IN THE CIRCUIT COURT OF THE ELEVENTH JUDICIAL CIRCUIT
OF FLORIDA IN AND FOR THE COUNTY OF DADE

SPRING TERM A.D. 1990

FINAL REPORT OF THE DADE COUNTY GRAND JURY

FILED

November 14, 1990

Circuit Judge Presiding

GEORGE ORR

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I N D E X

DIGNITY NOT NEGLECT FOR OUR ELDERS

"Grow old along with me
The best is yet to be
The last of life for which the first was made..."

I. INTRODUCTION

Aging and growing old are inescapable elements of life. For many of those who are healthy, growing old is as Robert Brownings' oft-quoted poem promises. Many elderly are independent, vibrant and vital resources for our community. Many still work, provide day care for children and volunteer for the general betterment of their communities. The recently deceased Congressman Claude Pepper is a shining example of the contribution older Americans can make to their family, friends and communities.

The demographics of our society indicate a "graying" of America, a general shift from a younger to an older population. Due to improved standards of living and advances in medical technology, we are living longer. Florida's elderly population has been expanding at an enormous rate with the present population over the age of sixty estimated at more than three million. Of this number, almost 1 million are over the age of seventy five. By the year 2000, the over eighty five population, that portion of the elderly who are most fragile and most in need of care, is expected to increase by 200 percent statewide.

The "graying" of Florida is no longer a future concern, it is happening now. Nowhere is this more evident than in Dade County where over 367,000, or nearly twenty percent of the population, are sixty years of age or older. Many members of this grand jury are approaching their senior years and all of us have relatives over sixty years old. Our thoughts and reflections on aging have heightened our concern with the issue. Some of us came to our Grand Jury service with independent knowledge of instances that raised concern for the treatment and care of our elderly. One juror is a hospice volunteer and works with terminally ill elderly. Another juror, a nurse's aide,

frequently works in nursing homes. A fifty year old juror is presently caring for her seventy five year old mother and is fearful of the need to institutionalize her. Another juror was forced to institutionalize her eighty five year old mother. With our large aged population, whose care needs increase as they grow older, we have concerns for those who need access to the existing elderly care system and for those disabled elderly who require long term care.

Many elderly Americans are cared for by their families, particularly daughters. According to a 1988 U.S. House of Representatives Report, the average American woman will spend seventeen years raising children and eighteen years caring for an aged parent. Even when the care has moved from the home to an assisted living facility, the elderly may continue to receive care, attention and assistance from their family. A telephone survey we conducted of families of Adult Congregate Living Facility (ACLF) residents found that almost ninety percent of those contacted visited their relative at least once a month. Even more revealing was the fact that almost fifty percent of those contacted visited several times a week.

If an elderly person becomes disabled, has no family care giver or through disability and dependence becomes a burden on that caregiver, the "last of life" may bring a loss of dignity and usefulness. A large percentage of our elderly population may indeed find themselves in this position as was revealed when we sought to contact the relatives of almost 250 residents of ACLF in Dade County. We were surprised to learn that almost fifty percent of them had no next of kin. Therefore, they had become entirely reliant upon a facility and the various government agencies to provide for them and oversee their care, making them easy targets for the careless and uncaring.

We reviewed several instances where elderly individuals sustained injuries which may have been preventable. As we analyzed these instances with medical and nursing professionals, as well as with representatives from various regulatory agencies,

we learned that there is a lack of agreement as to proper standards of care. The testimony we have heard, along with the incidents we have reviewed, left us with feelings of consternation and helplessness. These feelings were magnified by the conditions we found in some of the nursing homes and ACLFs we visited.

More questions were raised than we had the time to address or answer. Despite the inadequacy of time, we focused on the need to preserve the talents and abilities of our older citizens and to support those who are attempting to gain access to our elderly care services. Finally, we focused on the need to develop clearly defined protocols and standards of care for specific professionals that must be strictly enforced, particularly in institutional settings.

We are pessimistic as to this community's present ability to provide easily accessible services for our expanding elderly population. As a youth oriented society, we have increasingly focused proper attention on children's issues. We must continue to do so. We must also focus proper attention on the needs and abilities of the elderly. Dignity and adequate care are primarily what they require and to which are entitled.

II. ACCESSIBILITY TO SUPPORT SERVICES

There is a desperate need to ensure the easy accessibility by the elderly to the broad array of available support services. The purpose of these services is to sustain an optimal level of independent physical and psychological functioning of our elderly, particularly the frail and vulnerable. But in too many instances this purpose is defeated because few know how or where to access these services. The size and complexity of the various agencies who handle support services is overwhelming for an individual experiencing difficulty with the simple activities of daily life. Relatives of the elderly, who may feel guilt and shame due to their inability to care for their family member, become further

frustrated with the difficulties of accessing the service support system.

Last year an attempt to simplify access and provide an initial contact point for referral assistance resulted in the establishment of the Better Living for Seniors information hot-line. Our survey of relatives with elders in ACLFs revealed that ninety percent of those who responded had never contacted Better Living for Seniors nor had they received any assistance from the Department of Health and Rehabilitation Services (HRS) which is the primary umbrella agency for the delivery of elderly services in Dade County. In our survey, the relatives had heard of the ACLFs from other relatives, friends or doctors. We have also heard testimony about another information hot-line operated by Legal Services of Miami, Inc. It provides legal advice to our elderly population. Interestingly, the majority of the calls received concerned availability of social services and not legal advice.

Another attempt to better inform the general public exists in the form of a very comprehensive and apparently expensive directory of services prepared by the Dade County Elderly Services Division. The problem is that beyond professionals, no one seems to know how or to whom this directory is distributed or delivered. For all we could determine these directories may sit in a large box somewhere until requested or just go to the service providers themselves.

These findings echo a 1987 study conducted by the Southeast Florida Center on the Aging which further reported that the vast majority of elderly citizens and their relations were totally unaware of existing elderly services in Dade County. The service system needs to do more than passively await telephone calls and produce fancy directories. It must become more aggressively involved in reaching out to our elderly citizens. The system can and must do a better job of assisting the elderly so as to prevent or forestall their placement in an expensive,

unnecessarily restrictive facility. Public awareness campaigns are needed to inform citizens about the services available and how to access them.

III. CENTRALIZATION OF ASSESSMENT AND REFERRAL

The elderly generally have a wide variety of needs ranging from home care services, meals, transportation, guardianship, food stamps, Medicare and Medicaid to housing and legal services for estate planning and financial arrangements. However, under the present service system, attempting to meet these needs requires great effort and energy; qualities the frail elderly may lack.

Strategically placed, well known entry points to the entire delivery of services system need to be established throughout the county to provide easy accessibility for the elderly. Clients or their relatives should not be bounced around the county from one service to another with different access points and separate intake functions. These new entry points should provide a uniform client assessment process and a referral to services. A case management system involving all available services should also be established at this point. A total needs assessment encompassing all the person's requirements should occur to determine the most appropriate care with cost containment kept in mind.

We examined the following incident as an example of this problem:

> (EXAMPLE A) A seventy eight year old man was caring for his seventy six year old wife who was becoming increasingly disoriented and forgetful. He feared Alzheimer's disease. He did not know where to turn and although he wanted to continue to care for her in his home, he needed help. He tried several different places, his doctor, his lawyer, his priest and his neighbors. He was told over the phone by an unknown social service agency that he could hire a nurse at several hundreds of dollars a day, which he could not afford. So he and his wife continued to live in distress for several years until both died within six months of each other.

If this man and his wife had been properly assessed they could have received numerous elderly support services. This

is exactly the type of situation central intake centers could have corrected.

Centralized intake centers should assist more seniors to avail themselves of services though it will inevitably put a greater strain on already inadequate services. For example, United Home Care Services Inc., which provides homemaker services, home health aides, personal care, respite and companionship services has a waiting list of approximately 900 potential clients. We presently spend millions of dollars to increase life expectancy. We should allocate a portion of these funds to insure a proper balance between length and quality of life. Centralized intake and assessment will also insure better utilization of services by avoiding fragmentation, duplication and use of unnecessary or more expensive services. A sound assessment and evaluation of an elderly person's needs at an early stage can avoid costly procedures occasioned by delay in referrals.

IV. ASSESSING APPROPRIATE PLACEMENT

Appropriate placement of an elder is critical to the quality of care received. Inappropriate placement may be the precursor to inadequate care. We were appalled when we examined the following incident:

> (EXAMPLE B) Two daughters could no longer care for their deteriorating mother in their home. They contacted HRS for a list of places where she could be housed. The list was provided without any assessment. The daughters placed her in a licensed foster home. The mother required far more professional care than the home could adequately provide. While in the foster home she developed skin ulcers (decubitus ulcers) that were severe enough to require medical care and treatment. Despite being brought to a clinic twice for treatment, she was returned to the foster home. After several months the decubitus ulcers had increased, covering large areas of her body. Finally she went to the hospital. She died three weeks later. The decubitus ulcers were certified by a doctor to be a contributing cause of death.

In Dade County, an elderly person has three basic types of institutional or residential care facilities available. These are Adult Foster Homes, Adult Congregate Living Facilities (ACLFs) and Nursing Homes. Adult foster homes house no more than

three residents and ACLFs house more. Both adult foster homes and ACLFs provide less involved care than nursing homes in a less institutional, more homelike setting. Nursing homes are facilities supplying around-the-clock medical services and supervision for their clients. Most individuals in nursing homes require long-term care.

The placement of the woman in Example B was wrong. The woman required continuous skilled nursing care to treat her condition. The two daughters did not and could not have known about this requirement by themselves. The foster home should never have accepted her. Had a centralized system of assessment and referral been available, the daughters would have been given the guidance they needed and the inappropriate placement avoided. This incident clearly illustrates the necessity for a centralized assessment and referral process.

During our tour of a nursing home we identified and verified another inappropriate placement of another elderly woman, this time in a facility providing more intensive care than she needed. She was ambulatory, did not require round-the-clock nursing care, appeared to be lucid and able to participate in many of her daily activities. We later discovered that she had been determined to be incompetent by a Dade County Court. Long term care medical experts felt her placement in a nursing home to be erroneous, because an ACLF would have been quite adequate and would have been sixty percent less costly. Placement in an ACLF, which is by nature less restrictive than a nursing home, would have been a psychologically healthier placement for her.

Lack of a proper assessment can also lead to the placement of an individual in a more restrictive and more costly facility than necessary. Additionally troublesome is a recent trend in nursing home admissions in accepting individuals who in past years would never have been referred. This change has been attributed to the the federal Medicare policy based on Diagnostic Related Groups (DRGs). This policy limits the number of days of hospital care Medicare will pay for a particular diagnosis. Once

the time limit is reached, there is a strong impetus to discharge the patient based on his or her diagnostic group as opposed to his or her actual condition. This "quicker and sicker" discharge is resulting in nursing homes having to care for patients more suited for hospital care. ACLFs and foster homes have also felt the burden of caring for people more appropriately placed in a nursing home. We are concerned that this "trickle-down" effect may result in greater numbers of inappropriate placements and inferior quality of care.

V. INSTITUTIONAL CARE FOR THE ELDERLY

As we embarked on our review of institutional care, we came with preconceived notions. We feared that too often, elderly nursing home residents were sedated, confined in chairs and left for hours on their own. Testimony and a review of several incidents confirmed our fear. Witnesses have testified that physically restraining elderly persons for the convenience of facility staff is too common a practice. The utilization of "geri-chairs" with diapers has been described to us by geriatric advocates as an antiquated standard treatment for an elderly individual who is a "wanderer". Too often, staff convenience was the only reason for their continued use, particularly in cases involving "wanderers". Recent national surveys reflect that forty two percent of nursing home clients were physically restrained.

Too often psychotropic drugs, such as Haldol, are prescribed for the purpose of making it easier for nursing home staff to restrain a resident. With attention often focused on the use and abuse of physical restraints, chemical restraint via psychotropic medication, provides a cheap, easily dispensed and often poorly regulated means of "forcefully" controlling a person. Advocates for elderly and disabled adults are beginning to persuade the industry to recognize that the unnecessary use of physical and chemical restraints not only is barbaric, but also

is counter productive to the well being of the patient and to staff management. Additionally, effective October 1, 1990, new federal regulations prohibit the use of psychotropic drugs for controlling "wanderers". However, despite this enlightened trend in the industry, the unnecessary use of physical and chemical restraints continues. While no one can say how prevalent this practice is, all agree it commonly occurs.

The State Attorney's Office shared with us two incidents in which elderly women had sustained serious injury in separate nursing homes. Physical and chemical restraints were used in one of these incidents. In both of these incidents decubitus ulcers developed which became so severe that the patients were hospitalized and one eventually died.

A decubitus ulcer, frequently referred to as a "bed sore", is a deterioration of the skin at certain pressure points of the body. This occurs when an individual remains immobile for long periods of time and the condition is exacerbated by exposure to urine and fecal matter. At their worst, these ulcers can be large, open sores the size of a grapefruit which can become deep enough to expose muscle and bone. Medical and nursing professionals advised us that the development of decubitus ulcers is often an indication of a lack of care and proper medical treatment. Expert testimony indicates that there are several warning signs related to the risk of an elderly person developing a decubitus ulcer:

(a) Previous Malnutrition: In elderly people there is an apparent slowing down of the body's healing process. Malnutrition aggravates this problem. Indications of previous malnutrition implies a higher-than-normal risk that developing skin sores will not heal.

(b) Fragile Skin: The more fragile the skin, the greater the risk an elderly person has of developing a decubitus ulcer. Decubitus ulcers are pressure sores. They develop from skin irritations as a result of an area of the body being left in one position too long.

(c) Impaired Mobility and Sedation: The general consensus of the medical and expert testimony we have heard is that the more ambulatory the patient, the less likelihood a decubitus ulcer will develop. Conversely, the less ambulatory the patient, the greater the risk. Sedation of a patient generally results in less mobility, creating a even greater potential for the development of decubitus ulcer.

(d) Incontinence: An incontinent person is at ever greater risk of developing a decubitus ulcer due to the irritating effect of lengthy skin exposure to urine and fecal matter.

In several of the incidents we reviewed involving decubitus ulcers, Haldol was the prescribed drug of choice. This drug made the patients less mobile, creating a need for somebody to turn them. In our incidents this occurred infrequently. Expert testimony evaluating the medical records of our examples indicated no medical diagnosis justifying the use of Haldol. Excessive medication of patients resulted in the loss of dignity for the elderly person as well as potentially predisposing the patient to developing decubitus ulcers. We find such use of psychotropic drugs to be improper unless there exists a clear medical reason and a specific diagnosis for the prescription. Staff convenience is a blatantly insufficient and totally unacceptable justification.

The following incident reflects our concerns:

(EXAMPLE C) An active, ambulatory and relatively healthy eighty seven year old woman lived with her immediate family. At times she became confused, disoriented and wandered off. However, she was able to dress herself, feed herself and was continent. The family admitted her to a nursing home in late 1988. The day she was admitted she was placed in a "posey restraint" and several days later was prescribed "Haldol 5 mg. PRN". Shortly thereafter, she became incontinent and suffered from diarrhea for the following three weeks. At this point, the nurse recorded in her notes "small pressure coccyx side M.D. notified of patient condition states, he'll come to see patient". The next day, her doctor visited her, and apparently did not examine the developing decubitus ulcer, since nowhere in his progress notes nor in his orders did he mention the decubitus ulcer. Six days later, the nurse notified the doctor of the decubitus ulcer and he ordered standard routine care. Five days later the decubitus ulcer had become "foul smelling". For the subsequent six days the nurses' notes referred to "foul smelling necrotic material hanging, drainage and no improvement". The doctor never again examined the patient. She was referred on that subsequent sixth day for hospitalization for "infected large sacral decubitus ulcer".

She contracted septic pneumonia in the hospital and died three months later.

Several errors occurred with respect to the care of this individual. Upon admission to the nursing home, she was identified as a disoriented "wanderer" who had fragile skin. The treatment she immediately received upon admission increased the likelihood of her developing decubitus ulcers: (1) she was strapped into a geri-chair, eliminating mobility; and (2) she was heavily sedated. Together, these actions rendered her the equivalent of incontinent and she was placed in an adult diaper. Within three weeks, she began to develop a decubitus ulcer on her coccyx (base of spine). Her condition was further exacerbated by a series of apparent failures to act once the ulcer began to develop.

What occurred in the subsequent weeks with respect to this person's care is unclear. It is difficult to analyze who if anyone is responsible for the ultimate deterioration of the ulcer. The medical, nursing and licensing experts we consulted noted a series of failures by various professionals. Nearly all agree that she should not have been both physically restrained and sedated from the outset. Unfortunately, at the time this occurred, this was not an uncommon practice with respect to "wanderers". Medical testimony indicated that the doctor should have examined her and ordered treatment upon being notified by the nurse of the pressure sore. Nursing experts indicated that the development of the decubitus ulcer could have been prevented by the nursing staff: (1) removing the restraints; (2) moving, walking and rubbing her regularly; and (3) contacting the medical director who could have arranged for proper treatment when the private physician failed to examine her and order treatment for the ulcer. Nearly the same circumstances existed in another incident involving another elderly person residing in a different nursing home.

(EXAMPLE D) A seventy nine year old woman was placed into a nursing home because she was a wanderer and her family could no longer provide her with the twenty four hour care she needed. Her family had been taking turns, after work, caring for her. The decision was a difficult one.

The nursing home's records show a 125 pound, seventy nine year old woman with fragile skin. She had no abrasions or bruises and a blood pressure of 130/80 upon being admitted on April 29, 1989.

On August 1, 1989, just over three months later, she was transported from the nursing home to a hospital. She weighed ninety five pounds, had a blood pressure of 90/50, was malnourished, dehydrated and was suffering from a "foul smelling" decubitus ulcer almost six inches in diameter. During these months, her personal physician had visited twice. Despite the "foul smelling" ulcer, the on site doctor was never consulted. After being transported to a hospital, the treating physician found evidence of feces inside the decubitus ulcer.

As we analyzed these incidents, we were disturbed by the injuries these elderly ladies had sustained and we became frustrated with the process of ferreting out the perpetrators responsible for the injuries. Although these two people suffered as a result of the lack of care they received in their nursing homes, the determination of possible criminal responsibility was virtually impossible due to the overlapping duties of the different professionals and their provision of care or failure to provide that care. Even the medical professionals, who helped us analyze these incidents, are not in full agreement on these issues.

In light of these problems, it becomes increasingly imperative that the industry establish well defined protocols and standards of care which will be strictly and swiftly enforced by the regulatory agencies. Since large numbers of those being admitted to nursing homes either have, or are prone to developing decubitus ulcers, a standardized "at risk" skin assessment should be utilized. Several nursing homes, such as South Shore Nursing Home and Human Resources Health Center, provide for a very comprehensive assessment on admission. We believe "at-risk" skin assessments should be mandatory at all facilities. In most cases decubitus ulcers are preventable and treatable. Failure to prevent or treat these serious conditions are unconscionable and should be acted upon administratively by the professional regulatory agencies. The regulatory agencies should mandate the implementation of these assessments and the appropriate treatment criteria immediately and aggressively
enforce their use.

VI. REGULATORY AND PROFESSIONAL ENFORCEMENT

While we recognize that medical professionals are generally committed to the survival and well being of their patients, doctors and nurses must still be held accountable for their professional acts or omissions. Institutions that are in the business of providing medical services to their clients must also be held professionally accountable. We believe that our institutional care facilities and our medical professionals must provide a standard of care that also maintains dignity. Deviations from standards of care should be dealt with swiftly to prevent any reoccurrence.

The responsibility of enforcing and ensuring this accountability falls primarily upon two divisions of HRS: the Office of Licensure and Certification (for ACLFs and Nursing Homes) and Aging and Adult Services (for Adult Foster Homes). In addition, the Department of Professional Regulation (DPR) has the responsibility for enforcing and insuring this accountability for doctors, nurses and nursing home administrators. Each group has its own unique set of rules and regulations. Theoretically, these rules and regulations empower each of the enforcement agencies with full oversight of the standards of care being provided at each facility.

We have been advised that the Department of Professional Regulation (DPR) is presently reviewing only one of the prior examples to determine whether or not a breach of professional standards of care occurred, and if so, by whom. DPR, through the Board of Medicine, will ultimately determine if a doctor's actions were, pursuant to Florida Statutes 766.02:

> "a breach of the prevailing professional standard of care...[that] shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably similar health care providers."

DPR, through the Board of Nursing, will ultimately determine if attending nurses, pursuant to Florida Statute 464.018, "departed from, or failed to conform to, the minimal standards of acceptable and prevailing nursing practice..."

In the incidents we reviewed, we believe a number of the rules and regulations were violated. For instance, in Example D, one entire month's worth of records are missing or incomplete. In Example C, no documentation exists to "justify the diagnosis and treatment". A patient suffering from a decubitus ulcer is required to be moved or turned at least every two hours and this care should be entered into the nurses' records. This did not occur in the examples we reviewed. Either the patients were turned and it was not recorded, or the patients were not moved and the records accurately reflect these omissions. In both incidents, they have either failed to follow required procedures or they have failed to comply with the record keeping regulations.

Maintaining complete and accurate medical records are mandatory and critical. They serve to pin-point acts or omissions that occurred with respect to the care of a client. To a large extent, medical records act as a check and balance to insure proper care is provided to a patient.

We were surprised to learn that the one incident (Example C), being investigated by DPR, is also presently being investigated by two other independent agencies. All three investigations are being conducted separately from each other. Additionally, the resulting administrative reviews and proceedings will also be conducted separately. Throughout the proceedings no communication will take place between these different agencies inhibiting the free flow of investigative information between them.

Although all three agencies are pursuing their respective investigations, we question the need for three different, yet concurrent investigations of the same matter. More importantly, we are disturbed that no administrative conclusions have been reached or sanctions undertaken by DPR in the twenty months since the death of the woman in Example C. We have been informed by a representative of DPR that they are not lacking in the funds or staff necessary to handle their current

case load. In view of this, we feel that twenty months is an inexcusably long period of time to have passed without the reaching of an administrative conclusion.

The fact that only one of the incidents we reviewed here has been referred to DPR is also extremely disturbing. The reason for this was that there had been no complaints made to DPR by any of the other agencies. These agencies should better coordinate their investigative efforts and increase their sharing of information.

We also reviewed an incident that, although from another area in the state, appallingly exemplifies the void of communication between enforcement agencies. It involved an 83 year old diabetic who died in February 1990, as a result of failing to receive insulin while in a nursing home. DPR has not yet received a complaint regarding the doctor or nurses involved and therefore is not investigating the incident. OLC, while it has investigated and confirmed this incident, has apparently failed to refer it to DPR. In fact, only one of the incidents we reviewed has been referred to DPR by OLC.

OLC is the only agency that has reviewed all of these incidents to determine if the facilities themselves should be held accountable for any breaches from standards of care by their staff. As this report reaches its conclusion, there has been little punitive administrative action taken in any of these incidents. OLC claims to need additional staff to move more quickly on a backlog of cases it has in the South Florida area. If this is true, then we urge they be provided with the additional resources required to properly address such cases, particularly those involving serious injuries.

While we believe that OLC needs to prioritize its investigations and move more swiftly towards their resolution, we were generally encouraged by the emphasis it is currently placing on quality of care issues. Ten years ago a Dade County Grand Jury issued a report exclusively on the topic of nursing homes. It criticized OLC for overemphasizing simple items such as

lighting, number of bedpans and general form completion while ignoring harder to regulate items such as the quality of care. Today, a decade later, we find that OLC is now moving towards greater emphasis on the quality of care being rendered. It seems that changes in both the state and federal rules and regulations plus new leadership at the statewide level has lead to this. Certainly, the physical requirements of facilities are important. By these comments, we do not mean to belittle or diminish these criteria. However, we cannot overemphasize the vital importance of the dignified rendering of quality care and our belief that such care must be better integrated into both the annual inspection and complaint inspection process. We were impressed with the director of OLC and we believe, if adequately staffed, this can be accomplished.

Toward that end, OLC should more aggressively collect and analyze data so that patterns of neglect can be identified for possible enforcement purposes. Potential indicators of neglect which may signal a problem with overall care include: excessive use of physical restraints; inappropriate use of psychotropic medication; over medication; and the use of medication as a type of patient restraint. OLC needs to improve the present system so that patterns of breaches of client care can be tracked and utilized in enforcing standards of care.

VII. FAILURE TO REPORT ABUSE AND NEGLECT OF THE ELDERLY

Florida law mandates that known or suspected instances of abuse, neglect or exploitation of the elderly be reported to the HRS abuse hot-line by any person. This clearly includes physicians, nurses, nursing home and ACLF staff. A primary purpose of this mandate is to protect an elderly person from further harm and to trigger the whole array of services that may be available to them. Reporting also provides timely notification to the proper investigatory agency. A knowing failure to make such a report is a criminal misdemeanor.

There is a general lack of compliance with this requirement. When the neglect occurred in the incidents we

reviewed, none were reported to HRS. This was not for lack of opportunity. In Example B, a subject received treatment twice at the same clinic and was finally sent to a hospital because of the extreme condition of her decubitus ulcers. Neither the clinic, the two different doctors who treated her, the various nurses with whom she came in contact, nor the hospital reported this incident to HRS. The report was eventually made well after the neglect had already occurred.

These failures to report suggest either a lack of knowledge of the duty to report or a lack of sensitivity to the injuries sustained. In either case, these failures are unacceptable. In recent times, the public has become increasingly sensitized to child abuse and neglect. The increased numbers of reports bear this out. The same may not be true for elderly neglect and abuse. We have heard testimony that many incidents of elderly abuse and neglect go unreported. This may be due to a lack of public awareness as to what indicates and constitutes abuse, neglect and exploitation of the elderly. It may be that decubitus ulcers have been so commonplace in the industry that they have not been widely viewed as evidence of neglect. Clearly, that is not the case. They are and should be viewed as indicators of neglect. The healthcare and social service industries which provide care for the elderly are in a prime position to recognize abusive and negligent acts or omissions and therefore, must be urged to report them. HRS must act more swiftly in determining whether or not a grounded failure to report exists and make a timely referral of the matter for prosecution, if appropriate.

VIII. EDUCATION AND TRAINING

We have heard testimony and studied reports and surveys indicating that there is a present lack of geriatric education among health professionals. A brief telephone survey we conducted of several medical schools, including Harvard and Johns Hopkins indicated that almost no training for physicians exists relating to the specific needs of the elderly. Florida is

fortunate to have medical schools like the University of Miami and the University of South Florida where there is a focus on the health needs of the elderly. Nursing schools across the country are offering geriatric training at the master's degree level are beginning to emphasize it at the baccalaureate level. Every medical and nursing school in the nation should require training in geriatrics as a specific part of their curriculums. Florida should lead the nation towards that end and in some ways is already making the attempt.

The State of Florida, which licenses physicians, should require courses in geriatrics as part of its continuing medical education program. As twenty percent of our population is elderly, it seems fair to estimate that except for those specializing in pediatrics and obstetrics, that twenty percent of any physicians clientele will be over the age of sixty. The State of Florida requires all physicians to take ten hours of continuing education in AIDS as well as risk management, which deals with malpractice issues. We believe they should require the same for geriatrics.

Additionally, there remains an apparent lack of education with regard to the rules and regulations governing the standards of care in Florida's institutional facilities. We have heard testimony of medical professionals indicating a widespread lack of knowledge on the part of doctors and nurses of the HRS rules that establish the standards of care for the institutional care facilities.

Presently, volumes of rules and regulations exist. However, nursing home administrators appear to be the only ones who have a working knowledge of them. Even so, none of the nursing home medical records we reviewed complied with the present rules and regulations. Simply passing rules out is an inadequate means of educating the staff.

At the very least, everyone who is going to primarily work with the elderly should have training in the area of geriatrics. A certification in geriatrics should be required not

just of the licensed medical professionals, the licensed practical nurses, registered nurses, nurse practitioners, nursing director and director of medical services in a nursing home but also of the nurses aides and orderlies, who by far have the greatest contact with their clients. A thirty to forty hour course should be required that explains the implementation of the rules and regulations. This lack of knowledge needs to be addressed by the licensing agencies, OLC or DPR. Requiring such knowledge by both the facility staff and the individual professionals receiving licenses should merit close attention.

IX. PROMOTING GREATER AWARENESS OF OUR ELDERLY AS A RESOURCE

Those elderly who are healthy and independent are obviously a valuable resource. Encouraging a usefulness, fostering independence and cost containment are all good reasons why we should attempt to better utilize the rich talents and varied experiences the elderly possess. While an elderly person may require some support services, he or she may be able to also provide support services to someone else.

Depression, lack of stimulation and a loss of self esteem contribute to a general deterioration of an elderly person. Mere physical survival does not guarantee quality of life. A meaningful existence requires the use of a healthy brain. Many who fill nursing homes are not there due to loss of physical functions, rather many are there due to loss of mental faculties. Failing brain function can be a sign of neglect and lack of stimulation. A stimulating, challenging environment promotes increased brain function. Many programs exist which have begun to use seniors to assist other seniors. For instance, South Shore Hospital has volunteer programs where seniors take care of other seniors needing help. These volunteer hours are banked and entitle that volunteer to a commensurate number of hours if and when they need them.

Children represent the present, the elderly represent the past and together they can create a healthy link to the future. The elderly feel less lonely and disenfranchised when

just of the licensed medical professionals, the licensed practical nurses, registered nurses, nurse practitioners, nursing director and director of medical services in a nursing home but also of the nurses aides and orderlies, who by far have the greatest contact with their clients. A thirty to forty hour course should be required that explains the implementation of the rules and regulations. This lack of knowledge needs to be addressed by the licensing agencies, OLC or DPR. Requiring such knowledge by both the facility staff and the individual professionals receiving licenses should merit close attention.

IX. PROMOTING GREATER AWARENESS OF OUR ELDERLY AS A RESOURCE

Those elderly who are healthy and independent are obviously a valuable resource. Encouraging a usefulness, fostering independence and cost containment are all good reasons why we should attempt to better utilize the rich talents and varied experiences the elderly possess. While an elderly person may require some support services, he or she may be able to also provide support services to someone else.

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Children represent the present, the elderly represent the past and together they can create a healthy link to the future. The elderly feel less lonely and disenfranchised when

they are useful and valued. Programs which combine the stabilizing influence of the elderly with the vitalizing quality of children need to be developed and implemented statewide.

The Dade County Public School System has implemented several progressive programs that link elders with children. Some of these programs are the Adopt-A-Grandparent Project; Animal Companionship Program; Active Older Contributing Adults; Senior Mentors for Creative Students; and Foster Intergenerational Musical Program. A particularly innovative program called Project Move transports over 100 senior volunteers to and from fifteen inner city elementary schools. These volunteers contribute over 200 volunteer hours per week in classroom assistance with arts and crafts, storytelling and tutoring in reading and math.

All of the programs combined represent over 3,000 senior volunteers. More importantly, preliminary data suggests that these programs are having a direct impact on reducing school dropout rates. We hope Dade County Public Schools will continue expanding these programs and urge them to develop sound statistical data proving their effectiveness so that they can become better funded. We also applaud the wisdom of our legislature in enacting a new law on July 1, 1990 entitled Intergenerational School Volunteer Program to "recognize and unite senior citizens and school children in order to enrich the lives of both". Next year, we urge they adequately fund it, especially for transportation, which appears to be the greatest obstacle these programs have to overcome.

At a time when funding for education and human services is decreasing, we must fully use every other possible resource available. The elderly constitute a wise, experienced and underutilized resource. Many want to be involved and such involvement is healthy. We must not give up on them for having reached some arbitrary age and we can not afford to ignore the the valuable resources they present. It has been said that a society can be judged by how it treats its young and its old.

Only recently has Florida focused on improving the lives of its children. To succeed as a caring and just society, we must also recognize our present failures in caring for our elder citizens and we must correct them. The dignity and desire of Florida's seniors is so aptly summarized by a poem we came across in one of the ACLFs we visited:

> God, keep me working, keep me fit
> At windows I don't want to sit
> Watching my fellows hurrying by:
> Let me stay busy 'til I die.
> Grant me the strength, breath, and will,
> Some useful niche in life to fill,
> A need to serve, a task to do:
> Let me each morning rise anew,
> Eager and glad that I can bear
> My portion of the mornings care.
> God, I don't want to sit about,
> Broken and tired and all worn out,
> Afraid of wind and rain and cold,
> Let me stay busy when I am old.
> Although I walk with slower pace,
> Still let me meet life face to face.
> This is my Prayer as time goes by,
> God Keep me busy 'til I die.
>
> Sol Ehrlich

X. RECOMMENDATIONS:

(1) Create greater awareness of existing elderly services among Dade's elderly population, and their relatives, by better publicizing the Better Living for Seniors' information hot-line and putting referral information into the hands of Dade's citizens on a frequent, consistent basis.

(2) Involve the private sector of the community as a partner in publicizing the information hot-line.

(3) Create centralized assessment centers in different sections of the county. This will allow elderly citizens to be fully assessed so that they can obtain all of the services for which they qualify.

(4) Create a common assessment and case management system so that evaluative information on each client can be shared by each elderly service agency. This will reduce duplications of paperwork and assessments.

(5) The Office of Licensure and Certification should initiate a closer tracking and review of the number of incidents of decubitus ulcers at all licensed institutions. Quarterly evaluations of this information could act as an early warning sign of increasing problems at an institution. Increases in the number of incidents should trigger an immediate and total inspection of the facility.

(6) A uniform "at-risk" skin assessment should be developed and its use made mandatory at all facilities certified and licensed by the Office of Licensure and Certification.

(7) Physical restraints and the unnecessary prescription of psychotropic medications as defacto chemical restraints should be closely scrutinized by all licensing and regulatory agencies. Improper use of physical and chemical restraints must be cited and dealt with in the most severe manner possible.

(8) Greater emphasis on geriatric issues need to be incorporated into medical school curriculums. The current curriculums of the medical schools of the University of Miami and the University of South Florida can provide an excellent model for these changes.

(9) The State of Florida's Continuing Medical Education Program should require ten hours of training in geriatrics biannually.

(10) Require, as part of the Department of Professional Regulation's licensing procedures, that all licensed health care professionals, including doctors, nurses and nursing home administrators receive training in their responsibilities as set forth under the rules and regulations of both the Department of Profession Regulation and the Department of Health and Rehabilitative Services.

(11) The Department of Health and Rehabilitative Services needs to better inform those it licenses and regulates in the appropriate recognition of incidents of neglect and abuse,

placing particular emphasis on the issues of physical and chemical restraints and decubitus ulcers.

(12) All health care professionals, particularly those in Health Maintenance Organizations dealing with large numbers of elderly patients, must be made aware of their duty to report suspected incidents of elderly abuse and neglect to the Department of Health and Rehabilitative Services for investigation.

(13) The Office of Licensure Certification must pursue with greater vigor the requirement that facilities maintain complete and accurate medical records. The commonality of this deficiency indicates a lack of attentive care to detail on a facility's part which may also be a warning sign of additional quality of care problems.

(14) The Office of Licensure and Certification should report deficiencies in record keeping to Department of Professional Regulation for possible license violations on the part of doctors and nurses when such deficiencies are noted.

(15) Adult Protective Services and the Office of Licensure and Certification need to review their existing policies regarding the referral of information to the Department of Profession Regulation. A policy should be implemented that will provide the Department of Profession Regulation with information about an incident of abuse or neglect shortly after such incident occurs.

(16) The existing responsibilities for investigating and tracking known or suspected incidents of abuse or neglect need to be centralized and streamlined into one designated agency.

(17) All school districts throughout the State of Florida should implement senior volunteer programs such as Dade County has done.

(18) The State Legislature needs to adequately fund the newly enacted Intergenerational Volunteers Program to insure its implementation and effectiveness.

CAPITAL AND OTHER CRIMINAL CASES PRESENTED TO THE GRAND JURY

Defendant	Charge	Disposition
DECARLOS MOORE	First Degree Murder Attempted Armed Robbery	True Bill
JULIO ADOLFO GUERRA	First Degree Murder Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
LAZARO LAURENCIO-ALVAREZ	First Degree Murder	True Bill
ROGER BECKWITH	First Degree Murder Armed Robbery Burglary of Dwelling Grand Theft Motor Vehicle	True Bill
WILLY LAVILETTE [Prev. indicted 1/31/90]	First Degree Murder First Degree Arson Attempted First Degree Murder Attempted First Degree Murder Attempted First Degree Murder	True Bill
JUAN ESQUIVEL	Armed Kidnapping Armed Robbery Armed Robbery Armed Burglary with an Assault Aggravated Battery Grand Theft Auto Grand Theft Auto	True Bill
ANTHONY ORTIZ, DELBERT ELLIS AGUILA, and LUIS ORTIZ	First Degree Murder Armed Robbery	True Bill
WILFFORD NORRIS	Second Degree Murder Unlawful Possession of Firearm During Commission of a Felony	True Bill
GEORGE BERRIAN	First Degree Murder Unlawful Possession of a Firearm in the Commission of a Felony	True Bill
JESUS SANCHEZ	First Degree Murder First Degree Murder First Degree Murder Aggravated Assault Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill

Defendant	Charge	Disposition
MAX PRESTON RUSSELL, III	First Degree Murder Armed Robbery	True Bill
JAMES BENJAMIN BELL	First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Shooting a Deadly Missile into an Occupied Building Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill
JAMES MAURICE SIMMONS	First Degree Murder Attempted First Degree Murder Possession of a Firearm During the Commission of a Felony	True Bill
EMILIANO R. MEJIA [Prev. Presented 1/10/90]	First Degree Murder Unlawful Possession of a Weapon While Engaged in a Criminal Offense	True Bill
RICKY MOBLEY	First Degree Murder Possession of a Weapon While Engaged in a Criminal Offense	True Bill
ONELL SMITH	First Degree Murder Attempted First Degree Murder Shooting Into Occupied Vehicle Unlawful Possession of Firearm While Engaged in a Criminal Offense Carrying a Concealed Firearm	True Bill
CALVIN ALEXANDER LAZIER	First Degree Murder Second Degree Murder Conspiracy to Traffic in Cocaine Attempted Trafficking in Cocaine Armed Robbery	True Bill
MICHAEL WILLIAM BETSY	First Degree Murder Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill
CHARLES DAVIS, ALEXIE VELEZ CALEME CHERFRERE and LAMONT CLARK	First Degree Murder Armed Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
CARLTON D. BAILEY	Second Degree Murder Possession of a Firearm During the Commission of a Felony	True Bill

Defendant	Charge	Disposition
JERRY JERMAINE MOBLEY	First Degree Murder Attempted Armed Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
ANTWAIN MOORE	Second Degree Murder Attempted Second Degree Murder Carrying a Concealed Firearm Possession of a Firearm During the Commission of a Felony	True Bill
DOCK RANDOLPH JONES	First Degree Murder Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
LEONEL MARTINEZ	First Degree Murder First Degree Murder	True Bill
CALVIN ALEXANDER LAZIER [Prev. Presented 7/11/90]	First Degree Murder Second Degree Murder Conspiracy to Traffic in Cocaine Attempted Trafficking in Cocaine Armed Robbery	True Bill
ALBERTO REYES	First Degree Murder Kidnapping with a Weapon	True Bill
CHARLES STONE and LEE GETER	Armed Burglary Armed Robbery Murder - First Degree Unlawful Possession of a Firearm while Engaged in a Criminal Offense Carrying a Concealed Firearm "B" Unlawful Possession of a Firearm by a Convicted Felon "A" Unlawful Possession of a Firearm by a Convicted Felon "B"	True Bill
WILBERT LEE BUTLER	First Degree Murder Unlawful Possession of a Firearm While Committing a Felony	True Bill
CHARLES HARRY ALPERN and LUIS ALBERTO BELTRAN	First Degree Murder Use of Firearm in the Commission of a Felony	True Bill
GEORGE VEGA, also known as GEORGE VEGO	First Degree Murder Armed Kidnapping Armed Burglary Armed Robbery	True Bill

Defendant	Charge	Disposition
THOMAS RAYNARD JAMES	First Degree Murder Armed Robbery Armed Burglary Aggravated Assault	True Bill
KENNETH WATSON	First Degree Murder Armed Burglary with an Assault Armed Robbery	True Bill
RODNEY BERNARD BENNETT	First Degree Murder Armed Robbery Grand Theft Possession of a Firearm During the Commission of a Felony	True Bill
GARY DWAYNE HAYWARD and HENRY B. PEOPLES	First Degree Murder Attempted First Degree Murder Armed Robbery Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill
ALEXANDER SLATER	First Degree Murder Possession of a Firearm While Engaged in a Criminal Offense Carrying a Concealed Firearm Possession of a Firearm by a Convicted Felon	True Bill
ANTONIO VENZAL "A" and JOSE OSCAR DUQUE "B"	First Degree Murder Armed Burglary with Assault Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill
ISIDRO SALINAS, ROBERTO NUNEZ	First Degree Murder Trafficking in Cocaine	True Bill
ALEX GENNARO NAPOLITANO	First Degree Murder Attempted First Degree Murder Attempted Robbery Unlawful Possession of a Firearm during the Commission of a Felony	True Bill
ROBERT LEE JOHNSON	First Degree Murder Attempted Second Degree Murder of a Law Enforcement Officer Attempted Second Degree Murder of a Law Enforcement Resisting Officer with Violence to his Person Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill

Defendant	Charge	Disposition
NELSON RAMON CLEMENTE	First Degree Murder Armed Robbery	True Bill
PEARISON WARE	First Degree Murder	True Bill
ALFREDO MORA GONZALEZ	First Degree Murder	True Bill
JUAN ORENOS and ROGER CRUZ	First Degree Murder Kidnapping Attempted Sexual Battery	True Bill
JOSE MEDINA RIVAS	First Degree Murder Attempted Armed Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
ARTURO VILLATORO	Sexual Battery [794.011(2)] Sexual Battery [794.011(2)] Sexual Battery [794.011(2)] Sexual Battery [794.011(2)] Lewd Assault Act	True Bill
GUILLERMO HERNANDEZ	First Degree Murder Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
GEORGE ANTHONY SURITA, "A", MARK ANTHONY JOHNSON, also known as "FLATBUSH", "B", and RICARDO POUZA, also known as "POCHOLO", "C"	First Degree Murder Burglary Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
PETER HUGH MARKLAND	First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Attempted First Degree Murder Armed Burglary with a Firearm with the Intent to Commit an Assault Unlawful Possession of a Firearm in the Commission of a Felony	True Bill
MITCHEL PETITHOMME	Burglary of Conveyance Grand Theft - Auto First Degree Murder First Degree Murder	True Bill
NORILIEN JOSEPH and SAINT THOMAS NONOMME	First Degree Murder Armed Robbery Attempted Armed Robbery	True Bill

Defendant	Charge	Disposition
MAX PRESTON RUSSELL, III	First Degree Murder Armed Robbery	True Bill
LUCKNER BOUR JOLLY and YOUDLEY RENARD	First Degree Murder Robbery Burglary	True Bill
TERRY DENISE McNEALY	First Degree Murder Burglary	True Bill
CHRIS MOORE, also known as CHARLES WILLORD	First Degree Murder Kidnapping Attempted Robbery Robbery with Weapon Unlawful Possession of Firearm while engaged in Criminal Offense	True Bill
SPENCER ALEXANDER NEALY	First Degree Murder	True Bill
ALLAN RIMPEL, also known as ALAIN RIMPEL	First Degree Murder Attempted Armed Robbery Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill
GEORGE VEGA, also known as GEORGE VEGO, and JOHNNY ARROYO	First Degree Murder Armed Kidnapping Armed Burglary Armed Robbery	True Bill
ARNOLD ANCRUM, JERMAINE CLARINGTON, AFTON HOWARD, also known as "NUT", JERRY WHITE and MARC WORD	First Degree Murder Attempted First Degree Murder Armed Robbery Conspiracy to Commit Armed Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
RODNEY CRAIG EVERHART, also known as "KARATE" [prev. indicted 4/18/90]	First Degree Murder	True Bill

Defendant	Charge	Disposition
KEVIN LARELL MAINOR	First Degree Murder Attempted First Degree Murder Robbery with a Firearm Robbery with a Firearm Kidnapping Kidnapping Kidnapping Kidnapping Burglary Grand Theft Third Degree	True Bill
ALTON ODELL JACKSON, also known as ALTON SPELL	First Degree Murder Armed Robbery Unlawful Possession of a Firearm During the Commission of a Felony	True Bill
JOHN L. CLARK, also known as MICHAEL GRANT, also known as ANDREW CARTER, also known as THOMAS MARTELL	First Degree Murder Use of a Firearm While Engaged in a Criminal Offense	True Bill
CORY JOHNNIE SMALL [prev. indicted 12/6/89]	First Degree Murder Attempted Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense Robbery Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
MIGUEL RODRIGUEZ	First Degree Murder	True Bill
CHARLES HARRY ALPERN "A", LUIS ALBERTO BELTRAN "B", IAN DAVID RESPETO "C" [prev. presented 7/25/90]	First Degree Murder (A & B) Robbery With Firearm (A & B) Conspiracy to Commit Robbery (A, B, C) Conspiracy to Traffic Cocaine (A, B, C) Shooting or Throwing Deadly Missile into Occupied Vehicle (A & B) Unlawful Possession of Firearm while Engaged in Criminal Offense (A & B)	True Bill
LORI ANN GRAY	First Degree Murder Robbery	True Bill

Defendant	Charge	Disposition
JAMES BOND "A", and RODERICK VAUGN FULWOOD, "B"	I. First Degree Murder (A & B) II-IV. Attempted First Degree Murder (A & B) V. Unlawful Possession of a Firearm while Engaged in a Criminal Offense (A) VI. Unlawful Possession of a Firearm while Engaged in a Criminal Offense (B) VII. Unlawful Possession of a Firearm by a Convicted Felon (A)	True Bill
ROBERT PONDER, also known as RODNEY SMITH	First Degree Murder Robbery Kidnapping Burglary	True Bill
PETER G. DOYLE, and MARK A WILSON	First Degree Murder Attempted Trafficking in Cocaine	True Bill
JOSEPH RUFFIN "A" and XAVIER ROBERTS "B"	First Degree Murder, A & B Robbery with Firearm, A & B Unlawful Possession of a Firearm in the Commission of a Felony, A	True Bill
BYRON DAWSON; ANTRON DAVIS; LAVARIS ROSS; TAVARES WILLIAMS, also known as TAVARIS WIGGINS, also known as STEVE POSTELL, also known as "LITTLE STEVIE"; and CAMERON WILLIAMS	First Degree Murder Armed Robbery	True Bill
ALCIDES MEDINA QUILES, also known as PEDRO KILLE	First Degree Murder Kidnapping Sexual Battery	True Bill
TODD RICHARD DORIAN	First Degree Murder Armed Burglary First Degree Arson	True Bill
OSCAR THOMAS, also known as "DIAMOND"	First Degree Murder Unlawful Possession of a Firearm while Engaged in a Criminal Offense	True Bill
WARREN CAIL	First Degree Murder Attempted Armed Robbery	True Bill

Defendant	Charge	Disposition
PABLO LAZARO LOPEZ	First Degree Murder Armed Burglary Unlawful Possession of a Firearm while Engaged in Commission of a Felony	True Bill
CHARLES DANIEL ORANGE and TRAVIS DION ATKINS	First Degree Murder Attempted Armed Robbery Attempted First Degree Murder Armed Robbery Attempted First Degree Murder Attempted Armed Robbery Attempted First Degree Murder Attempted Armed Robbery Attempted First Degree Murder Attempted Armed Robbery Shooting a Deadly Missile into an Occupied Vehicle Unlawful Possession of a Firearm While Engaged in a Criminal Offense	True Bill

ACKNOWLEDGEMENTS

We would like to thank The Honorable George Orr, The Honorable Martin Greenbaum and State Attorney Janet Reno. We are also most appreciative of our bailiff, "Bud" Wesson, and Rose Anne Dare, the Grand Jury Administrative Assistant, both of whom were so helpful and pleasant at all times. Assistant State Attorney Chet Zerlin did an outstanding job on our investigation into "Dignity Not Neglect For Our Elders". He was able to find capable and caring witnesses to help us become better informed about this most important issue. Our sincerest gratitude goes to Chief Assistant State Attorney Katherine Fernandez Rundle for her patience, guidance and enthusiasm. She represents the office well. Thank you Kathy and all for being so special.

Many police officers from all police departments in Dade County were heard. We compliment them for their professionalism and thorough investigations which enabled us to do our job with greater efficiency.

The testimony of the many witnesses who came before us proved to be most valuable to our report. They made us "experts" on a very broad bureaucracy. We thank these professionals for their cooperation and candor.

Respectfully submitted,

Dana L. Cunningham

Dana L. Cunninghan, Foreperson
Dade County Grand Jury
Spring Term 1990

ATTEST:

Stella B. Workman
Stella B. Workman
Clerk

DATE: November 14, 1990