1).

<sup>15</sup> 6 Pa. Code § 15.42(a)(2).

<sup>16</sup> 6 Pa. Code § 15.42(a)(3).

<sup>17</sup> 6 Pa. Code § 15.42(a)(4).

<sup>18</sup> 6 Pa. Code § 15.42(e).

<sup>19</sup> 6 Pa. Code § 15.13(b).

<sup>20</sup> 6 Pa. Code § 15.13(e).

<sup>21</sup> 6 Pa. Code § 15.13(e).



Staff from [REDACTED] and [REDACTED] agree that AAA staff do not receive sufficient training to properly categorize and investigate the cases they receive. According to [REDACTED]

[REDACTED] there is heavy turnover in AAA staff because they are neither prepared nor properly trained to do their jobs. [REDACTED] added that AAA staff are sent into environments where there is some type of risk (whether it be interaction with people, bed bugs, or even poor living conditions). [REDACTED] said Temple is developing topic-based training and online modules to offer a broader selection to the AAA investigative staff, but the current training is not nearly enough to equip them for the jobs they are asked to perform. PDA should require that AAA staff be properly trained to enforce Pennsylvania law and regulations. However, a majority of those interviewed expressed concerns with the training currently offered to the AAAs.

*PDA Does Not Offer Sufficient Training for AAA Intake Employees*

AAA intake workers receive RONS for protective services to determine if the older adult is in need of protective services, and the immediacy of the required response. The intake staff are often the first persons in the AAA who are informed of concerns regarding an older adult. RONS may be received in writing or orally (through the State Elder Abuse Hotline).<sup>22</sup> According to PDA regulations, intake staff must, at a minimum, gather (1) the date and time of the report; (2) the name and contact information of the reporter, unless withheld; (3) the name, age, and contact information of the older adult in need of protective services; (4) the nature of the incident that precipitated the RON; (5) the nature and extent of the need for protective services (particularly if the older adult is in a life threatening situation); and (6) the physical and mental status of the older adult in need.<sup>23</sup> Immediately following receipt of the RON, the intake workers must screen the RON to assign it to one of the referral categories identified above (*i.e.*, Emergency, Priority, etc.).<sup>24</sup>

PDA regulations require that RONS “be received only by persons who have received training on the minimum requirements and procedures for receiving, recording, screening, and referring” RONS under the intake training curriculum (the required training components of the intake curriculum are listed in Table 1).<sup>25</sup> The current protective services intake training is a web-based training module maintained by the Pennsylvania Association of AAAs (Temple is not responsible for the intake training). According to [REDACTED] AAA intake staff receive one initial training when they are hired,

TABLE 1 INTAKE TRAINING CURRICULUM
According to PDA’s regulations, the intake training shall include the following: (1) Interviewing the reporter; (2) Completion of the report form; (3) Preliminary case status assessment to determine report categories; (4) Requirements for referral of the report to the protective services staff; (5) Emergency procedures; and (6) Confidentiality.

<sup>22</sup> A RON received orally must immediately be reduced to writing on PDA’s standardized RON form.

<sup>23</sup> 6 Pa. Code § 15.25(e).

<sup>24</sup> 6 Pa. Code § 15.26(n).

<sup>25</sup> 6 Pa. Code §§ 15.24, 15.121, and 15.124.





investigative staff semi-annually. Basic training is a 3 ½-day course,<sup>29</sup> with an online “knowledge evaluation” (not a test) at the end, consisting of 25 questions serving as a basic knowledge assessment about the course material. The results of the evaluation are sent to the protective services supervisors at the AAAs. ██████ said the scores and the exam are meaningless because if an investigator fails the evaluation, they do not have to return for more training, and they continue to investigate cases. ██████ said they are not even asked to retake the exam.

In 2016, Temple increased the number of basic trainings from 2 sessions to 10 sessions offered throughout the year. ██████ said the additional sessions allowed the average class size to decrease from over 100 participants to less than 30. The increased frequency also reduced the time that newly hired investigators need to wait to receive the basic training. ██████ said the evaluation scores are also increasing as the class sizes decrease.

██████ said to fulfil the one-day in-service training requirement, AAA staff also receive a minimum of six hours of enhancement training. By contract, Temple is only required to offer seven enhancement trainings and three supervisory trainings per year. ██████ said that in fiscal year 2017/18, Temple would increase the number of enhancement trainings from 7 sessions to 15 sessions offered each year, which would significantly reduce class size. ██████ said Temple is currently developing e-based learning modules, and intends to make the topic-based modules available to the AAAs to utilize as training tools or refreshers when certain issues arise in actual cases.

In addition to the insufficient training, ██████ ██████ said some AAAs have little or no medical support on their cases, so they do not consult nurses on basic fundamentals, and they typically do not review medical records during investigations. ██████ said AAA staff have no access to, or training from, nursing or medical professionals. By comparison, ██████ said that in cases handled by the Adult Protective Services division (APS) of DHS, Liberty Healthcare Corporation (Liberty)<sup>30</sup> has staff to handle specific topic areas of need in APS cases, such as registered nurses, financial exploitation, and more typical/general reports. Additionally, with APS, if the workload grows and caseloads rise past a certain threshold, contractors may request additional staff.

**The Same Issues in Every County**  
██████ said, “A lot of the same issues permeate throughout each county: lack of funds, lack of training and lack of experience.”

By way of comparison, ██████ told the OSIG that Adult Protective Services through the Texas Department of Family and Protective Services is considered the leading model in protective services training. ██████ said Texas Protective Services requires 160 hours of core training and 18 hours of continuing education per year. ██████ stated the National Adult Protective Services Association (NASPA), established a master curriculum, which includes a six-hour annual

<sup>29</sup> According to ██████ ██████ in the 1990’s basic training was a 5-day course, but it was eventually reduced to 3 ½ days due to AAA budget cuts.

<sup>30</sup> Effective April 2015, Liberty is the statewide contracted provider of protective services to adults ages 18 to 59.



requirement.

Likewise, ██████ said Pennsylvania child welfare regulations require at least 120 hours of basic training and 20 hours of annual continuing education.<sup>31</sup> ██████ said the Office of Children, Youth, and Families (OCYF), DHS, uses modules from the University of Pittsburgh for investigator certification. ██████ said compared to OCYF, AAA investigators are required to receive only a quarter of the education and training required of their counterparts in child protective services. ██████ said the minimum one day of classroom continuing education (in-service training) specified in the regulations is inadequate to provide protective services investigators the depth of knowledge that they need to perform at the highest quality standards. ██████ said that in light of the identified disparity between training offered through OCYF and PDA, Temple began addressing these disparities on their own with more quantity and enhanced quality standards of the training provided.

██████ and ██████ staff told the OSIG that based on their research and the success of other programs, they believe implementing the following changes to the current training would assist Pennsylvania's protective services program:

- *Create standards that require a more thorough and expansive knowledge base for investigators within their first 18 months of conducting protective services investigations.* Given the current structure, it can be years before an investigator gets training on [all of] the many issues they will confront in the first months of their role. A core basic curriculum should include not only the topics outlined in the regulations, but also include comprehensive modules on each type of abuse (physical, sexual, caregiver neglect, self-neglect, emotional, financial exploitation and abandonment), risk assessment, risk mitigation and case planning, involuntary interventions, capacity and decision-making assessment, the aging process, mental health issues in Aging, substance abuse issues in Aging, ethics and values, and safety in the field.
- *Utilize an educational mentoring program for the first 18 months for new investigators.* While investigators need to rely on their colleagues and supervisors at their agency to receive on-the-job training, this does not always mean that what they are learning matches [PDA] expectations and National best practices. An educational mentoring setup allows investigators to have someone outside their agency to receive one-on-one feedback and instruction during initial experiences as an Investigator.
- *Increase the amount of continuing education hours for Older Adult Protective Services Investigators - Six hours is not adequate.* Not only does it not meet the level of Child Protective Services, but it can be argued that there are levels of knowledge, such as capacity issues, that Older Adult Protective Services needs that Child Protective [Services] does not. The needs of vulnerable older adults are constantly changing with new research and population shifts. Continuing education

<sup>31</sup> A recent audit report issued by the Pennsylvania Department of the Auditor General "State of the Child" found issues with the amount of training Office of Children, Youth, and Families (DHS) staff receive.



must allow for Investigators to stay on top of the latest in best practice and resources beyond the basic and core information.

- *Use hybrid training as a format for expanding training opportunities.* For both the enrichment and basic training, it is not practical or necessary to require all of it to be classroom based. The training should utilize a hybrid format that offers instruction through a variety of e-learning methods that then is reinforced through experiential classroom instruction.
- *Require certification for Older Adult Protective Services investigators.* Upon completion of the core training period, investigators should receive testing that provides assurance that those working in the field have the necessary knowledge and skills to complete their work. Standards of continuing education and potentially retesting should be set for the maintenance of a certification standard.
- *Standards/Guidance supported from both [the AAAs and PDA]* – provide basic ground rules for PS Investigators to go out and do their jobs. (Emphasis added.)

**PDA IS NOT MONITORING THE AAAs WHILE THEY CATEGORIZE AND INVESTIGATE REPORTS OF NEED, WHICH ALLOWS OLDER ADULTS TO REMAIN AT RISK WHEN AAAs DO NOT PROPERLY CATEGORIZE AND INVESTIGATE REPORTS OF NEED**

██████████ said in most cases, PDA does not become aware of problems at the AAA until the next scheduled annual Quality Assurance Monitoring Review (QAMR);<sup>32</sup> therefore, PDA's oversight is reactive rather than proactive. ██████████ said PDA staff do not always agree with the AAA's categorization or investigation, but if the problem is not identified until the QAMR (sometimes many months later), it may be too late for PDA to intervene on behalf of the older adult. A majority of those interviewed expressed concerns with inconsistencies among the AAAs. For example, ██████████ said that there is "no consistency" in how AAAs categorize RONS. Additionally, ██████████ said that a set standard of guidelines may minimize the "gray areas" and negate the inconsistencies from one county to another.

***PDA Does Not Monitor AAAs as They Categorize Reports of Need, Which Causes Inconsistencies Across the Counties***

Every investigation requires at least one face-to-face visit, or an attempt, with the older adult. AAAs are required to attempt a face-to-face visit in any RON categorized as Emergency immediately upon receipt, Priority within 24 hours, and Non-Priority within 72 hours; and are required to document all investigative activities in the case record.<sup>33</sup> The OSIG reviewed information from PDA regarding 18,275 RONS investigated in fiscal year 2016/17.<sup>34</sup> Of the RONS reviewed:

<sup>32</sup> A QAMR is a periodic review by PDA staff of consumer-specific data and AAA work product to identify best practices and areas in need of remediation.

<sup>33</sup> 35 P.S. § 10225.303(n); 6 Pa. Code § 15.42.

<sup>34</sup> OSIG NOTE: Earlier in this *Investigative Report*, the OSIG mentioned 23,984 RONS received by AAAs, but not all RONS received by AAAs will result in an investigation.

- 13,676 had a face-to-face visit within 72 hours of the date the RON was received;
- 3,724 had a face-to-face visit more than 72 hours after the date the RON was received;
- 163 had incorrect information (or clerical errors) that resulted in a negative length of time for the face-to-face visit (i.e., the date of face-to-face visit predates the date of the RON); and
- 712 had no date entered for the face-to-face visit.

*Time Delay in 3,724 RONs for Which the Face-to-face Visit Exceeded 72 Hours*

TIME IN WHICH FACE-TO-FACE VISIT OCCURRED	NUMBER OF CASES
4 Days to 6 Days	1,603
7 Days to 10 Days	766
11 Days to 20 Days	619
21 Days to 100 Days	495
101 Days to 364 Days	71
** One Year or Greater	170

\*\* NOTE: The OSIG recognizes that many of these entries might have resulted from an incorrect year being entered into the PDA database for the interview date. For example, many of these records show the interview took 365 or 366 days to occur, which would result from entering the wrong year (2017 rather than 2016) into the database in cases where the interview actually took place by the next day after the RON was received.

Based on these figures, in almost 75% of the cases reviewed, the face-to-face visit occurred within 72 hours of the receipt of the RON. Conversely, in 25% of the cases, the face-to-face visit either occurred more than 72 hours after receipt of the RON, was incorrectly documented in the Social Assistance Management System (SAMS),<sup>35</sup> or did not occur at all.

The Older Adult Protective Services Department, PDA, and APS, share a toll-free 1-800 number through the State Elder Abuse Hotline. ██████ said the hotline is very similar to ChildLine used by OCYF to report matters involving children at risk. The Elder Abuse Hotline system identifies where the caller is located and routes the caller to the nearest AAA for assistance. RONs for adults (18-59) are forwarded to Liberty/APS for review, while RONs for older adults (60 and over) are taken by the AAA intake staff. PDA does not routinely review RONs as they are received; PDA reviews RONs during scheduled QAMRs.

52 AAAs Doing Their Own Thing

██████ said, "52 County AAAs doing their own thing ██████"

Three individuals interviewed said there is very little consistency regarding how AAAs categorize their RONs. ██████ said each AAA has an intake unit that takes the reports and categorizes the RON, but there is no consistency in how AAAs categorize reports. ██████ said PDA has no control over the categorization. ██████ has observed AAAs presented with the same RON categorize the report differently. In one instance, one county categorized the report as "No Need" with no follow up completed, while another county categorized the report as "Priority." ██████ a case where one county initiated an investigation because they found the report lacked sufficient information to make a determination, but another county did not even conduct a site visit because there was not sufficient information.

<sup>35</sup> SAMS is a web-based system that provides PDA with client tracking and information collection on older adults, and provides functionality to support the administration and management of the AAAs.



**SAMPLE REPORT OF NEED**

*As part of its investigation, the OSIG reviewed examples of actual RONS used by Temple in the basic training modules. One of the reports from 2015 involved an older adult who was brought to a treatment center with his oxygen level at 78%. The older adult said [REDACTED] had left his oxygen tank in a neighbor's vehicle. When the reporter contacted the neighbor, he/she was told the older adult's oxygen tank was almost empty, the older adult's pain medication was missing, and the older adult's caretaker was verbally abusive, leaving the older adult unattended, and giving the older adult heroin in place of the prescribed pain medication. The AAA categorized the RON as "No Need."*

According to PDA's records for fiscal year 2016/17, approximately 20% of RONS are categorized as "No Need" at the AAA. [REDACTED] said intake staff can be influenced by protective services supervisors who force staff to categorize RONS as "No Need." [REDACTED] said AAA intake staff can be swayed by supervisors or other external factors to categorize a report of abuse as "No Need" or low Priority for a multitude of reasons, ranging from staffing issues at the AAA to "it's late on a Friday afternoon." [REDACTED] has observed intake workers categorize reports as "Priority," but the protective services supervisor downgrades the report based on their

own assessment, sometimes simply to delay the initiation of the investigation. Unfortunately, PDA would not become aware of these issues until the next scheduled QAMR because PDA is not reviewing reports as they are received.

[REDACTED] said AAA staff rarely go out after normal work hours to conduct investigations because their supervisors tell them to categorize the RONS as "Non-Priority."<sup>36</sup> The AAAs do not want to pay workers to work after hours or on-call hours. [REDACTED] stated that [REDACTED] has become aware that some AAAs are deleting RONS because they do not want to deal with them, which [REDACTED] believes is completely unethical. Again, since PDA is usually reviewing these cases during a scheduled QAMR, PDA is not aware of specific incidents of noncompliance or trends developing within specific AAAs.

One individual interviewed by the OSIG suggested a centralized call center may

Categories Listed in RONS Received in Fiscal Year 2016/17		
Category(s)	# of RONS	
Non-Priority	11,371	47.41%
Priority	6,539	27.26%
No Need	4,188	17.46%
Emergency	1,112	4.64%
Non-Priority/Referred	277	1.15%
Referred	180	0.79%
Priority/Referred	83	0.35%
Priority/Non-Priority	58	0.24%
No Category Listed	50	0.21%
Non-Priority/No Need	33	0.14%
Emergency/Priority	27	0.11%
No Need/Referred	27	0.11%
Priority/No Need	10	0.04%
Emergency/Referred	9	0.04%
Emergency/Non-Priority	5	0.02%
Non-Priority/No Need/Referred	4	0.02%
Emergency/No Need	2	0.01%
Total	23,934	

<sup>36</sup> According to PDA's report, during the period July 1, 2016 to June 30, 2017, AAAs received 4,191 RONS (which include "non-call" hours R.A.M. to 11 P.M. Monday through Saturday). Of those 4,191 RONS, 1,519 (36%) were categorized as "Home Priority," 2,413 (58%) were categorized as "No Need" or "Low Priority" and another 259 (6%) were categorized as "Priority," and 120 (3%) were categorized as "Emergency."



reduce/eliminate improper categorization; allow PDA to actively monitor cases; and assist PDA in sustaining the ever-growing number of RONS. The OSIG notes that a centralized call center, such as ChildLine, would allow all reports to be addressed by similarly trained staff, and be monitored by the Commonwealth agency (DHS, in the case of ChildLine) as they are received. Likewise, the APS call center allows DHS to review all reports categorized as "No Need" upon receipt. According to [REDACTED] APS reviews every case identified by the contractor (Liberty) as "No Need" to ensure DHS agrees with the categorization. [REDACTED] said APS receives approximately 300-400 "No Need" cases per month, which are reviewed immediately.<sup>37</sup> [REDACTED] also said that APS monitors every open and active case, looking for patterns or issues happening as the case progresses. [REDACTED] believes a centralized intake unit to handle both incoming reports for adults and older adults would make life easier for both APS and PDA.

[REDACTED] said PDA has discussed the possibility of a centralized intake unit for protective services, but [REDACTED] is not fully aware of the cost or if it would fit into PDA's budget. [REDACTED] said that within the last year, PDA met with the Department of General Services (DGS) and the Department of Labor and Industry (L&I) to discuss the potential for a call center. There were some concerns about what to actually name the call center and how it was going to be used. [REDACTED] said cost is the biggest hurdle to creating a call center. [REDACTED] said Allegheny County currently manages the toll-free 800 number for PDA, and hired a third-party contractor to address the calls and RONS. [REDACTED] added that Allegheny County would love to turn over the toll-free 800 number because it is losing money on it.

The OSIG interviewed [REDACTED] regarding the potential for a centralized call center dedicated to protective services calls. [REDACTED] the call center used by PACE that is staffed by contracted employees from Magellan Health Services. [REDACTED] said PACE's call centers have the capacity to expand at any time. [REDACTED] said the call centers currently manage calls for some PDA programs, such as Aging and Disability Resources,<sup>38</sup> as well as other Commonwealth programs, including programs on HIV/AIDS and Dialysis. [REDACTED] said [REDACTED] has been offering the services of [REDACTED] call centers for the past six years, to current and former PDA administrations. [REDACTED] said [REDACTED] is unsure of the cost and space limitations at the PACE call center, and is unsure whether it would be a viable option.

#### ***PDA Does Not Monitor the AAAs as They Investigate Reports of Need, Which Causes Inconsistencies Across the Counties***

AAAs are required by regulation to complete all investigations involving abuse and neglect within 20 days of receiving the RON. The OSIG reviewed information from PDA regarding

<sup>37</sup> [REDACTED] said years ago, the then-Secretary of DHS directed APS to review all cases categorized as "No Need."

<sup>38</sup> [REDACTED] said PACE recently created two new positions for Aging and Disability Resources and got the system up and running in approximately 45 days for the new initiative.

18,275 RONs<sup>39</sup> investigated in fiscal year 2016/17. Of the RONs reviewed:

- 9,265 had a date of determination<sup>40</sup> within 20 days of the date the RON was received;
- 7,859 had a date of determination more than 20 days after the date the RON was received;
- 105 had incorrect information (or clerical errors) that resulted in a negative length of time to reach a determination on the allegations (*i.e.*, the date of determination predates the date of the RON); and
- 1,046 had insufficient information to determine the length of time to reach a determination on the allegations (*i.e.*, no date entered in SAMS for the RON or no date entered for the date of determination).

*Time Delay in 7,859 RONs for Which the Determination Exceeded 20 Days*

Total Time in Which Determination Made	Number of Cases
21 Days to 30 Days	2,186
31 Days to 40 Days	1,269
41 Days to 50 Days	920
51 Days to 64 Days	840
65 Days to 100 Days	1,095
Greater Than 100 Days	1,549

Based on these figures, in more than 49% of the cases reviewed, the investigation was not completed within the required 20-day timeframe, or SAMS did not contain sufficient information to determine the date of determination. PDA explained that when monitoring, the AAA is considered compliant if there is a journal entry notating a valid reason the investigation has exceeded the 20-day requirement. However, PDA is generally not monitoring RONs as they are received, categorized, or investigated. In most cases, PDA will only become aware of the categorization and possible investigation of a RON during an annual QAMR, which may occur a year after the RON was received. In the alternative, PDA will become aware of cases of abuse or neglect through various media outlets.

Multiple persons interviewed stated, and anecdotal evidence suggests that, when PDA learns about cases of abuse and neglect from the media, it may already be too late to offer any meaningful assistance to the older adults. [REDACTED] told the OSIG that PDA may never know about some Protective Services cases (unless covered by the media) because the cases are closed and marked as "incomplete due to death," and PDA never learns the true facts of the cases. The below cases are illustrative:

<sup>39</sup> The OSIG did not review RONs where only financial exploitation was alleged because investigations to make a determination on those allegations generally require more than 20 days.

<sup>40</sup> The date of determination is the date when the AAA determined whether the allegation(s) was substantiated or unsubstantiated. The date of determination is not the date the investigation was completed, because the investigator may need to proceed with the investigation after making a determination.



STORIES OF ELDER ABUSE SPAN THE COMMONWEALTH FROM ONE CORNER TO THE NEXT

PRANE PACIUNAS – 89

*A December 5, 2014 article in THE PHILADELPHIA INQUIRER told the story of Prane Paciunas, an 89 year-old Philadelphia resident who died after months of elder abuse at the hands of her caretaker. On November 7, 2014, the Philadelphia Police Department and a court-ordered guardian entered Ms. Paciunas' home "to find her clinging to life on a bed covered in trash bags in her house, which by then was nearly uninhabitable. She was filthy, emaciated, suffering from maggot-infected bedsores so deep that they exposed her bones. She died in a hospital eight days later. Prosecutors called it one of the worst cases of elder abuse they had ever seen." Ms. Paciunas' caretaker was charged with assault and, later, murder.*

*According to the article, between February and November of 2014, neighbors and fellow parishioners say they tried to seek help for Ms. Paciunas by notifying the Philadelphia Corporation for Aging (PCA). In February, a neighbor sent an e-mail to her state representative, who notified PCA that renters living in Ms. Paciunas' home were throwing out Paciunas' belongings as if she were dead. "A PCA representative wrote back that the matter had been forwarded to its Protective Services unit with urgency."*

*Another neighbor said he "called PCA in April after visiting Paciunas with a gift of Easter babka and finding her pantry bare. She told him, he said, that [her caretaker] was no longer giving her her heart medication." "On Nov. 6, a judge assigned Paciunas a guardian and ordered that she be seen 'immediately,' according to a police report, because 'no one has seen her for an extended period of time.'" See, Mike Nowall & Aubrey Whelan, Before Frankford women's death, neighbors reported neglect, THE PHILADELPHIA INQUIRER, December 5, 2014.*

VINCENT FORCE – 85

*An August 3, 2018 article in THE ERIE TIMES relays the story of Vincent Force, an 85 year-old Erie resident whose body was found in a shallow grave behind his apartment building on July 14, 2018. The police received information indicating that "Force had died due to injuries sustained from scalding water and bed sores." His caregivers told police that Force died on June 18, 2018. They admitted to wrapping his body in plastic and garbage bags and burying him in the backyard of his apartment building.*

*"The investigation that led to the discovery of Force's body was launched on May 29, [2018] when an older adult protective services employee with the Greater Erie Community Action Committee received a report of neglect and exploitation concerning Force and attempted to locate him at [his] apartment house... The [protective services] employee sent a letter to [Force's caregiver] a month later, regarding the location of Force... The [protective services] employee filed a missing person report concerning Force with Millcreek police on July 13, " 45 days after the Report of Need. See, Tim Hahn, ID confirmed, death cause unknown in Erie body discovery, THE ERIE TIMES, August 3, 2018. (<http://www.goerie.com/news/20180803/id-confirmed-death-cause-unknown-in-erie-body-discovery>)*

The OAPSA is to be liberally construed to ensure the availability of protective services to all older adults in need of them.<sup>41</sup> Ultimately, if PDA determines that AAAs are unable to conduct, or have not conducted, what PDA considers to be an acceptable investigation, PDA may intervene in the investigation or conduct its own investigation.<sup>42</sup> In a January 2018 case in Lycoming County, PDA became aware of a RON from social media attention surrounding the story of an

<sup>41</sup> 35 P.S. § 10225.102.

<sup>42</sup> 6 Pa. Code § 15.42(e).



older adult with intellectual disabilities in need. An older adult left a personal care home in Lycoming County and wandered into a person's home. The homeowner posted details about the incident on Facebook in an attempt to identify the older adult. ██████ said a PDA employee saw the Facebook post and followed up. PDA Executive Staff contacted the ██████ to ask that ██████ agency file a RON and conduct an investigation. ██████ refused because the AAA does not take RONs from Facebook and the personal care home was considered a good facility. After four days of discussions between ██████ and PDA, the AAA took the RON. PDA, including the Secretary of Aging, is continuing to monitor the investigation and outcome of the RON.

Additionally, ██████ said one of the common findings during a review is the failure of the AAA to enter information into SAMS in a timely fashion. However, ██████ said there is no policy regarding when AAAs are required to enter information into SAMS.<sup>93</sup> During QAMRs, PDA staff have found numerous instances where investigative cases are open, yet nothing is documented in SAMS showing any activity on the case. Even worse, staff will sometimes find no written documentation in the case file either. In these situations, the AAA cannot prove that any investigation was conducted. For example, during one monitoring review, PDA sampled 60 cases and found that 53 investigations had not been initiated within the required timeframe, and 59 cases did not reflect whether a comprehensive investigation had been conducted (the review will be discussed in more detail in the Dauphin County section on pages 16 and 17 of this *Investigative Report*). Similarly, during another monitoring review, PDA sampled 55 cases and found that 35 cases had no documented face-to-face visit, and none of the 55 cases reflected if a comprehensive investigation had been conducted (the review will be discussed in more detail in the Lawrence County section on pages 18 and 19 of this *Investigative Report*).

██████ said ██████ has been approached by AAA staff complaining that their AAAs do not allow them to perform their jobs properly. ██████ said some AAAs have the protective services staff do something completely opposite from the way Temple trained the staff. ██████ said Temple could train investigators on the proper regulations, but that may change when the investigator returns to the AAA. ██████ stated most county AAA protective services supervisors feel that they know everything, again stating that when the protective services investigators return to their county AAAs, they do things as directed by their supervisors, regardless of the training they received.

**PDA IS NOT OFFERING TIMELY GUIDANCE TO THE AAAs ON CASE MANAGEMENT, WHICH ALLOWS DEFICIENCIES AT THE AAAs TO PERSIST WITHOUT REMEDIATION**

PDA regularly conducts QAMRs at each AAA by reviewing a random sampling of cases. ██████ said PDA staff review entries in SAMS and update ██████ on any patterns or concerns prior to conducting the on-site portion of the review. ██████ said there is no official written policy or procedure regarding sampling, but over the years, PDA has adopted a standard practice where

<sup>93</sup> ██████ said the current version of the SAMS Manual is approximately seven years old. PDA has had a revised SAMS Manual completed for two years, but has not issued it to the AAAs. Other than this Manual, no one has developed standards for entering information into SAMS.

staff review no more than 50 cases, or as many as it takes to see a pattern (if there are less than 20 cases, they will review all 20 of the cases). When possible, PDA tries to obtain a sample from each AAA staff member assigned to protective services cases, as well as samples of Substantiated, Unsubstantiated, No Need, and Guardianship cases.

At the conclusion of a monitoring or site visit, PDA staff hold an exit interview with the AAA director and/or protective services supervisor. Copies of PDA's working spreadsheets from the review are provided to the AAA during the exit interview. After conducting its review, if PDA found any areas of concern, PDA mails a post-monitoring letter to the AAA director or county commissioners,<sup>44</sup> identifying any findings, issues, or concerns. ██████ said PDA sends the same style of letter if the AAA is performing well or performing poorly.

After the reviews are completed, AAAs with issues to be addressed submit Corrective Action Plans (CAP) or Statement of Findings Plans (SFP) to PDA to correct any identified findings and deficiencies. ██████ said PDA typically uses an 80% or more compliance rate, and any AAA below the benchmark is asked to submit a CAP.

***PDA Does Not Address Deficiencies at AAAs and Issue Communications Resulting from QAMRs Within Consistent Timeframes After the Monitoring Reviews***

During its investigation, the OSIG reviewed documentation from monitoring visits conducted since 2013 in four counties: Dauphin, Delaware, Lawrence, and Westmoreland.<sup>45</sup> The OSIG found that PDA is not consistently issuing the post monitoring letters from QAMRs to the AAAs within a reasonable time-period after the monitoring review (if at all).

Dauphin County

PDA completed four annual monitoring reviews and one follow-up review during the period from June 12, 2013 to December 1, 2016. PDA issued the post-monitoring letters from the 2013 and 2014 reviews to Dauphin County less than 10 days after the site visit. Unlike the previous two years when letters were issued within ten days, in

Summary of Monitoring Reviews in Dauphin County			
** Indicates a follow-up review			
Date of On-site Monitoring	Sample Period	Sample Size	Areas of Noncompliance
June 12, 2013	January 15, 2013 to April 15, 2013	15	9
June 25, 2014	February 1, 2014 to May 14, 2014	Unknown	19
October 7, 2015	February 1, 2015 to July 1, 2015	26	19
March 11, 2016 **	Unknown	60	Unknown
December 1, 2016	July 1, 2016 to October 31, 2016	38	5

<sup>44</sup> ██████ told the OSIG that monitoring letters are issued based on who signed the agreement with PDA, and whether the AAA is a profit or non-profit entity. If the agreement is with a non-profit, monitoring letters and letters of communication are issued to AAA directors; if the agreement is with a for profit entity, the monitoring letters and communication documents are issued to the county commissioners or their designee.

<sup>45</sup> The four counties were identified during interviews as counties with potential issues and deficiencies.



2015, PDA issued its post-monitoring letter to Dauphin County on December 17, 2015, two months after the on-site visit. During the 2014 and 2015 reviews, PDA found that, among other deficiencies, the individual AAA caseworkers were assigned more than 30 cases, which is a violation of PDA's regulations.<sup>46</sup> [REDACTED] said it was clear supervisors and investigators were not actively involved in their caseloads. [REDACTED] said [REDACTED] personally found 10 individuals still listed on Dauphin County's active caseload with corroborating obituaries, some at least three months old. According to [REDACTED] PDA began monitoring Dauphin County more closely and more frequently.

On March 11, 2016, PDA conducted a follow-up review on 60 sample cases. Of the 60 cases reviewed, PDA found that 53 investigations had not been initiated within the required timeframe; 59 cases did not reflect whether a comprehensive investigation had been conducted; 33 cases had 4 or less journal entries;<sup>47</sup> and in all 60 cases, Investigation Summary and Assessment (ISA) forms<sup>48</sup> were either incomplete or missing. PDA also found that the average caseload per worker was 99, more than three times the maximum allowed by PDA regulations. On May 23, 2016, more than two months after the on-site visit, PDA issued a post-monitoring letter to Dauphin County. After the letter was issued, PDA began holding biweekly telephone calls with the AAA staff, and PDA staff worked with Dauphin County to bring them into compliance. By December 1, 2016, Dauphin County had only 5 areas of noncompliance and only 1 of the 7 caseworkers at Dauphin County had a caseload higher than 30 cases.

On March 8, 2018, PDA conducted a QAMR of Dauphin County and determined that staff retraining was necessary.

Delaware County

PDA completed five monitoring reviews during the period from April 17, 2013 to June 29, 2016. [REDACTED]

[REDACTED] said Delaware County had ongoing problems for almost 5 years. PDA issued the post-monitoring letter from the April 2013 review to Delaware County 6 days after the site visit, but issued the post-

Summary of Monitoring Reviews in Delaware County			
Date of On-site Monitoring	Sample Period	Sample Size	Areas of Noncompliance
April 17-18, 2013	December 20, 2012 to February 20, 2013	25	23
December 11, 2013	July 15, 2013 to October 15, 2013	10	22
June 24, 2014	January 15, 2014 to April 15, 2014	25	21
September 23, 2015	February 1, 2015 to July 1, 2015	22	16
June 28-29, 2016	January 28, 2016 to April 30, 2016	21	15

<sup>46</sup> 6 Pa. Code § 15.13(b)(5).

<sup>47</sup> Investigators document each investigative activity they perform in the Care Plan Journal (a chronological narrative of interviews, phone calls, observations, next steps, etc.). Each event/activity is recorded as an individual, date/time-stamped "journal entry" within the Care Plan Journal.

<sup>48</sup> ISA forms are used to record data about the older adult and the investigation, including whether the allegations were substantiated or unsubstantiated, when the investigation was complete, etc. The ISA form is also used for "reassessments" for substantiated cases to ensure the services provided reduced or eliminated risk.

monitoring letters from the December 2013 and 2015 reviews 30 days after the site visits. Additionally, despite finding deficiencies during its review, PDA did not issue a post-monitoring letter to Delaware County in 2014. During its investigation, the OSIG reviewed a draft post-monitoring letter regarding the 2014 review. The draft letter stated that Delaware County “has been consistently out of compliance since August 2012, in the areas of inadequate investigations, form completion, supervisory oversight throughout investigations, and redaction of [alleged perpetrator]/reporter information (in unsubstantiated and “No Need” cases).” [REDACTED] was not certain if PDA felt the letter regarding the 2014 review was too harsh, but regardless, the letter was never issued.

In response to each post-monitoring letter sent by PDA, Delaware County submitted a CAP or SFP that was approved by PDA. Unfortunately, despite the approved CAPs/SFPs, 18 areas of noncompliance were consistently identified during three or more monitoring reviews.

[REDACTED] said [REDACTED] eventually became involved in the process with Delaware County. PDA staff and Temple trainers made several follow-up visits to Delaware County to provide additional onsite staff training. [REDACTED] said Delaware County is turning things around and performing well. [REDACTED] said Delaware AAA was especially grateful for the efforts of PDA staff in assisting the AAA to correct its deficiencies.

On April 4, 2018, PDA conducted a QAMR of Delaware County and determined that retraining was necessary. As of May 22, 2018, the retraining had been completed at Delaware County.

Lawrence County

PDA completed five annual monitoring reviews and one follow-up review during the period from February 28, 2013 to April 20, 2017.

[REDACTED] said Lawrence County had issues similar to Dauphin County. During the reviewed time period, PDA issued most letters to Lawrence County less than 30 days after the site visits, ranging from 1 day to 23 days (only the post-monitoring letter from the June 2015 review was issued more than 30 days after the visit; the letter was issued July 23, 2015). From April 17, 2017

Summary of Monitoring Reviews in Lawrence County <i>** indicates a follow-up review</i>			
Date of On-site Monitoring	Sample Period	Sample Size	Areas of Noncompliance
February 28, 2013	October 1, 2012 to December 31, 2012	22	32
September 11, 2013	April 1, 2013 to July 18, 2013	17	15
May 29-30, 2014	October 30, 2013 to March 30, 2014	15	13
June 3-4, 2015	October 1, 2014 to March 31, 2015	25	22
June 28-29, 2016	January 20, 2016 to May 7, 2016	17	11
April 17-19, 2017**	Unknown	55	Unknown



through April 19, 2017, PDA conducted a follow-up review on 55 sample cases. Of the 55 cases reviewed, PDA found that 35 cases had no documented face-to-face visit, and 8 of the older adults in those 35 cases had died while the investigation was open. PDA also found that of the 55 cases, 19 cases were still open with the most recent face-to-face visit conducted in fiscal year 2015/16; 55 cases did not reflect whether a comprehensive investigation had been conducted; in 54 cases, the ISA forms were either incomplete or missing; cases had minimal journal entries and no indication if actions were completed; and, of all the case files reviewed, none contained all the required information. Finally, PDA found that 2 former investigators had a total of 90 cases that had not been reassigned to current employees.

On November 17, 2017, PDA conducted a QAMR of Lawrence County and determined that no retraining or technical assistance were necessary.

Westmoreland County

PDA completed five monitoring reviews during the period from March 18, 2013 to December 13, 2016. During the reviewed time-period, PDA issued most of its letters to Westmoreland County less than 30 days after the site visits, ranging from 12 days to 26 days (only

the post-monitoring letter from the March 2014 review was issued more than 30 days after the visit; the letter was issued May 5, 2014). ██████ said the issues at Westmoreland County did not rise to the level of Delaware and Lawrence Counties, but they did receive media attention. ██████ said that in 2016, PDA learned of an older adult who was the victim of financial exploitation. ██████ said when ██████ reviewed Westmoreland's file, it showed

Summary of Monitoring Reviews in Westmoreland County			
Date of On-site monitoring	Sample Period	Sample Size	Areas of Noncompliance
March 18-19, 2013	November 1, 2012 to March 1, 2013	40	4
August 7-8, 2013	May 1, 2013 to July 1, 2013	49	2
March 28, 2014	October 1, 2013 to January 1, 2014	12	
October 29, 2015	February 1, 2015 to June 30, 2015	20	1
December 13, 2016	March 1, 2016 to October 31, 2016	21	4

three reports involving the same individual in early 2016. The last two reports named the same alleged perpetrator and investigations were opened, yet the investigator(s) did not request bank records. ██████ said at least six months of bank records should have been requested before closing the investigation. Despite the investigator not requesting bank records, the cases were closed as "unsubstantiated." In May or June 2016, the AAA received three additional reports from financial institutions regarding the same alleged victim and the same alleged perpetrator. The AAA opened an investigation, and the investigator requested bank records and found the alleged perpetrator was spending the older adult's funds without permission. ██████ said it was clear that Westmoreland County's actions/inactions permitted the perpetrator to steal additional funds from the older adult after the initial reports. Unfortunately, the alleged victim died while Westmoreland County was investigating the allegations.

On April 11, 2018, PDA conducted a QAMR of Westmoreland County. As of May 22, 2018, the post-monitoring letter had not been sent by PDA.

*During the Pendency of the OSIG's Investigation, PDA Implemented Changes to the QAMR Process that Dictate More Frequent Monitoring of Noncompliant AAAs*

During the OSIG's investigation, PDA released Aging Program Directive (APD) 17-24-01,<sup>49</sup> that consists of the following rating scale coinciding with the AAA's performance:

- Red – Monitoring results reveal significant and/or repetitive quality issues and one or more individuals were left at risk (PDA staff will monitor again within 90 days of an approved CAP);
- Yellow – Monitoring results reveal significant or repetitive quality issues; however, no individuals were left at risk (PDA staff will monitor again in six months); and
- Green – Monitoring results that indicate no or minimal quality issues and that no individuals were left at risk (PDA will schedule annual QAMRs).

Some individuals interviewed expressed concerns with PDA's lack of power to ensure the AAAs comply with Pennsylvania law and regulations. The individuals generally said that this results from a number of factors including outdated regulations that do not empower PDA to take action against AAAs for lack of compliance. Additionally, the nature of the relationship between PDA and the AAAs is cooperative rather than contractual; a partnership rather than supervisory oversight. However, the OSIG notes that PDA's own regulations require it to monitor the AAAs for compliance with the regulations and approved protective services plans; yet PDA's regulatory oversight has developed into the current cooperative relationship.

██████████ said PDA's jurisdiction is limited and that there are not many remedies other than working with the AAAs to correct any issues. ██████████ said the protective services language in PDA's contracts with the AAAs is "very light." ██████████ said APD 17-24-01 allows PDA to pull funding from any AAA found to be noncompliant over an extended period of time; and also authorizes PDA to send monitoring letters to the County Director of Human Services or County Commissioners should matters not be rectified in a timely fashion. ██████████ said APD 17-24-01 holds AAAs accountable and presents consequences for continued poor performance. ██████████ said AAAs sign cooperative agreements with PDA, and PDA can threaten and stop the AAA's funding for lack of performance, if necessary. As of October 11, 2017, ██████████ said PDA had not considered adding language from APD 17-24-01 to the cooperative agreements with the AAAs. In comparison, ██████████ said the OCYF model provides ways for the Commonwealth to hold county offices accountable, and APS is authorized, by contract, to fine its contractors for wrongdoing or noncompliance. According to ██████████ once stronger language is used in the contracts, PDA will be better suited to hold the AAAs accountable.

<sup>49</sup> APD 17-24-01 became effective on September 12, 2017.



██████████ told the OSIG that recently, PDA made changes to the post-monitoring letters issued to the AAAs. ██████████ said PDA removed a lot of the detailed information from the letters, and made them more template-based. ██████████ is hopeful that the letters will be issued more quickly under the new format.

PDA Noted That a New Animal Protection Law was Passed in Less Time than Older Adults Protection Law

██████████ said that it took two years to get an older adult protective services law passed and it took one week to get a new dogs/animal protection from abuse law passed. No one is pushing matters forward when it comes to protecting older adults. Yet, these issues and concerns for older adults continue to move forward and grow without politicians updating old laws or passing new ones.

In August 2017, ██████████ said most AAAs were in the green and performing well, with approximately nine AAAs in the red. As of May 22, 2018, of the 52 AAAs, 31 were classified as Green, 9 were classified as Yellow, and 5 were classified as Red. Seven AAAs were scheduled for a monitoring visit later in 2018. A full Monitoring Status Summary is attached as Appendix A to this *Investigative Report*.

#### ***PDA Does Not Issue Directives and Bulletins in a Timely Fashion***

PDA offers guidance to the AAAs by issuing APDs and Aging Technical Assistance Bulletins (ATAB). ██████████ told the OSIG that timely issuance of these directives has been a problem with PDA over the years, and this Administration has been no different so far.<sup>50</sup>

PDA staff told the OSIG that proposed internal policies, APDs, and ATABs, drafted at the non-executive staff level, remain with PDA's Executive staff without being issued, sometimes for years. ██████████ said one such APD relates to very minor changes that need to be made to the RON form used at the Intake level (regarding the ability to identify if an individual is under or over 60 in situations without their exact date of birth). ██████████ said a second example is an ATAB regarding payments made to the AAAs. ██████████ said that both the APD and ATAB have been with the Executive staff for approximately one year, without action. ██████████ acknowledged that the APD is stalled, and explained that PDA staff need to understand that a document is not finalized until the Secretary reviews and approves it.

██████████ said ██████████ and ██████████ recently began revising the process to review and issue APDs and ATABs through the PDA Executive staff in a timely manner. ██████████ said the new process will maintain stricter timeframes to keep the review process moving. Once the document is ready for the Secretary's review, the staff will schedule a meeting with the Secretary to provide detailed information to allow the Secretary to either sign the policy/procedure, suggest revisions, or request additional information.

<sup>50</sup> ██████████ said staff assigned to the policy and legislative functions has not been consistent; PDA has had three different policy employees and four different legislative contacts within the past two years.

**PDA IS NOT ADEQUATELY STAFFING ITS OWN PROTECTIVE SERVICES DEPARTMENT**

██████████ said it has become clear that there is not enough Protective Services staff at PDA to adequately monitor the AAAs, especially considering that RONs have multiplied in the last three years. ██████████ supervises approximately seven staff members consisting of half Commonwealth employees and half contract employees. ██████████ said there is heavy turnover among ██████████ contract employees. ██████████ said this constant turnover affects the consistency of the entire protective services program.

██████████ told the OSIG that PDA sets target dates for QAMRs based on completion of the previous monitoring review. According to PDA's records, 24 of the 25 QAMRs PDA completed in 2018 were completed after the target date (See, Appendix A). ██████████ explained that the main reason PDA has difficulty meeting the established target dates is due to PDA being significantly understaffed. ██████████ and ██████████ said that in September 2017, PDA assigned a team of approximately 8 to 12 Quality Assurance (QA) employees to review active caseload files at eight AAAs thought to be in the green [performing well]. The QA staff conducted reviews for approximately six months, and ██████████ said it went fairly well. ██████████ said the true test for the QA monitoring visits will be for Protective Services staff to conduct follow-up visits with the AAAs identified as red and yellow who need monitoring within 30 or 60 days after the initial monitoring visit. ██████████ stated that ██████████ is not certain PDA can meet those timelines and deadlines with its current staff. However, ██████████ said ██████████ believes some QA staff will continue to assist with Protective Services monitoring visits.

**Protective Services is an Afterthought**

*No one has reviewed or looked at the Protective Services model in over thirty years – this [OSIG's investigation] might be the only chance for people to make significant changes in the Protective Services system. There are major systemic issues affecting Protective Services that I can no longer stand to see go unnoticed. Protective Services has kind of been an afterthought since the 1990s*

PDA staff said ██████████ is responsible for everything from approving documents, conducting meetings, and speaking engagements as well as approving staff leave requests, background checks, and administering the Temple contract. They said ██████████ is the only ██████████ who does not have a subordinate supervisor on staff. ██████████ said at times there is a line of at least four people waiting to discuss matters with ██████████, so the Protective Services staff do not have easy access to ██████████.

**CONCLUSIONS**

***PDA is Neither Requiring Nor Offering Sufficient Training to Adequately Prepare AAA Staff to Properly Categorize and Investigate Reports of Need***

PDA regulations require a training curriculum for intake staff, caseworkers/investigators, and supervisors. However, the regulations leave the amount and frequency of training to the



discretion of PDA. Currently, through the contract with Temple, PDA only requires intake staff to attend a web-based training module at the time of hire; and PDA does not require continuing education training or refresher courses for intake staff. Furthermore, the current intake training is old, outdated, and the information discussed in the training is not relevant to the actual RONS received by staff.

Currently, PDA only requires investigative and supervisory staff to attend a 3 ½-day basic training course, as well as a minimum of six hours of enhancement training annually. PDA and Temple staff agreed that the minimum training requirements are not equipping the AAA staff to properly conduct investigations of alleged physical abuse, neglect, financial exploitation, and abandonment. By comparison, the Commonwealth requires investigative staff employed in child protective services to complete four times more training than their counterparts in older adult protective services. Both agencies are tasked with protecting the Commonwealth's most vulnerable citizens from abuse and exploitation, and likewise both agencies should be dedicated to equipping its protective services staff with the knowledge and tools necessary to protect those whom they serve. Older Pennsylvanians are particularly susceptible to abuse and neglect. PDA regulations and Pennsylvania law sought to put in place protective measures and develop programs to report and investigate cases of elder abuse for the purposes of prevention and protection. If AAA staff are not adequately trained to perform their investigative duties, PDA cannot fully execute its directive to protect older adults from abuse and neglect; the very thing it was created to do.

*PDA is not Monitoring the AAAs While They Categorize and Investigate Reports of Need, Which Allows Older Adults to Remain at Risk When AAAs do not Properly Categorize and Investigate Reports of Need*

PDA is required to enforce its regulations and monitor AAAs, which includes the proper categorization and investigation of RONS. However, PDA is not monitoring categorization and investigation of reports as they are received and investigated; PDA limits its review of reports to periodic monitoring reviews, that are usually conducted annually. PDA has no real-time oversight to ensure intake staff are not allowing external (and internal) influences to affect the categorization of reports (*i.e.*, downgrading a report based on the time of day it is received, or the availability of investigative staff in the office). Likewise, PDA has no real-time oversight of the investigations of alleged abuse and neglect, and therefore has no procedure to ensure investigations are completed within the required 20-day timeframe. Generally, PDA learns about older adults left at risk after-the-fact (while conducting its periodic monitoring reviews). By then it may be too late to actually intervene on the older adults' behalf. In these cases of alleged elder abuse, a less than timely response by the AAA may truly have fatal consequences, so it is incumbent upon PDA to develop oversight measures that foster and demand proper categorization and timely investigation by the AAAs

Furthermore, even after PDA reviews caseloads and is alerted to problems, until recently, PDA had no procedure in place to monitor corrective action or require compliance with its regulations. However, even with the release of the new APD, unless its provisions are added to

the AAAs' contracts, PDA may lack any ability to hold the AAAs accountable for noncompliance. Increased standards agreed upon by both PDA and the AAAs will help ensure regulatory compliance and reduce any inconsistencies among counties. But, PDA must establish regulatory provisions to prohibit noncompliance or contract language with enforcement measures to prevent noncompliance.

***PDA is not Offering Timely Guidance to the AAAs on Case Management, Which Allows Deficiencies at the AAAs to Persist Without Remediation***

Historically, PDA has maintained little consistency in the time-frame in which post-monitoring letters and guidance are issued to the AAAs. However, as evidenced in Dauphin County alone, PDA's targeted monitoring, technical assistance, and steady guidance was the direct cause of a significant reduction in areas of non-compliance in the AAA.

With the release of APD 17-24-01, PDA is taking steps to establish consistent timeframes for continued review and monitoring of the AAAs. Additionally, PDA's Executive staff are implementing new procedures to streamline the release of guidance and directives to the AAA network. Unfortunately, as ██████ stated, the true test of the new processes will be whether PDA can meet the new self-imposed deadlines. PDA should foster the changes it has implemented and develop new procedures that ensure guidance is disseminated to the AAAs in a timeframe that offers relevant assistance to address areas of uncertainty and noncompliance.

***PDA is not Adequately Staffing its Own Protective Services Department***

With the release of APD 17-24-01, PDA exponentially increased the potential monitoring workload of its Protective Services Department. If problematic AAAs are identified, PDA will need to increase the frequency of monitoring visits and technical assistance. However, as suggested above, the only means to properly monitor AAA casefiles may be to review categorization and investigations of RONS as they are received and investigated, thus requiring an immediate increase in staffing. Add in the continually rising number of RONS, the current PDA staff will be unable to maintain sufficient monitoring of AAA investigatory work. Finally, increased monitoring inherently requires PDA staff to fully understand the subject matter and constraints of the investigations the AAAs are conducting.

**RECOMMENDATIONS**

Based on the findings of its investigation, the OSIG recommends:

1. PDA review its intake training modules to ensure the content is current and relevant to AAA intake staff;
2. PDA implement and require regular enhancement training for intake staff;
3. PDA and the legislature strengthen and increase the mandatory training requirements for investigative and supervisory staff;
4. PDA consider ways to better educate AAA staff on subject matter topics within a



- reasonable time after hire;
5. PDA and the legislature consider the viability and advantages of a centralized call center for Older Adult Protective Services;
  6. PDA consider developing procedures to more closely monitor the length of time Report of Need investigations remain open to ensure the investigations are completed within the statutorily required timeframe;
  7. PDA consider implementing a real-time review component to the Quality Assurance Monitoring Reviews to allow PDA to monitor the categorization and investigation of RONs as they are received and address problems and incidents of regulatory noncompliance as they arise;
  8. PDA timely address indicated incidents of regulatory violations discovered during reviews and provide technical assistance as needed until the AAAs are compliant;
  9. PDA revise the cooperative agreements/contracts with the AAAs to afford PDA more authority and control to ensure compliance with Pennsylvania laws and regulations;
  10. PDA consider methods, such as increased training and monitoring, to enhance consistency in categorization and investigation of RONs across the individual AAAs;
  11. PDA establish best practices in categorization and investigation, and provide guidance to the AAAs to ensure compliance with the identified best practices; and
  12. PDA hire additional staff and cross-train existing PDA staff to allow for increased monitoring and technical assistance availability.

The OSIG respectfully requests that you notify our office in writing upon the receipt of this *Investigative Report* and that you subsequently inform us of any action taken as a result of the information provided within sixty (60) days of the issuance of this *Investigative Report*. The OSIG is available and prepared to conduct any further investigation as necessary and warranted by the findings and recommendations outlined in this *Investigative Report*.

If you have any questions or need further information, please contact [REDACTED]

[REDACTED] at [REDACTED]

cc: [REDACTED]  
[REDACTED]

APPENDIX A

Monitoring Status Summary <i>Courtesy of the Pennsylvania Department of Aging</i>			
AAA Name	Monitor Due Date <sup>21</sup>	Date Monitored	Color
Adams	11/15/18	8/31/17	Green
Allegheny	2/8/18	4/3/18	Green
Armstrong	9/8/17	2/14/18	Green
Beaver	12/31/17		Green
Berks	1/11/18	1/25/18	Green
Blair	2/4/18	3/28/18	Green
Bradford/Sullivan/Snyder/Lancaster/Columbia	10/1/18		
Bucks	3/19/18	4/5/18	Yellow
Butler	12/30/17		Green
Cambria	12/20/18	11/20/17	Yellow
Cameron/Elk/McKean	3/18/18		
Carbon	5/10/18		Red
Centre	2/18/18	3/27/18	Green
Chester	2/16/18		Green
Clarion	11/26/17	4/18/18	Green
Clearfield	11/25/17	5/2/18	Yellow
Clinton/Lycoming	8/10/17	1/24/18	Green
Columbia/Montour	7/10/18		
Crawford	1/27/18		Green
Cumberland	12/29/17	1/31/18	Green
Dauphin	2/25/18	3/8/18	Yellow
Delaware	10/8/17	4/4/18	Yellow
Eric	8/6/18		
Forest/Warren	5/11/18		
Fayette	9/9/18		
Huntingdon/Bedford/Fulton	12/15/18	11/15/17	Green
Indiana	9/10/17	4/12/18	Green
Jefferson	6/5/17	2/13/18	Green
Lackawanna	1/26/18	4/4/18	Green
Lancaster	2/22/18	2/6/18	Green
Lawrence		11/17/17	Green

<sup>21</sup> The monitoring due date is the ideal date by which PDA would like to complete the onsite review and is calculated from the completion of the previous monitoring session. Difficulty in hitting the target date was due to significant understaffing.



Monitoring Status Summary <i>Courtesy of the Pennsylvania Department of Aging</i>			
AAA Name	Monitor Due Date <sup>51</sup>	Date Monitored	Color
Lobanon	10/2/17	3/22/18	Green
Lehigh	1/29/18	5/8/18	Green
Luzerne	4/21/18		Green
Mercer	1/28/18		Yellow
Mifflin/Juniata	2/4/18	3/26/18	Green
Monroe	12/18/17	4/25/18	Green
Montgomery	3/4/18		Green
Northampton	10/20/18	10/24/17	Yellow
Northumberland	6/30/18		
Perry	11/15/18	9/6/17	Green
Philadelphia	8/21/17	1/9/18	Red
Pike	2/2/18		Green
Potter	10/1/18	6/8/17	Green
Schrykill	12/28/18	11/28/17	Red
Somerset	3/2/18		Green
Union/Snyder	8/26/17	2/21/18	Green
Verango	3/3/18	4/17/18	Yellow
Washington/Fayette/Greene	12/28/18	11/28/17	Red
Wayne	5/11/18	1/20/17	Yellow
Westmoreland	2/23/18	4/11/18	Red
York	2/18/18	5/8/18	Green