



# *Adults with Cognitive and Physical Disabilities Services*

*An Office of the  
Department of Health and Human Services*

*Paul R. LePage, Governor*

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## **Adult Protective Services Developmental Services 2010 Annual Report**

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**APS Report**  
**Adult Protective Services**  
**January through December, 2010**

The Adult Protective Services Unit (APS) has been in operation since October 2003 investigating allegations of abuse, neglect and exploitation of adult consumers eligible for Developmental Disability Services. The investigative and protective activities of APS are governed by the Maine Revised Statute Title 22, Chapter 958-A: Adult Protective Services Act and Chapter 12, the *Regulations Governing Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Mental Retardation or Autism*.

The goals of APS are to investigate allegations of abuse, neglect and exploitation, to provide information about services to vulnerable adults who are victims of mistreatment and to increase the reporting of suspected abuse, and to provide training and supports to Agency Investigators. State wide coverage is accomplished with six full time and one part time APS Investigators and one full time APS Manager. One full time APS Investigator resigned in October 2010; the position remains vacant. Another full time APS Investigator was out on Family Medical Leave for several months during 2010. It is becoming increasingly challenging for APS to meet its adult protective responsibilities with temporary staff re-assignments and limited overtime hours. We have been able to respond to every Reportable Event needing an APS investigation. In partnership with the Crisis Teams and case managers, the priority of keeping consumers safe from harm or danger was maintained throughout this reporting period. However the timeliness of screening Reportable Events, writing, editing Agency and DHHS Investigator reports and disseminating reports was significantly impacted by the APS staff vacancy.

**Agency Investigator Training**

Over several months of dedicated time, APS Investigators, the APS Manager and University of Maine Muskie Institute staff developed a two-day APS New Agency Investigator Training curriculum. Training sessions were offered at Bangor, Sept. 23-24 and Portland, Oct. 26-27, 2010. Forty-two agency staff members participated in the Agency Investigator Trainings bringing the total of approved Agency Investigators to one hundred and sixty nine (169). Overall participant comments were positive. Some newly trained Investigators have conducted investigations with peer Agency Investigators or with close APS supervision. Agency Investigators perform the majority of agency investigations; ongoing individual training is provided as needed. Refresher Training is currently limited due to vacancies and workload of APS staff

**Data Operations**

APS investigations depend on an electronic Reportable Events Enterprise Information System (EIS). EIS Reportable Event categories have remained unchanged since 2008. APS COGNOS reports, which obtain data from EIS, are the basis for this Annual Report. A recommendation to divide the category of Physical or Verbal Abuse into two separate categories has not yet been implemented in EIS. It remains a single category in EIS; therefore a manual separation is required for this report. Extensive efforts have gone into verifying the accuracy of the data while acknowledging the possibility of undiscovered duplicates and errors.

The Adult Protective Services Access data base tracked Level I and Level II Substantiation findings as noted in all APS Investigation Reports. The APS Manager tracked all Administrative Hearing requests for Level I appeals.

**Reportable Events**

APS has been integrally involved in the Developmental Services Adult Protective Services Improvement Action Plan during 2009 and 2010. This Bending the Curve process involved simultaneous endeavors reviewing the entire spectrum from APS Reportable Events screening identification through consumer outcomes. Completion and delivery of the APS Agency Trainings was part of this plan. APS drafted criteria modifying what rises to the level of an APS Reportable Event with joint meetings planned to finalize the criteria by mid 2010.

A Reportable Event may include more than one event category type on the Reportable Event Form. A Rights Violation alone would be referred to the Office of Advocacy while an allegation involving harm and a Rights Violation on

the same Reportable would be referred to both APS and the Office of Advocacy. During 2010, **1871 Reportable Events** were filed including multiple categories on one Reportable Event, involving **897** distinct consumers. This is 9% increase over calendar year 2009 **1718 APS Reportable Events**, involving **903** distinct consumers. One Region 2 Lewiston (2L) consumer had 107 APS Reportable Events filed in 2010; one was assigned for investigation. The remainder was a pattern of unfounded accusation utterances against staff following either a restraint or the inability to go out into the community until the consumer regained control. Given this consumer has a Behavior Plan, 106 of these events should not have been reported or referred to APS.

For three years now, Physical or Verbal Abuse category has needed to be manually separated as they remain combined in EIS. Physical Abuse generally refers to assault, cruel punishment, infliction of injury, physical harm or pain and unreasonable confinement while Verbal Abuse refers to intimidation or emotional abuse. Those Reportable Events involving both Physical and Verbal Abuse allegations were categorized as Physical Abuse. Suicidal Ideation/Acts, Medication Related Events and Restraints reportable events were no longer routinely referred to APS unless there was an element of staff neglect, abuse or exploitation. Staff failing to administer medication in a timely manner was determined to be a medication error while staff deliberately withholding medications was considered abuse or staff stealing consumer medications was considered exploitation. Unsuspecting deaths were no longer referred to APS during 2010. Dangerous Situation remains a generic subjective category that is often attached as an additional category to a Reportable Event. When a consumer moved to a different geographic location, the Reportable Events were reflected in the Region most currently updated in EIS.

These Reportables as reported by EIS fell into the following broad categories:

### Total 2010 APS Reportable Events by Category by Region

Reportable event	R 1	R 2A	R 2L	R 2R	R 3B	R 3C	Totals
Physical Abuse	91	67	181	27	80	19	465
Verbal Abuse	24	23	27	10	38	14	136
Dangerous Situation	5	21	9	5	57	5	102
Exploitation (other than sexual)	59	40	28	17	82	21	247
Serious Illness/injury	5	8	4	1	12	2	32
Neglect	133	100	59	19	144	75	530
Rights Violation	3	24	1	13	38	14	93
Sexual Abuse/Exploitation	29	26	32	8	42	4	141
Suicidal Ideation/Acts	3	1	2	1	3	0	10
Medication Related Events	1	7	3	3	8	3	25
Restraints	1	2	38	3	1	0	45
Death	14	5	11	3	8	4	45
<b>TOTAL</b>	<b>368</b>	<b>324</b>	<b>395</b>	<b>110</b>	<b>513</b>	<b>161</b>	<b>1871</b>

### Investigation Process

APS Investigators screen APS Reportable Events in their geographic area throughout the workday and confer with the APS Manager. Screening can take a considerable amount of time, conferring with case management, clarifying the allegation with the Reporter, waiting for return calls, reviewing EIS information, all in order to make an informed decision. When a reported allegation or event meets the definition of abuse, neglect or exploitation as set forth in Title 22 and the *Regulations* and an investigation is warranted, high and moderate priority investigations are generally assigned to the APS Investigator while low priority agency matters are assigned to Agency Investigators. All community allegations are assigned to APS Investigators. The reporter is usually the first contact. If after preliminary screening it is determined that the matter has already been resolved or would better be resolved by the involved parties, such as case management, the case is referred to the appropriate community resource for resolution. An APS investigation should be the measure of last resort.

The Investigation process involves gathering information about the reported event by interviewing witnesses, including the consumer when applicable, reviewing relevant documents, taking statements, and collecting other pertinent

evidence and information. To obtain medical records, APS Investigators have increasingly relied on subpoenas. Law enforcement takes the lead in the majority of criminal event investigations though this significantly lengthens the process. The Crisis Teams provide crisis supports for Reportable Events involving APS matters during overnights and weekends/holidays.

Copies of all finalized APS reports were sent to the consumer or guardian unless the guardian was the subject of the investigation, to the involved Regional Office staff, the Consumer Advisory Board through October 2010 and the appropriate contracted agency when appropriate. Substantiation notices were sent by certified mail for all Level I and Level II findings.

APS Reportable Events were assigned as follows:

**2010 Assigned Reportable Events by Category and Region**

<b>Reportable event</b>	<b>R 1</b>	<b>R 2A</b>	<b>R 2L</b>	<b>R 2R</b>	<b>R 3B</b>	<b>R 3C</b>	<b>Totals</b>
Physical Abuse	26	17	17	5	6	2	<b>73</b>
Verbal abuse	7	1	4	2	1	1	<b>16</b>
Dangerous Situation	1	3	1	1	1	1	<b>8</b>
Exploitation	30	11	12	7	8	2	<b>70</b>
Serious Illness/injury	4	0	2	1	1	0	<b>8</b>
Neglect	34	11	22	4	6	6	<b>83</b>
Rights Violation	1	5	0	1	3	1	<b>11</b>
Sexual Abuse/Exploitation	7	3	10	3	8	0	<b>31</b>
Suicidal Ideation/Acts	0	0	0	1	0	0	<b>1</b>
Medication Related Events	1	4	3	0	1	0	<b>9</b>
Restraints	0	1	0	2	1	0	<b>4</b>
Death	1	1	1	0	0	0	<b>3</b>
<b>TOTAL</b>	<b>112</b>	<b>57</b>	<b>72</b>	<b>27</b>	<b>36</b>	<b>13</b>	<b>317</b>

Of the **1871** total APS Reportable Events, **317** (17%) were assigned for investigation. This percentage is below the usual 30% average assignment rate but higher than 2009 (1781, 14%). Neglect is once again the largest assigned category, followed by Physical Abuse and Exploitation.

Reportable Events involving criminal matters have increased in 2010, particularly theft of Schedule II drugs and theft of consumer money. Capsule tampering is becoming a problem and theft of the entire medication box and log as well as the money safe has occurred.

The table below displays the referred and assigned APS Reportable Events for 2007-2010.

Reportable Event Type	2007		2008		2009		2010	
	Ref.	Asgn.	Ref.	Asgn.	Ref.	Asgn.	Ref.	Asgn.
Calendar Year	2007	2007	2008	2008	2009	2009	2010	2010
Physical/Verbal Abuse	0	0	0	0	0	0	0	0
P/Verbal Abuse including Assault	523	81	0	0	0	0	0	0
Physical Abuse	0	50	366	157	390	72	465	73
Verbal Abuse	0	44	189	38	101	8	136	16
Dangerous Situation	78	13	90	16	113	13	102	8
Exploitation (not sexual)	174	67	220	95	207	39	247	70
Serious Illness or Injury	50	5	27	4	17	2	32	8
Neglect	555	158	698	260	537	71	530	83
Rights Violation	68	25	68	18	66	6	93	11
Sexual Abuse/Exploit	179	46	196	57	170	28	141	31
Restraints	24	5	13	1	13	1	45	4
Medication Related Event	14	1	15	3	22	4	25	9
Death	18	4	55	0	80	0	45	3
Suicidal Attempts/Act	8	1	12	0	2	0	45	1
<b>Total</b>	<b>1691</b>	<b>500 (30%)</b>	<b>1949</b>	<b>649 (33%)</b>	<b>1718</b>	<b>244 (14%)</b>	<b>1871</b>	<b>317 (17%)</b>

### Assignment of APS Reportable Events

APS Reportable Events increased 9% in 2010, with Physical Abuse and Exploitation categories increasing 16% from 2009. The majority (83%) of Reportable Events referred to APS do not rise to the level of APS investigation. Neglect had the greatest number of Reportables and assignments, followed by Physical Abuse. Statewide, the number of reported theft of consumer medications and funds increased over 2009, with police involved in the majority of these investigations. There is a significant delay in law enforcement getting back to APS with updated information. As part of the Lean Process, criteria for reporting deaths changed to suspicious or unexpected deaths, thus a 56% reduction. .

### Comparison of Reportable Events and APS Referrals 2004 thru 2010

\*The data in the table below came from the EIS, not from previously developed APS reports.

Year	Number of APS Reportable Events	Number of APS Assigned Referrals	APS Assigned Referral Percent
*2004	1592	814	51%
*2005	1862	741	40%
*2006	1410	466	33%
*2007	1691	500	30%
2008	1949	649	33%
2009	1718	244	14%
2010	1871	317	17%

### Yearly Assignments by Region

Year	R 1	R 2A	R 2L	R 2R	R 3B	R 3C	Total
<b>Total 2004</b>	231	115	125	18	259	66	<b>814</b>
<b>Total 2005</b>	224	131	120	13	203	50	<b>741</b>
<b>Total 2006</b>	120	113	58	24	123	28	<b>466</b>
<b>Total 2007</b>	118	117	82	25	131	27	<b>500</b>
<b>Total 2008</b>	<b>212</b>	<b>113</b>	<b>75</b>	<b>28</b>	<b>142</b>	<b>79</b>	<b>649</b>
<b>Total 2009</b>	<b>93</b>	<b>39</b>	<b>58</b>	<b>13</b>	<b>16</b>	<b>25</b>	<b>244</b>
<b>Total 2010</b>	<b>112</b>	<b>57</b>	<b>72</b>	<b>27</b>	<b>36</b>	<b>13</b>	<b>317</b>

### Priority of APS Assigned Referrals

The Adult Protective Services Unit categorizes cases as High, Moderate, or Low Priority based on the seriousness of the allegation. The seriousness of the allegation will take into account the subject person's capacity, dependency, danger and whether there is substantial risk of harm, and the ability/inability of the person to give informed consent to medical treatment or services if this appears necessary. By way of reminder:

- (1) **High:** High priority cases are those in which the allegation, if substantiated, would indicate that the person is in imminent risk of serious harm or immediate need of medical attention. If the person is receiving agency services, steps must be taken immediately by the agency to assure the person's safety. The APS staff will formulate a plan of action immediately with regard to the most expedient way to protect the person and assess the validity of the allegations. If the situation becomes known after regular business hours, a crisis worker will respond to assure the safety of the person pursuant to paragraph 5 above. Investigation of high priority referrals shall commence on the **day of receipt** of the referral, report or complaint.
- (2) **Moderate:** Moderate priority cases are those that do not present an imminent risk of serious harm or immediate need for medical attention, but nevertheless, if not addressed, are likely to get worse without intervention and could, if continued, expose the client to serious physical injury or harm. Investigation of these cases shall be initiated within **three (3) working days** of receipt of a referral, report or complaint.
- (3) **Low:** Low priority cases are all other APS reports of alleged abuse, neglect or exploitation. Investigation shall commence within **five (5) working days** of the date of the receipt of the referral, report or complaint.

In total, the **317** APS Reportable Events for **2010** were categorized as follows:

- **18 High Priority: (6%)**
- **60 Moderate Priority: (19%)**
- **239 Low Priority: (75%)**

### Regional Priority Comparison from 2004 through 2010

Regional Office	Portland			Augusta			Lewiston			Rockland			Bangor			Caribou			Overall Totals		
	H	M	L	H	M	L	H	M	L	H	M	L	H	M	L	H	M	L	H	M	L
Totals 2004	3	71	156	3	44	68	3	35	87	0	6	12	9	51	199	1	21	44	20	228	566
Totals 2005	1	68	155	4	49	78	4	43	73	1	6	6	0	50	153	1	8	41	11	224	506
Totals 2006	1	19	100	4	8	101	4	11	43	1	0	23	4	35	84	5	2	21	19	75	372
Totals 2007	2	9	105	15	7	95	1	5	76	0	17	18	1	19	110	2	3	23	21	50	429
Totals 2008	11	28	173	5	15	93	1	1	73	1	3	24	16	14	112	0	3	76	34	64	551
Totals 2009	8	31	54	0	4	35	2	16	40	0	3	10	0	4	12	2	3	2	12	61	171
Totals 2010	93	15	4	51	3	3	47	15	10	18	9	0	19	16	1	11	2	0	239	60	18

## APS Investigation Assignments and Report Writing

Of the **317** Reportable Events assigned for investigation in 2010, **153 (48%)** were assigned to Agency Investigators; **164 (52%)** to DHHS Investigators. This distribution is consistent with past investigation assignments noting that more investigations were assigned to DHHS Investigators.

APS assigned as many agency matters to Agency Investigators as feasible. Some Agency Investigators conduct and write excellent APS investigations and reports. Timely submission of reports is a challenge for some Agency Investigators and has been time consuming for APS Investigators. Many APS Investigation reports have been delayed due to picking up assignments in staff vacancy areas, the serious nature of Reportable Events involving extensive interviews and analysis of information and frequent consultation with the APS Manager which in turn delayed the editing of Agency and APS reports. The priority is and always will be front line investigation of abuse, neglect, exploitation events and keeping consumers safe.

### AGENCY & DHHS INVESTIGATION DISTRIBUTION FOR 2006- 2010

<b>Region</b>	<b>Portland</b>	<b>Augusta</b>	<b>Lewiston</b>	<b>Rockland</b>	<b>Bangor</b>	<b>Caribou</b>	<b>Total</b>	<b>Average</b>
<b>Agency 2006</b>	<b>86 (73%)</b>	<b>19 (17%)</b>	<b>18 (32%)</b>	<b>4 (16%)</b>	<b>76 (62%)</b>	<b>7 (24%)</b>	<b>210 (45%)</b>	<b>38%</b>
<b>DHHS 2006</b>	<b>36 (30%)</b>	<b>93 (85%)</b>	<b>37 (67%)</b>	<b>21 (84%)</b>	<b>47 (38%)</b>	<b>22 (76%)</b>	<b>256 (55%)</b>	<b>63%</b>
<b>Agency 2007</b>	<b>64 (54%)</b>	<b>54 (46%)</b>	<b>34 (41%)</b>	<b>9 (36%)</b>	<b>89 (68%)</b>	<b>10 (37%)</b>	<b>260 (52%)</b>	<b>52%</b>
<b>DHHS 2007</b>	<b>54 (46%)</b>	<b>63 (54%)</b>	<b>48 (59%)</b>	<b>16 (64%)</b>	<b>42 (32%)</b>	<b>17 (63%)</b>	<b>240 (48%)</b>	<b>48%</b>
<b>Agency 2008</b>	<b>124 (58%)</b>	<b>55 (49%)</b>	<b>26 (35%)</b>	<b>10 (36%)</b>	<b>77 (54%)</b>	<b>50 (63%)</b>	<b>342 (53%)</b>	<b>53%</b>
<b>DHHS 2008</b>	<b>88 (42%)</b>	<b>58 (51%)</b>	<b>49 (65%)</b>	<b>18 (64%)</b>	<b>65 (46%)</b>	<b>29 (37%)</b>	<b>307 (47%)</b>	<b>47%</b>
<b>Agency 2009</b>	<b>41 (44%)</b>	<b>12 (31%)</b>	<b>37 (64%)</b>	<b>5 (39%)</b>	<b>8 (50%)</b>	<b>17 (68%)</b>	<b>120 (49%)</b>	<b>49%</b>
<b>DHHS 2009</b>	<b>52 (56%)</b>	<b>27 (69%)</b>	<b>21 (36%)</b>	<b>8 (61%)</b>	<b>8 (50%)</b>	<b>8 (32%)</b>	<b>124 (51%)</b>	<b>51%</b>
<b>Agency 2010</b>	<b>61 (54%)</b>	<b>31 (54%)</b>	<b>30 (42%)</b>	<b>7 (26%)</b>	<b>13 (36%)</b>	<b>11 (85%)</b>	<b>153 (48%)</b>	<b>48%</b>
<b>DHHS 2010</b>	<b>51 (44%)</b>	<b>26 (46%)</b>	<b>42 (58%)</b>	<b>20 (74%)</b>	<b>23 (64%)</b>	<b>2 (15%)</b>	<b>164 (52%)</b>	<b>52%</b>

### 2010 Completed Investigations

Of the 317 assigned investigations, 236 (74%) reports were finalized; the majority of the 81 outstanding reports are awaiting law enforcement or District Attorney action before APS can finalize the reports. APS staff follows up monthly on the status of these cases. Due to agency commitments, some Agency Investigators have been unable to complete their reports even with several APS reminders. These Investigators will no longer be able to conduct investigations due to the ineffectiveness of the protracted process. APS continues to work on the challenge of agencies conducting Human Resources investigations before or simultaneous to filing a Reportable Event before APS is notified of the event. Terminated staff often do not avail themselves of an interview.

The report completion rate has been affected by other factors as well. There have been an increased number of shared investigations with law enforcement involving criminal matters including theft of consumer funds, medications or sexual exploitation. Because of law enforcement and District Attorney involvement, the writing and dissemination of APS reports was delayed so as not to compromise court proceedings. Regional DHHS staff regularly monitors police progress

where the burden of proof is higher than APS preponderance of evidence. Some cases have gone over a year awaiting law enforcement updates; some are more responsive than others.

An Investigation Report may combine more than one related Reportable Event and each event is identified in the report, specifying the alleged categories of harm. During this reporting period, there were 11 findings of Program Substantiation compared to 4 in 2009. Rights Violations are always part of other mistreatment allegations included in the Reportable Event. When the primary category is assigned in one Reportable Event, all categories are assigned in EIS. The Office of Advocacy was also ticklered for these Reportable Events and therefore the majority of Rights Violations investigations were deferred to the Advocates.

**FTS = Failure to Substantiate; LI = Level I Substantiation; LII = Level II Substantiation; Program Substantiation.** Below is the table for the 2004-2010 Substantiations.

### 2004-2010 Findings and Substantiations

Outcome	T 2004	T 2005	T 2006	T 2007	T 2008	T 2009	T 2010
Failure to Sub.	367	447	166	211	238	143	145
Level I Sub.	360	229	48	44	79	24	21
Level II Sub.	0	24	107	90	105	52	59
Program Sub.	0	0	0	2	14	3	11
<b>Total</b>	<b>727</b>	<b>700</b>	<b>321</b>	<b>347</b>	<b>436</b>	<b>222</b>	<b>236</b>

### Findings/Substantiations for 2008

### Findings/Substantiations for 2009

### Findings/Substantiations for 2010

Reg.	2008					2009					2010				
	FTS	Lev I	Lev II	Prog. Sub.	Total	FTS	Lev I	Lev II	Prog. Sub.	Total	FTS	Lev I	Lev II	Prog. Sub.	Total
1	104	12	32	10	158	59	7	16	2	84	58	6	19	2	85
2A	41	28	41	0	110	26	2	10	0	38	22	1	1	14	43
2L	11	11	4	0	26	33	2	12	0	47	22	5	11	3	41
2R	21	2	3	0	26	9	3	0	0	12	13	4	5	0	22
3B	17	8	10	3	38	5	6	4	1	16	25	3	4	0	32
3C	44	18	15	1	78	11	4	10	0	25	5	2	6	0	13
<b>Total</b>	<b>238</b>	<b>79</b>	<b>105</b>	<b>14</b>	<b>436</b>	<b>143</b>	<b>24</b>	<b>52</b>	<b>3</b>	<b>222</b>	<b>145</b>	<b>21</b>	<b>59</b>	<b>11</b>	<b>236</b>

Both agency and DHHS investigators strive to complete assigned investigations within the standard 30 day time frame. Investigations taking 120 days or longer are mostly attributed to police involvement, secondly attributed to DHHS staff priorities of conducting investigations over finalizing reports and lastly attributed to APS Manager priorities in finalizing APS reports.

Below is a table that displays the overdue reports beyond 121 days from both agencies and DHHS Investigators. Improving this trend was a challenge for 2010. The time for DHHS investigators has been compromised by the screening challenges of a higher number of Reportable Events, the complexity of some events, the increased assignment of investigations, APS staff vacancies, the time dedicated to developing the Training Curriculum and the push-back from some agency investigators to complete assigned investigations. The majority of reports are completed within 30 days of assignment. However, a growing number of reports are taking much longer to complete. It continues to be clear that expecting reports to be finished in 30 days is not an expectation that is being accomplished by agency or DHHS investigators and the standard will be modified in the upcoming rule changes.

**2010 Timeliness of Agency and DHHS Investigations of Completed Reportable Categories**

Region	<30 days	<60 days	<90 days	<120 days	>121 days	Still Overdue	Totals	Assigned
<b>R1</b>	19	23	11	6	29	24	<b>88</b>	<b>112</b>
<b>2A</b>	23	2	2	0	15	15	<b>42</b>	<b>57</b>
<b>2L</b>	10	2	3	5	15	37	<b>35</b>	<b>72</b>
<b>2R</b>	12	2	0	4	4	5	<b>22</b>	<b>27</b>
<b>3B</b>	19	1	8	5	1	2	<b>34</b>	<b>36</b>
<b>3C</b>	11	2	0	0	0	0	<b>13</b>	<b>13</b>
<b>Totals</b>	<b>94</b>	<b>32</b>	<b>24</b>	<b>20</b>	<b>64</b>	<b>83</b>	<b>234</b>	<b>317</b>

**2007-2010 Substantiations and Administrative Hearings**

Since December 2006, the APS unit notified the affected person of a Substantiation Level I or II finding in writing. To comply with the *Bouyea* decision, Level I and Level II Substantiations were tracked. In 2009, there were 24 Level I and 52 Level II Substantiations. This compares to 57 Level I and 79 Level II Substantiation findings during 2008. The following table compares 2007 through 2010 Substantiation findings and Administrative Hearings.

Year	Level I	Appeals	Pending	Upheld	Overtured at Hearing	Overtured by DHHS	Abandoned Dismissed, Withdrawn	Level I Not Appealed	Level II
2007	24	2	0	1	0	1	0	21	58
2008	57	10	3	4	3	7	0	65	79
2009	24	7	1	1	2	1	3	9	52
2010	21	12	4	6	0	0	2	9	59

**Patterns of Recommendations in 2007-2010 Completed Investigation Reports**

With the help of Central Office Administrative support, all completed 2010 APS report Findings and Recommendations were entered into EIS. Each Regional Office follows up on the completion of these Recommendations. Many Recommendations are implemented while the investigation is ongoing; therefore no further Recommendations are added to the report.

### COMPARISON OF 2007-2010 RECOMMENDATIONS

2007	2008	2009	2010	RECOMMENDATION
Total	Total	Total	Total	
103	83	5	32	Recommendation for employee discipline/counseling
10	3	0	0	Cases referred to the police (now part of criminal investigative matters)
7	6	6	3	Recommendations that DHHS or someone other than the current payee become the payee for the consumer.
10	31	10	14	Recommendations for consumer/family education or counseling
124	121	22	61	Recommendation about staff training
71	100	22	40	Recommendation that a Team Meeting or PCP be convened.
11	18	2	7	Recommendations for Guardianship (either DS Services or Private) to be pursued.
15	7	0	4	Recommendations for respite placement pending the development or location of a more permanent placement.
2	8	0	2	Recommendation for a placement to occur or be developed.
40	6	1	6	Recommendation for DS Intake Services or Case Management.
11	3	0	0	Referrals to DHHS Licensing and Regulatory Services
2	0	0	0	Report forwarded to DHHS Assisted Living Licensing for suggested follow-up.
4	1	1	0	Referrals to the Healthcare Crimes Unit or Provider Integrity Unit
0	1	0	0	Referrals to Code Enforcement Officers
26	18	0	2	Referrals to Office of Advocacy
25	54	0	43	Recommendations for agency policy review/modification
5	17	6	10	Recommendation for increased staffing
	35	4	7	Other*
		(16)	8	No Recommendations (not included in total count)
466	512	81	239	Total Recommendations

In 2007 there were a total of 466 Recommendations while there were 512 Recommendations in 2008. These standard Recommendations were created since 2003 and the greatest Recommendation has consistently been for staff training followed by a team meeting or a Person Centered Planning meeting to address a modification to a consumer's plan. Other\* was added as a category in 2008 to capture many of the consumer treatment Recommendations, such as Regional Office oversight of agency program 11; PT/OT evaluation 4; physical modification to the home 5; and consumer equipment modifications 5. For 2010, 5 of the 7 Recommendations under Other involved home modifications.

#### Reportable Events Not Assigned

In 2010, **1554** (83%) of the Reportable Events were screened out compared to **1474** (86%) of the 1718 Reportable Events screened out in 2009 while **1300** (67%) of 1949 Reportable Events in 2008 were screened out. This compares to **1191** (70%) of **1691** Reportable Events screened out in 2007 and **944** (67%) of **1410** Reportable Events screened out in 2006.

These events always involve an initial DHHS review and APS screening of the reported events as part of a preliminary assessment. The purpose of the initial review is to clarify the event happenings and persons involved in the event so as to better determine if the event rises to the level of an APS allegation needing an investigation. Every APS Reportable Event is screened. Screening often involves DHHS APS staff contacting the filer of the Reportable Event, obtaining background information from the case manager, reviewing EIS notes and previous APS reports, previous Reportable Events in consultation with the APS manager to determine the need or benefit of an investigation. There are circumstances when the better more appropriate intervention is not APS, but rather case management or the provider agency, particularly when housing, medical attention and/or other social supports are needed. Consumer health and safety is always a priority. The APS Investigator will refer the matter to an agency or individual that may more appropriately address the supports needed to attend to the reported events at the level where there is the greatest benefit to the consumer. Some incidental events are immediately resolved and other events turn out to be false reports. Each Reportable Event is evaluated and carefully reviewed before a determination is made to further investigate or to refer the matter to a more appropriate entity. Some agency reporters file a Reportable Event rather than chance that an event was not a reportable matter. APS Investigators spend a

significant amount of time collecting information to clarify a Reportable Event that is screened out to be Not an APS Matter (31%). The greatest number of Reportable Events occurs in agency locations with 30% referred back to the agency for appropriate resolution. The next largest category of screened out Reportable Events involves the need for case management supports either State or Community with 35% being referred to the Regional Office.

The quality of Reportable Events information has sometimes been challenging during this reporting period. Some Reportable Events consist of one sentence involving a vague allegation or event. Such Reportables require significant APS follow up. This has been an issue for the past few years and is likely reflective of agency staff turnover and/or agency preferences in completing Reportable Events. Though screening by APS staff is crucial, it is the major time consuming responsibility and takes away from valuable investigation and report writing time. This needs to be addressed.

Reasons for screening out are as follows:

- Accept Provider Resolution (APR) –agency took appropriate/reasonable corrective action
- Refer to Regional Office Review (RO) – CCM/ISC attention/follow-up is needed
- Refer to Office of Advocacy (Adv)– consumer rights matter
- Refer to Licensing (Lic.) – Licensing and Regulatory Services matter
- Refer to Office of Elder Services (OES) – consumer is not eligible for DD services
- Refer to police – Criminal matter
- Refer to Provider Integrity Unit/DHHS (PIU) – question of MaineCare fraud/abuse
- Not an APS Matter/incident – client-to-client incident without harm or with staff intervention, or the event is without factual basis, or the event does not rise to the level of APS

The following table compares 2008, 2009 and 2010 unassigned Reportables by region.

Event	R1	2A	2L	2R	3B	3C	Total	R1	2A	2L	2R	3B	3C	Total	R1	2A	2L	2R	3B	3C	Total
Accept Provider Resolution	84	72	60	31	98	47	392	103	102	55	33	174	51	518	82	103	52	21	149	74	481
Refer to Regional Office review	124	81	47	55	124	49	481	104	82	75	68	137	47	513	79	111	95	35	174	44	538
Refer to Office of Advocacy	6	2	5	7	7	2	29	1	7	11	0	20	0	39	0	8	2	3	8	5	26
Refer to Licensing	8	6	6	1	1	2	24	3	9	3	0	6	0	21	7	2	2	1	8	0	20
Refer to Office of Elder Services	0	2	2	0	0	0	4	1	2	2	0	0	0	5	2	1	1	0	0	0	4
Not an APS matter	45	97	59	19	88	63	372	73	52	36	23	122	72	378	86	42	171	23	138	25	485
Totals	267	260	179	113	318	163	1300	285	254	182	124	459	170	1474	256	267	323	83	477	148	1554

**Statewide Unassigned Event Categories/Region, comparing 2008, 2009 and 2010**

<b>Event</b>	<b>R1</b>	<b>2A</b>	<b>2L</b>	<b>2R</b>	<b>3B</b>	<b>3C</b>	<b>Total</b>	<b>R1</b>	<b>2A</b>	<b>2L</b>	<b>2R</b>	<b>3B</b>	<b>3C</b>	<b>Total</b>	<b>R1</b>	<b>2A</b>	<b>2L</b>	<b>2R</b>	<b>3B</b>	<b>3C</b>	<b>Total</b>
Physical Abuse	58	43	36	22	54	10	<b>223</b>	69	63	44	39	79	23	<b>317</b>	65	50	164	22	74	17	<b>392</b>
Verbal Abuse	38	18	19	21	26	17	<b>139</b>	20	13	15	5	20	21	<b>94</b>	17	22	23	8	37	13	<b>120</b>
Dangerous Situation	15	11	3	6	32	7	<b>74</b>	19	9	13	6	41	12	<b>100</b>	4	18	8	4	56	4	<b>94</b>
Exploitation	29	20	22	10	29	16	<b>126</b>	23	38	16	14	51	26	<b>168</b>	29	29	16	10	74	19	<b>177</b>
Serious Illness/Injury	3	10	1	2	5	2	<b>23</b>	5	2	1	1	5	1	<b>15</b>	1	8	2	0	11	2	<b>24</b>
Neglect	84	76	61	27	117	69	<b>434</b>	95	78	54	35	163	41	<b>466</b>	99	89	37	15	138	69	<b>447</b>
Rights Violation	6	14	2	7	19	2	<b>50</b>	3	12	4	4	33	4	<b>60</b>	2	19	1	12	35	13	<b>82</b>
Sexual Exploitation	17	46	18	8	26	25	<b>140</b>	21	25	16	11	41	28	<b>142</b>	22	23	22	5	34	4	<b>110</b>
Restraint	2	3	2	2	1	2	<b>12</b>	3	2	6	0	1	0	<b>12</b>	1	1	38	1	0	0	<b>41</b>
Med. Related Event	4	3	2	1	0	2	<b>12</b>	5	3	2	1	6	1	<b>18</b>	0	3	0	3	7	3	<b>16</b>
Suicidal Attempt/Act	3	7	0	1	1	0	<b>12</b>	0	1	0	0	1	0	<b>2</b>	3	1	2	0	3	0	<b>9</b>
Death	8	9	13	6	8	11	<b>55</b>	22	8	11	8	18	13	<b>80</b>	13	4	10	3	8	4	<b>42</b>
<b>Total</b>	<b>267</b>	<b>260</b>	<b>179</b>	<b>113</b>	<b>318</b>	<b>163</b>	<b>1300</b>	<b>285</b>	<b>254</b>	<b>182</b>	<b>124</b>	<b>459</b>	<b>170</b>	<b>1474</b>	<b>256</b>	<b>267</b>	<b>323</b>	<b>83</b>	<b>477</b>	<b>148</b>	<b>1554</b>

**APS Workload Forward**

The APS workload continues to be extremely busy yet we have managed to respond to each Reportable Event identified as APS that needed to be investigated. Every reportable was investigated that was identified as needing to be investigated. DHHS investigators continue to conduct a considerable amount of inquiry seeking additional information that could have been included on the Reportable Event. Our efforts need to be directed more towards investigation than towards screening matters that are not abuse, neglect, and exploitation. The Unit is now operating with only 4 full time and 1 part time APS Investigators, plus the APS Manager. Two staff vacancies has impacted the timeliness of response as well as report writing.

The Office of Adults with Cognitive and Physical Disability Services oversees support services to consumers with developmental disabilities. From the Regional Office to the local community level, there is a shared responsibility for assuring consumer safety while promoting individual growth and independence. From this perspective, the most beneficial and least intrusive approach to address the threat or act of harm including abuse, neglect, or exploitation is in the consumer's best interest if we are to support consumer community integration. APS should be reserved for addressing the more egregious threats or acts of abuse, neglect, exploitation because the presence of APS is noticeably more significant and involved than that of the other constants in the consumer's life. The remaining Reportable Events were responsibly and properly delegated to the qualified resources available within the State human services system; to not utilize such resources would be irresponsible. As previously noted, the APS Unit works in conjunction with other Department and Office staff within the State and it is as a shared responsibility that all Reportable Events affecting our consumers were examined and addressed.

Reportable Event categories need to be examined as to their relationship to APS. Dangerous Situation and Serious Injury are too subjective and are often added to a Neglect or Physical Abuse Reportable Event. A Restraint Reportable Event usually implies Physical Abuse. Several Reportable Events identified as Sexual Exploitation were screened out because they did not meet the definition of sexual exploitation.

### **Recommendations for 2011**

The Lean process began to identify and differentiate those events that rise to APS abuse, neglect, exploitation and those events that would best be addressed to other entities for more immediate remedy. This process needs to be completed so there's more consistency throughout the state on what is referred to APS. We need to address the multitude of EIS categories that are referred to APS which simply subjectively amplify an abuse or neglect allegation. They are extraneous and add unnecessary triage to APS staff.

EIS needs to separate Physical from Verbal Abuse. There is a definite distinction between these two categories.

When a consumer's Behavior Plan identifies certain patterns of behavior and supports, consideration should be given to the context of the event when a consumer makes non credible allegations. The *Regulations* allow for such patterns of behaviors to be documented per the Behavior Plan and are thus exempt from filing a Reportable Event.

At the onset of police involvement, APS will need to develop a better method of law enforcement accountability so as to track their progress with the investigation. At present, law enforcement is well intended, but cases lose momentum and get put on a back burner, and then get forgotten.

Investigator training of Agency Investigators will resume when APS staffing is up to full staffing levels.

Respectfully submitted,

*Priscille Côté*

Adult Protective Services Unit Manager

cc: Mary Mayhew, Commissioner DHHS  
Jane Gallivan, Director, Office of Adults with Cognitive & Physical Disability Services  
Christopher C. Leighton, Deputy Attorney General  
Richard Estabrook, Chief Advocate  
Margaret Rode, Director of Quality Assurance

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