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SECTION 1 Introduction

1.1 Introduction and Overview

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

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

1.1.1 Client's Consent

In general, the client's consent must be obtained before services are provided. However, there are times in which consent cannot be obtained; such as when the client is:

- a) in an emergency situation, appears to be incapacitated, and is unwilling to remove themselves from danger; or
- b) in an emergency situation, appears to be incapacitated, and is unwilling to be removed by others.

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

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

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

Culturally competent practice is ensured by recognizing, respecting and responding to the culturally defined needs of individuals that we serve. If someone is in need of an interpreter, the APS worker must contact Interpreters Unlimited, Inc. at 877-625-6482 and supply the following information: WV Department of Health and Human Resources, Bureau for Children and Families, the APS worker's name requesting interpreter services, and an access code. In order to receive an access code, the APS worker must first contact the appropriate Bureau's representative or DHHR Purchasing. If an interpreter is used, it is advisable to obtain a signed Confidentiality Statement. The APS worker will stress to the interpreter that confidentially must be discussed with this individual, reminding them that all information is confidential and must not be shared with anyone.

1.2 Statutory Basis

1.2.1 Mandates for the Department by [WV Code §9-6-2](#)

- a) There is hereby established and continued within the DHHR the system of APS heretofore existing;
- b) The secretary shall propose rules for legislative approval in accordance with the provisions of article three, chapter twenty-nine-a of this code regarding the organization and duties of the APS system and the procedures to be used by the department to effectuate the purposes of this article. The rules may be amended and supplemented from time to time;
- c) The secretary shall design and arrange such rules to attain, or move toward the attainment, of the following goals to the extent that the secretary believes feasible under the provisions of this article within the state appropriations and other funds available:
 - Assisting adults who are abused, neglected or incapacitated in achieving or maintaining self-sufficiency and self-support and preventing, reducing and eliminating their dependency on the state;
 - Preventing, reducing and eliminating neglect and abuse of adults who are unable to protect their own interests;
 - Preventing and reducing institutional care of adults by providing less intensive forms of care, preferably in the home;
 - Referring and admitting abused, neglected or incapacitated adults to institutional care only where other available services are inappropriate;
 - Providing services and monitoring to adults in institutions designed to assist adults in returning to community settings;
 - Preventing, reducing and eliminating the exploitation of incapacitated adults and facility residents through the joint efforts of the various agencies of the DHHR, the APS system, the state and regional long-

- term care ombudsmen, administrators of nursing homes or other residential facilities and county prosecutors;
- Preventing, reducing and eliminating abuse and neglect of residents in nursing homes or facilities; and
 - Coordinating investigation activities for complaints of abuse and neglect of incapacitated adults and facility residents among the various agencies of the DHHR, the APS system, the state and regional long-term care ombudsmen, administrators of nursing homes or other residential facilities, county prosecutors, if necessary, and other state or federal agencies or officials, as appropriate;
- d) No APS worker may be held personally liable for any professional decision or action thereupon arrived at in the performance of his or her official duties as set forth in this section or agency rules promulgated thereupon: Provided, That nothing in this subsection protects any APS worker from any liability arising from the operation of a motor vehicle or for any loss caused by gross negligence, willful and wanton misconduct or intentional misconduct;
- e) The rules proposed by the secretary shall provide for the means by which the department shall cooperate with federal, state and other agencies to fulfill the objectives of the system of APS.
- f) [WV Code §44A-1-8](#): Does not permit DHHR to serve as conservator or a representative payee for a client. If the court appoints DHHR as conservator, a petition must be filed to name the Sheriff in the appropriate county as conservator, in consultation with the APS Legal Counsel.

1.3 Definitions

1.3.1 Terms Defined by Law

Definition	WV Code
<p>Abuse: The infliction or threat to inflict physical pain or injury on or the imprisonment of any incapacitated adult or facility resident. <i>(Similar definition is contained in §61-2-29 regarding criminal penalties).</i></p>	<p>§9-6-1</p>
<p>Caregiver: A person or entity who cares for or shares in the responsibility for the care of an incapacitated adult on a full-time or temporary basis, regardless of whether such person or entity has been designated as a guardian or custodian of the incapacitated adult by any contract, agreement or legal procedures. Caregiver includes health care providers, family members, and any person who otherwise voluntarily accepts a supervisory role towards any incapacitated adult. <i>(Similar definition contained in §61-2-29(3) regarding criminal penalties).</i></p>	<p>§9-6-1</p>

Elder: a person who is sixty-five (65) years or older.	§61-2-29b
Emergency or Emergency Situation: A situation or set of circumstances which present a substantial and immediate risk of death or serious injury to an incapacitated adult.	§9-6-1
Facility or Nursing Home: Any institution, residence, intermediate care facility for an individual with an intellectual disability, care home or any other adult residential facility, or any part or unit thereof, that is subject to the provisions of articles 5-C, 5-D, 5-E, or 5-H, Chapter 16 of the WV Code (nursing homes, assisted living [previously residential board and care and personal care homes], registered unlicensed homes that serve elderly and disabled adults).	§9-6-1
Facility Resident: an individual living in a nursing home or other facility, as that term is defined in subdivision (7) of this section.	§9-6-1
Domestic Violence: The occurrence of one or more of the following acts between family or household members: (1) attempting to cause or intentionally, knowingly or recklessly causing physical harm to another with or without dangerous or deadly weapons; (2) placing another in reasonable apprehension of physical harm; (3) creating fear of physical harm by harassment, psychological abuse or threatening acts; (4) committing either sexual assault or sexual abuse as those terms are defined in articles eight-b and eight-d, chapter sixty-one of this code; and (5) holding, confining, detaining or abducting another person against that person's will.	§48-27-202
Emancipated Minor: A child over the age of sixteen (16) who has been emancipated by 1) order of the court based on a determination that the child can provide for his physical well-being and has the ability to make decisions for himself or 2) marriage of the child. An emancipated minor has all the privileges, rights and duties of an adult including the right to contract.	§49-4-115
Family or Household Member: Current or former spouses, persons living as spouses, persons who formerly resided as spouses, parents, children and stepchildren, current or former sexual or intimate partners, other persons related by blood or marriage, persons who are presently or in the past have resided or cohabitated together or a person with whom the victim has a child in common.	§48-27-204
Incapacitated Adult: Any person, who by reason of physical, mental or other infirmity, is unable to physically carry on the daily activities of	§9-6-1

life necessary to sustaining life and reasonable health. <i>(Note: Incompetence of an adult is determined by a legal proceeding and is not the same as a determination of incapacity. Similar definition is contained in §61-2-29 regarding criminal penalties).</i>	
Financial Exploitation: The intentional misappropriation or misuse of funds or assets of an elderly person, protected person or incapacitated adult, but shall not apply to a transaction or disposition of funds or assets where the accused made a good-faith effort to assist the elderly person, protected person or incapacitated adult with the management of his or her money or other things of value.	§55-7J-1
Legal Representative: A person lawfully invested with the power and charged with the duty of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, medical power of attorney, trustee or other duly appointed person.	§9-6-1
Neglect: Means A) The unreasonable failure by a caregiver to provide the care necessary to assure the physical safety or health of an incapacitated adult; or B) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or facility resident. <i>(Similar definition is contained in §61-2-29 regarding criminal penalties).</i>	§9-6-1
Responsible Family Member: A member of a resident's family who has undertaken primary responsibility for the care of the resident and who has established a working relationship with the nursing home or other facility in which the resident resides. For the purpose of this article, a responsible family member may include someone other than the resident's legal representative.	§9-6-1

1.3.2 Terms Not Specifically Defined In The Law, But Defined for Case Work Purposes

Definitions
Adult Preventive Services or Preventative Adult Services (PAPS): A range of supportive services provided to an adult who does not meet all four criteria to qualify as an APS client but for whom sufficient risk exists that it is likely that APS situation will result without intervention.
Adult Protective Services (APS): Specific intervention activities designed to

<p>protect mentally and/or physically incapacitated adults or facility residents from abuse, neglect or financial exploitation resulting in neglect by others and from self-neglect. The specific intervention activities utilized are investigation, client assessment, and time limited case management.</p>
<p>Basic Needs: The essential requirements necessary to sustain life, health and well-being such as food, clothing, shelter, and necessary medical care.</p>
<p>Centralized Intake (CI): The Centralized Intake Unit is a specialized unit of social workers and supervisors who are responsible for receiving and screening abuse and neglect referrals, requests to receive services, and contacting after-hours workers when necessary, as well as other duties. The Centralized Intake Unit operates twenty-four (24) hours a day, seven (7) days a week.</p>
<p>Electronic Communication: Any communication sent or received electronically through one or more computers and/or electronic communication devices, which includes but is not limited to cell phones, I pads, fax machines, etc.</p>
<p>FACTS: Acronym for the Family and Children's Tracking System and is the automated client information system used by the West Virginia Department of Health and Human Resources, Bureau for Children and Families.</p>
<p>Fiduciary Duty: A special relation of trust, confidence, or responsibility exists. This duty legally obligates one entity/individual to act in the best interest of another and abide by the client's expressed wishes if possible. A guardian, conservator, Power of Attorney, etc. has a fiduciary relationship to a protected person.</p>
<p>Financial Exploitation: A type of neglect of an incapacitated adult involving the illegal, unethical and/or improper use of or willful dissipation of an individual's funds, property or other assets by a person, formal or informal caregiver, family member, or legal representative - either directly (i.e. as the perpetrator) or in-directly (i.e. by allowing or enabling the condition which permitted the financial exploitation).</p>
<p>Imminent Danger: Circumstances exist which indicate the presence or risk of death or serious physical injury.</p>
<p>Self-Neglect: The inability of an incapacitated adult to meet his/her own basic needs of daily living due to mental or physical incapacity.</p>
<p>Sexual Abuse: The coercion of an incapacitated adult or facility resident into having sexual contact with the perpetrator or another person with the</p>

incapacitated adult. A caregiver of the incapacitated person or facility resident must be involved either directly (i.e. as the perpetrator or sexual partner) or indirectly (by allowing or enabling the conditions which result in the sexual coercion).

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

Subpoena: The process by which a court commands a witness to appear and give testimony.

Subpoena Duces Tecum: A subpoena that commands the production of specified evidence in a person's possession.

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

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

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

SECTION 2 Intake

2.1 Procedures for Reporting Abuse/Neglect

[WV Code §9-6-11](#) sets forth the details regarding reporting of abuse, neglect or emergency situations involving an incapacitated adult or facility resident. Any individual may report known or suspected cases of abuse, neglect or emergency situations involving an incapacitated adult or resident of a nursing home or residential facility. These reports shall be made directly to the DHHR's Centralized Intake (1-800-352-6513). Reports may be received twenty-four (24) hours/day, seven (7) days/week. In addition, if the incapacitated adult or facility resident is willing and able, they may make a report on their own behalf.

In addition to the general provisions related to reporting of abuse, neglect or an emergency situation involving an incapacitated adult or facility resident, [WV Code §9-6-1](#) also sets forth requirements related to mandatory reporting. These include:

- Identification of various individuals who are mandatory reporters;
- Statement of requirements regarding immediate reporting by mandatory reporters;
- Statement of requirement to submit a written report within 48 hours;
- Statement of requirement to use specified reporting form for the purpose of submission of the required written report;
- Statement of requirement that mandatory reporters distribute copies of the completed written report to various parties; and,
- Identification of the instances in which the DHHR is required to report substantiated APS to others such as the prosecuting attorney, law enforcement, medical examiner, etc.

2.2 Abrogation of Privileged Communications

[WV Code §9-6-13](#) states that privileged status of communications between husband and wife and with any person identified as a mandatory reporter in the WV Code is nullified in circumstances involving suspected or known abuse or neglect of an incapacitated adult who is in a verified or suspected emergency situation. Therefore, in APS cases privileged communications do not apply between husband and wife, patient and doctor or with any mandated reporter. The only exclusion to this requirement is communication between an attorney and their client which continues to be considered privileged communication.

2.3 Mandatory Reporting

In addition to the general provisions related to reporting of abuse, neglect or an emergency situation involving an incapacitated adult, [WV Code §9-6-9](#) also identifies various individuals who are mandatory reporters. This means that if any of these individuals believe, suspect or know that an incapacitated adult or facility resident is being subjected to or has the potential to be subjected to abuse, neglect or an emergent situation, they must immediately report the circumstances to the DHHR through Centralized Intake. The following are identified as mandatory reporters:

- Medical professionals;
- Dental professionals;
- Mental health professionals;
- Christian Science practitioners;
- Religious healers;
- Social service worker (including those employed by the DHHR);
- Law enforcement officers;
- Humane officers;
- State or regional ombudsman; and,
- Any employee of a nursing home or other residential facility.

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

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

- If alleged victim is a resident of a nursing home or other residential facility, submit a report to state or regional ombudsman, Office of Health Facilities Licensure and Certification (OHFLAC), and facility administrator;
- In case of death of the alleged victim, submit a report to appropriate local medical examiner or coroner and if abuse or neglect is believed to have been a contributing factor to the death, report also to law enforcement; and,

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

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

Under [WV Code §9-6-9\(d\)](#), the DHHR is required to provide notification to mandated reporters whether the referral has been accepted for investigation or screened out with no further action required, and at the conclusion of the investigation, if the referral was accepted (refer to [Appendix H](#) Notification Letter).

2.4 Reporting Suspected Animal Cruelty

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

2.5 Follow-Up Reporting to the Medical Examiner

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

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

- a) If there is no medical examiner or coroner responsible for the county where the death occurred, or:
- b) The local medical examiner or coroner in the county where the death occurred cannot be reached or is unavailable. In these instances the referral would be made to the state medical examiner's Forensic Investigations Unit.

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

2.6 Immunity from Liability

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

2.7 Cooperation Among Agencies

[WV Code §9-6-3](#) states whenever possible and appropriate, conducting investigations of alleged abuse and/or neglect should be coordinated between APS and other applicable state and federally authorized entities. Specifically, APS staff should coordinate investigations as appropriate with OHFLAC, BHHF, Medicaid Fraud, State and Regional Long-Term Care Ombudsman, law enforcement, patient advocates in state operated behavioral health facilities, and the identified Protection and Advocacy Agency (WV Advocates). These and other state and federal agencies are required to cooperate with each other for the purposes of observing, reporting, investigating and acting on complaints of abuse or neglect of any incapacitated adult or facility resident.

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

2.8 Penalties for Caregiver, if Convicted

[WV Code §61-2-29](#) provides for criminal penalties for any person, caregiver, guardian or custodian who, directly or indirectly, abuses, neglects or financially exploits an incapacitated adult or elder person.

2.9 Eligibility Criteria

In order to be eligible to receive APS or PAPS, the individual must meet certain criteria. These are set forth in the following sections.

2.9.1 APS & PAPS – Intake and Investigation

APS

In order to be eligible to receive an APS intake and investigation, the individual need only meet the following three (3) criteria:

- i. Being eighteen (18) years of age or older, or an emancipated minor;
- ii. Incapacitated or a facility resident; and,
- iii. Reported to be the victim of abuse, neglect (including self-neglect and financial exploitation) or in an emergency situation.

PAPS

In order to be eligible to receive PAPS intake and investigation, the individual need only meet the following three (3) criteria:

- i. Being eighteen (18) years of age or older, or an emancipated minor;
- ii. Incapacitated or a facility resident; and,
- iii. Reported to be at risk of abuse or neglect (including self-neglect).

Whenever these criteria are met and the intake is assigned for investigation, an investigation is to commence and be completed within a specified period of time (refer to sections [Section 2.12](#) Referral Triage/ Disposition and [Section 3.1](#) Client Assessment Process for detailed information).

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

2.9.2 APS & PAPS – Ongoing

APS

In order to be eligible to receive ongoing APS, the referral must come through the APS intake process and the individual must meet all four (4) of the following criteria simultaneously. The determination as to whether the criteria is met or not is made based on the information gathered and the conclusions drawn during completion of the APS investigation Risk Assessment. The four (4) criteria are:

- i. Being eighteen (18) years of age or older or an emancipated minor;
- ii. Incapacitated or a facility resident; and,
- iii.
 - a) According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.
 - If the investigation determined this, then an APS case can be opened.
 - b) The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).

- If the investigation determined this, then a PAPS case can be opened; not an APS case.
- iv. The client is, excluding the perpetrator, 1) alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s), or 2) is in a care facility.

Whenever all four (4) of the criteria listed above are present, an APS situation is to be substantiated. Usually, whenever a report is substantiated a case will be opened. There are a few exceptional situations when a case may not be opened even though the report is substantiated; such as: 1) all four (4) criteria are met but criteria "ii" is met based on the adult's physical incapacity rather than mental incapacity. Mentally the client is able to make sound decisions and understand the consequences of those decisions and they choose to refuse intervention by the DHHR beyond the investigation; and 2) the client is in a facility and the verified abuse/neglect was limited to a perpetrator who is no longer employed with the facility.

PAPS

In order to be eligible to receive PAPS, the referral must come through the APS intake process and the individual must meet three (3) of the following criteria simultaneously. The determination as to whether the criteria is met or not is made based on the information gathered and the conclusions drawn during completion of the APS investigation and Risk Assessment. The three (3) criteria are:

- i. Being eighteen (18) years of age, or an emancipated minor;
- ii. The client is functionally disabled due to his/her physical and/or mental disabilities.
- iii. a) According to the legal definition of abuse and neglect, the client is determined to have been neglected or abused.
 - If the investigation determined this, then an APS case can be opened; not a PAPS.b) The client is in probable danger of being neglected or abused through action or inaction, intentional or unintentional, of his/her own volition, or the volition of another individual(s).
 - If the investigation determined this, then a PAPS case can be opened; not an APS case.
- iv. The client is, excluding the perpetrator, 1) alone or without an interested person(s) who is able and willing to provide the needed support/services to alleviate the underlying problem(s) or presenting problem(s), or 2) is in a care facility.

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

Note: Poor judgment does not necessarily indicate mental impairment (incapacity). Further, the APS worker does not determine incapacity; however, if the client's decision-making capacity is in question, the APS worker may request that an evaluation be completed to further assess the adult's decision making capacity. Refer to [APS Substitute Decision Maker Policy](#) for additional information.

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

2.9.3 Other Departmental Social Services

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

2.10 Required Information

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

- Name(s) of alleged victim;
- County of incident;
- Current location of the alleged victim;
- Age/date of birth of alleged victim;
- Address of the alleged victim's home;
- Phone number for the alleged victim;
- Directions to the home;
- Name, age and relationship of alleged perpetrator (if applicable):

- a. Must be eighteen (18) years of age or an emancipated minor;
 - b. If alleged perpetrator is under age eighteen (18) and is not an emancipated minor, the caregiver must be listed as the alleged perpetrator. If a minor, it may require a Child Protective Service referral.
- Other individuals involved in or who have knowledge of the incident;
 - Description of the alleged abuse/neglect incident(s) and any resulting injuries including type of alleged abuse/neglect, where and when the incident occurred, location(s) of injuries, etc.;
 - Physical and psychological description of the alleged victim;
 - Name of reporter or indication that referral was made anonymously if the reporter is unwilling to give their name. If the reporter indicates that their name is not to be shared with others, this must be documented. To do this check the box in FACTS on the reporter screen that the reporter wishes to remain anonymous.
 - Relationship of the reporter to the alleged victim;
 - Identification of the reporter as a mandatory reporter, when applicable;
 - If a mandatory reporter, worker should request that a written report be submitted;
 - When receiving referrals from mandated referents, notification at the onset whether the referral has been accepted for investigation or screened with no further action taken, will be mailed to the mandated reporter; and,
 - When a non-mandated reporter indicates they want APS to follow-up after completion of the investigation, follow-up is limited to informing the reporter the information is not available.

The name of the referent as well as any information that may identify the reporter to others is confidential and is not to be released except to certain parties such as the prosecuting attorney and law enforcement officials as authorized by state law. If the name of the reporter is requested, the APS worker will consult with their immediate supervisor who will consult with the Adult Services Legal Counsel.

In situations where the incident being reported involves self-neglect or self-abuse, the same person will be identified in FACTS as both the alleged victim and the alleged perpetrator. In situations where referrals are received involving more than one household member as an alleged victim (example: both a husband and a wife), separate referrals for each individual are required. The two (2) referrals would then be associated in FACTS to show that there is a relationship between them.

When all referral information is gathered and documented in FACTS, a search of the FACTS system must be completed to determine if there are other

referrals/investigations/cases for the identified client. If so, the new referral is to be associated to the referral/investigation/case as appropriate, and a merge request must be submitted to the FACTS help desk.

2.11 Referral Triage or Disposition

Centralized Intake is the primary decision-maker at the intake stage of the APS process. Centralized Intake's role includes: 1) ensuring that all referrals are appropriately considered to determine if the referral is to be assigned for a Risk Assessment or screened out, and 2) for those assigned for assessment, determination of the required response time for the initial contact based on the degree of risk indicated in the referral information. Screening of the referral is to be done promptly.

Centralized Intake will:

- Review the information collected at intake for thoroughness and completeness. If further clarification/information is required, Centralized Intake may contact the reporter;
- Identify the type of referral: "in-home" (i.e. client's own home); "institutional" (i.e. nursing home, ICF/ID group home, Specialized Family Care homes, I/DD Waiver home, Assisted Living facilities, Adult Family Care, state operated mental health facilities, etc.); or "non-residential" (i.e. day treatment, adult day care, home-health agency, hospice, sheltered workshop, etc.);
- conduct a search of the FACTS system to determine if other referrals/investigations/cases already exist for the identified client;
- Create associations in FACTS between the current referral and other referrals/investigations/cases as appropriate, including creating a link between the referral and the provider record whenever the alleged abuse/neglect occurred in a setting other than the alleged victim's home;
- When an APS referral is received for a client in an institutional or other out-of-home residential setting, a file must be opened in FACTS if one does not already exist on the institution/facility, in addition to the client file and the two (2) files must be associated within FACTS (*Link provider/referral on Referral Acceptance screen). When the provider/facility is set up it is important that it be marked as "unavailable" in FACTS unless it is a facility in which DHHR makes placements. For the purposes of Adult Protective Services, Adult Family Care homes, licensed assisted living settings, registered unlicensed homes, Waiver homes, Medley Homes, ICF/ID Group homes, etc. are considered to be facilities.
- Determine if the referral will be screened out and not accepted for an APS investigation. In determining whether to accept or screen out the referral, the Centralized Intake worker must consider:
 - a) The presence of factors which present a risk to the adult;

- b) The information related to the alleged abuse and/or neglect, the alleged victim, and the alleged perpetrator;
 - c) Whether there are recent/current referrals under investigation with identical allegations;
 - d) Whether the information collected appears to meet the definition of APS; and,
 - e) The sufficiency of information in order to locate the individual/family.
- Accept all referrals for an APS Risk Assessment that appear to meet the definition of APS or, based on the information provided, are at risk of being abused and/or neglected;
 - Ensure notification of acceptance or screening of the referral has been sent to mandated reporters;
 - Ensure a follow-up notification letter has been sent to the mandated reporter that the assessment has been completed.

In reports involving facility/agency settings, the critical factor in determining whether to screen a referral are determined whether or not the allegations reported meet the definition of abuse/neglect. If they do, the report is to be investigated even if the injury's origin is not known, the perpetrator is not known, or the alleged perpetrator is no longer employed by the agency. For example, if the report is a minor bruise or skin tear with no indication that the injury occurred as a result of abuse/neglect the report may be screened out. If the referral is screened out, document the basis for that decision, and ensure that additional referrals to other resources (within and outside of the Department) are made, if appropriate. However, if the same injury is reported but there is reason to believe it occurred as a result of abuse/neglect it would be accepted for investigation. Once accepted, determine the appropriate response time for the referral based on the information presented on the intake and assign for investigation. Response time is to be determined from the time the referral is received by the DHHR.

2.11.1 Response Times

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

2.11.2 Response Time Options

- a) **Immediate Response- zero (0) to two (2) hours:** This time frame will apply in cases where it is determined that, based on the referral information, an emergency situation exists. (Emergency is a situation or set of circumstances which presents a substantial and immediate risk of death or serious injury to an incapacitated adult). A face-to-face contact with the alleged victim must be made within two (2) hours.
- b) **Within seventy-two (72) hours:** This time frame will apply in cases where it is determined, based on the referral information, an emergency situation does not currently exist, but circumstances are severe enough that without prompt intervention, an emergency situation could result. A face-to-face contact with the alleged victim must be made within seventy-two (72) hours.
- c) **Within fourteen (14) days:** This time frame will apply in cases where it is determined that, based on the referral information, an emergency situation does not currently exist and/or is not expected to develop without immediate intervention. A face-to-face contact with the alleged victim must be made within fourteen (14) days.

Note: If “imminent danger” is selected by the Centralized Intake, FACTS will trigger a response time of “0 - 2 hours”. Otherwise, the default timeframe is “within seventy-two (72) hours”.

2.11.3 Considerations in Determining Response Time

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

- Whether the information reported contains an allegation that indicates the presence of imminent danger or the presence/risk of death or serious physical injury;
- Whether the alleged victim has the physical, cognitive and emotional capacity to make decisions and independently act on them;
- The location of the alleged victim at the time the intake is received (whether or not the victim is in a location that can assure their safety, or victims ability to remove themselves from danger if necessary);
- The potential/likely effect of Adult Protective Service intervention in escalating the circumstances in the home/facility and the capacity of Adult Protective Services to remain with the situation once intervention is initiated;
- Whether the nature of the alleged abuse/neglect indicates premeditation or bizarre behavior or circumstances;
- Whether the alleged abuse/neglect is occurring at this moment;
- Whether the alleged circumstances that exist could change rapidly;

- Whether the alleged perpetrator's behavior is bizarre, out of control, or dangerous;
- Whether the alleged victim or perpetrator will flee;
- Whether the living arrangements are life threatening;
- Whether the alleged victim requires medical attention;
- Whether the caregiver is gone and the alleged victim is without needed assistance and supervision;
- Whether the alleged victim is capable of self-preservation/protection;
- Whether the alleged victim is isolated socially or geographically;
- Whether there are indications of family violence;
- Whether the family is transient or new to the community;
- Whether the adult is currently connected to any formal support system;
- Whether there are any family or friends available for support;
- Whether the caregiver(s) are physically, cognitively and emotionally able to provide needed care to the adult;
- Whether there is a past history of referrals or multiple current referrals;
- Whether there are multiple injuries; and,
- Whether the location of the injuries suggest more serious harm.

2.11.4 After Determination of Response Time

- Document the decision in FACTS indicating the selected response time and the date of this decision;
- Assign the referral to a APS worker to initiate the investigation;
- Ensure notification of acceptance or screening of the referral has been sent to mandated reporters;
- Follow-up to assure that the assigned APS worker adhered to the designated response time; and,
- Ensure a follow-up notification letter has been sent to the mandated reporter that the assessment has been completed.

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

2.11.5 Recurrent APS Referrals

All referrals must be evaluated to determine whether or not an emergency situation exists. There may be times when recurrent referrals are received. Recurrent referrals mean identical referrals involving an active case or a client

who is currently or was recently (within the past thirty (30) days) the subject of an APS investigation. Regardless of past contact with the client, each referral must be considered separately to determine whether or not any additional action is required.

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

2.12 APS Referrals Involving Specific Situations

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

- Violent crimes;
- An active mental health client;
- Financial exploitation;
- Nursing home, assisted living, group home and residential settings;
- Mental health and state operated long-term care facilities;
- Nursing homes, assisted living facilities and other privately operated facilities;
- A service agency (i.e. sheltered workshop, community mental health center, home health agency);
- An acute primary care hospital;
- Law enforcement agency;
- Receiving Adult Family Care services; or,
- Suspected Methamphetamine laboratories and/or use.

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

2.12.1 APS Referrals in Violent Crimes

Referrals that are received regarding a mentally and/or physically incapacitated adult or facility resident who is the victim of a violent crime, including but not limited to aggravated assault, sexual assault, attempted murder, etc., shall be received by Centralized Intake. Centralized Intake will determine if the referral meets the definition of abuse and/or neglect as defined by [WV Code §9-6-1](#) and make a screening decision. Centralized Intake then will notify the WV State Police of a reported violent crime. If it is known that a violent crime is alleged when the referral is received, Centralized Intake should first request that the

reporter call law enforcement directly to report the situation. Whether or not the reporter refuses or agrees to call law enforcement, the referral is to be reported immediately by Centralized Intake to law enforcement in either instance.

APS involvement in these types of cases is limited to those involving an incapacitated adult and facility residents. An APS worker involved in a situation that is under investigation by a law enforcement agency must proceed with caution. Any involvement by the APS worker is not to interfere with or jeopardize the investigation by law enforcement. Close coordination between the two (2) agencies is essential. The nature and scope of APS involvement should be determined by law enforcement and/or the prosecuting attorney if either entity is involved in the case.

The responsibility of the APS worker in situations involving a violent crime is to work in cooperation with law enforcement to ensure the safety of the alleged victim while their investigation is being conducted. To ensure the safety of the worker, APS should not intervene or respond to an active/on-going violent crime scene or situation. Regardless whether or not law enforcement conducts an investigation, initiation or intervention by APS should not exceed fourteen (14) days from the date the referral was received. The APS worker is also responsible to ensure the victim is safe and to secure safe placement for the victim immediately.

2.12.2 APS Referrals Involving an Active Mental Health Client

Referrals involving active clients of a mental health/community behavioral health center who are endangering themselves or others should be referred to the center where they are receiving treatment. While these individuals may be in need of protection, the involvement of the mental health/behavioral health center is essential to the provision of appropriate services to this population. In some situations, the mental health/behavioral health center's involvement with the client may preclude the necessity of action taken by APS. However, if abuse/neglect is included in the report, APS is to respond in order to address the abuse/neglect issues; in addition to any intervention that may be offered by the behavioral health provider. (See also [Section 2.13.7](#) APS Referrals Involving a Service Agency for the requirements if the alleged perpetrator is a staff member of the Mental Health agency).

2.12.3 APS Referrals Involving Financial Exploitation

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

thirty (30) day extension approved by the supervisor. Refer to [Appendix E](#) for Signs of Financial Exploitation.

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

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

Under the [WV Code §39B](#), the Uniform Power of Attorney Act, if a person suspects an agent of abuse, neglect, financial exploitation a referral may be filed with APS. If the referral is accepted for investigation, APS can ask for an accounting of transactions made by the agent on behalf of the client.

The agent must provide APS within thirty (30) days the requested information or must provide in writing why they need an additional thirty (30) days. If the agent fails to provide information within the allotted time frame, APS may file a petition with the court. APS workers should follow regional protocol to file this petition requesting the aforementioned documents.

2.12.4 APS Referrals Involving Nursing Home, Assisted Living, Group Home and Residential Settings

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

Reports that deal solely with past due accounts do not meet the criteria as APS and generally will be screened out, unless the referrals indicates the resident is currently being exploited. The APS worker must not get involved in delinquent accounts and must focus on prevention of current and/or future financial exploitation. Whenever financial exploitation is substantiated that involves a

nursing home, assisted living resident or a resident of a legally unlicensed home or a residential care community, the worker is to notify the long-term care ombudsman (except Group Homes), OHFLAC, law enforcement, prosecuting attorney and Medicaid Fraud.

Whenever financial exploitation is substantiated that involves a resident of any other placement setting, the APS worker is to notify law enforcement, prosecuting attorney, OHFLAC, Medicaid Fraud, BHHF, Bureau for Medical Services or other appropriate regulatory agency

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

The DHHR has established a mechanism for addressing APS complaints that involve state operated mental health facilities and state operated long-term care facilities. A person(s) identified as a “Patient Advocate” is responsible for investigating all referrals received involving residents in state operated Mental Health facilities, regardless of the nature of the referral.

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

- Referrals that allege a specific client has been the victim of neglect or abuse by a staff person;
- Upon receipt of a complaint by APS involving a specific client in one of these types of settings, the APS worker must discuss the complaint with the facility administrator or their designee;
- Referrals that indicate abuse of a patient/resident by another patient/resident in general are to be considered behavioral management issues within the institution and should be screened out and referred to the facility administrator or their designee. However, if there is a question as to whether or not neglect on the part of the facility was a contributing factor to the allegations of abuse, the referral may be accepted for investigation;
- In any of the state operated facilities specified above, referrals that are general in nature and may concern the entire facility population should be referred to the facility administrator or their designee and forwarded, in writing, to the DHHR with attention of the Commissioner of BHHF. In addition, situations involving a long-term care facility are also to be referred to OHFLAC.

Note: Use the form titled “APS Notification Letter - Within DHHR” to provide written notification to the BHHF and/or OHFLAC. This form is available in FACTS.

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

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

- Referrals that concern the general population of the facility rather than an individual (i.e. “food is not meeting dietary requirements”) must be referred, in writing, to the Long-Term Care Unit in the Bureau of Medical Services, OHFLAC, and the Ombudsman. Information about the reporter is not to be shared as part of this notification. The reporter is to be encouraged to contact the appropriate agency to report the incident directly. If they refuse to make this report or it is unlikely or questionable as to whether or not the report will be made to the appropriate agency, Centralized Intake must document the information reported and forward the information to the appropriate agency;
- If the referral, however, indicates that the resident in the facility may be in immediate danger, (i.e. it is 10 degrees outside and the facility’s heating unit is broken), the DHHR should evaluate and may respond by conducting an APS investigation and making appropriate referrals as indicated previously;
- Referrals that are received alleging abuse/neglect of a resident by a staff person or a visitor require an investigation by APS. If there are multiple victims named in the complaint, a separate referral must be taken for each alleged victim;
- Referrals that allege resident to resident abuse generally are considered to be behavioral issues and therefore not considered to be appropriate for investigation by APS, unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the facility. The prior situation should be referred to the facility administrator or their designee to be addressed. Further, if it is determined that there is or appears be a pattern of this type of allegation in a facility, a referral to OHFLAC or other applicable regulatory body and/or Ombudsman should be made.

Note: Use the form titled “APS Notification Letter - Within DHHR” or “APS Notification Letter - NON-DHHR,” as applicable, to provide written notification to the appropriate regulatory or advocacy body. This form is available in FACTS.

2.12.7 APS Referrals Involving a Service Agency

Referrals alleging that abuse/neglect occurred at a service agency (i.e. sheltered workshop, community mental health center, home health provider, day treatment program, etc.) and the report alleges that the perpetrator was a staff member of that service agency or a visitor, an investigation must be initiated. If more than

one victim is named in the report, a separate referral must be completed for each individual.

Allegations of client to client abuse in this type of setting are generally not considered to be appropriate for an APS investigation unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the service agency. Rather, these situations are to be referred to the agency administrator and the appropriate licensing agency(s) for follow-up; such as: OHFLAC and BHHF.

Note: Use the form titled “APS Notification Letter-Within DHHR” or “APS Notification Letter-NON-DHHR,” as applicable, to provide written notification to the appropriate regulatory body. This form is available in FACTS.

2.12.8 APS Referrals Involving Acute Primary Care Hospital

Referrals involving abuse or neglect by hospital personnel that occurred in an acute primary care hospital are not appropriate for an APS investigation. These are to be referred to the administrator of the hospital. Quality of Care issues are to be referred to West Virginia Medical Institute Quality Insights (WVMI), OHFLAC and/or Medicaid Fraud Control Unit through the DHHR. The reporter should be encouraged to contact these entities directly to make the referral. If the reporter is unwilling or unable to do so, the DHHR is to send a written referral after gathering all relevant intake information.

2.12.9 APS Referrals Involving Law Enforcement or Correctional Facility

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

2.12.10 Referrals Involving Adult Family Care Recipients

Since Adult Family Care (AFC) homes are certified by the DHHR, the APS worker must notify the appropriate Home Finder and Adult Service worker of an APS referral regarding AFC homes and/or providers. APS referrals involving adults who reside in an Adult Family Care home shall be handled as follows:

- To avoid a conflict of interest, it is recommended that the referral be assigned to another county rather than the resident county of AFC home for investigation. If that is not possible it is then recommended that the worker conducting the APS investigation not be the same worker who also

carries an active Adult Services Request to Receive case (Adult Residential, Guardianship or Health Care Surrogate);

- If the worker or supervisor is the reporter, the supervisor or an employee in that unit should not be assigned to the investigation. In these situations, the referral should be assigned to another APS worker;
- If the referral indicates that one (1) or more residents of the AFC home may be in immediate danger, (i.e. it is 10 degrees outside and the heating unit is broken), the DHHR will evaluate and may respond by conducting an APS investigation and making appropriate referrals;
- Referrals that are received alleging abuse/neglect of a resident by a provider or a visitor require an investigation by APS. If there are multiple individuals named in the complaint, a separate referral must be taken for each alleged victim; and,
- Referrals that allege client to client abuse are considered to be behavioral issues and therefore not considered to be appropriate for investigation by APS. Rather, these should be referred to the Home Finding supervisor. These referrals would not be accepted for APS investigation unless the abuse/neglect is believed to have occurred as a result of action or failure to act on the part of the AFC provider.

2.12.11 APS Referrals Involving Suspected Methamphetamine Laboratories and/or Use

Referrals involving a suspected meth lab should be referred to law enforcement as they should be the first responder. Law enforcement may request placement assistance if there is a mentally and/or physically incapacitated adult. These may be accepted upon supervisory discretion. If the APS worker discovers a meth lab or suspects that they have come across chemicals being used to make meth during a home visit or an investigation, the APS worker will leave the house, depart the immediate area, and contact their supervisor and law enforcement. (See [Appendix C](#) for Protocol for Methamphetamine Investigations).

2.13 Investigations

2.13.1 Introduction

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

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

whether the crime is a felony or a misdemeanor, and the severity of the sentence imposed.

2.13.2 Conducting Investigations

Refer to [Appendix B](#) for Worker Safety.

There is a consensus among law makers and APS workers as well as the community that clients and alleged perpetrators have a right to be as educated and involved as possible in the decisions being made during an APS investigation. The more knowledgeable and invested individuals are during an investigation the more willing they are to accept intervention. The APS worker is entrusted with the responsibility to share information with the individual during key points throughout the intervention process, not just those concerning the investigation. It is also important to keep in mind that the way in which information is disclosed is important. An APS worker must balance the right of notification with concern for not compromising any criminal proceedings that may be initiated as a result of substantiated abuse/neglect. Below outlines the client's and alleged perpetrator's rights; refer to [Appendix G](#) and [Appendix H](#).

a) **Client rights include:**

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

b) **Alleged perpetrator rights include:**

- The right to object to someone coming into your home without your permission to conduct an investigation;
- The right to have certain information about you that APS has in their records kept private and confidential;
- The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted;
- The right to file a grievance if you disagree with a substantiated allegation;
- The right to have fair and reasonable decisions made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs;
- You may have the right to request certain help for you if you have disabilities as defined by the Americans with Disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process;
- The right to know if the allegations against you as an alleged perpetrator were substantiated, if you provide the Department of Health and Human Resources with a complete mailing address.

The duties of the APS worker during the investigation include:

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

- c. under order of the court;
- Involving relevant individuals/service providers as needed throughout the APS process;
- Explaining the reasons behind actions taken by the APS worker;
- Contact the alleged perpetrator(s) regarding the allegation(s) and all potential witnesses and collaterals;
- Identify themselves as a social worker from the DHHR, and displays state employee identification to the alleged victim and any other individuals to be interviewed;
- Give the alleged victim a brief verbal description of the abuse or neglect allegations. If permission to conduct the interview(s) is denied, the APS worker will explain to the alleged victim that the worker must discuss this situation with the APS supervisor. Once the supervisor has reviewed the situation, the supervisor or worker must contact Adult Services Legal Counsel for consultation on how to gain access so that the alleged victim can be interviewed;
- Provide the alleged perpetrator with the handout “Alleged Perpetrator’s Rights during the Adult Protective Service Process,” and briefly explain the content. If the alleged perpetrator has a Guardian/Conservator or Uniform Power of Attorney that is in effect, the handout “Alleged Perpetrator’s Rights during the Adult Protective Service Process” must be provided to them as well. If the client has a Health Care Surrogate/Medical Power of Attorney, the worker is not required to provide this to the Health Care Surrogate or Medical Power of Attorney;
- If the alleged perpetrator refuses to be interviewed face-to-face, but opts for a telephone interview, the APS worker will request a mailing address so the Alleged Perpetrator’s Rights can be mailed. If the alleged perpetrator refuses to provide a home mailing address, the worker will verbally explain the rights if the alleged perpetrator agrees. the APS worker will clarify any questions the alleged perpetrator has about their rights;
- Request a complete home mailing address from the alleged perpetrator explaining this is necessary for notification if the findings are substantiated. If the alleged perpetrator refuses to provide the worker with a complete home mailing address, the APS worker must explain that a notification letter will not be sent regarding the findings, if substantiated. The APS worker must also explain to the alleged perpetrator that the findings may affect future employment. The APS worker then must document in FACTS if the alleged perpetrator refuses to provide a complete home mailing address. APS cannot not mail the notification letter to the alleged perpetrator’s place of employment, without written permission from the alleged perpetrator;

- If the alleged perpetrator refuses to be interviewed, the APS worker must inform them that the findings will be completed without their input; **Note:** If the alleged perpetrator refuses to provide you any information the worker may want to send them a certified letter as a means of verifying attempts were made to get their information on record.
- If it is known that the alleged perpetrator or victim has legal counsel, the APS worker must ask permission to continue the interview. If permission is granted, the APS worker will proceed with the interview. If permission is denied, the APS worker will discuss this with their supervisor and Adult Services Legal Counsel; and still complete the Investigation and Risk Assessment as deemed appropriate.
- Attempt to privately interview all relevant individuals.

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

The order in which interviews are conducted is important to ensure that the information obtained is as factual as possible. The recommended order for completing the interviews is as follows:

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

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

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

All interviews with the alleged victim, witnesses and the alleged perpetrator are to be conducted face-to-face. The interview with the alleged victim **MUST** be completed face-to-face and must be done within the assigned time frame. All other interviews are to be completed as quickly as possible, within the thirty (30)

day period allowed for completion of the Risk Assessment (exception are Financial Exploitation investigations that are allowed sixty (60) days for completion). Every attempt must be made to conduct these interviews face-to-face. If, after every possible attempt is made, a face-to-face interview with individuals, other than the alleged victim, is not possible, the interview(s) may be conducted by telephone. When a face-to-face interview is not possible (excluding the alleged victim) must be documented in FACTS. Each contact with the alleged victim and others must be documented in FACTS as soon as possible.

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

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

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

- Client chart;
- Care plan;
- Flow books/daily observation log;
- Nurses notes/social service notes;
- Communication log;
- Physician's orders;
- Prescribed medications/medication log;
- Photos;
- Body audit;
- Incident report(s);
- Results of the provider's internal investigation of the incident; and,
- Others as applicable.

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

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

2.14 Corrective Action Planning – Facilities

When abuse/neglect in a facility involving staff of the facility or a visitor has been substantiated, a Corrective Action Plan (CAP) is required to assure the safety of the resident. The APS worker must provide written notification to the facility administrator within seven (7) calendar days following the completion of the Risk Assessment. The CAP is to be completed by the facility and must address all the issues identified that are contributing factors to the abuse/neglect. It must clearly identify the specific actions that are to be taken to alleviate the problems. It should include who is responsible for carrying out each task, time frames for completion of each task and other relevant information. The facility must submit a CAP to the DHHR within fifteen (15) days following receipt of the Investigation Summary from the DHHR.

The APS worker is to review the CAP to determine whether or not the plan adequately addresses all problem areas identified. To ensure that the CAP submitted by a facility has been adhered to, the APS worker will request notification from the facility when the plan has been implemented. In most instances the CAP should be fully implemented or completed within thirty (30) days following the date the CAP is approved. Upon receipt of notification that implementation has been completed, the APS worker will conduct a site visit to verify that the plan was implemented. See the following sections for details related to various types of settings.

Upon approval by the DHHR of the CAP, a copy of the approved plan is to be forwarded to the appropriate regulatory office (i.e. OHFLAC, BHHF, etc.). In the event the facility is unable or unwilling to submit a CAP that adequately addresses the identified problems, the prosecuting attorney and the appropriate regulatory body are to be advised of the facility's failure to provide an acceptable CAP.

The CAP process is separate from the written notification that is required to be sent to the regulatory entities, prosecuting attorney, etc. whenever abuse or

neglect has been substantiated in a facility setting. Sharing a copy of the CAP and other information related to implementation of this plan is separate from the initial notification of substantiation.

2.14.1 State Operated Mental Health Hospitals and Long-Term Care Facilities

Substantiated Abuse/Neglect

If an APS investigation is substantiated, the APS worker must provide written notification to the facility administrator within seven (7) calendar days following completion of the Risk Assessment. This notification is to include allegations that were substantiated. A form letter titled "Corrective Action Letter" has been developed for this purpose and is available in the reports section of FACTS. The facility administrator is then responsible for developing a CAP to address the findings and requirements identified.

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

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

If efforts to obtain an acceptable CAP from the facility administrator are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney and the BHHF and OHFLAC. Further action should be at the discretion of the prosecuting attorney. In addition to this notification, if it is a long-term care facility when the nature of the concerns identified during the investigation relate to resident rights within the facility, notification is to be sent to the Ombudsman.

Not Substantiated Abuse/Neglect

A CAP is not routinely required when the abuse/neglect has not been substantiated. In this instance, the APS worker is to notify the facility of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the facility

may be discovered. When this occurs, the APS worker is to provide the facility administrator with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the facility that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non- DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS.

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

If abuse or neglect has not been substantiated and an PAPS Case is going to be opened, a CAP may be requested by the APS worker for appropriate follow-up to correct the situation.

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

Substantiated Abuse/Neglect

If an APS situation is substantiated, the APS worker must provide written notification to the facility administrator/operator within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. Additionally, the cover letter is to advise the operator of the confidential nature of the information contained in it and any attachment(s) to the letter and that the information is only to be shared with appropriate staff within the facility. A form letter titled "Corrective Action Letter" is available in FACTS.

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

Once the CAP is approved by the DHHR, it is to be filed in the paper record for the facility and the client and recorded in Document Tracking. Finally, a copy of the approved plan is to be forwarded as follows:

- Nursing home: OHFLAC, Medicaid Fraud, Ombudsman, and Bureau for Medical Services;
- Assisted living residences, and registered/unlicensed homes: OHFLAC, Ombudsman, and Medicaid Fraud;

- I/DD Waiver homes: OHFLAC, Medicaid Fraud, and Office of Behavioral Health and Health Facilities;
- ICF/ID Group homes: OHFLAC, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for Medical Services;
- Specialized Family Care homes (Medley): Bureau for Children and Families, Medley Program manager and Medicaid Fraud; and
- Adult Family Care home: Bureau for Children and Families, regional AFC home finding supervisor.

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

If efforts to obtain an acceptable CAP from the facility administrator are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney, BHHF and OHFLAC. Further action should be at the discretion of the prosecuting attorney. In addition to this notification, if it is a long-term care facility when the nature of the concerns identified during the investigation relate to resident rights within the facility, notification is to be sent to the local Ombudsman.

Not Substantiated Abuse/Neglect

A CAP is not routinely required when the abuse/neglect has not been substantiated. In this instance, the APS worker is to notify the facility of the outcome of the investigation. However, there may be instances when, although abuse or neglect is not substantiated, poor or inappropriate practice by the facility may be discovered. When this occurs, the APS worker is to provide the facility administrator with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the facility that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non- DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS.

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

If abuse or neglect has not been substantiated and a PAPS is going to be opened, a CAP may be requested by the worker for appropriate follow-up to correct the situation.

2.14.3 Adult Family Care Homes

Since the DHHR is responsible for recruitment and providing support and assistance to both AFC providers and the clients placed in these homes, it is essential that the APS worker coordinate closely with both the AFC Home Finding staff and the Adult Family Care staff involved with the home. Even so, it is important for the APS worker to focus their involvement in the home on the issues of alleged abuse/neglect rather than compliance issues. If there are issues related to compliance that are identified during the course of the investigation, these are to be referred to the AFC Home Finding and/or AFC staff to address (see [Section 2.13.10](#) to review APS Referrals Involving a Client that Receives Adult Family Care Services and See [Section 5.5.3](#) to review Conflict of Interest).

Substantiated Abuse/Neglect

If an APS situation is substantiated and the perpetrator is the provider or a household member that is going to remain in the home, the APS worker is to notify the home finder to assist in evaluating whether or not closure of the home and/or removal of the client(s) is necessary. If the substantiated abuse or neglect is minor and correctable, the APS worker must provide written notification to the provider within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. Additionally, the cover letter is to advise the provider of the confidential nature of the information contained in it and any attachment(s) to the letter. A form letter titled "Corrective Action Letter" is in FACTS. A copy of the notification letter is also to be sent to the regional AFC home finding supervisor.

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

If the APS worker and their supervisor believe that the CAP submitted by the AFC provider fails to adequately address the problems, the APS worker is to

contact the provider to resolve the issues in question and document this contact in FACTS. Written notification is to be sent to the provider identifying the areas that must be addressed in the CAP. The provider has seven (7) days from receipt of this second notification to submit an acceptable CAP. Upon receipt of notification that implementation has been completed, the APS worker will conduct another home visit to verify that the plan was implemented.

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

Not Substantiated Abuse/Neglect

A CAP is not routinely required when the abuse/neglect has not been substantiated. In this instance the APS worker is to notify the provider of the outcome of the investigation. However, there may be instances when, although abuse/neglect is not substantiated, poor or inappropriate practice by the provider may be discovered. When this occurs, the APS worker is to furnish the provider and the regional AFC home finding supervisor with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the provider that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non-DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS. Though AFC homes act as an extension of the DHHR in their provision of services to clients, this letter is the most appropriate option to use in this instance.

If abuse or neglect has not been substantiated and a PAPS is going to be opened, a CAP may be requested by the worker for appropriate follow-up to correct the situation.

2.14.4 APS Referrals Involving Services Agencies

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

Substantiated Abuse/Neglect

If an APS situation is substantiated, the APS worker must provide written notification to the administrative official within seven (7) calendar days following completion of the Risk Assessment. This notification is to include a summary of the investigation findings and a cover letter setting forth the conditions that must be corrected. A form letter titled "Corrective Action Letter" has been developed for this purpose is available in FACTS.

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

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

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

If efforts to obtain an acceptable CAP from the administrative official are unsuccessful, a report describing the remaining concerns and recommendations must be submitted to the prosecuting attorney and the appropriate regulatory agency(s). Further action should be at the discretion of the prosecuting attorney.

Not Substantiated Abuse/Neglect

A CAP is not routinely required when the abuse or neglect has not been substantiated. In this instance, the APS worker is to notify the administrative official of the outcome of the investigation. However, there may be instances when, although abuse or neglect is not substantiated, poor or inappropriate practice by the program may be discovered. When this occurs, the APS worker is to provide the administrative official with a copy of a summary of the investigation findings along with the notification. The purpose of this notification is to facilitate improved services to clients in general by alerting the program that some remedial action may be appropriate. The notification letter titled "APS Notification Letter to Non- DHHR entities" may be used to provide notification in either instance. This letter is available in FACTS.

If abuse or neglect has not been substantiated and a PAPS case is going to be opened, a CAP may be requested by the worker for appropriate follow-up to correct the situation.

2.15 Legal Processes

Refer to the [APS Legal Requirements and Processes Policy](#) for information pertaining to legal requirements and processes.

SECTION 3 Assessment

3.1 Client Assessment Process

3.1.1 Risk Assessment

Once the referral is assigned to an APS worker, the Risk Assessment is to be initiated within the assigned time frame. Completion of the Risk Assessment involves gathering a variety of information about the client, their current status, whether or not the allegations of abuse or neglect can be verified, and if so, the details of the abuse or neglect. Information is to be gathered by conducting a series of interviews with the client, caregiver (if applicable), alleged perpetrator, others having knowledge of the situation, and family members or other significant individuals. When interviewing the alleged perpetrator in a facility setting and the individual is still employed, they must cooperate with the investigation. If the alleged perpetrator has been terminated by the facility the APS worker must make every attempt to conduct the interview. In this instance, the alleged

perpetrator, may or may not agree to be interviewed. If they refuse to be interviewed, this is to be documented in FACTS. This is the investigation phase of APS (see the [Section 2.14](#) Investigations for detailed information).

3.1.2 Information to be Collected

Demographic information about the client, the client's family and unique circumstances is to be documented. The following list is not intended to be all-inclusive: This includes information such as:

- Name;
- Address (mailing and residence);
- Date of birth/age;
- Household members;
- Other significant individuals;
- Legal representatives/substitute decision-makers, if applicable;
- Identification numbers (SSN, Medicaid, Medicare, SSA Claim, etc.);
- Gender;
- Ethnicity;
- Marital status;
- Advance directives in effect, if applicable; and,
- Directions to the current residence.

3.1.3 Living Arrangements

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

- Client's current location (own home, relative's home, hospital, etc.);
- Is this setting considered permanent or temporary;
- Type of setting (private home, residential facility);
- Household/family composition;
- Physical description of residence (single family dwelling, duplex, townhouse, apartment, retirement community, foster home, group home, nursing facility, etc.);
- Interior condition of the residence;
- Exterior condition of the residence;
- Type of geographic area (rural, urban, suburban, etc.); and,
- Access to resources such as family/friends, transportation, shopping, medical care/services, social/recreational, religious affiliations, etc.

3.1.4 Client Functioning

Documenting information about the client's personal characteristics should include information about how the client's personal needs are currently met,

including an assessment of their strengths, needs, and supports in areas, such as:

- Activities of daily living (ADLs);
- Whether or not their needs are currently being met and by whom;
- Caregiver functioning, if applicable;
- Ability to manage finances;
- Ability to manage personal affairs;
- Ability to make and understand medical decisions; and,
- Assessment of decision-making capacity.

3.1.5 Physical/ Medical Health

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

- Observed/reported physical conditions of the client;
- Primary care physician;
- Diagnosed health conditions;
- Current medications;
- Durable medical equipment and supplies used/needed; and,
- Nutritional status.

3.1.6 Mental/ Emotional Health

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

- Current treatment status;
- Current mental health provider, if applicable;
- Mental health services currently receiving;
- Medication prescribed for treatment of a mental health condition;
- Observed/reported mental health/behavioral conditions; and,
- Mental health treatment history.

3.1.7 Financial Information

It is important to document information about the client's resources and their ability to manage these independently or with assistance. Included are areas such as:

- Financial resources - type and amount;
- Other resources available to the client - non-financial (i.e. bonds);
- Assets available to the client;
- Health insurance coverage;
- Life insurance coverage;
- Pre-need burial agreements/ arrangements in effect, if applicable;
- Information about client's ability to manage their own finances;
- Outstanding debts or expenses;
- Court ordered obligation for child support or alimony; and,
- Whoever manages the client's finances or who has access to client's accounts.

3.1.8 Education/ Vocational Information

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

- Last grade completed;
- Field of study;
- History of college attendance/graduation;
- History of special licensure/training; and,
- Current educational/training needs.

3.1.9 Employment Information

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

- Current employment status;
- Current employer;
- Prior employment history; and,
- Current employment needs.

3.1.10 Military Information

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

- Branch of service/dates of service;
- Type of discharge received;
- Service related disability, if applicable; and,
- Veteran's eligibility for benefits (contact local veteran representative).

3.1.11 Legal Information

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

- Assessment of client's decision-making capacity by the APS worker;
- Information about legal determination of competence, if applicable;
- Information about efforts to have client's decision-making capacity formally evaluated;
- Identification of name and decision-making capacity of individuals who assist the client with decision-making; and,
- Court/hearing information.

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

- Is the alleged victim safe or can their safety be arranged/assured through resources available to them? (Resources include financial, social, familial, etc.)
- Can any of the allegations presented in the referral, or identified during the investigation process, be verified?
- Does the alleged victim meet all four (4) APS eligibility criteria?
- If they do not meet all four (4) APS criteria, do they meet the criteria to be considered for APS Preventive Services?
- If the alleged victim has decision-making capacity, are they willing to accept services?
- If APS or APS Preventive Services will not be provided, are referrals to other resources needed?

Although the APS worker should make every effort to interview the alleged victim and obtain consent from their legal representative when necessary, the APS worker must nevertheless complete the Investigation and Risk Assessment in a timely manner. It is not required for the APS worker to obtain the permission of the alleged victim or their legal representative, if applicable, to complete the Investigation and Risk Assessment component. If the APS worker is met with resistance that cannot be resolved, it may be necessary to pursue legal action to proceed.

If at any time during the Investigation and Risk Assessment process doubt arises regarding the emergent nature of the situation (emergent vs. non-emergent) the APS worker shall resolve the doubt in favor of the client's safety and immediately initiate face-to-face contact with the alleged victim. If the allegations are of a violent nature and the perpetrator is likely to be present, the APS worker may want to have a conference with their supervisor to request that law enforcement accompany them to the home to complete the initial face-to-face contact (see [Appendix B](#) Worker Safety for more information).

3.1.12 Time Frames

Time frames for initiation of the Risk Assessment are determined by Centralized Intake. It is critical that the APS worker complete a face-to-face contact within the assigned time frame. This contact is to be documented in FACTS within twenty-four (24) hours of completion of the contact. Documentation is to be pertinent and relevant to activities necessary to complete the Risk Assessment.

The Investigation/Risk Assessment process, including all applicable documentation in FACTS, must be completed and approved by the supervisor within thirty (30) calendar days from the day the referral is received. In order to complete the investigation process, in addition to the alleged victim, the caregiver (if applicable), the alleged perpetrator, witnesses, and all other relevant parties must also be interviewed (see [Section 2.12.2](#) Referral Triage or Disposition for more detailed information).

3.1.13 Extension Beyond Allowed Time Frames

Face-to-face Contact

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

Completion of Risk Assessment

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

- a) Explanation of why the assigned time frame cannot be met;
- b) Statement of the extenuating circumstances that exist;
- c) Estimation of the amount of additional time required; and,
- d) Other relevant information.

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

3.2 Assessing Eligibility

Refer to section [2.10 Eligibility Criteria](#) on APS and PAPS investigations and on-going eligibility.

3.2.1 Decision Making Capacity

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

3.2.2 Assessment of Risk

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

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

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

3.2.3 Short-Term Service Planning

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

Department Will Provide Social Services Beyond Risk Assessment

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

Department Will NOT Provide Social Service Beyond Risk Assessment

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

Note: The short-term Service Plan is primarily intended to be a way for the APS worker to document the tasks the DHHR has implemented or is going to implement until the Risk Assessment is completed or prior to completion of the regular Service Plan.

3.2.4 Conclusion of Risk Assessment

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

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

- If at least one (1) allegation of abuse/neglect has been substantiated according to the legal definition of abuse or neglect and the other three criteria are met, the referral must be substantiated;
- If abuse or neglect has not been substantiated and the client is at risk of being abused or neglected, and at least criteria A, B and C-2 are met, a Preventive case should be opened;
- Generally, if the client meets all the eligibility criteria, the case will be opened for APS services. Refer to section [2.10 Eligibility Criteria](#) for further information. Two (2) instances where all four (4) eligibility criteria are met that an APS case may not be opened include:
 - a) The client is in a facility, the verified abuse/neglect was limited to a perpetrator who is no longer employed with the facility; and
 - b) The client has not been deemed to be incompetent by a court of law and is not willing to accept services.
- If allegations of abuse/neglect were substantiated, and it was not self-neglect, and an APS or PAPS case was not opened then required notifications still need to be sent. See section 3.2.8 Required Notifications for additional information;
- Any time an individual is open in the FACTS system for multiple case types, one of which is APS (i.e. APS and AFC or APS and Guardianship), the APS case must be set up separate from any other case type. If there is an APS/Preventive case and the client is in need of guardianship, health care surrogate or adult residential placement, a Request to Receive Intake must be entered in FACTS for the appropriate service needed. If it is determined that services will be provided, the appropriate case must be opened.;
- When follow-up is requested by a reporter, the APS worker must follow-up with the reporter regarding the investigation within fourteen (14) days following completion of the Risk Assessment. The only information the APS worker can give the reporter is to advise that appropriate action is being taken and that all information obtained during the investigation is considered confidential and may not be shared; and,
- Whenever the APS worker identifies a need that can be met through community resources, they must make appropriate referrals.

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

3.2.5 Investigation Disposition Options

At the conclusion of the investigation and completion of the Risk Assessment, the APS worker will then submit the Risk Assessment, along with their recommendation about disposition of the investigation, to the supervisor for approval. The possible dispositions available are:

- Close the investigation and open an APS case;
- Close the investigation and open an APS Preventive Services case;
- Close the investigation and refer to other resources (internal/external to Department);
- Close the investigation with no additional action needed; or,
- Incomplete - in some instances it will not be possible to complete an investigation (death of alleged victim, alleged victim moved to another state, after all possible attempts the APS worker is unable to locate alleged victim, etc.).

The disposition shall be based on all the information gathered during the investigation and completion of the Risk Assessment. From this information, the APS worker will determine if the referral was “substantiated” or “unsubstantiated”. This determination shall be based on whether or not the applicable eligibility criteria have been met according to [WV Code §9-6](#). [WV Code §61-2-29](#) provides for criminal penalties for caregivers who, directly or indirectly, abuse, neglect or create an emergency situation for an incapacitated adult. Because of this, it is extremely important that contact with and observations of the caregiver in an APS investigation be accurately, carefully, and thoughtfully documented. In the event the perpetrator is prosecuted as a result of a substantiated APS complaint, the APS worker will, in many cases, be the primary source of evidence for the court hearing. The information documented in the case record is critical since it may be used in the court’s determination about the guilt or innocence of the perpetrator, whether the crime is a felony or a misdemeanor, and the severity of the sentence imposed.

3.2.6 Required Notifications

When an APS investigation is substantiated, the APS worker must send a Notification Letter to the Prosecuting Attorney and Law Enforcement provided in FACTS. The letter populates information from the following sections of FACTS: allegation findings, client response, caretaker/perpetrator response, and APS worker summary. Because of this, information in these boxes should only be a narrative of the investigation - not detailed information. The Reporter’s name must not be revealed in this letter.

Any time a referral for APS involving a known perpetrator is substantiated (excluding self-neglect), the APS worker must provide written documentation to the following:

- a) Prosecuting attorney
 - i. Use the form letter titled “Notification to the Prosecuting Attorney” for this purpose;
 - ii. Include in the body of the notification letter a description of the allegation(s) and investigation findings, potential witnesses, and action being requested of the court or the prosecuting attorney;
 - iii. The perpetrator’s name and address, (if the abuse occurred in a facility, the perpetrator’s title is to be included, the name of the facility, as well as a summary of the investigation. In addition, the APS worker must include the following:
 - Condition of the home;
 - Condition of the client;
 - What intervention has been attempted and the results;
 - What further intervention is needed to ensure the client’s safety (if removal from the home is being recommended, where the adult will be taken to, how they are to be transported, any applicable precautions, etc.); and,
 - Any other pertinent information.

- b) Perpetrator
 - i. To accomplish this, the supervisor must approve the Allegation Findings Screen;
 - ii. Then this information will be forwarded to the Information Services and Communication (IS&C) through the WV Office of Technology automatically;
 - iii. Complete demographic information must be entered in FACTS for the client;
 - iv. the Personnel Screen in FACTS must be complete and accurate for the worker and supervisor;
 - v. The letter will state that the findings can be used in the future when the individual is seeking employment as a Foster Parent, Child Care Provider, Adult Family Care Provider or other professions that work with children, adults and families within and outside of DHHR;
 - vi. The letter will also notify the alleged perpetrator of their right to appeal and the process to request a grievance;
 - vii. A pre-hearing conference must be offered to the individual to attempt to come to a resolution;
 - viii. If a resolution cannot be achieved and the individual wants to continue with the grievance, the appropriate grievance forms must be completed and forwarded to the appropriate Hearings Office in accordance with the grievance procedure outlined in Common Chapters, Chapter 700. Refer to [Personnel Common Chapters Policy](#).

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

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

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

c) A Residential Facility

i. Nursing home:

- OHFLAC, Medicaid Fraud, Ombudsman, and Bureau for Medical Services (Long Term Care unit);

ii. Assisted living facilities, and registered/unlicensed homes

- OHFLAC, Ombudsman and Medicaid Fraud;

iii. I/DD Waiver homes

- OHFLAC, Medicaid Fraud, and Office of Behavioral Health and Health Facilities;

iv. ICF/ID Group homes

- OHFLAC, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for (Long Term Care unit);

v. State Operated Mental Health or State Operated Long-Term Care Facilities

- OHFLAC, Ombudsman, Medicaid Fraud and Office of Behavioral Health and Health Facilities, and Bureau for Medical Services (Long Term Care unit);

vi. Specialized Family Care homes (Medley)

- Bureau for Children and Families/ Medley Program Manager and Medicaid Fraud;

- vii. Adult Family Care home
 - Bureau for Children and Families regional home finding supervisor, Ombudsman, and Medicaid Fraud; and,
- viii. Non-residential Service providers (home health, homemaker agencies, behavioral health centers, sheltered workshop, etc.)
 - OHFLAC or the regulatory agency that licenses that entity, and Medicaid Fraud;

In addition, if it is determined that there is or appears to be a pattern of allegations involving resident rights issues in a facility, a referral to the applicable regulatory agency (i.e. Ombudsman and OHFLAC) shall be made.

When an investigation is substantiated and the decision is reversed, written notification must be sent to all individuals/entities that were previously notified of the substantiation and a copy filed in the client's record.

Follow-up with the reporter is permitted:

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

APS Referrals That Have Been Substantiated and a Subsequent Record Check is Completed: All referrals prior to May 18, 2006 must be fully reviewed to determine investigation results of substantiated or unsubstantiated, as the finding screen may be inaccurate due to a FACTS system change.

SECTION 4 Case Planning

4.1 Service Plan

When a case is opened for a client in an institutional or other out-of-home residential setting, a file must be opened in FACTS if one does not already exist, on the institution/facility, in addition to the client file and the two (2) files must be associated within FACTS (on Referral Acceptance screen). When the provider/facility is set up it is important that it be marked as "unavailable" in FACTS unless it is a facility in which DHHR makes placements. For the purposes of APS, Adult Family Care homes, Specialized Family Care homes, licensed

assisted living settings, registered unlicensed homes, I/DD Waiver homes, Medley homes, ICF/ID Group homes, etc. are considered to be facilities.

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

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

Development of the Service Plan is to be a collaborative process between the APS worker, the client, and others such as provider(s) or legal guardian. In addition, the principle of self-determination, which is critical in intervention with adults, extends to the client's right to decide with whom they associate and who should be included in service planning for them. Those individuals who are involved in the development of the Service Plan should also be involved in making modifications to the plan.

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

4.1.1 Inclusion of the Incapacitated Adult in Service Planning

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

- When there has been a legal determination that the client lacks decision-making capacity and has a court appointed representative, the representative must be respected as the spokesperson for the client and the representative's consent must be obtained in completion of the Service Plan. If the court appointed representative is the perpetrator in APS case, and is unwilling or unable to take/permit the action(s) necessary to carry out the Service Plan, that individual shall not participate in development of the Service Plan nor shall they sign the completed document. In this situation, the Service Plan must address seeking a change in the client's legal representative;
- When the client has an informal representative (i.e. close relative or other long-term caregiver), this individual should be included in the service planning process and may sign the Service Plan. The relationship of the informal representative is to be documented in the client record;
- When the client appears to lack decision-making capacity, but does not have a court appointed or informal representative, the APS worker may complete the Service Plan without the client's consent and involvement if the primary goal in the plan is to obtain appropriate legal representation; and,
- When a client appears to have decision-making capacity and could benefit from intervention but is resistant, it is appropriate for the APS worker to try to overcome some of this resistance. Ultimately, however, a client with decision-making capacity has the right to refuse case management services. In this situation, a Service Plan would not be developed and the APS/Preventive case is to be closed.

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

4.1.2 Determining the Least Intrusive Level of Intervention

In the provision of services to adults, the principle is well established both in law and policy that the least intrusive means of intervention should always be used. When applying this principle to individual situations there is some discretion in determining the appropriateness of the manner in which the DHHR intervenes in

the life of the client and the level of care/assistance required in order to meet the client's needs. Intervention is to move from the least intrusive to the most intrusive option(s).

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

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

4.1.3 Required Elements – General

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

- Specific criteria which can be applied to measure accomplishment of the goals;
- Specific, realistic goals for every area identified as a problem, including but not limited to those identified through the Risk Assessment process. This will include identification of the person(s) for whom the goal is established, person(s)/agency responsible for carrying out the associated task(s), identification of services, and frequency/duration of services;
- Specific tasks which will be required in order to accomplish the goal. These are tasks or activities that are designed to help the client progress toward achieving a particular goal and should be very specific and stated in behavioral terms. These tasks are typically short-term and should be monitored frequently; and,
- Identification of the estimated date for goal attainment. This is a projection of the date that the APS worker and the client expect that all applicable tasks will be achieved, that minimal standards associated with change will have been attained.

Other important considerations for the service planning process are:

- The client's real and potential strengths;
- Attitudes, influences and interpersonal relationships and their real or potential impact on implementation of the Service Plan;
- The circumstances precipitating involvement by the APS system; and,

- Levels of motivation.

4.1.4 Developing a Plan to Assure Safety

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

- Identify the conditions that establish/support the need for out-of-home placement;
- Identify the recommended placement arrangement;
- Describe arrangements for visitation with family and friends, including any restrictions, if applicable; and,
- Describe the efforts that have been made to prevent out-of-home placement and the results of these efforts.

SECTION 5 Case Management

5.1 Introduction

Case management is the primary service provided by the DHHR for clients who have been opened for APS or PAPS Services. It consists of identification of problem areas/needs, identification of appropriate services and resources to address the identified problems/needs, referral of the client to appropriate service agencies, and coordination of service delivery. It is important to note that APS case management is voluntary on the part of the client, or on the part of their legally appointed representative. Case management cannot be forced upon an unwilling client who has not been determined to be incapacitated. Case management in all APS is to be time-limited. APS cases are not to exceed twelve (12) months and PAPS are not to exceed six (6) months. The end goal of case

management for these cases is to link clients with appropriate supportive services. Once this is accomplished, the case is to be closed. Case management should only continue long enough for the APS worker to determine that the arranged services and supports are adequate to address the client's needs and to ensure that the abuse or neglect situation has been adequately remedied.

5.2 Comprehensive Assessment

A Comprehensive Assessment must be completed for each individual whose case has been opened for APS or PAPS. In order to develop a detailed understanding of the client and their needs, the APS worker must conduct a face-to-face with the client and complete an assessment. Each individual contact is to be documented by the end of the next working day. Information gathered on the Risk Assessment screen will populate forward to the Comprehensive Assessment screen in FACTS if it has been approved before the Case Connect, as well as information in the Client screens. Any information that was not gathered during the Risk Assessment phase or information that has changed since the Risk Assessment was completed must be documented on the appropriate screens in FACTS.

5.2.1 Time Frames

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

5.2.2 Conclusion of Comprehensive Assessment

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

5.3 Out-of-Home Placement Considerations

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

- Placement with a relative, friend, or other interested party (with or without supportive services);
- Adult Family Care;
- Adult Emergency Shelter Care Home (if placement needed on short-term, emergency basis);
- Specialized Family Care Home;
- Assisted Living facility;
- I/DD Waiver Home;
- ICF/IID Group Home;
- Nursing Home; or
- State Operated Behavioral Health Facility.

5.4 Administrative Processes

Refer to the [Adult Services Legal Requirements Procedures Policy](#) and [Substitute Decision Maker Policy](#) for information regarding administrative processes.

5.5 Confidentiality

Legal provisions concerning confidentiality have been established on both the state and federal levels. In federal law, provisions are contained in the Social Security Act and the Health Insurance Portability and Accountability Act 1996 (HIPAA). On the state level, provisions related to confidentiality of client information is contained in [WV Code §9-6-8](#). Additionally, requirements related to confidentiality specifically related to APS cases are contained in [WV Code §9-6-8](#) and can also be found in [Personnel Common Chapters Policy](#).

Refer to [Adult Services Legal Requirements and Processes](#), Section 4 for additional information pertaining to confidentiality and when to release information.

5.5.1 Access by APS to Protected Health Information of Alleged Victims

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

5.5.2 Electronic Communication

Electronic communication regarding confidential client information is forbidden between DHHR staff and outside community agencies. Any agency within DHHR has access and it is acceptable to e-mail confidential client information. It is also forbidden to text confidential information or take client pictures utilizing a

communication device that is not agency approved (this includes your own personal cell phone, camera, etc.).

Any agency and client information including general statements must not be posted on any social networking site such as Facebook, My Space, Twitter, Linked In, Blogs, etc. Additionally, no videotaping/pictures of clients is permitted on social network sites, such as You Tube.

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

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

5.5.3 Conflict of Interest

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

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

5.6 Exceptions to Policy

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

- Explanation of why the exception is requested;
- Alternate methods resources attempted;
- Anticipated impact if the policy exception is not granted;

- Efforts to resolve the situation;
- Information supporting the request;
- The time period for which the exception is being requested; and,
- Other relevant information.

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

5.7 Payment by the Bureau for Children and Families

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

5.7.1 Court Ordered Payments - General

There are certain instances when the DHHR is ordered by the court to make payment on behalf of an APS client. Whenever the DHHR is court ordered to pay for services or fees, the client's Service Plan must address the efforts being made to obtain/access resources for the client so they may assume this responsibility. Additionally, the APS worker will object when the DHHR is court ordered to pay for services so their objections are noted in the court order. The APS worker will consult with their supervisor and follow regional protocol in regards to contacting Adult Services Legal Counsel

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

5.7.2 Court Ordered Payments – Required Procedures

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

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

- Cover memo stating that the client is an active recipient of APS;
- Court order which 1) has an embossed court seal, 2) has been signed by the judge, and 3) specifically states what costs the Bureau for Children and Families is required to pay; and,
- Itemized invoice that meets the following requirements:
 - a) Is on the guardian ad litem/provider's letterhead;
 - b) Contains the FEIN or social security number of the guardian ad litem/provider;
 - c) The total amount invoiced is identified and matches the amount specified in the court order;
 - d) The specific amount(s) invoiced shall not exceed the current rates established by the public defender's office; and,
 - e) In order to request reimbursement for this type of expense, it should be completed within six (6) months after the hearing.

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

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

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

5.7.3 Emergency Hospital/ Nursing Home Placement for APS Client

Occasionally, it becomes necessary to arrange for placement in a hospital or nursing home of an APS client for whom Medicaid eligibility has not yet been established. If the nursing home or hospital will not admit the client pending Medicaid approval and if there are no other available resources, the Bureau for Children and Families may authorize payment for the hospital or nursing home care for a brief period of time until Medicaid eligibility can be determined or other appropriate funds are obtained. [WV Code §9-6-6](#) permits payment by the DHHR in these instances. This option may be considered only under the following limited circumstances:

- When abuse/neglect has been substantiated;
- Prior to permanent placement, hospital admittance may be required to determine client's level of care. When it has been determined that the adult appears to meet nursing home eligibility criteria, worker will need to check to see if a Pre-Admission Screening-2000 (PAS-2000) has been approved within the past sixty (60) days. If not, a PAS-2000 will have to be completed and approved prior to placement;
- When there are no other available resources to assure the client's safety; and,
- When it is determined by the APS worker and their supervisor that this is the only way to ensure the victim's safety until permanent arrangements for their care can be made.

Approval for Emergency Hospital/Nursing Home Placement

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

- Client name;
- Explanation of why hospital/nursing home placement is needed;

- Amount of available financial resources;
- Other options explored/considered and reason(s) each was ruled out;
- Name of hospital/nursing home where client is to be placed;
- Length of stay at DHHR's expense being requested - except in very extraordinary circumstances, not to exceed thirty (30) days;
- Plans for arranging for alternate placement/securing alternate funding for placement;
- Whether an application for other resources have been made such as Medicare, Medicaid, Social Security, Veteran's benefits, private funds/benefits, etc.; and,
- Other relevant information.

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

- If the need occurs during non-work hours; and,
- If the need occurs during normal work hours but the emergency situation is so serious that immediate action must be taken.

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

If approval for the policy exception is granted, the worker must diligently seek an alternate payment source for the client's cost of care. Examples of this include, but are not limited to, facilitating a Medicaid application, determining the client's monthly income and assets and who is the appropriate individual to authorize payment to the hospital/nursing home. Depending on the circumstances, the APS worker may need to request change of payee to the nursing home or file a petition for the Sheriff to be appointed as Conservator in order to access client's income and/or assets. Also, during this thirty (30) day time period, the APS worker must make getting an approved PAS-2000 a priority.

The role of the Regional Adult Services Field Consultant in these instances is for authorization of short-term payment for the emergency placement of an adult in the hospital/nursing home as a result of an AP investigation. Invoices from the hospital/nursing home for these placements will not be submitted by the Regional

Adult Services Field Consultant to the Finance and Administration for reimbursement until written documentation to support the invoice has been received by the Regional Adult Services Field Consultant.

Invoicing for APS Hospital/ Nursing Home Placement

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

- Client name;
- Name of facility;
- Signature of individual authorized by the facility to submit invoices;
- Statement of daily rate for room and board (not to exceed the approved Medicaid rate);
- Date(s) of service (except in extraordinary situations, should not exceed thirty (30) days, dates of service on the invoice should match the dates reflected in the approved request for payment); and,
- Total amount due.

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

5.7.4 Special Medical Authorization

Most adults who are served through APS will have or be eligible for some type of medical insurance coverage. If the client does not have coverage for necessary medical care, (prescriptions and limited doctor visits) the APS worker must thoroughly explore all potential options for securing appropriate medical coverage; such as: DHHR Income Maintenance Services, Social Security, community/civic organizations, family members, churches, Medicare Part D, drug company assistance programs, samples from physicians, mental health agencies, health right clinics, etc. If, after this exploration, an active APS client requires medical services for limited doctor services, prescriptions, chuxs and disposable briefs and does not have the resources available to obtain them, a Special Medical Authorization may be requested to cover the cost of eligible services at a rate not to exceed the current Medicaid rate. For clients that are sixty-five (65) years of age or older, the Special Medical card will not cover any prescriptions that are covered under Medicare Part D, regardless of whether the client is enrolled in or receiving Medicare Part D; therefore, the Special Medical Card must not be issued for any prescriptions covered by Medicare Part D.

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

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

- Client's goal related to providing the requested services;
- List the specific service(s) payment is being requested for and the associated cost(s) (cannot exceed current Medicaid rate);
- Statement of verification that all potential resources have been explored and there are no other resources available to meet the cost;
- Anticipated duration of request (not to exceed thirty (30) days);
- Name of provider;
- Client income amount and source; and,
- Any other relevant information.

Ideally this information should be documented in summary form as a contact, "other" type, in addition to documentation, as appropriate, in other areas of FACTS (i.e. income information would also be recorded on Income screens; information related to goals would be documented on the Service Plan screens, etc.). In a situation where a client needs services from more than one vendor (i.e. an office visit with a physician and prescriptions from a pharmacy) a separate Special Medical Authorization request will be required for each vendor.

If Approved

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

Vendors need to be made aware there is generally a delay of about five (5) working days between when the Special Medical Authorization is generated by the Bureau for Children and Families and when this information is received by the Bureau for Medical Services. Therefore, if the Special Medical Authorization

is used immediately upon issuance, the vendor may need to wait a few days to submit the request for reimbursement otherwise, Medicaid may not have received verification that the service has been authorized.

If Denied

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

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

5.7.5 Other Payments

Other payments that may be considered emergent in nature may include, but are not limited to food, identification card, birth certificate, etc. Prior supervisory approval must be verbal and/or written. A policy exception must be requested by the worker to the Regional Adult Services Field Consultant.

If granted, the written request, including a description of the emergency situation that prompted the verbal approval, must be submitted to the Regional Adult Services Field Consultant. If the policy exception is granted, the APS worker must diligently seek an alternate payment source for future client needs.

In the case of an out-of-state birth certificate, the APS worker can request their Financial Officer to pay by check and reimbursement will be made by the APS worker entering a demand payment.

5.8 Transfer of Cases between Counties

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

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

5.8.1 Timing of Transfers

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

5.8.2 Sending County Responsibilities

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

- Prior to arranging or actually completing a transfer to a provider in another county, the sending supervisor must contact the supervisor in the receiving county to notify them that a client is being transferred to their county
- Provide a summary about the client's needs (i.e. reason for the transfer, problems in other settings, disturbing behaviors, family and financial resources, insurance coverage, and legal representative(s), if applicable);
- Complete all applicable case documentation prior to case transfer;
- Immediately upon transfer of the client to the receiving county, send the updated client record (paper and FACTS) to the receiving county; and,
- Notify the DHHR Family Support staff, the Social Security Administration office, and all other appropriate agencies of the client's change of address.

5.8.3 Receiving County Responsibilities

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

- Notify the DHHR Family Support staff of the client's arrival when the transfer is complete;
- Complete all applicable documentation; and,
- Assist with arranging or initiating any needed community resources.

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

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

SECTION 6 Case Review

6.1 Introduction

Evaluation and monitoring of the APS case and the progress being made should be a dynamic process and ongoing throughout the life of the case. For APS and PAPS, frequent monitoring is essential since both are short-term services. In unique situations, it may not be possible to complete all necessary tasks to resolve the abuse/neglect or risk within specified time frames. Should this occur, an extension must be requested by the APS worker to exceed the allowed time (see [Section 6.3](#) Time Frames and [Section 6.4](#) Extension Beyond Allowed Time Frames).

6.2 Purpose

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

6.3 Time Frames

6.3.1 APS

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

6.3.2 PAPS

Formalized case review must occur in three (3) month intervals following opening of the Preventative APS case, and prior to case closure at six (6) months. While this is the minimum standard, the APS worker must have a face-to-face contact with the client at least once monthly, and a case review may be completed if circumstances warrant. A review can and should be completed any time there is a significant change in the client's circumstances. In the event the abuse/neglect cannot be resolved within the allowed six (6) month period, the APS worker must request an extension. This extension request must be submitted to the supervisor according to the established protocol, prior to the end of the allowed six (6) months.

6.4 Extension Beyond Allowed Time Frames

6.4.1 APS

In extenuating circumstances, it may be necessary to keep the APS case open beyond the maximum of twelve (12) months in order to resolve the abuse/neglect. Should an extension become necessary, the APS worker must request a policy exception to go beyond the maximum allowed time frames. This

request must be submitted prior to the end of the twelve (12) month deadline for case closure. If approved, the extension must be time-limited. Policy exceptions will not exceed thirty (30) days per request. If more time is needed, a second policy exception must be requested prior to the expiration of the original policy exception that was granted. A policy exception request must include the following, at a minimum:

- Explanation of why extension is being requested;
- Explanation of why required time frames cannot be met;
- Efforts to date to resolve the risk;
- Barriers encountered preventing completion of the plan within the allowed time frame;
- Duration of extension being requested;
- Plans to resolve the outstanding issues during the extension period, if granted;
- Anticipated impact if the policy exception is not granted; and,
- Other relevant information.

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

6.4.2 PAPS

In extenuating circumstances, it may be necessary to keep the Preventative APS case open beyond the maximum of six (6) months in order to resolve the abuse/neglect. Should an extension become necessary, the APS worker must request a policy exception to go beyond the maximum allowed time frames. This request must be submitted prior to the end of the six (6) month deadline for case closure. If approved, the extension must be time-limited. Policy exceptions will not exceed thirty (30) days per request. If more time is needed, a second policy exception must be requested prior to the expiration of the original policy exception that was granted. A policy exception request must include the following, at a minimum:

- Explanation of why an additional extension is being requested;
- Describe efforts to date to resolve the risk;
- Barriers encountered preventing completion of the plan within the initial six (6) months;
- Duration of extension being requested;
- Plans to resolve the outstanding issues during the extension period, if granted;
- Impact if policy exception is not granted; and,
- Other relevant information.

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

6.5 Conducting the Review

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

- Extent of progress made toward goal achievement;
- Whether or not the identified goals continue to be appropriate and, if not, what changes and/or modifications are needed;
- Barriers to achieving the identified goals; and,
- Other relevant factors.

6.6 Documentation of Review

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

When completed, the APS worker must submit the review and new Service Plan to the supervisor for approval. Once approved, the APS worker needs to secure all required signatures. Finally, the APS worker must provide a copy of the Service Plan to the client and to all signatories. The original signed Service Plan is to be filed in the client's case record (paper file).

SECTION 7 Case Closure

7.1 Assessment Prior to Case Closure

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

Upon completion, the APS worker must document the results of this assessment in FACTS and submit to the supervisor for approval of recommendation for case

closure. Upon supervisory approval, the case is to be closed. When the need for aftercare is identified, the APS worker and the client will work together to develop an aftercare plan, if requested by the client.

7.2 Case Closure

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

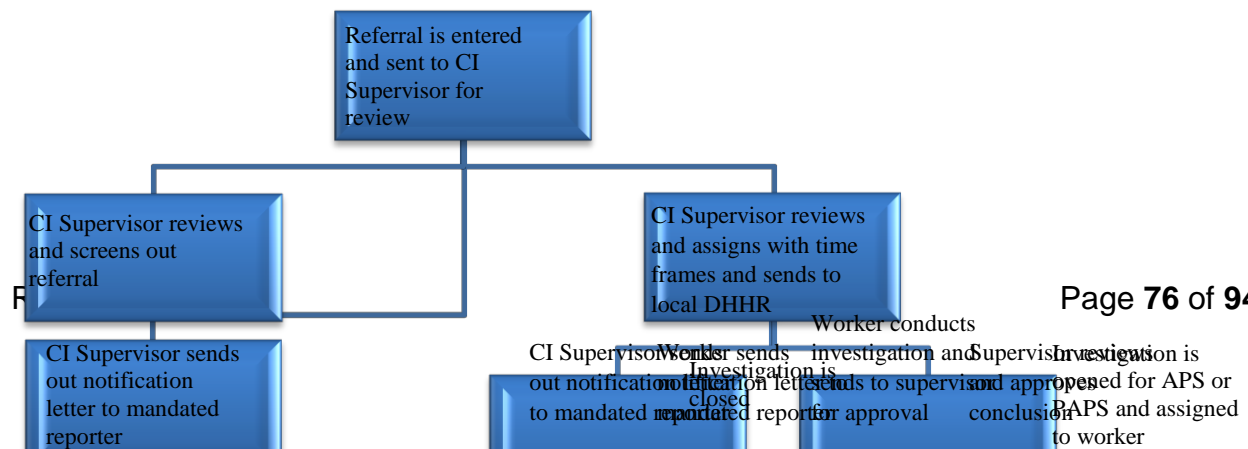
7.3 Purging of APS Records

In accordance with [WV Code §9-6-8](#), case records of individuals who have received Adult Protective Services shall be destroyed thirty (30) years following their preparation.

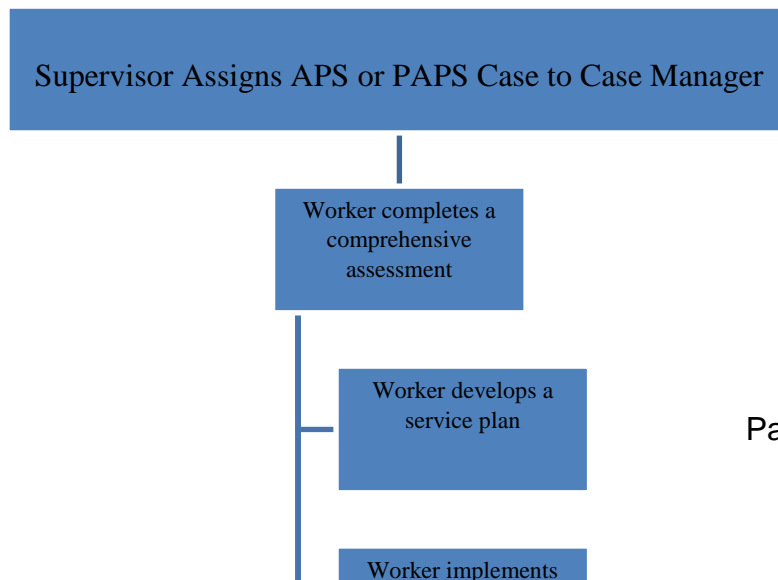
APPENDIX A

Flow Charts

Intake and Investigation Flow Chart



Case Management Flow Chart



APPENDIX B

Worker Safety

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

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

problems consisted of;

- If there is the potential for danger, take someone with you or contact the police to accompany you to the home. Discuss this with your supervisor for the best solution;
- Are the directions sufficient in the referral so you will have no difficulty locating the home? If not, check with others who may have been to the home previously and co-workers who may know of the general area. Make sure you have plenty of gas;
- Develop a buddy system or adhere to the local district protocol. Let other co-workers, supervisor know where you are going and have a code word for if you are in danger. Utilize the sign in and out sheet in your office to indicate what client you will be seeing, the address or telephone number and if there are any changes deviating from your planned visits, to inform your supervisor of that change;
- Once you have arrived at your destination, it is best practice to park by backing in, but be sure to give yourself room for an easy exit and not allow yourself to be blocked in;
- Before exiting your car, look around and observe if there are any animals, broken glass, creeks, etc. that may be hazardous or harmful if you are trying to exit. It is also wise to check out the porch environment for safety issues;
- When you knock, be polite. Don't bang on the door. Then step back and to the side so the person can see you;
- Once the door is answered ask if anyone else is home. Then scan the home environment;
- When sitting, sit two (2) to three (3) inches in your seat. This will enable you to stand up quickly if needed;
- Watch for any behavior changes in the client. If the client begins ranting, don't sit and take notes! If the client stands to rant, you stand. If the client leaves to get something, go to the door and stand to be prepared to leave quickly if needed. If at any time you feel unsafe, leave!;
- Clients become upset due to a loss of power and helplessness;
- Find a common area of agreement by providing them with options. By doing this you are essentially giving the client back some of their power. You are also de-

escalating the situation;

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

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

APPENDIX C

Protocol for Methamphetamine Investigations

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

a) **A Protocol for Methamphetamine Investigations**

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

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

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

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

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

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

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

- i. Specific description of condition of the house fires: Safety hazards?
- ii. Proximity of the lab to the home, in the home, in a shed in the back yard?
- iii. Are incapacitated adults present when the drug is being cooked?
- iv. High frequency of visitors to the home?
- v. Drug paraphernalia?
- vi. Chemicals?
- vii. Surveillance equipment?
- viii. Booby traps?
- ix. Description of adult substance abuser (paranoia, abnormal patterns, aggression, tweaked);
- x. Have the police ever been to the home?
- xi. Where are the incapacitated adults at time of report?
- xii. Any other relevant information.

Whether the report is screened out or accepted for assessment, APS must make an immediate oral and subsequent written report of that information to the appropriate local law enforcement agency within forty-eight (48) hours after receipt of the information. When deciding whether the report is accepted for assessment of abuse and/or neglect, **Centralized Intake** will consider the following:

- i. Where is the laboratory in relation to the incapacitated adult?
- ii. Are individuals, including the incapacitated adult smoking/using methamphetamine in the home?
- iii. Is the product being brought into the home?
- iv. Are chemicals accessible to the incapacitated adult?
- v. Has the incapacitated adult been injured by the chemicals?
- vi. Is the reporter aware of the incapacitated adult being present during a "cook"?
- vii. Is the reporter doubtful or certain of the presence of a methamphetamine laboratory?
- viii. Are there any other allegations of abuse and/or neglect?

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

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

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

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

Law enforcement should be responsible for securing the area, gathering physical evidence and removing the incapacitated adult to outside the home if they are in the home at the time of the initial contact. The APS worker shall obtain information concerning the general conditions of the home from law enforcement's photos and observations. Law enforcement should be responsible for documenting what chemicals were found in the home. At this point, the information obtained from law enforcement and others at the scene would be used to complete the Risk Assessment along with other information the social worker has gathered. The main focus for the APS worker is the safety of the incapacitated adult and removal to a

safe place, or evaluating the need to file a Petition of Attachment if the incapacitated adult is not willing to go to a safe place.

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

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

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

The APS worker shall assume the primary role for transfer of the incapacitated adult at the scene to a safe place once law enforcement has removed them from the home. If the incapacitated adult refuses the APS worker's assistance with transfer to a safe place, the APS worker must evaluate the need for a Petition of Attachment and document all attempts to get the incapacitated adult to a safe place. Once the incapacitated adult is in the appropriate placement, the APS worker must fully

apprise the incapacitated adult(s) or caretaker of the need for any follow-up medical treatment recommended at the medical assessment. The APS worker must further emphasize the importance of obtaining the correct follow-up treatment for the incapacitated adult.

Facilitating an immediate medical assessment may include gathering the incapacitated adult's medical history, and arranging transportation by ambulance or other means. Please be aware that this medical examination may take several hours and the client may need to be fed.

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

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

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

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

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

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

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

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

d) Ongoing Investigation

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

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

The APS worker shall coordinate a joint interview of the incapacitated adult and law enforcement within forty-eight (48) hours, if not completed at the initial contact and if necessary. The incapacitated adult must be interviewed using a general protocol that screens for all types of abuse and neglect. Incapacitated adults who live in a

home where methamphetamine is used are often subjected to neglect, physical abuse and/or sexual abuse. At the initial contact, the incapacitated adult's medical evaluation, safety and needs take priority. This time frame is necessary to assure that the incapacitated adult is interviewed quickly and to gather as much information as is needed to make an informed decision regarding safety, abuse, neglect or dependency.

e) **Social Work Safety**

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

If after being in the home or laboratory site, the APS worker begins to have headaches, burning eyes, difficulty breathing, etc., medical attention should be sought immediately. The APS worker may also have come into contact with chemicals or toxins that could contaminate others. This contamination may not be obvious, so some precautions are necessary. Place any clothes worn at the lab site into a paper bag until they can be washed. The clothes should be washed separately on the hottest setting. Rewash a second time and air dry outside the home, not in the dryer. Run the washer once empty to clean it thoroughly. Shoes should be washed with the clothes if possible or wiped clean with soap and hot water. The social worker should shower in very warm, but not hot water and use lots of soap. Clean the tub/shower thoroughly afterwards.

f) **Placement Provider Preparation and Safety**

It is imperative that the placement providers are given as much information concerning what the incapacitated adult has been exposed to, what medical treatment the incapacitated adult has received and any follow-up appointments the

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

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

- i. Headache;
- ii. Drowsiness;
- iii. Unusual movements like tremors, shaking, jumpiness, agitation or seizures;
- iv. Difficulty breathing, wheezing, coughing or poor color;
- v. Fever;
- vi. Hallucinations or mental confusion; and,
- vii. Any other unusual symptom that seems severe.

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

g) Protocol for APS Investigation Involving Meth

- If the APS worker discovers a meth lab or suspects that they has come across chemicals being used to make meth during a home visit or incapacitated adult abuse/neglect investigation, the worker will leave the house, depart the immediate area and contact their supervisor and law enforcement;
- The worker will remain away from the home until after law enforcement has responded to the worker's call and secured the home and the people inside;
- The worker will return to the scene and accompany law enforcement as appropriate;

- The worker will facilitate appropriate, safe placement of the incapacitated adult, or evaluate the need to file an Order of Attachment if the incapacitated adult is not willing to go to a safe place;
- The worker will arrange for decontamination of the incapacitated adult at the site, if possible. Worker will provide clean clothing and wipes for the incapacitated adult to use, if possible. If this is not possible on-site, worker will arrange for this as soon as possible after leaving site if not taking incapacitated adult straight to a hospital;
- The worker will arrange for transportation of the incapacitated adult to a safe place or nearest hospital emergency department (please call ahead to the hospital):
 - i. Items from the drug site are left on site and not taken with the incapacitated adult, with the exception of necessary medication or medical equipment, which must be decontaminated;
 - ii. Transport vehicle should have protective gear for occupants. Examples include blankets or plastic to cover the seat. If the incapacitated adult cannot be decontaminated on site, wrap a blanket around the individual prior to placing them in the transport vehicle.
 - iii. The transport vehicle will need to be decontaminated after transporting the incapacitated adult.
- Advise placement provider of immediate needs of incapacitated adult as a result of meth contamination:
 - i. The incapacitated adult is not allowed to bring anything with them from the contaminated site (clothing, personal belongings, food, etc.). An exception to this may be necessary medication or medical equipment that may be decontaminated by wiping off with soap and hot water. Medication that is in an enclosed container may be taken with the incapacitated adult; and,
 - ii. Follow-up medical care needs to be scheduled and completed.

APPENDIX D

Financial Services Modernization Act

The Financial Services Modernization Act passed in 1999 (often known as the Gramm-Leach-Bliley Act or GLBA). The GLBA contains strong privacy protection. It requires notification to customers before disclosures of their records and an opportunity to disapprove the proposed disclosure. However, Section 502(e) of the GLBA contains exceptions to this privacy protection. Three are relevant to state reporting programs:

- (e)(3)(B) permits disclosure “to protect against or prevent actual or potential fraud, unauthorized transactions, claims, or other liability.”

- (e)(5) permits disclosure, “to the extent specifically permitted or required under other provision of law...to law enforcement agencies...or for an investigation on a matter related to public safety”.
- (e)(8) permits disclosure “to comply with Federal, State or local laws, rules, and other applicable legal requirements.[.]”

APPENDIX E

Signs of Financial Exploitation

The signs of financial exploitation may not be subtle or blatantly obvious. This is not intended to be an all-inclusive list:

- Numerous cash withdrawals from an incapacitated adult’s checking account in a short period of time, especially if inconsistent with previous spending habits;
- Signatures on checks, wills, powers of attorney or other documents that look forged, unusual or suspicious;
- Several checks that are used out of numerical order;

- Reports by the incapacitated adult or collaterals (i.e. friends, neighbors, relatives Senior Citizens Center, banks, etc.) that funds are missing from his or her account;
- Someone forcing, pressuring, or coercing the incapacitated adult into withdrawing large sums of cash from checking or savings accounts;
- An incapacitated adult applying for several new credit cards;
- An unexpected increase in ATM or credit card usage by an incapacitated adult;
- An incapacitated adult failing to understand recently completed financial transactions;
- An incapacitated adult making unusual changes to bank accounts;
- Having credit card statement sent to someone other than the incapacitated adult who is named on the account;
- Unexpected or unexplained changes by an incapacitated adult in account beneficiaries, property titles, deeds or other ownership documents;
- An incapacitated adult refinancing a mortgage;
- Abrupt and unexpected changes in a will, trust, power of attorney, or other legal document;
- An incapacitated adult who is unexpectedly and uncharacteristically unkempt, forgetful, disoriented;
- An incapacitated adult who is unexpectedly not meeting their financial obligations such as food, utilities, rent, mortgage payments, and/or medical expenses (health care or long term care expenses, etc.);
- Substandard care being provided or bills unpaid despite the availability of adequate financial resources;
- Sudden appearance of previously uninvolved relatives claiming their rights to an incapacitated individual's affairs and possessions; and,
- Provision of services that are not necessary.

APPENDIX F

Client's Rights During the APS Process

Client's Rights During the APS Process

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

Some of those rights include:

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

Please keep this list in a safe place where you can find it. If you have any questions in regard to your rights, you may contact your worker or the Adult Services Supervisor. They are available to clarify any questions about your rights.

Worker's Name/ Telephone Number: _____

Supervisor's Name/ Telephone Number: _____

APPENDIX G

Alleged Perpetrator's Rights During APS Process

Alleged Perpetrator's Rights During APS Process

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

Some of those rights include:

- The right to object to someone coming into your home without your permission to conduct an investigation.
- The right to have certain information about you that APS has in their records kept private and confidential.
- The right to discuss the situation with the Adult Services Supervisor if you have concerns with the manner in which the investigation was conducted.
- The right to file a grievance if you disagree with a substantiated allegation.
- The right to have fair and reasonable decisions made about you, free from discrimination because of your age, race, color, sex, mental or physical disability, religious creed, national origin or political beliefs.
- You have the right to request certain help for you if you have disabilities as defined by the Americans with disabilities Act, when they are needed to help you with any hearing, vision or speech impairments during the APS process.
- The right to know if the allegations against you as an alleged perpetrator were substantiated, if you provide the Department of Health and Human Resources with a complete mailing address.

Worker's Name/ Telephone Number: _____

Supervisor's Name/ Telephone Number: _____

APPENDIX H

Notification Letter

West Virginia Department of Health and Human Resources Bureau for Children and Families

DISPOSITION OF REFERRAL/ INVESTIGATION REPORT

Disposition of Referral

Name of Client Referred: _____ Date Received: _____

Address: _____

Action Taken: _____ Referral Assigned for Investigation
_____ Referral Not Assigned for Investigation

Worker Assigned, if applicable: _____

Explanation (if not assigned):

Disposition of Investigation

_____ Investigation Completed on _____

_____ Investigation Not Completed Due To Extenuating Circumstances

Remarks:

Worker: _____

Date: _____

**This information is confidential. It is provided to persons mandated to report
by 9-6-8 of the West Virginia Code**