Transcript for Elder Sexual Abuse in Care Facilities: Detection, Response and Prevention Part 1

Maya's Story

Maya Fischer: Hi Mom. Hi Mom. How are you feeling today? My mother was born in Jakarta, Indonesia in 1931. She remained there until 1942, ended up in various parts of Europe for a number of years, from there she build a wonderful life here in the United States.

We moved her into initially, kind of a senior living apartment building, so there wasn't any assistance but she was fine there for a while and then we noticed it was time that we probably needed to move her into a facility that had a little bit more help for, for elderly folks.

On December 18th, 2014, I had gone to work, as I normally would. I usually get to work around 6:30 and I just happened to be walking to my office and I had checked my cell phone and saw that I missed a phone call from the nursing home. They had tried to call me at 5:30 in the morning and I missed that call and so I called them back. You know, the first thought I had was this isn't good. Why is the nursing home calling me a 5:30 in the morning and because my mother had been in the nursing home for so many years, my first thought was that she, she passed. But when I called them back, I was connected immediately to a nurse, who had told me that my mother had been sexually assaulted.

You know, one thing that was horrible in the emergency room was watching her hooked up to an IV and her Alzheimer's was far enough in progression that she couldn't swallow very well, so they couldn't give her any oral medication, so that was heartbreaking watching her be stuck with pins and needles, because you know, at 83-years old, they wanted to make sure she didn't get a sexually transmitted disease. Then after this event, we noticed that she was banging quite a bit on her private parts trying to tell us something. You know, tears rolling down her eyes and, and the, the heartbreaking thing was that though she couldn't move a lot, I had seen that motion before but it wasn't until we knew what had happened to her and that we knew that she had been raped that I kinda put two and two together and realized she could very well have been trying to tell me this for months. And so to have assured her that she'd been safe, that she'd be safe, only to have her raped.

How do you ever forgive yourself as a child, that you made that promise that she'd be safe and she wasn't.

And my mom was always a very dignified woman and, and you know, such a wonderful, beautiful soul, and this event just stole any dignity she had left. It's just so inconceivable that somebody would do this to an 83-year old woman, who can't speak and can barely move. It's just not something you ever expect.

Lynn Gerard: People find it hard to believe that the elderly are going to be subjected to sexual abuse. They're not understanding that this is a very vulnerable population and that unfortunately, it continues to happen in our facilities.

Dr. John Brose: We don't think that there is anything like that going on, who would want to be "sexual" with a 94-year old man or woman?

Kalease Smith: As a society, we do feel that way that elderly can't be abused and then when we hear about it, we're shocked. And the really sad part about that is it's usually staff. It's people that we're paying to take care of our folks and they're the ones doing it.

Linda Walther: I think about it a lot from my own perspective and my mother started having dementia and I cared for her at home for a long time and about three years ago, I wasn't able to do that anymore. I needed to get looking at a place for her to be. Every single place I went, I asked them how they handled the, the concern about sexual abuse either from staff or from, from other residents and every place I went, they looked at me with you know, deer in the headlights kind of look like, well we've never even thought about that.

Frank Weber: The elderly are vulnerable for a number of reasons that you have communication deficits for some individuals, you have memory issues, and you have lack of mobility, sometimes isolation.

Tara Patet: Someone who may not be able to recall what's happened to them, they're not likely to report, they're often not likely to be believed, and they're not likely to be able to give us specific recount of something that's happened to them.

Cheryl Hennen: And I recall one of the first individuals I met, as a new regional ombudsman was this beautiful elderly lady, living in a nursing home. She had just had surgery. It was difficult for her to communicate, but what we would later learn, a staff member was utilizing a back staircase to avoid any cameras that were placed in public areas and enter her room in the middle of the night and would proceed to sexually assault her in the bathroom.

Kalease Smith: I had a blind patient in an elderly home that was sexually assaulted and the perpetrator was a staff person and he thought that she wouldn't be able to identify him because she was blind.

Cheryl Hennen: Often times we think of sexual assault between a male and a female. I know of instances where sexual assault is between two males, sexual assault is between two females. So we must keep an open mind.

Frank Weber: Sometimes the offense is committed by women – have a different angle. For example, there was one situation, I dealt with a woman who felt very sorry for this particular man and kept crossing boundaries with him, eventually he asked to see her breasts and she thought she was doing him a favor, she gets charged with criminal sexual conduct.

Josh Heggem: I've done investigations and handled issues in towns of less than 200 people and then you know, all the way up to obviously larger city areas. But it is not – you see it anywhere, anywhere there are people.

Dr. John Brose: It's about power differential and taking advantage of somebody.

Dr. John Brose: So if you look at all sexual abuse of older adults 70% occurs in nursing homes. Only 30% of sexual abuse victims over the age 65 report their abusers to the police. Females are six times more likely to experience elder sexual abuse. Approximately 76% of elder sexual abuse situations have had at least one witness. 81% of the older adult sexual abuse survivors, the perpetrator was actually the caregiver to the older adult.

Lynn Gerard: So sexual abuse is multifaceted and it requires a very complex level of thinking and many things to consider. You need to have your antenna up through each shift. We need to be aware that sexual abuse can and does occur in nursing homes. The second we don't believe it doesn't, we've opened our residents to a greater risk of abuse.

Legal Definitions

Tara Patet: It is a crime for a caregiver, staff person, or anyone employed in a care facility to engage in sexual contact or penetration with a resident in the facility. Sexual contact is the intentional touching of another person's intimate parts. Sexual contact can also include coercing another person to touch the perpetrator's intimate parts. Intimate parts include the genital area, buttocks, breasts, inner thighs, or even the clothing that's covering any of those areas.

Sexual penetration includes sexual intercourse, oral sex, anal sex, or really any penetration of another person's body however slight and this could be on both – either the perpetrator or the victim's part, including with a foreign object. In other words, it's a crime even if the victim says it's okay, it's a crime even if the victim doesn't say anything at all, it's a crime if the victim, even if the victim wants to engage in sexual activity. The law bars any kind of sexual contact between a facility employee and resident.

The criminal penalties for an employee who engages in a sexual relationship with a resident are severe and include not only mail or prison time, but would also include a mandatory requirement that they register as a sex offender.

Lynn Gerard: So the vulnerable adult law specifies for us the definition of sexual abuse, which does include inappropriate touch or penetration of a staff member or a person rendering services in a facility to a resident, a patient or a client. Certainly, sexual abuse can be taken far beyond that. We want to talk to our staff about being aware of sexual harassment statements, making comments about individual body parts. We do know and unfortunately, we've seen throughout the years that people will take inappropriate pictures of residents.

Tara Patet: A person who's convicted of the crime of disseminating sexual images of a resident faces up to one year in jail and/or a $3,000 fine. If that person puts those photographs onto a public website, it's a felony. The bottom line, don't take pictures of residents in the course of your work and providing care. Just don't take pictures.

Lynn Gerard: We forget in our facilities and we train staff. If something like this happens, it's illegal. We need to be involving law enforcement.

Warning Signs

Kalease Smith: Dementia gets very, very hard and tricky when someone discloses sexual assault, right? Because you don't know is it current, did it just happen, is this something they thought about, is it something they're dreaming? Sexual assault victims no matter what age will isolate themselves. They feel like this is only happening to me. Nobody understands this. Nobody understands why I can't get out of bed, why I'm depressed, why I'm crying, why I don't want to come out of my room for meals. It's very hard and it's very traumatizing.

Tara Patet: It's not unusual for someone to minimize or even trivialize. We've even seen cases where people were laughing somewhat, as they're relaying the story of what happened to them in a really quite awful situation, not at all the kind of response that you might expect from somebody whose been victimized. It's important that you not read anything into that. It doesn't mean that it didn't happen, it doesn't mean that they consented to having something happen. Everybody responds to trauma in a different way.

Lynn Gerard: The sexual abuser preys on the individual that can't say something, that can't call attention to the fact that they've been abused. So we look for soft signs of abuse.

Dr. John Brose: Soft signs of abuse is anytime that you see a resident changing from how they were behaving before. Pay attention to why are they doing it that way? We do this with our pets. We do this with our children. They maybe can't put words to it, we go something's wrong.

Lynn Gerard: We're also looking for staff who are territorial maybe with a resident. They volunteer to always care for that resident. They volunteer to care for that resident behind a closed door and maybe they're in there for an excessive period of time. Is there a specific caregiver that continually wants to provide care and then are they making choices for timing or interventions that are different than the normal for that resident.

Tara Patet: A particular case that comes to mind is where a caregiver was leaving the wing that he was assigned to and going to another wing of the facility and providing shaving services for this male victim in the middle of the night. That was a red flag to other people in the facility and ultimately, he was caught as someone who was sexually abusing that patient.

Lynn Gerard: For instance, if a staff member comes out of a room and they're adjusting their clothing, they're tying their pants, they're buttoning their shirt, and any of those kind of things are clues that something has happened that shouldn't have happened.

Dr. John Brose: There's all kinds of boundary violations that can occur. It can be standing too close to somebody. It could be flirting. It could be using endearing names to a resident calling somebody honey, that sort of thing. It can be bringing in gifts.

Lynn Gerard: Maybe there are interactions that we see with a staff member or a resident where they're always together or maybe they always have an arm draped around them. Or maybe they're always complimenting them on how they look, on their clothing. We need to be aware that those are indicators that maybe there's an unhealthy relationship there, and that unhealthy relationship could be a sexual abuse relationship.

Frank Weber: An abuse situation I worked with involved a professional woman who actually had a good reputation at work who became sexually involved with a client. Initially, she started sharing stories about how her relationship wasn't working particularly well, she felt she wasn't being respected, and her partner was gone for long periods of time. This client started sharing personal information about his past relationships and there was an emotionally intimacy first between the two of them. There was eventual kissing, hugs that became progressively longer, and she eventually started taking him home.

Dr. John Brose: Some of it is intuition, where you see a staff member talking differently about a resident, spending more time with that resident, talking about them in a different way. All those things are I think warning signs.

Lynn Gerard: If we notice that when a visitor or a staff member or another resident leaves a resident room, and maybe that resident's clothing is askew, maybe the buttons no longer line up, maybe the, the clothes is are, are off the shoulder.

Frank Weber: I did an assessment on an individual who's a nephew of two aunts who were in a residential facility. And he would visit them regularly. He would request that he had part of the visit in their bedrooms with the door closed, and finally one staff person decided to walk in and they found him sexually abusing the women.

Lynn Gerard: If you notice bruising, particularly on the breasts and genitalia, if you notice discharge from genitalia, if you notice skin tears from different areas of the body that normally you would not expect to see a skin tear.

Tara Patet: While there are a number of indicators that may tell you that someone has been sexually abused or assaulted, you may have a case where there are actually no physical signs of someone you have, someone having been assaulted. They may not have any injury at all. There may not be any physical evidence at all that a sexual assault has occurred.

Lynn Gerard: But we also need to be considering staff that maybe have other boundary issues. So for instance, a staff member that participates in drug diversion, they already have crossed the

line from a safe culture to an illegal culture. And somebody who is using or taking other resident medications, particularly of a narcotic nature, may be more prone to a sexual abuse.

Frank Weber: I've worked with offenders who talk about the manner in which they set people up. That sometimes they'll allow the vulnerable adult to cross boundaries with them and even encourage it, and the rationalization is this way when I abuse them, they'll think it's their fault and they probably won't report it.

Tim Wendler: If you do stumble across something and don't want to be involved or you think, you know, that maybe it wasn't what it was, I would tell you that trust your gut, go with your gut instinct. If it's telling you this isn't right in here, it's probably not right.

Josh Heggem: If there's even something that feels slightly off kilter, or there's even the slightest suspicion that something might be going on between another staff member and a resident, or you witness something that just seems a little off but you're not quite sure, something seemingly small like that has turned into, you know, a full scale sexual assault investigation and criminal charges.

Culture and Training

Josh Heggem: Elderly resident comfort and boundaries and risk or let's say sexual assault of residents is all tied to your overall workplace culture.

Lynn Gerard: When we accept undignified or disrespectful care, it opens the door for any type of abuse or decrease in the quality of the care that we provide our residents. It, it opens the door to physical abuse, it opens the door to emotional abuse, but it also opens the door to sexual abuse.

Frank Weber: One of the concerns is when someone starts getting by with inappropriate behavior, it becomes a rationale for a number of other staff to relax the boundaries also, and the community gets progressively worse, the clients become more frustrated and angry, which compounds the problem.

Lynn Gerard: Disrespectful communication is heard by and repeated, unfortunately, by our line staff. And that goes to the patient, it goes to the family, and it goes to our interactions with the patient.

Josh Heggem: I'm not saying that flirtatious behavior or sexualized talk or sexual innuendo leads automatically to sexual assault. But I have seen number of workplaces over and over I've seen this, where you have that type of culture and then we have an incident that is sexual assault. And so you cannot push the boundaries even close to that ledge because the closer you get to that ledge, the easier it is to fall off down the hill to sexual assault.

Lynn Gerard: The culture of the workplace is vital in determining the type of care that we provide, the quality of the care that we provide, the meaningful care that we provide, and it impacts how we feel about our residents as individuals that are worthy of respectful and dignified care.

Josh Heggem: All of these things are all in the same culture and the same building and the same environment together and it's difficult, if not impossible, to separate out the culture between two employees and the culture between employees and your elderly residents.

Lynn Gerard: The silent culture is the other barrier to providing safe care. If your employees are fearful of communicating information to you, if they have fear of their fellow staff members that they can't report something for fear they'll be retaliated against, if they have fear of the management staff not believing them, if they're silent about the needs of their resident, there can be an undercurrent of abuse.

Josh Heggem: The culture of silence also is created because sometimes let's say it's a resident, they don't necessarily believe that anybody's going to do anything about it or they're afraid that they won't be believed, address the culture of the silence by empowering employees first of all to feel comfortable reporting to people who can get something done about situations.

Lynn Gerard: Positive cultural traits in a facility are those facilities that are open, that dialogue with their staff that emphasize the importance of all of our staff members, that everybody's part of the team.

Cheryl Hennen: And as a leader, are you rolling up your sleeves, getting out of your office, and walking among your community and talking to the people that call this place home.

Dr. John Brose: I also think it's important to show up unannounced in the middle of the night at least once a week, being unpredictable, not because people working in your building are bad, but it's a way to help protect the people that you say you're going to protect and under state and federal law, you're mandated to protect. It's a way to increase the probability that everybody stays within their boundary.

Frank Weber: When you're working with vulnerable people, it's essential that you have clear boundaries. The more vulnerable they are, the more important the boundaries are. They need them to established, it'll make them more comfortable, it'll make the environment healthier for everybody.

Lynn Gerard: All approaches with our residents need to be dignified, the approach needs to be positive with intent, with explanation, with necessity, so that the resident is as comfortable as possible when we provide the care.

Dr. John Brose: The steps are go slow, have an exaggerated facial expression, which conveys a message you are important to me, I'm here as a positive entity in your life. Connect with the person before beginning a task.

Frank Weber: I think any time you touch a client's body, you make certain you let them know what you're doing and why you're doing that. That people can understand if they feel there's a legitimate reason for this occurring. Where people often get into trouble is they view themselves as an expert and they're doing what they have to do or they're following whatever orders they need to follow, and they don't talk to the client about it, which makes someone very uncomfortable and can lead to allegations of abuse.

Dr. John Brose: To get somebody up in the morning, rather than come in, whip off the covers, the better is it's time to get up, Bob, time to get up, Mary. How are you? Did you have any good dreams?

Lynn Gerard: So when we're explaining to the resident what it is that we're going to do with them, we need to help them remove clothing, obviously, but keeping the clothing removed for as short a time period as possible and providing privacy. When we're providing incontinence care, it's important that we turn on the light, that we let the resident know what it is that we're going to do. I'm going to check to see if your incontinent brief is wet or soiled. Let me just take a look at the product itself here and I'll be able to tell you if you need to be helped.

Dr. John Brose: But if you don't customer service important, it goes by the wayside. Because it's a corner that people can cut.

Frank Weber: You don't put yourself in a situation where someone can make an allegation, so you do as much safety planning as possible. You think about how this could all play out and if someone else needs to be present, someone else needs to be present, that you are very careful of how you approach things with people.

Lynn Gerard: Part of our training also has to include the fact that abuse, sexual abuse to resident, is not limited to staff to resident. We also have to be prepared for family, for visitor, but also resident to resident sexual abuse.

Dr. John Brose: Most people can't picture their parents being sexual, let alone their grandparents, and sometimes the right thing to do is to let them be sexual. In fact, under the patient bill of rights, there's some stipulation in there about providing privacy.

Lynn Gerard: As we age, we still have our need for touch, we still have our need for companionship, and where the boundary line goes with the resident in terms of touch and in terms of sexual abuse needs to be closely monitored.

Dr. John Brose: And you have a responsibility as a staff member to not violate the rights of a resident or violate their vulnerability. Both of those things are true.

Cheryl Hennen: Person-centered care is a requirement to preventing abuse.

Dr. John Brose: What would you do if there was no health department? What care would you deliver? Think about that for a minute. What would be going on in your building? What would you do to create a phenomenal culture? To create a great experience for people that chose you to become their health care provider.

Maya Fischer: I have been able to tell my story to others via news media, speaking in front of the Senate.

I still felt the guilt of not being able to take care of her myself and having to entrust her care to others, only to have her subjected to this unthinkable assault.

To be able to tell it to people who can really make a difference, that certainly helped in the healing process. Just being able to turn something so horrible into something that might help another family or might bring awareness to people who don't believe that these horrible things can happen.

So my mom had wanted her ashes thrown into the waters of around Maui so she could swim with the humpback whales. My husband and I went out on an outrigger with some lovely people who performed a ceremony and spread her ashes. Just very simple and but very beautiful. The blowing of the horn, the seashell horn, and chanting and threw flower petals and it was beautiful. And that was, it was closure. It was a little bit of closure as to obviously her death, but closure on kind of what happened to and it's helpful in the healing process. It was very meaningful to me that at the end of her life, under very tragic circumstances, I was able to fulfill her wish, you know, for the end of her life, and now she's swimming with the whales in Maui, and that's what she always wanted.