ENFORCEMENT OF STANDARDS OF CARE IN THE LONG-TERM CARE INDUSTRY: HOW FAR HAVE WE COME AND WHERE DO WE GO FROM HERE?

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Many elderly Americans move into long-term care facilities because they can no longer live on their own or because their daily needs cannot be met by their families or friends. Sadly, the high standards of care that these elders seek and require in their new homes often fall below expectations. In his note, Mr. Dreher highlights the myriad forms of abuse and mistreatment suffered by many elderly residents in long-term care facilities, and analyzes the government's responses to these problems. This analysis reveals the startling ineffectiveness of the current system to deal with abuse in these facilities. The note concludes with concrete suggestions on how to deter future occurrences of mistreatment.

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The author would like to dedicate this note to the memory of James and Erma Durham (1906–2001, 1907–2001, respectively).

I. Introduction: The Expansion of the Elderly Population Necessitates Heightened Protection from Mistreatment, Abuse and Neglect

Elder abuse occurs in long-term care facilities across the United States,[1] permeating the very fabric of American society and affecting the elderly regardless of sex, race, ethnicity, or socioeconomic background.[2] It is estimated that between one and two million cases of elder mistreatment occur annually.[3] Mistreatment of the elderly frequently takes the form of physical abuse, but more often it involves less dramatic but equally damaging behaviors such as psychological or emotional abuse, financial exploitation, and neglect of care taking.[4] In response, the federal government and many states have enacted legislation designed to prevent mistreatment of the elderly and punish abusers.[5] But in spite of the growing awareness of elder abuse and statutory efforts to address it, few cases are reported to authorities,[6] and of those that are, only a fraction lead to imposition of any penalty.[7]

1. *See, e.g.*, *Elder Abuse: A Decade of Shame and Inaction: Hearing Before the Subcomm. on Health & Long-Term Care of the House Select Comm. on Aging*, 101st Cong., 2d Sess. 3 (1990) [hereinafter *Elder Abuse Report*] (finding that the incidence of elder abuse is increasing nationally and that five percent, or more than 1.5 million elderly persons may be abused yearly); HOUSE SELECT COMM. ON AGING, 97TH CONG., ELDER ABUSE: AN EXAMINATION OF A HIDDEN PROBLEM (Comm. Print 1981); THE BATTERED ELDER SYNDROME: AN EXPLORATORY STUDY (Marilyn R. Block & Jan D. Sinnott eds., 1979); ELDER ABUSE PROJECT, AM. PUBLIC WELFARE ASS'N (APWA), NAT'L ASS'N OF STATE UNITS ON AGING (NASUA), A COMPREHENSIVE ANALYSIS OF STATE POLICY AND PRACTICE RELATED TO ELDER ABUSE, at vii–viii (1986) (indicating that the total number of reports of suspected or alleged abuse or neglect increased significantly since the release of the 1981 House Report); HELEN O'MALLEY ET AL., LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, ELDER ABUSE IN MASSACHUSETTS: A SURVEY OF PROFESSIONALS AND PARAPROFESSIONALS (1979); Elizabeth E. Lau & Jordan I. Kosberg, *Abuse of the Elderly by Informal Care Providers*, AGING, Sept.–Oct. 1979, at 10.

2. *See* Joanne Steuer & Elizabeth Austin, *Family Abuse of the Elderly*, 28 J. AM. GERIATRICS SOC'Y 372, 372 (1980).

3. *See* Karl A. Pillemer & David Finkelhor, *The Prevalence of Elder Abuse: A Random Sample Survey*, 28 GERONTOLOGIST 51–57 (1988).

4. *Elder Abuse Report*, *supra* note 1, at 1–6.

5. *See infra* notes 35–47 and accompanying text (discussing federal regulation of nursing homes); *infra* notes 48–51 and accompanying text (discussing state regulation of nursing homes).

6. Due to vast underreporting of elder abuse, it is difficult to estimate with much accuracy the exact figures of elder mistreatment. *See Elder Abuse Report*, *supra* note 1, at 42 (estimating that approximately one in eight cases of elder abuse are reported); Pillemer & Finkelhor, *supra* note 3, at 51 (estimating that around one in fourteen cases of elder mistreatment are reported); Lori Smith, *The Abuse of Vulnerable Adults: Examining the Damage Done to Our Elders*, MONT. LAW., June–July

A poignant article from the *St. Louis Post-Dispatch* illustrates the pervasiveness of elder abuse in long-term care facilities and the inability of governmental agencies to appropriately address the problem.[8] The article reported that "[i]n the last two years, at least 19 people have died in Missouri nursing homes and care centers because of abysmal treatment or indifference."[9] In response, the state agency charged with enforcement of quality of care standards, the Missouri Division of Aging, sought no fines against eight facilities, imposed minimal monetary fines against six facilities, and pursued seizure of an operating license against only two facilities.[10] According to Andrea Roth, head of the Missouri Division of Aging, from October 1997 to February 2000, the agency did not pursue fines or other penalties in most of these cases because it is an "expensive and time-consuming" process.[11] Phyllis Krambeck, vice president of the Missouri Coalition for Quality Care, succinctly summarized the situation, "'They're old, they're expected to die and they die[,] . . . I don't think anyone looks into it that much.'"[12]

This note explores the legal issues that surround the unfortunate and disturbing reality of elder abuse in long-term care facilities. It argues that the current system of governmental regulation and criminal prosecution is ineffective to deter and punish rampant and persistent abuse of the elderly.[13] The background section will discuss the growth of the elderly population and the corresponding expansion of elder abuse. It will then describe the current regulatory framework employed by the government to enforce standards of care against long-term care facilities. The analysis section considers the effectiveness of regulatory mechanisms before extolling the utility of the private cause

2001, at 27 (finding that only "twenty-one percent of elder abuse incidents are reported and investigated while a staggering seventy-nine percent" are unreported and uninvestigated).

7. *See Elder Abuse Report*, *supra* note 1, at 3–4.

8. Phillip O'Connor, *Aging Dangerously: Inadequate Care in Missouri Nursing Homes*, ST. LOUIS POST-DISPATCH, Aug. 5, 2001, at A1.

9. *Id.* at 2. Ten of the deaths occurred in nursing homes in the St. Louis area, while nine occurred outside of St. Louis. *Id.*

10. *Id.* at 1–2. In the two homes where the state Division of Aging pursued seizure of the operating license there were five deaths. *Id.* at 2.

11. *Id.* at 4–5.

12. *Id.* at 3.

13. While the term "long-term care" encompasses a variety of issues, this note is only concerned with the nursing home context. "Nursing home" encompasses facilities under operation by a private corporation, federal or state government, or those operated as a for-profit corporation or charitable institution.

of action to remedy elder abuse. The recommendations section poses alternative concepts designed to bolster the rights of the elderly against their abusers and deter future occurrences of mistreatment.

II. Background: The Governmental Regulatory System in the Long-Term Care Industry, Protecting the Elderly from Mistreatment, Abuse, and Neglect

Nursing homes have taken on a vital role in the vast American health care system.[14] The development of Medicare[15] and Medicaid[16] programs in 1965 initiated a broad expansion in the number of nursing homes.[17] Driven by for-profit chains, nursing homes began to charge residents fees[18] in return for medical care, food, shelter, and round-the-clock assistance for individuals incapable of caring for themselves.[19] By 1987, approximately 14,000 nursing homes were in operation with over 1.3 million residents.[20] As of 1998, roughly 17,000 nursing homes were in operation in the United States with over 1.6 million residents.[21]

14. *See generally* David A. Bohm, *Striving for Quality Care in America's Nursing Homes: Tracing the History of Nursing Homes and Noting the Effect of Recent Federal Government Initiatives to Ensure Quality Care in the Nursing Home Setting*, 4 DEPAUL J. HEALTH CARE L. 317 (2001) (providing a more thorough analysis of the history of the nursing home in American society).

15. 42 U.S.C. § 1395 (1994). Medicare is generally considered the program that cares for the elderly, and is administered by the federal government. *See generally id*.

16. Codified at 42 U.S.C. § 1396 (1994). Medicaid, generally considered the program that cares for the poor, is administered by each individual state. *See generally id.*

17. *See* BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 113 (3d ed. 1997). In 1997, Medicare and Medicaid programs contributed nearly $28 billion dollars to nursing homes. *See* SPECIAL COMM. ON AGING, U.S. GEN. ACCOUNTING OFFICE, CALIFORNIA NURSING HOMES: CARE PROBLEMS PERSIST DESPITE FEDERAL AND STATE OVERSIGHT 1 (1998) [hereinafter GAO REPORT].

18. *See Nursing Homes: When a Loved One Needs Care*, CONSUMER REPORTS, August 1995, at 519 [hereinafter *When a Loved One Needs Care*]. Nearly seventy percent of all nursing homes are investor-owned. *Id*. One particular nursing home, Beverly Enterprises, operates more than 700 nursing homes and reports annual revenues of approximately $3 billion. *Id.*

19. Theresamarie Mantese & Gerard Mantese, *Nursing Homes and the Care of the Elderly*, 51 J. MO. B. 155, 156 (1995).

20. 79 METROPOLITAN LIFE INS. CO. STAT. BULL., Apr. 15, 1998, *available at* 1998 WL 13261609 (information derived from the 1987 National Medical Expenditure Survey "Institutional Population Component" and the 1996 "Nursing Home Component" of the Medical Expenditure Panel Survey).

21. *Id.* According to some estimates, there are now more than 20,000 nursing homes. *See, e.g., When a Loved One Needs Care, supra* note 18, at 518; *see also* Robert

As the demand for nursing home beds rises, the corresponding need for increased quality of care will rise as well. Quality nursing home services remain essential to meet the growing demands of the elderly population.[22] Annually, at least 1.5 million Americans are admitted to nursing homes, and it is projected that by 2030 persons above the age of sixty-five will comprise twenty percent of the total U.S. population, compared to thirteen percent in 1990.[23] Despite these staggering numbers, it remains essential that the long-term care industry not prioritize quantity, in the interest of maximum profit, at the expense of quality care.

A. Elderly Dependency, Vulnerability, and the Need for Quality Care

Nursing home residents are among the most vulnerable groups in American society due to their age, physical and mental ability, financial status, and medical conditions.[24] The impact of physical, psychological, and financial mistreatment against the elderly by caretak-

N. Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 304 (1975). In 1997, there were more than 17,000 nursing homes in the United States with over 1.7 million beds. GAO REPORT, *supra* note 17, at 1. Seventy-five percent of these homes are operated for profit, and annual revenue is more than 7 billion dollars. Brown, *supra,* at 304–05. It is estimated that by 1995, nearly $77.9 billion was spent on nursing homes. *See* Katherine R. Levit et al., *National Health Expenditures*, 18 HEALTH CARE FIN. REV. 175, 189 (1996).

22. *See* GAO REPORT, *supra* note 17, at 1; *see also* Beatrice S. Brown, *Long-Term Care and the Challenge of an Aging America: An Overview*, 1 QUINNIPIAC HEALTH L.J. 113, 113 (1997) [hereinafter *Long-Term Care Overview*] (finding that since 1900, the percentage of the American population reaching age sixty-five and older has tripled, from 4.1 percent in 1900 to 12.8 percent in 1995, with the absolute number of seniors increasing nearly eleven times, from 3.1 million to 33.5 million).

23. AM. ASS'N OF RETIRED PERSONS, A PROFILE OF OLDER AMERICANS, http://research.aarp.org/general/profile97.html#table 1 (last visited Jan. 18, 2002). In 1990, one out of every eight persons in the United States was sixty-five years old or older, however, it has been estimated that by the year 2050, one out of every five will be sixty-five years of age or older. U. S. BUREAU OF THE CENSUS, STATISTICAL BRIEF: SIXTY-FIVE PLUS IN THE UNITED STATES (1995). Since 1997, persons eighty-five and older comprise the fastest-growing age group, while persons one-hundred and over comprise the second-fastest growing age group. *Long-Term Care Overview*, *supra* note 22, at 113.

24. Mantese & Mantese, *supra* note 19, at 156. Nursing home patients present a particular problem due to their age (average of eighty-two); failing health (average of four disabilities for each resident); mental disabilities (approximately fifty-five percent are mentally impaired); reduced physical mobility (approximately fifty percent cannot walk); sensory impairment, including loss of hearing, vision, and smell; reduced tolerance to heat smoke and gases; and greater susceptibility to shock. *See* Kira Anne Larson, Note, *Nursing Homes: Standards of Care, Sources of Potential Liability, Defenses to Suit, and Reform*, 37 DRAKE L. REV. 699, 711–12 (1988).

ers is much greater than upon most other segments of society.[25] Many elderly residents have physical and mental disabilities that inhibit them from effectively communicating, making it extremely difficult to ask for assistance or to retain legal counsel to seek redress for mistreatment.[26] As a result, victims of elder abuse are often defenseless against their abusers and are forced to rely on the government regulatory system for protection.[27]

B. Governmental Regulation of the Long-Term Care Industry: The Search for a Standard of Care

The long-term care industry is one of the most heavily regulated industries in the United States.[28] Governmental agencies subject the facilities to a wide array of federal and state statutes, regulations, and rules that control virtually every aspect of the nursing home, including the medical treatment provided to the residents, the residents' rights, and the residents' activities.[29] Long-term care facilities must be licensed by the states in which they are located[30] and are required to enter into provider agreements and obtain federal certification to participate in federal Medicare and joint federal/state Medicaid programs.[31]

The Federal Health Care Financing Administration (HCFA) is responsible for both Medicare and the federal aspect of Medicaid and

25. *See* ROBERT J. SMITH, CRIME AGAINST THE ELDERLY: IMPLICATIONS FOR POLICYMAKERS AND PRACTITIONERS 18–21 (1979); *see also* Joan N. Scott, *Senior Citizens Present a Special Case*, JUDGES J., Summer 1982, at 19.

26. Jordon I. Kosberg, *Victimization of the Elderly: Causation and Prevention*, 10 VICTIMOLOGY 376, 377 (1985).

27. *Id.*

28. *See* Joseph L. Bianculli, *Developments in Long-Term Care and Assisted Living*, 700 PRACTISING L. INST. 307, 317 (1994), 700 PLI/Comm. 307.

29. *See generally* Omnibus Reconciliation Act of 1987 (OBRA 1987), Pub. L. No. 100-203, 101 Stat. 1330-179, 1330-182 (1987) (codified at 42 U.S.C. §§ 1395i-3(a)-(h), 1396r(a)-(h) (1994)). Under the Preadmission Screening and Annual Resident Review (PASARR) provision of OBRA 1987, states must screen mentally ill persons before nursing home admission to determine each person's level of care to be provided, review and determine at least annually whether resident's physical and mental condition requires services provided by the nursing facility or by inpatient psychiatric hospital or another institution, and review and determine at least annually whether nursing facility residents need specialized services for mental illness. 42 U.S.C. § 1396r(e)(7) (1994).

30. 42 U.S.C. §§ 1395i-3(e), (f), (h)(2)(C)(i).

31. *Id.* §§ 1395i-3(g), 1396(r). Specific legislation covers provider violations for quality care standards under Medicare and Medicaid programs. *See generally id.* § 1320a-7.

carries the ultimate responsibility for enforcement of federal health and safety regulations.[32] Each state provides a survey agency that performs annual inspections of nursing facilities on behalf of the state to ensure compliance with licensing standards and also on behalf of the HCFA.[33] These agencies conduct surveys on behalf of the federal government for initial certification and continued participation in Medicare and Medicaid,[34] and in response to complaints about a facility.[35] Facilities found performing below the minimum level of compliance are subject to fines and penalties that can be imposed both by the state[36] and federal government,[37] including loss of license and loss of eligibility to receive Medicare and Medicaid funds.[38]

1. FEDERAL STATUTORY ENFORCEMENT OF STANDARDS OF CARE

In an effort to address the growing problem of elder abuse, Congress, in 1974, passed the Nursing Home Bill of Rights as a condition to nursing home acceptance of Medicare and Medicaid funds.[39] In 1987, Congress expanded the scope of federal regulation in the long-term care industry when it passed the Federal Omnibus Budget Reconciliation Act (OBRA 1987).[40] OBRA 1987 replaced a program concerned only with the delivery and results of care with a system that requires surveyors to more closely analyze the facility operations to determine whether residents receive appropriate levels of care—namely, quality care.[41] In general, OBRA 1987 mandates that facilities support individual needs and preferences and promote or maintain

32. Civil Money Penalties for Nursing Homes (SNF/NF), 64 Fed. Reg. 13354–62 (Mar. 18, 1999) (codified at 42 C.F.R. § 488.402 (2001)); *see also* GAO REPORT, *supra* note 17, at 22.

33. 42 U.S.C. §§ 1395i-3(e), (h)(2)(C)(i); 42 C.F.R. § 431.115 (2001).

34. 42 U.S.C. §§ 1395i-3(e), (h)(2)(C)(i), (g); 42C.F.R. § 431.153(k).

35. 42 U.S.C. § 1395i-3(g)(1)(C).

36. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1507 (West 1998).

37. *See* GAO REPORT, *supra* note 17, at 5.

38. *See id.*

39. Charles A. Lattanzi, *Nursing Home Contracts: Is It Time for Bad Faith to Come Out of Retirement*, 6 J.L. & HEALTH 61, 74 (1991).

40. 42 U.S.C. §§ 1395i-3(a)–(h), 1396r(a)–(h). OBRA 1987 is collectively known as the "Nursing Home Reform Act."

41. *Id.* §§ 1395i-3(a)–(h), 1396r(a)–(h). Under OBRA 1987, nursing facilities must initially and periodically conduct a thorough assessment of each resident's functional capacity, develop a comprehensive care plan, and design measurable objectives and timetables to meet each resident's medical, nursing, and mental and psychosocial needs. *Id.* §§ 1395i-3(b)(1)(A), (b)(2), 1396r(b)(1)(A), (b)(2).

the highest quality of life, which includes the physical, mental, and psychosocial well-being of each resident.[42]

The Residents' Bill of Rights delineates the minimum requirements for the care of residents in skilled nursing facilities.[43] The statute provides that "[a] skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident."[44] The facility must make available upon admission, both orally and in writing, the residents' legal rights and the services available in that facility, all entitlement requirements for benefits to which the residents may be eligible, complaint procedures, and notification procedures.[45] Moreover, facilities are required to provide policies and practices regarding transfer, discharge, and covered services that apply identically to all residents.[46]

The Bill of Rights is intended to place nursing homes on notice. First, every resident has the same right to a dignified existence in the home. Second, every home is responsible to ensure that each resident is accorded this right.[47] Accordingly, facilities must not require the resident to waive any rights under Medicare or Medicaid or a third

42. *Id.* §§ 1396r(b)(1)(A), (2), 1395i-3(b)(1)(A), (b)(2). A number of years after the passage of OBRA 1987, Congress, in 1990, passed measures to specifically define the requirements for states and long-term care facilities. 42 C.F.R. §§ 483.1 (1995). In 1995, Congress attempted to strengthen OBRA 1987's enforcement mechanism by specifying compliance standards for long-term care facilities with deficiencies. *Id.* § 488.40.

43. *See* 42 U.S.C. § 1395i-3(c)–(h). The Residents' Bill of Rights provides that residents have a freedom of choice to choose a personal physician and to participate in and be informed about any changes in their own care and treatment. *Id.* § 1395i-3(c)(1)(A)(i). Residents also have a right of privacy in their own "accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups." *Id.* § 1395i-3(c)(1)(A)(iii). Residents can refuse certain transfers to another room, and they must be able to remain in the facility unless their condition improves or such a transfer is necessary for the resident's welfare. *Id.* § 1395i-3(c)(2)(A). Strict confidentiality is to be observed with regard to all personal and clinical records. *Id.* § 1395i-3(c)(1)(A)(iv). All residents will be able to voice any grievances about their care and treatment without fear of discrimination or reprisal. *Id.* § 1395i-3(c)(1)(A)(vi). Residents are free to participate in resident and family groups; to participate in social, religious, and community activities; and to receive visits from the state Ombudsmen's Office, legal services, health services, or other residential services. *Id.* § 1395i-3(c)(1)(A)(vii), (viii), (ix), (3)(D). Residents also have the right to examine the results of any surveys pertaining to the facility and any corrections directed by the Secretary. *Id.* § 1395i-3(c)(1)(A)(ix).

44. *Id.* § 1395i-3(b)(1)(A).

45. *Id.* § 1395i-3(c)(1)(B).

46. *Id.* § 1395i-3(c)(4).

47. *See generally id.* § 1395i-3.

party guarantee of payment as a condition of admission.[48] Moreover, OBRA 1987 provides the resident with the following rights: the freedom to choose a physician, the right to be free from restraints, privacy, confidentiality, the right to receive reasonable accommodation of individual needs, the right to voice grievances, the right to participate in other activities, the right to review survey results, and the right to refuse transfer.[49] Although federal regulations broadly define a residents' rights, such rights never get beyond words on paper without imposition of an effective enforcement mechanism.

2. STATE INITIATIVES TO ENFORCE THE RIGHTS OF THE ELDERLY

In addition to federal statutes, most states have passed legislation to provide increased protection and expanded legal remedies for the elderly.[50] These laws recognize that the elderly are more susceptible to abuse, neglect, and exploitation than the general population.[51] Much like the federal regulatory system, many state statutes incorporate a Nursing Home Resident's Bill of Rights, which guarantees protection against certain violations by the nursing home.[52] Currently, at least twenty states have enacted statutes that create a private right of action for elderly mistreatment, abuse, and neglect.[53]

3. CRIMINAL PENALTIES FOR ELDER ABUSE AND MISTREATMENT

In addition to providing elderly victims with a civil remedy, many states have sought to confront elder abuse through imposition

48. *Id.* § 1395i-3(c)(5)(A)(i)–(ii).
49. *Id.* § 1395i-3(c)(1)(A)(i)-(x).
50. *See, e.g.*, FLA. STAT. ANN. §§ 400.011–.335 (West 1998 & Supp. 2002); GA. CODE ANN. § 31-8-126 (2001); MASS. GEN. LAWS ANN. ch. 111, § 70E (West 1996 & Supp. 2001).
51. *See* Friedman v. Div. of Health, 537 S.W.2d 547, 548–49 (Mo. 1976).
52. *See, e.g.*, FLA. STAT. ANN. § 400.022 (West 1998 & Supp. 2002); LA. REV. STAT. ANN. § 40:2010.8(A)-(E) (West 2001); MASS. GEN. LAWS ANN. ch. 111, § 70E.
53. *See* CAL. WELF & INST. CODE § 15600 (West 2001); CONN. GEN. STAT. ANN. § 19a-550(b) (West 1997 & Supp. 2001); D.C. CODE ANN. § 44-105.09 (2001); FLA. STAT. ANN. § 400.023 (West 1997 & Supp. 2001); GA. CODE ANN. § 31-8-126; HAW. REV. STAT. § 657-73 (2001); 210 ILL. COMP. STAT. 45/3-601 (2000 & Supp. 2001); IND. CODE § 12-10-17-20 (2001); LA. REV. STAT. ANN. § 40:2010.9 (West 2001); MASS. GEN. LAWS ANN. ch. 111, § 70E; MICH. COMP. LAWS § 333.21772 (1996 & Supp. 2001); MO. REV. STAT. § 198.093 (West 1996 & 2001); N.H. REV. STAT. ANN. § 151:30 (2001); N.J. STAT. ANN. § 30:13-8 (West 2001); N.Y. PUB. HEALTH LAW § 2801-d(1) (McKinney 2001 & 2002); N.C. GEN. STAT. § 14-322 (2001); OHIO REV. CODE ANN. §§ 3721.17(I), 3721.19 (Anderson 1980 & Supp. 2001); OKLA. STAT. tit 63, §§ 1-1918(f), 1-1939 (2001); WASH. REV. CODE ANN. § 70.124.020 (West 2001); W. VA. CODE § 16-5C-15 (2000); WIS. STAT. ANN. §§ 50.10, 50.11 (West Supp. 2001).

of criminal sanctions. State statutory criminal provisions are typically designed to criminalize attempts to exploit the particular vulnerabilities of the elderly.[54] Some state statutes define elder abuse, neglect, and financial exploitation with specificity and as punishable by clearly articulated criminal penalties.[55] However, among state statutes there is very little consistency.[56] A number of states merely define elder abuse in very general terms and set minimum age specifications for protection.[57] Other states focus their attention on the caregiver when defining criminal sanctions.[58] While at times inconsistent and confusing, state criminal statutes can serve as an effective deterrent against elder abuse.

III. Analysis: The Failure of Governmental Regulatory Efforts to Adequately Define and Enforce Standards of Care in the Long-Term Care Industry Necessitates Reinforcement of a Resident's Private Cause of Action

A. The Federal Regulatory System Has Proven Incapable of Effective Enforcement of Standards of Care in the Long-Term Care Industry

Although OBRA 1987 identifies numerous fines and penalties designed to ensure compliance, its effectiveness is highly dependent on the level of commitment exercised by those responsible for en-

54. *See generally* NAT'L CTR. ON ELDER ABUSE, AN ANALYSIS OF STATE LAWS ADDRESSING ELDER ABUSE, NEGLECT, AND EXPLOITATION (1995) (listing prohibited behavior as defined by state laws that cover elder abuse).

55. *See, e.g.*, LA. REV. STAT. ANN. § 14:93.3(A) (criminalizing mistreatment of elderly in nursing homes); MASS. ANN. LAWS ch. 265, § 38 (prohibiting by criminal penalty knowing and willful abuse, mistreatment, or neglect of a patient or resident of a nursing home); TENN. CODE ANN. § 71-6-117 (1995) (stating, "It is unlawful for any person to willfully abuse, neglect or exploit any adult within the meaning of the provisions of this part. Any person who willfully abuses, neglects or exploits a person in violation of the provisions of this part commits a Class A misdemeanor."); WYO. STAT. ANN. § 35-20-109 (Michie 2001) (stating, "A person who abuses, neglects, exploits or abandons a disabled adult is guilty of a misdemeanor and upon conviction shall be fined not more than one thousand dollars.").

56. *See generally* NAT'L CTR. ON ELDER ABUSE, *supra* note 54.

57. *See generally id.*

58. MD. ANN. CODE art. 27, § 35D(b)(1) (1996 & Supp. 2001) (defining a caregiver as "a person who has permanent or temporary care or responsibility for the supervision of a vulnerable adult."); N.D. CENT. CODE § 12.1-31-07(1)(a) (1997) (specifying that a caregiver includes someone who assumes responsibility for a disabled or vulnerable adult).

forcement—namely, the HCFA and the individual states. Recent reports and commentaries indicate that OBRA 1987's enforcement procedures are not sufficiently employed by the HCFA and, thus, do not serve their intended purpose.[59] The GAO Report, submitted to the Special Committee on Aging, concluded that the HCFA's enforcement policies and use of sanctions are ineffective to ensure that nursing homes are in compliance with federal regulations, because the HCFA seldom imposes any sanctions.[60] Although the GAO report focuses specifically on California nursing homes, the findings indicate that repeated serious violations are "more common nationally than in California."[61]

In addition to the failure of OBRA 1987's compliance mechanisms, the GAO Report indicates that grace periods extended by the HCFA encourage nursing homes to continue operations in noncompliance with federal regulations and run the risk that serious harm will be inflicted on their residents.[62] Termination of nursing homes' participation in Medicare and Medicaid for serious and repeated violations is extremely rare and appears to be a hollow threat.[63] As a result, nursing homes cited with deficiencies fail to correct the problems, most likely because they have confidence that the HCFA will not impose or enforce any sanctions for noncompliance.[64]

59. *See* George S. Ingalls et al., *Elder Abuse Originating in the Institutional Setting*, 74 N.D. L. REV. 313, 321 (1998). Although regulatory remedies are specified in OBRA 1987, they are based on sporadic survey results that are difficult to enforce effectively and uniformly. *See id.*

60. GAO REPORT, *supra* note 17, at 4. The GAO report reviewed the records of 122 nursing homes cited repeatedly for mistreatment of the elderly and found that seventy-three percent were not federally sanctioned. *Id.* at 22–23. Additionally, the GAO report found that in California nursing homes the HCFA considered to have the highest number of serious deficiencies that threatened the health and safety of the residents, only half were ever sanctioned. *Id.* at 24.

61. *Id.* at 23. Although OBRA 1987 requires that nursing homes provide a standard of care conducive to "protect the health, safety, welfare, and rights of residents" the reports indicate that the objective of OBRA 1987 is not being enforced by the regulatory mechanism and, therefore, is not being met. *Id.* at 22.

62. *Id.* at 24–26. The House Budget Committee thought that by permitting the state to assess civil monetary penalties of up to $10,000 per day, for each noncompliance with a standard of care, nursing homes would comply with federal regulations. H.R. 391, 100th Cong. (1987). However, this result was never achieved as nursing homes learned that they could avoid the penalties if violations were corrected within a designated time period. *See* GAO REPORT, *supra* note 17, at 27–28.

63. *See* GAO REPORT, *supra* note 17, at 27 (finding that out "of sixteen homes terminated from 1995 to 1998, fourteen have been reinstated, . . . [e]leven of which were reinstated with the same ownership").

64. *See* Robert Tomsho, *Old Problem: A Trail of Complaints Slows but Can't Stop Nursing-Home Mogul*, WALL ST. J., Sept. 3, 1997, at A1 (stating that the current sys-

The GAO Report further indicates that the federal government, specifically the HCFA, is incapable of adequately and effectively surveying, inspecting, and enforcing standards of care against long-term care facilities.[65] The exceptionally tolerant approach of "substantial compliance,"[66] coupled with inadequate enforcement by the HCFA, allows nursing homes to operate with little incentive and motivation to comply with regulations and provide residents with mandated standards of quality care.[67] Indeed, the federal process designed to ensure enforcement of standards of care and provide for the health and safety of the elderly is failing in its mission.[68]

B. State Regulatory Measures Are Too Complex and Inconsistent to Be Effective Enforcement Measures

Although a variety of state regulatory statutes are intended to protect the elderly from mistreatment, they have been largely unsuccessful. While state statutes generally list definitions of abuse, neglect, and exploitation, they contain myriad specific sections regarding protected classes, mandatory reporting of suspected abuse and neglect,[69] definitions of reportable behavior, guidelines for investigations of reports, and a variety of other subjects.[70] These numerous provisions make it extremely difficult for an elderly resident to understand their

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tem of monitoring 17,000 nursing home is an ineffective method for enforcing regulations); *see also* John Pray, Note, State v. Serebin*: Causation and the Criminal Liability of Nursing Home Administrators*, 1986 WISC. L. REV. 339, 359. (finding that in the past, regulatory enforcement mechanisms were not employed very often because the only available remedies were drastic, such as closing the facility).

65. William J. Scanlon, Testimony Before the Special Committee on Aging, U.S. Senate (July 28, 1998) (transcript available in the General Accounting Office).

66. *Id.*

67. *See* 42 U.S.C. § 1395i-3(h)(3) (1994).

68. *See generally* GAO REPORT, *supra* note 17.

69. *See generally* Audrey Garfield, Note, *Elder Abuse & the States' Adult Protective Services: Response Time for Change in California*, 42 HASTINGS L.J. 859, 874–85 (1991).

70. *See* WASH. REV. CODE ANN. § 74.34.020(2) (West 2001) (The definition of abuse in Washington State is "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation or punishment on a vulnerable adult."); *see also* ARIZ. REV. STAT. ANN. § 46-451(A)(1) (West 1997) (Arizona defines abuse as the: "(a) Intentional infliction of physical harm; (b) Injury caused by negligent acts or omissions; (c) Unreasonable confinement; or (d) Sexual abuse or sexual assault"); CAL. WELF. & INST. CODE § 15610.07 (West 1998) (California law defines elder abuse as "physical abuse, neglect, fiduciary abuse, abandonment, isolation or other treatment with resulting physical harm or pain or mental suffering. The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.").

rights, let alone identify when they have a cause of action for mistreatment.

Further complicating the situation, no common definition of elder mistreatment exists among state statutory provisions.[71] Under state statutes, prohibited conduct may include acts of commission or omission, intentional or inadvertent mistreatment, and malice or recklessness.[72] Other relevant provisions can be found in penal provisions or domestic violence laws.[73] And while some states have specific elder abuse statutes,[74] many states use generic Adult Protective Services laws to define elder mistreatment.[75] This vast state regulatory labyrinth serves the unintended purpose of discouraging elderly residents from pursing statutory redress to enforce their rights against nursing home caretakers.

C. The Failure to Prosecute for Criminal Mistreatment of the Elderly

Despite the potential for criminal sanctions to hold abusers accountable for their actions, prosecution under the various states' criminal statutes is very rare.[76] This occurs for a number of reasons. The most discouraging include: lack of time, resources, or experience; low expectation of conviction due to high standards of proof; problems with establishing causation; inability of victims to participate in trial due to poor health, loss of memory, or death; and a belief that

71. *See* Garfield, *supra* note 69, at 872–74. Whether behavior is labeled as abusive or as neglectful may depend on the frequency of the mistreatment, its duration, intensity, and severity. *See id.*

72. *See, e.g.*, CAL. WELF. & INST. CODE § 15610.07; ARIZ. REV. STAT. ANN. § 46-451(A)(7); N.Y. PUB. HEALTH § 2801-d(1)–(10) (McKinney 2001); MO. ANN. STAT. § 198.093 (Vernon 1983 & Supp. 1994).

73. *See, e.g.*, 720 ILL. COMP. STAT. ANN. 5/12-21 (West 1996) (penal statute).

74. *See, e.g.*, FLA. STAT. ANN. § 415.102(20) (West 1998).

75. *See* Garfield, *supra* note 69, at 872.

76. *See* Charles B. Schudson et al., *Nailing an Omelet to the Wall: Prosecuting Nursing Home Homicide*, *in* CORPORATIONS AS CRIMINALS 130, 135 (E. Hochstedler ed., 1984). In 1999, Missouri's Department of Social Services received about 7,400 complaints of nursing home regulation violations and other institutional services. *See* MO. OFFICE OF STATE AUDITOR, REVIEW OF THE DIVISION OF AGING'S MONITORING OF NURSING HOMES AND HANDLING OF COMPLAINT INVESTIGATIONS, 2000 AUDIT REPORT 13, *available at* http://www.auditor.state.mo.us/press/2000-13.pdf. Of these 5,591 reports received in total, twenty-three cases were opened for criminal investigation for patient abuse and fifty-eight were opened for fraud. *See* 1997 ATT'Y GEN. ANN. REP. 40.

nursing home problems are more effectively resolved through regulatory measures or civil actions.[77]

If the criminal justice system has any hope of success in the fight against elder abuse, the system must take into account the unique vulnerability of the elderly and the apparent reluctance of the victim to report mistreatment.[78] Moreover, the criminal justice system must adequately train and educate police and other law enforcement authorities about the unique issues involved in elder mistreatment. In the absence of effective law enforcement and reporting mechanisms to combat elder abuse, criminal prosecution will continue to be ineffective in the fight against elder abuse. Until that time, residents may seek to enforce their rights against long-term care facilities under a number of private causes of action.

D. Enforcement of Standards of Care Through Effective Allocation of Accountability: The Role of the Individual Resident and the Private Cause of Action

Elderly residents have sought to enforce their rights in a private cause of action against long-term care facilities under a number of different legal theories. Although this note focuses primarily on resident suits for unintentional torts, it is important to note that residents have brought claims against nursing homes based on a variety of legal theories, including breach of contract,[79] the False Claims Act,[80] and state unfair trade laws.[81] Other theories utilized by nursing home

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77. *See* Pray, *supra* note 64, at 359; *see also* Schudson et al., *supra* note 76, at 135.

78. *See supra* notes 24–27 and accompanying text.

79. *See* Smith v. Silver Spring-Wheaton Nursing Home, Inc., 220 A.2d 574, 579 (Md. 1966). The court found that defendant nursing home did not breach its contractual duty to provide adequate supervision and care of plaintiff. *See id.*; Dunahoo v. Brooks, 128 So. 2d 485, 486, 488 (Ala. 1961). *See generally* Brown v. Univ. Nursing Home, Inc., 496 S.W.2d 503 (Tenn. App. 1972). In holding that the duty imposed on the defendant nursing home was the same duty expressed in the contract, the court stated that "the measure of this duty is that degree of care, skill and diligence which is used by Nursing Homes generally in this community." *Id.* at 509 (citing Thompson v. Methodist Hospital, 367 S.W.2d 134 (1963); Perkins v. Park View Hospital, 456 S.W.2d 276 (1970)).

80. *See* 31 U.S.C. § 3279 (1994).

81. *See* Diane Horvath & Patricia Nemore, *Nursing Home Abuses as Unfair Trade Practices*, 20 CLEARINGHOUSE REV. 801, 802 (1986). Theories based on unfair trade laws have been successful in a number of cases, but have not been widely pursued. *Id.* at 804–05. In general, remedies are limited by the damages available and the inconsistencies between the various state statutes. *Id.* A majority of states exempt regulated practices, which would likely include a nursing home's regulations. *Id.* Statutes in twenty-six states limit private litigants to injunctive relief,

residents include state statutory causes of action, intentional torts,[82] malpractice, and negligence.[83]

1. STATE STATUTES PROVIDE RESIDENTS WITH A CAUSE OF ACTION

Although federal law does not give nursing home residents an explicit right of action to enforce compliance with federal regulations, Congress, in enacting OBRA 1987, specifically stated that federal enforcement procedures did not preempt states from adopting statutes to address mistreatment of the elderly.[84] States realized that the protections provided for in OBRA 1987 and the HCFA regulations were not effective enough to ensure that nursing home residents maintained a quality life, free from abuse and neglect.[85] The answer was to encourage private suits through the creation of a state statutory cause of action.[86] States sought to further aid private litigants through provision of a common prohibition against mistreatment, typically characterized as abuse or neglect.[87] Where a state statute does not effectively provide the appropriate cause of action, other civil remedies are available.

while the damage amounts allowed, even under the more liberal laws, range from between $25 and $2,000. *Id.* at 809.

82. Although not specifically addressed here, the claim of false imprisonment has been employed by residents in nursing home suits. *See generally* Cathrael Kazin, *'Nowhere to Go and Chose to Stay': Using the Tort of False Imprisonment to Redress Involuntary Confinement of the Elderly in Nursing Homes and Hospitals*, 137 U. PA. L. REV. 903 (1989).

83. *See supra* note 76, *infra* notes 102–03 and accompanying text.

84. *See* 42 U.S.C. § 1395i-3(h)(5). Congress stated, "The remedies provided . . . are in addition to those . . . available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law." *Id.* § 1395i-3(h)(5).

85. *See* Steven M. Levin, *Protecting the Rights of Nursing Home Residents Through Litigation*, 84 ILL. B.J. 36, 36–37 (1996).

86. *See, e.g.*, CAL. WELF. & INST. CODE § 15600 (West 2001 & Supp. 2002); Illinois Nursing Home Care Act, 210 ILL. COMP. STAT. ANN. 45/1-101 (2000). "The [Illinois Nursing Home Care Act] is one of the few Illinois legislative enactments of the last 20 years to explicitly encourage victims of negligence and abuse to pursue civil remedies." Levin, *supra* note 85, at 36.

87. *See* 42 U.S.C. §§ 3022–3030(g) (1997); 42 U.S.C. §§ 3002(13)(A-B), (24), (34)(A-B) (1994). Other common elements include nonaccidental physical injury, sexual molestation, emotional or mental abuse, financial exploitation, and neglect. *See, e.g.*, ARK. CODE ANN. § 5-28-101(3)(A) (Michie 1997); CAL. WELF. & INST. CODE § 15610.07 (West Supp. 2002); IDAHO CODE § 39-3516(10) (1998 & Supp. 2001); MISS. CODE ANN. § 43-47-5(i) (1993); N.Y. SOC. SERV. LAW § 473(6)(a) (McKinney Supp. 2001); NEV. REV. STAT. ANN. § 41.1395(4)(a)(1) (Michie Supp. 2001); N.D. CENT. CODE § 50-25.2-01(1) (1999).

2. SUITS UNDER COMMON-LAW THEORIES OF TORT LIABILITY ILLUSTRATE THE POTENTIAL FOR EFFECTIVE ENFORCEMENT

Entrance into a nursing home strips an elderly individual of his or her personal autonomy.[88] Residents are often isolated, requiring relatives or visitors to demand that the resident receive appropriate medical care.[89] When these requests fall on deaf ears, nursing home residents and their families are left with little recourse but to sue facilities for infringement of personal rights under theories of negligent care. These cases represent only a small percentage of instances where nursing home residents have suffered mistreatment while under the care of nursing facilities.[90] Nevertheless, these cases may serve as an effective mechanism to enforce and improve the standards of care in the long-term care industry.[91]

The failure to meet minimum standards of safety and care on the part of the facility may result in injury to a resident and give rise to grounds for a suit in negligence.[92] Because most residents are in need of assistance with activities of daily living,[93] they must depend on undertrained and underpaid staff who often provide substandard care.[94] Additionally, underfinanced facilities, poor management, and poor staffing place the safety and well-being of each resident in jeopardy.[95]

Where an action or inaction on the part of the facility results in injury to a resident, the resident may file suit against the facility based on theories of intentional or unintentional torts. Some common types of intentional torts utilized in suits against long-term care facilities in-

88. *See generally* Charles W. Lidz & Robert M. Arnold, *Symposium: The Law of Competence, Rethinking Autonomy in Long-Term Care*, 47 U. MIAMI L. REV. 603 (1993).

89. *See* David F. Bragg, *Dealing with Nursing Home Neglect: The Need for Private Litigation*, 39 S. TEX. L. REV. 1, 2 (1997). In Texas, half of nursing home residents have no close relatives in the community, and over half receive no visitors. *Id.* (citing TEX. DEP'T OF HUMAN SERVS., OMBUDSMAN CERTIFICATION MANUAL 17 (1996)).

90. *See, e.g.*, Pillemer & Finkelhor, *supra* note 3 (estimating that around one in fourteen cases of elder mistreatment is reported).

91. *See, e.g.*, Dunahoo v. Brooks, 128 So. 2d 485, 488 (Ala. 1961)

92. *See, e.g.*, *id.*

93. *See* GAO REPORT, *supra* note 17, at 1.

94. *See* Karl Pillemer & Beth Hudson, *A Model Abuse Prevention Program for Nursing Assistants*, 33 GERONTOLOGIST 128, 129–31 (1993).

95. *See* Daniel M. Gitner, *Nursing the Problem: Responding to Patient Abuse in New York State*, 28 COLUM. J.L. & SOC. PROBS. 559, 567 (1995). Underfinancing of nursing facilities generally results in understaffing, low to minimum wages, high staff turnover, and a general lack of resources. *Id.*

clude fraud,[96] assault,[97] battery,[98] and false imprisonment.[99] Under each of these theories, the resident bears the burden of proving the requisite intent on the part of the facility.[100] Where the elderly plaintiff would be unable to establish the requisite intent, but still suffers a cognizable harm, an action may be brought based on an unintentional tort—namely, negligence.[101] To prove negligence, the elderly resident must prove that the defendant failed to act as a reasonable person would in the same or similar circumstances. More specifically, to prevail in a negligence suit, the resident must prove four elements: duty, breach, causation, and damages.[102] To establish each of these elements, the plaintiff will need to contemplate the legal distinctions between theories of malpractice, negligence, res ipsa loquitur, and negligence per se.

a. Malpractice Liability One theory available for residents to enforce their rights against a facility that caused them harm is malpractice. Malpractice is legal fault, a breach of the standard of care in the profession, which caused injury to the plaintiff.[103] In malpractice cases brought against nursing homes, courts have held generally that expert testimony is essential to establish the standard of care against which the behavior of the defendant must be measured.[104] Professionals who fail to diagnose, treat, and report reasonably identifiable cases of elder

96. *See generally* Mark Fajfar, *An Economic Analysis of Informed Consent to Medical Care*, 80 GEO. L.J. 1941 (1992) (discussing the economic consequences of a medical professional's failure to obtain the plaintiff's informed consent); Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137 (1977); Marjorie M. Schultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985); Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise with Ethical Theory*, 65 NEB. L. REV. 749 (1986).

97. *See generally* RESTATEMENT (SECOND) OF TORTS § 21 (1977).

98. *See generally id.* §§ 13, 16, 18.

99. *See generally id.* § 42.

100. *See generally* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW § 6.15 (4th ed. 1992); David J. Jung & David I. Levine, *Whence Knowledge Intent? Wither Knowledge Intent?*, 20 U.C. DAVIS L. REV. 551 (1987).

101. *See generally* Edward Green, *The Reasonable Man: Legal Fiction or Psychosocial Reality?*, 2 LAW & SOC'Y REV. 241 (1968); David E. Seidelson, *Reasonable Expectations and Subjective Standards in Negligence Law: The Minor, the Mentally Impaired, and the Mentally Incompetent*, 50 GEO. WASH. L. REV. 17 (1981).

102. *See generally* Richard A. Posner, *A Theory of Negligence*, 1 J. LEGAL STUD. 29, 38–53 (1972).

103. *See* Bardessono v. Michels, 478 P.2d 480, 484 (Cal. 1970). *See generally* DAVID W. LOUSELL & HAROLD WILLIAMS, MEDICAL MALPRACTICE (1994).

104. Stogsdill v. Manor Convalescent Home, Inc., 343 N.E.2d. 589, 610 (Ill. App. Ct. 1976).

maltreatment should be civilly liable if the failure subsequently leads to injury.[105] Plaintiffs in such cases might be elderly victims who have escaped from an abusive situation, relatives acting on the elder victim's behalf, guardians, or public agencies. However, quite often a malpractice suit is not the best option; a resident may wish to consider enforcing their rights under a negligence theory.

b. Negligence The general standard of care required of a nursing home is the "degree of care, skill, and diligence" used by such homes generally in the community.[106] However, the mere fact that "the nursing care given was 'usual' or customary would not of itself preclude the possibility of negligence."[107] It is sometimes assumed[108] and sometimes expressly held[109] that the rules applicable to a private hospital are also applicable to nursing homes. However, it has been observed that a nursing home is not a hospital, and "[i]t may be that what would be negligence in a hospital because of its greater control over physicians and its more extensive facilities would not be negligence in a nursing home."[110] Thus, the duty of a nursing home in any particular case depends on the specific circumstances and must take into consideration "the capacity of the patient to care for himself."[111]

As a general rule, nursing homes are under a duty to exercise reasonable care to avoid injuries to patients, and the reasonableness of such care is to be determined in light of the patient's known physical

105. "[I]n a suit against a physician, expert testimony is ordinarily required to establish that the injuries suffered by the plaintiff were a result of that want of skill or negligence." *Id.*

106. LeBlanc v. Midland Nat'l Ins. Co., 219 So. 2d 251, 253 (La. Ct. App. 1969); *see also* Dunsine v. Golden Shores Convalescent Ctr., Inc., 249 So. 2d 40, 42 (Fla. Dist. Ct. App. 1971); MacAlpine v. Martin, 205 So. 2d 347, 349 (Fla. Dist. Ct. App. 1967); Collier v. AMI, Inc., 254 So. 2d 170, 173 (La. Ct. App. 1971); Brown v. Univ. Nursing Home, Inc., 496 S.W.2d 503, 509 (Tenn. Ct. App. 1972) (citing Thompson v. Methodist Hosp., 367 S.W.2d 134 (Tenn. 1962)); Perkins v. Park View Hosp., 456 S.W.2d 276) (Tenn. Ct. App. 1970).

107. *Stogsdill*, 343 N.E.2d at 610 (citing Lundahl v. Rockford Mem'l Hosp. Ass'n, 235 N.E.2d 671 (Ill. App. Ct. 1968)). "It is entirely possible . . . that what is usual and customary may itself be negligence." *Id.* at 610 (citing Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253 (Ill. 1965)).

108. *See MacAlpine*, 205 So. 2d at 349; *LeBlanc*, 219 So. 2d at 253.

109. *See* Murphy v. Allstate Ins. Co., 295 So. 2d 29, 34–35 (La. Ct. App., 1974), *cert. denied*, 299 So. 2d 787 (La. 1974); Collier v. AMI, Inc., 254 So. 2d 170, 174 (La. Ct. App., 1971).

110. *See Stogsdill*, 343 N.E.2d. at 610, 612.

111. *MacAlpine*, 205 So. 2d at 349; *see also LeBlanc*, 219 So. 2d at 253.

and mental condition.[112] The resident plaintiff may seek to establish breach of such a standard through the use of an expert witness. Such testimony may be used to show that the injuries sustained by the resident were a result of the home's failure to use such care.[113]

Where the facts of a particular case lend themselves to application of the "common-knowledge" or "gross-negligence" standard, expert testimony may not be necessary.[114] For example, in *Juhnke v. Engelical Lutheran Good Samaritan Society*, the plaintiff, a resident of the Hutchinson Good Samaritan Center, was injured after being struck by another resident who the staff knew to be physically harmful to others.[115] The court applied the common-knowledge exception to the requirement for expert testimony.[116] In doing so, the court held that "[t]he primary purpose of expert testimony is to establish the community standards for the benefit of the trier of fact when the facts are somewhat alien in terminology and the technological complexities would preclude an ordinary trier of fact from rendering an intelligent judgment."[117] Because much of the care in the nursing home setting is not medical, the common-knowledge exception may assist the resident plaintiffs in establishing a breach of the standard of care with or without the aid of an expert. Two other strategies which may be util-

112. *See* Dunsine v. Golden Shores Convalescent Ctr., Inc., 249 So. 2d 40, 42 (Fla. Dist. Ct. App. 1971); 40 AM. JUR. 2D *Hospitals and Asylums* § 36 (1999). An assessment of the standard of care in the nursing home context mandates consideration of the patient's physical and mental condition and must take into account her age and ability or inability to care for herself. *See* Dunahoo v. Brooks, 128 So. 2d 485, 488 (Ala. 1961); *Murphy*, 295 So. 2d at 34; Lagrone v. Helman, 103 So. 2d 365, 368 (Miss. 1958). Treatment is the physician's responsibility, not the home's, especially where the patient has her own private physician. *See Stogsdill*, 343 N.E.2d. at 611–12. It may be negligence for a home, knowing that a patient has a condition requiring special precautions, to transfer her to a hospital without giving the hospital instructions for her special supervision. *See* Krestview Nursing Home, Inc. v. Synowiec, 317 So. 2d 94, 95–96 (Fla. Dist. Ct. App. 1975), *cert. denied*, 333 So. 2d 463 (1976).

113. *See Stogsdill*, 343 N.E.2d. at 610.

114. *See id.*; McKnight v. St. Francis Hosp. & Sch. of Nursing, 585 P.2d 984, 986 (Kan. 1978); Webb v. Lungstrum, 575 P.2d 22, 25 (Kan. 1978).

115. *See* Juhnke v. Evangelical Lutheran Good Samaritan Soc'y, 634 P.2d 1132, 1135 (Kan. Ct. App. 1981).

116. *Id.* at 1136.

117. *Id.* at 1137. The court stated the general principle that "[w]hether expert testimony is necessary to prove negligence is dependent on whether, under the facts of a particular case, the trier of fact would be able to understand, absent expert testimony, the nature of the standard of care required of defendant and the alleged deviation therefrom." *Id.* at 1336.

ized by the elderly resident to establish negligence with or without the aid of an expert are theories of res ipsa loquitor and negligence per se.

c. Res Ipsa Loquitur The doctrine of res ipsa loquitur could be a helpful tool in a resident's fight to enforce standards of care against long-term care facilities. The doctrine of res ipsa loquitur applies in cases in which the accident is of a kind that ordinarily does not occur in the absence of negligence and the defendant is probably the person responsible.[118] The theory of res ipsa loquitur has been urged in several jurisdictions involving injuries to a resident but has met with mixed results.[119]

Resident plaintiffs have brought suit against nursing homes under theories of res ipsa loquitur seeking recovery for a variety of injuries.[120] In a number of cases courts have held that where a patient de-

118. *See* Ybarra v. Spangard, 154 P.2d 687, 689 (Cal. 1944). In *Ybarra*, the court established three conditions for the application of the res ipsa loquitor doctrine. "First, the accident must be of a kind that ordinarily does not occur in the absence of . . . negligence." *Id.* "[Second,] it must be caused by an agency or instrumentality within the exclusive control of the defendant." *Id.* "[And third,] it must not have been due to any voluntary action or contribution on the part of the plaintiff." *Id.* More recently in *Zentz v. Coca Cola Bottling Company* the court simplified and reduced the three original conditions into two propositions without any loss in meaning. "[A]s a general rule, res ipsa loquitur applies where the accident is of such a nature that it can be said, in the light of past experience, that it probably was the result of negligence by someone and that the defendant is probably the person who is responsible." Zentz v. Coca Cola Bottling Co., 247 P.2d 344, 349 (Cal. 1952).

119. *Compare* Ivy Manor Nursing Home, Inc. v. Brown, 488 P.2d 246, 248 (Colo. Ct. App. 1971) (citing Hamilton v. Smith, 428 P.2d 706 (1967) ("[W]here . . . the facts indicate with equal reasonableness that the injury was due to a cause other than the negligence of the defendant, the doctrine of res ipsa loquitor is inapplicable."), *and* Murphy v. Allstate Ins. Co., 295 So. 2d 29, 34 (La. Ct. App. 1974) (finding that there is no presumption of negligence simply because a resident was injured while under the care of a nursing home), *and* Brown v. Univ. Nursing Home, Inc., 496 S.W.2d 503, 509 (Tenn. Ct. App. 1972) (concluding that the theory of res ipsa loquitor is inapplicable when the accident is one of a kind, which might occur without negligence), *with* Caruso v. Pine Manor Nursing Ctr., 538 N.E.2d 722, 725 (Ill. 1989) (the court applied a res ipsa loquitur analysis to find that the nursing home acted negligently by failing to provide a resident with sufficient fluid intake, which resulted in dehydration), *and* Franklin v. Collins Chapel Connectional Hosp., 696 S.W.2d 16, 20 (Tenn. Ct. App. 1985) (holding that it was error to refuse to give a res ipsa loquitur instruction where the injury, thermal burns, would not ordinarily occur absent negligence on the part of the nursing home, and where the instrumentality, the bath, was within the home's exclusive control).

120. The doctrine of res ipsa loquitor has been urged in several cases involving patient falls. *See, e.g.*, Ericson v. Petersen, 253 P.2d 99, 100 (Cal. Ct. App. 1953); *Ivy Manor Nursing Home, Inc.*, 488 P.2d at 247; Tait v. Western World Ins. Co., 220 So. 2d 226, 228 (La. Ct. App. 1969); *Brown*, 496 S.W.2d at 509.

velops a harmful condition while under the care of the nursing home, the injury would not have occurred absent negligence on the part of the nursing home.[121]

The theory is most applicable where the plaintiff can show that the instrumentality that caused the injury was under the exclusive control of the defendant nursing home.[122] Although a number of courts have been reluctant to apply the res ipsa loquitur doctrine to a resident's injury suffered while under nursing home care,[123] it remains incumbent upon the plaintiff to establish that the accident would not have happened absent negligence. Far too often plaintiffs fail to distinguish an accident that could only have happened as the result of negligence from an accident that may have happened without negligence.[124] For example, in *Ivy Manor Nursing Home v. Brown*, the plaintiff brought suit under res ipsa loquitur when she was injured as the result of a fall.[125] However, plaintiff produced no evidence to show that the injury from the fall could not have happened absent negligence on the part of the nursing home.[126] As a result, the court refused to consider suit under that theory.[127]

To the contrary, in *Franklin v. Collins Chapel Connectional Hospital*,[128] the plaintiff brought suit against a nursing home alleging that the burns suffered by decedent while a patient at the facility contributed to his death.[129] The plaintiff argued that the decedent was

121. *See, e.g.*, *Caruso*, 538 N.E.2d at 725 (applying a res ipsa loquitur analysis to find that the nursing home acted negligently by failing to provide a resident with sufficient fluid intake, which resulted in dehydration.); *Franklin*, 696 S.W.2d at 16 (holding that it was error to refuse to give a res ipsa loquitur instruction where the injury, thermal burns, would not ordinarily occur absent negligence on the part of the nursing home, and where the instrumentality, the bath, was within the home's exclusive control.).

122. *See, e.g.*, *Franklin*, 696 S.W.2d at 16.

123. *See, e.g.*, Ericson v. Petersen, 253 P.2d 99, 101 (Cal. Ct. App. 1953) (finding application of res ipsa loquitor inapplicable when the injury may have been caused by something other than the negligence of the nursing home); *Ivy Manor Nursing Home, Inc.*, 488 P.2d at 248 (concluding that res ipsa loquitor is not applicable where "the facts indicate with equal reasonableness that the injury was due to a cause other than the negligence of the defendant."); *Tait*, 220 So. 2d at 229; *Brown*, 496 S.W.2d at 509 (finding that res ipsa loquitor does not apply where a fall is not the type of injury that necessarily occurs as the result of negligence alone).

124. *See, e.g.*, *Ivy Manor Nursing Home, Inc.*, 488 P.2d at 248.

125. *Id.* at 247.

126. *Id.* at 248.

127. *Id.*

128. Franklin v. Collins Chapel Connectional Hosp., 696 S.W.2d 16, 20 (Tenn. Ct. App. 1985).

129. *Id.* at 18.

burned while "in the exclusive care, custody, and control of defendant."[130] In support, the plaintiff produced evidence that the burns occurred when an orderly bathed the decedent.[131] Furthermore, the plaintiff provided testimony from two treating physicians that the burns they observed on the body of the decedent were thermal burns caused by "heat from a source of air, liquid or a solid" and not an allergic reaction.[132] The court found this evidence sufficient to raise an inference of negligence on behalf of the defendant.[133] Although the court in *Franklin* acknowledged the applicability of res ipsa loquitur other elderly plaintiffs may have been injured under a fact pattern more conducive to a theory of negligence per se.

d. Negligence Per Se Under the theory of negligence per se an unexcused violation of a statute would constitute negligence on the part of the long-term care facility.[134] Under this theory the judge must examine the statute to determine whether the statute was designed to protect against the type of harm suffered by the plaintiff, and whether the class of persons designed to be protected by the statute includes the plaintiff.[135] Where statutory violation alone constitutes negligence, the defendant would have the opportunity to show that it did everything that reasonably could be done to comply with the statute or regulation.[136]

Under a theory of negligence per se, a plaintiff may utilize specific statutory regulations to set a standard of at least reasonable care, which should be adhered to.[137] However, courts do not always agree.

130. *Id.*
131. *Id.* at 18–19.
132. *Id.* at 17–18.
133. *Id.* at 20–21.
134. *See Health and Long Term Care*, 23 ELDER L.F. 2, 5 (2001). In *Lesperance v. Beverly Enterprises*, the plaintiff argued that the nursing home's failure to maintain adequate documentation was a violation of a federal quality of care regulation and constituted negligence per se. *See Health and Long Term Care*, *supra*, at 5 (summarizing this trial-level case); *see also* Terri D. Keville et al., *Recent Developments in Long-Term Care Law and Litigation*, 20 WHITTIER L. REV. 325, 331–33 (discussing the implications of the theory of negligence per se in *Lesperance*).
135. RESTATEMENT (SECOND) OF TORTS § 286 (1977).
136. *See id.* § 288A.
137. *See* Dusine v. Golden Shores Convalescent Ctr., Inc., 249 So. 2d 40, 41–42 (Fla. Dist. Ct. App. 1971). "In *Alford* . . . it was held . . . that: 'The rationale supporting the admission of a statute, ordinance, or administrative rule or regulation as prima facie evidence of negligence is that the standard of conduct or care embraced within such legislative or quasi-legislative measures represent a standard of at least reasonable care which should be adhered to in the performance of any

For example, one court has held that a number of such regulations were too vague to be sufficient indicators, by themselves, of the standard of due care required of nursing homes.[138] Likewise, a city ordinance requiring that the number of personnel directly involved in caring for residents in homes licensed under a particular statute should be adequate to ensure proper protection and care for all guests at all times has been held to add nothing to the home's responsibilities, because it merely restates the home's common-law duty.[139] As these examples illustrate the application of negligence per se in the nursing home context has met with limited success, however, under appropriate circumstances it may be an effective tool to protect the elderly against abuse.

3. COMMON PROBLEMS ENCOUNTERED BY AN ELDERLY LITIGANT IN PURSUIT OF A PRIVATE CAUSE OF ACTION

a. Isolation, Dependency, Limited Resources, and the Slow Pace of Litigation Despite the overwhelming mistreatment of the elderly while under the care of a nursing home, a resident's pursuit of a private cause of action faces problems on multiple levels.[140] On the more practical side, elderly victims tend to not bring suit due to isolation, dependency, lack of resources, and the slow pace of litigation.[141] Residents fear that the initiation of suit will cause more problems than it will solve. Victims often fear that initiating suit will lead to unwarranted confrontations with family members and further institutionalization.[142] Additionally, nursing home residents, as Medicaid recipients, generally have limited resources, and generally are incapable of financing a potentially costly and drawn out suit against the facility. Moreover, due to age and illness, the slow pace of

given activity.'" *Id.* (quoting Alford v. Meyer, 201 So. 2d 489, 491 (Fla. Dist. Ct. App. 1971)).

138. *See* Stogsdill v. Manor Convalescent Home, Inc., 343 N.E.2d. 589, 610–11 (Ill. App. 1976).

139. *See* Laurie v. Patton Home for the Friendless, 516 P.2d 76, 78 (Or. 1973). An ordinance that requires nursing homes to provide enough personnel to ensure protection against intruders does not impose an absolute legal duty on the defendant. *Id.* at 78.

140. *See generally* Susan J. Hemp, *The Right to a Remedy: When Should an Abused Nursing Home Resident Sue?*, 2 ELDER L.J. 195 (1994).

141. Seymour Moskowitz, *Saving Granny from the Wolf: Elder Abuse and Neglect—The Legal Framework*, 31 CONN. L. REV. 77, 111 (1998).

142. *See id.*

litigation generally works to the disadvantage of the resident litigant in a claim against a nursing home.[143]

Even more difficult to overcome in pursuit of a private cause of action are problems associated with the merits of a successful negligence the suit. The most common impediments include determining the applicable standard of care, breach, causation, and damages.

b. Establishing the Standard of Care In an action for negligence, nursing homes generally have been acknowledged to owe a duty of reasonable care to avoid foreseeable injury, which must include recognition of a resident's age and mental and physical condition as it is known or reasonably should be known by the facility.[144] However, defining the standard of care is not always so simple. To address this issue, many courts adopt a medical malpractice model for nursing home negligence suits.[145] This requires the use of expert testimony to establish general standards and to look to the local standard of care in other nursing homes, which itself may be abysmally low, to determine the specifics of the standard.[146]

Although state and federal certification and licensing regulations, when sufficiently specific, have on occasion been used to establish a standard of care,[147] courts have often refused to use the statutes to define reasonable care.[148] One reason for this apparent reluctance

143. *See, e.g.*, Drucker v. Goscar, Inc., 168 N.W.2d 534, 535 (Neb. 1969). The plaintiff was near death and, consequently, unable to testify in her negligence suit against defendant nursing home for injuries sustained in a fall. *Id.*

144. *See* Moore v. Halifax Hosp. Dist., 202 So. 2d 568, 570 (Ga. Ct. App. 1967); Bezark v. Kostner Manor, Inc., 172 N.E.2d 424, 427 (Ill. App. Ct. 1961); Juhnke v. Evangelical Lutheran Good Samaritan Soc'y, 634 P.2d 1132, 1136 (Kan. Ct. App. 1981); Garner v. Crawford, 288 So. 2d 886, 888 (La. Ct. App. 1973); Brown v. Univ. Nursing Home, Inc., 496 S.W.2d 503, 509 (Tenn. Ct. App. 1972).

145. *See, e.g.*, Stogsdill v. Manor Convalescent Home, Inc., 343 N.E.2d. 589, 610 (Ill. App. Ct. 1976).

146. *See* Patricia A. Butler, *A Long Term Health Care Strategy for Legal Services*, 14 CLEARINGHOUSE REV. 613, 642 (1980).

147. *See* Dusine v. Golden Shores Convalescent Ctr., Inc., 249 So. 2d 40, 41–42 (Fla. Dist. Ct. App. 1971).

148.

> The Nursing Homes Patients' Bill of Rights does not set the standard to which nursing homes are held accountable in negligence damage actions. Such a holding would ignore the purpose of the negligence per se doctrine and the malpractice law of this State. It would permit the trier of fact to set its own standard of care for health care providers and speculate virtually without limits on the culpability of their conduct.

on the part of courts lies in the underlying theory of a negligence action. The standard of care is theoretically an objective standard favoring neither party.[149] Thus, unless a regulation directly addresses the specific circumstances at issue in the case, the court is not really justified in interpreting what may be an ambiguous statute in favor of the plaintiff just because the nursing home might be in a better financial position to bear the economic loss.[150]

c. Establishing Breach and Causation Often in negligence actions the plaintiff will have a difficult time establishing basic elements of breach and causation. This occurs for several reasons. First, the elderly patient may not be mentally aware of the injuries incurred and may be unable to testify about the injury. Second, given the resident's physical frailty, multiple medical problems, and diminished mental capacity, it is often difficult to place the blame for enhanced injury of the resident's condition on any particular act of the nursing home.[151] Nursing homes often argue in a negligence claim that the injury in question occurred through no one's fault or that the injury resulted from a preexisting condition.[152] And finally, nursing home residents, whose mental health is often failing, generally do not make reliable witnesses.

d. Establishing Damages Normally, damage awards are based on future or lost earnings, emotional distress, medical expenses, and loss of physical well-being.[153] Consequently, damages awarded in successful resident suits have generally been minimal at best.[154] Because elder abuse claims usually concern residents with little earning capac-

Case Notes, Health Care Facilities Licensure Act, N.C. GEN. STAT. § 131E-115 (1999) (citing Makas v. Hillhaven, Inc., 589 F. Supp. 736 (M.D. N.C. 1984)); *see also* Laurie v. Patton Home for the Friendless, 516 P.2d 76, 78 (Or. 1973) (holding that an ordinance requiring sufficient number of staff merely restated the common-law duty of reasonable care).

149. *See Stogsdill*, 343 N.E.2d at 610 (discussing the relevant standard of care).

150. *See id.* at 611.

151. *See, e.g.*, Littleton v. Montelepre Extended Care Hosp., 657 So. 2d 572, 574 (La. Ct. App. 1995) (holding that defendant nursing home was not liable for failure to provide special care for a preexisting condition).

152. *See, e.g.*, *id.* at 574 (finding that the defendant did not negligently aggravate a preexisting decubitus ulcer).

153. Moskowitz, *supra* note 141, at 148.

154. Butler, *supra* note 146, at 642 (stating that generally damage awards for elderly residents in negligence actions range between $2,000 and $40,000).

ity, diminished life expectancy, and possibly preexisting physical and mental conditions, damages suffered are small under the traditional analysis.[155]

Alternatively, a successful action that results in a sizeable damage award also presents problems for the elderly litigant. Where an elderly litigant who receives Medicaid is awarded a large sum as the result of successful litigation, she may become ineligible for continued Medicaid benefits.[156] Without careful planning, the resident can lose eligibility, which is based on need, where a large damage award is received.[157] Thus, damage awards may ultimately end up being paid to the defendant nursing home, at least until the award is depleted and the resident is again eligible for Medicaid.

IV. Recommendations: Redefine the System of Accountability and Empower the Elderly Litigant Through Private Enforcement of the Standard of Care

The responsibility to ensure that nursing home residents receive quality care ultimately lies with the federal government under its financing authority;[158] however, given that federal supervision of nursing homes has proven less than adequate to ensure acceptable standards of care, more must be done to assure accountability.[159] It is incumbent upon the federal government (and the states where appropriate) to establish a system of accountability to assure the enforcement of standards of care by removing roadblocks to individual suits against long-term care facilities and expanding participation of governmental and third parties in monitoring and tracking cases of elder abuse.

155. *See id.*

156. For a discussion of Medicaid eligibility requirements, see LAWRENCE A. FROLIK & RICHARD L. KAPLAN, ELDER LAW NUTSHELL 104–10 (2d ed. 1999).

157. *See id.* at 104–05.

158. Katherine R. Levit et. al., *National Health Expenditures*, 18 HEALTH CARE FINANCING REV. 175, 190 (1996) (finding that the federal government pays for approximately fifty-six percent of nursing home care through Medicare and Medicaid).

159. Federal regulations require only "substantial" compliance, indicating that imperfection is allowed. 42 U.S.C. § 1395i-3(h)(3) (Supp. IV 1998).

A. Deter Violations of the Standards of Care by Removing Roadblocks to the Private Cause of Action

1. PLACE RESIDENT SUITS ON THE FAST TRACK

One of the problems incurred by residents in pursuit of a civil action against a nursing home is the delay caused by the slow pace of litigation. To remedy this problem the legal system should recognize the heightened sensitivity of an elderly plaintiff who brings suit against a facility for mistreatment. It is incumbent on our courts to provide efficient and effective resolution to an elderly litigant's claim within a meaningful timeframe. Excessive delays may result in a resolution that comes too late to have any meaningful effect on the resident's quality of life or the facility's compliance with standards of care. Therefore, it is imperative that our legal system recognizes the particular sensitivity of the elderly litigant to litigation delays and takes steps to accelerate litigation intended to protect the rights of an elderly resident.

2. STRENGTHEN A RESIDENT'S CAUSE OF ACTION UNDER RES IPSA LOQUITOR

One of the central problems faced by the elderly litigant is proving that the negligence of the facility or staff caused injury to the resident. However, jumping this hurdle is assisted when the court allows a cause of action based on a theory of res ipsa loquitor. The theory of res ipsa loquitor can be a powerful tool in a resident's fight to enforce standards of care against a nursing home that fails to provide adequate care.

In *Caruso v. Pine Manor Nursing Center*, the court found that the resident suffered dehydration caused by the nursing home's failure to adequately provide treatment.[160] The plaintiff produced evidence that when he arrived in the home he could speak his name, he had adequate orientation, normal skin turgor, and smiled often.[161] Plaintiff further showed that when taken to the hospital emergency room the doctor diagnosed him as suffering from severe dehydration likely caused by inadequate fluid intake.[162] Plaintiff then showed that he was dependent on the nursing home for fluid intake because of prob-

160. Caruso v. Pine Manor Nursing Ctr., 538 N.E.2d 722, 725 (Ill. App. Ct. 1989).
161. *Id.*
162. *Id.*

lems with his central nervous system.[163] The nursing home offered no alternative explanation for plaintiff's dehydrated condition and maintained no chart of plaintiff's intake and outtake of fluid as a standard nursing home procedure.[164] Although the Illinois Appellate Court agreed that plaintiff had successfully established an inference of negligence, they reversed and remanded due to the trial court's abuse of discretion in barring the nursing home's expert's testimony because he merely stepped outside the scope of basis of one of his opinions.[165]

Caruso illustrates how advantageous it is to a plaintiff's cause of action to establish an inference of negligence. When a resident enters a nursing home in decent health, is dependent on the nursing home for care and medical services, and is injured during his stay for a reason other than fault of his own, courts should allow an inference of negligence to be drawn against the facility.[166]

3. PROVIDE MEANINGFUL STANDARDS OF CARE CAPABLE OF EFFECTIVE ENFORCEMENT

Standards of care are only meaningful if capable of effective enforcement. Consequentially, it is imperative that the legal system take notice of recognized standards of care in the medical industry as being equally applicable in the long-term context.[167] An application of this principle recently took place in *Bergman v. Eden Medical Center*.[168] In *Bergman*, the plaintiff brought suit under California's Elder Abuse and Dependent Adult Civil Protection Act against a physician who failed to adequately treat the patient's pain.[169] The plaintiff successfully established that the physician departed from the standard of care as defined by the Agency for Health Care Policy and Research (AHCPR).[170] In finding for the plaintiff, the court recognized that the AHCPR set the appropriate standard of care in its clinical practice guidelines on

163. *Id.*
164. *Id.*
165. *Id.*
166. *See generally id*. It is incumbent upon the justice system to realize the utter dependency that most elderly residents endure under the care of a nursing home. *See* Moskowitz, *supra* note 141, at 111–12.
167. *See* Rebecca Porter, *Failure to Treat Pain Is Elder Abuse, Jury Finds*, 37 TRIAL 87 (2001) (discussing Bergman v. Eden Med. Ctr., No. H205732-1 (Cal., Alameda Co. Super. Ct., June 13, 2001)).
168. *Id.*
169. *Id.* The plaintiff did not bring a malpractice suit because under California law only the victim may bring malpractice suit to collect awards for pain and suffering. *Id.*
170. *Id.*

pain management.[171] As *Bergman* illustrates, courts can and should allow plaintiffs to pursue claims for breach of standards of care in the long-term care industry by looking to authorities such as clinical practice guidelines and other recognized authorities in the medical and long-term care industries.

4. EXPAND THE AVAILABILITY OF DAMAGE AWARDS AND EXEMPT AWARDS FROM MEDICAID ELIGIBILITY REQUIREMENTS

In light of the fact that elderly plaintiffs are not the best candidates for large verdicts, due to deteriorating health, little to no earning capacity, and diminished life expectancy,[172] it is even more essential that damage awards be encouraged to deter violations of standards of care.[173] For this reason, it is imperative to establish at least a statutory minimum amount of damages recoverable for violation of an elderly resident's rights.[174] Should the plaintiff establish traditional damages above the mandatory minimum amount, he or she should be entitled to the larger damage award.

In addition to the statutory minimum, punitive damages should be made available in a broader array of situations. Numerous courts have indicated that punishment and deterrence are the principal social functions of punitive damages.[175] The terms "punitive" and "exemplary" damages reflect the policy underlying the punitive damages, that is, to teach both the potential and actual violator: "tort does not pay."[176] Additionally, it has been suggested that "[p]unitive damages more effectively deter institutions than individuals who may flee jurisdictions rather than correct their practices."[177]

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171. *Id.*

172. *See supra* Part III.D.3.d.

173. Mark Curriden, *Lawyers Inundated with Calls to Sue Hospitals*, ATLANTA J. CONST., Aug. 26, 1991, at C2.

174. *See, e.g.*, N.Y. PUB. HEALTH LAWS § 2801-(d)(2) (McKinney 2000) (setting a minimum amount of damages to be assessed against nursing homes who violate an elderly patient's rights).

175. *See, e.g.*, Tetuan v. A.H. Robins Co., 738 P.2d 1210, 1239 (Kan. 1987) (stating that punitive damages serve the social functions of punishment and deterrence); Burk Royalty Co. v. Walls, 616 S.W.2d 911, 916–17 (Tex. 1981) (stating that the purpose of exemplary damages is to punish the mental attitude of the defendant, as opposed to the defendant's conduct).

176. *See* Rookes v. Barnard, 2 W.L.R. 269, 329 (1964, House of Lords, Lord Devlin).

177. *See* Michael Rustad & Thomas Keening, *Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporation*, 47 RUTGERS L. REV. 975, 1045 (1995).

The threat of sizeable punitive damage awards creates a strong incentive for nursing homes to develop new protocols and practices designed to improve the care of elderly residents.[178] The expansion of damage awards, particularly punitive awards, available to elderly litigants who suffer mistreatment at the hands of the nursing home, will deter continued violations of the standards of care and encourage the mistreated elderly to bring suit.[179] States can increase the availability of punitive damage awards where nursing homes are found to have violated the rights of their residents.[180] The potential threat of a large damage award against a facility in violation of a standard of care will alter the landscape of future litigation brought by a mistreated resident and provide incentives for the facility to abide by recognized standards of care.[181]

Additionally, states can act to exempt damage awards from Medicaid eligibility requirements.[182] When a resident receives a damage award out of a suit against a facility, it is too often the case that the monetary award exempts the resident from continued Medicaid coverage.[183] By exempting the award from consideration for continued Medicaid coverage, the resident will not be punished for exercis-

178. *Id.* at 1062 (citing In Davis v. Fairburn Health Care Ctr., No C97368 (Ga. Super. Ct. Fulton County, Oct. 1988)). Improved staff-training programs were initiated following a sizeable punitive damage award against the nursing facility. Questionnaire of Warner R. Wilson, Jr., Plaintiff's Counsel in Davis (Apr. 1, 1994) (on file with author). *See generally* Fred H. Cate & Barbara A. Gill, *The Patient Self-Determination Act: Implementation Issues and Opportunities*, 6 HEALTH L. 1 (1992).

179. "Punitive damages are damages, other than compensatory or nominal damages, awarded against a person to punish him for his outrageous conduct and to deter him and others like him from similar conduct in the future." RESTATEMENT (SECOND) OF TORTS § 908 (1) (1977).

180. *See* Tetuan v. A.H. Robins Co., 738 P.2d 1210, 1239 (Kan. 1987). Punitive damages may be awarded "to punish the wrongdoer for his malicious, vindictive, or willful and wanton invasion of another's rights, with the ultimate purpose being to 'restrain and deter others from the commission of like wrongs.'" *Id.* (quoting Wooderson v. Ortho Pharm. Corp., 681 P.2d 1038 (1984)). Punitive damages may also be awarded

> for conduct that is outrageous, because of the defendant's evil motive or his reckless indifference to the rights of others. In assessing punitive damages, the trier of fact can properly consider the character of the defendant's act, the nature and extent of the harm to the plaintiff that the defendant caused or intended to cause and the wealth of the defendant.

RESTATEMENT (SECOND) OF TORTS § 908(2) (1977).

181. Rustad & Keening, *supra* note 177, at 984.

182. *See, e.g.*, N.Y. PUB. HEALTH LAW § 2801-d(5) (McKinney 1993).

183. *See supra* notes 156–57 and accompanying text.

ing his or her rights and the facility will not simply be taking money out of its left pocket to place it in the right pocket.

B. Broaden the Scope of Governmental Involvement in the Identification and Prevention of Abuse

While expansion and fortification of the resident's cause of action provides an avenue for individuals and families to seek compensation for abuse and mistreatment, the federal government will continue to carry the burden to prevent elder abuse in the institutional setting. To be successful in this increasingly important role, it is incumbent upon legislators and bureaucrats to aggressively pursue measures to hold abusers accountable for their actions and to prevent future violations. Proposals espoused by the Clinton administration serve as illustrations of initiatives designed to confront abuse before it begins.[184] On July 21, 1998, President Clinton released a statement in which he identified seventeen initiatives to be adopted by the administration in an effort to provide "tougher enforcement of Medicare and Medicaid rules with strengthened oversight of nursing home quality and safety."[185] The Clinton administration focused its initiative on increased inspections and civil penalties designed to "prevent bed sores, dehydration and nutrition problems."[186]

The Clinton initiative includes adoption of the following administrative steps in an effort to improve care in nursing homes:

> Nursing homes found guilty of a second offense for violations that harm residents will face sanctions without a grace period to allow them to correct problems and avoid penalties. Nursing home inspections will be conducted more frequently for repeat offenders with serious violations without decreasing inspections at other facilities. Inspection times will be staggered, with a set amount done on weekends and evenings. HCFA will instruct states to impose civil monetary penalties for each instance of serious or chronic violation. Until now, penalties have been linked only to the number of days a facility was out of compliance with regulations. Federal and state officials will focus their enforcement efforts on nursing homes within chains that have a record of non-compliance with federal rules. HCFA will provide additional training and other assistance to inspectors in states that are not

184. Press Release, Health Care Fin. Admin., Clinton Administration Announces New Initiatives to Improve the Quality of Care in Nursing Homes (July 21, 1998), http://www.hcfa.gov/news/pr1998/pr072198.htm.
185. *Id.*
186. *Id.*

> adequately protecting residents. HCFA will enhance its review of the surveys conducted by the states and implement standard evaluation protocols. States that fail to adequately perform surveys would lose federal funding for nursing home surveys. HCFA will contract instead with other entities to conduct survey and certification activities. HCFA will step up its review of nursing homes' ability to prevent bed sores, dehydration, and malnutrition. HCFA also will work with the Administration on Aging, the American Dietetic Association, clinicians, consumers, and nursing homes to share best practices for residents at risk of weight loss and dehydration. State inspectors will review each nursing home's system to prevent, identify, and stop physical or verbal abuse, neglect, and misappropriation of resident property. A description of each nursing home's abuse prevention plan will be shared with residents and their families. HCFA will work with the HHS Inspector General and the Department of Justice to ensure that state survey agencies and others refer appropriate cases for prosecution under federal civil and criminal statutes, particularly cases that result in harm to patients. Individual nursing home survey results and violation records will be posted on the Internet to increase accountability and make information more accessible.[187]

The Clinton initiatives aggressively seek to ensure safety and accountability in the long-term care industry and should be given serious consideration during future assessment of how to improve care for the elderly.[188] Complete adoption and effective implementation of initiatives such as these will go a long way toward improving the quality of elderly residents lives and ensuring accountability for mistreatment and abuse in the long-term care setting.

V. Conclusion: Meaningful Deterrents and Incentives Are the Foundation of an Effective System of Accountability to Assure the Enforcement of Standards of Care in the Long-Term Care Industry

Mistreatment of the elderly is a serious problem in the United States that is not likely to go away without vigorous and effective enforcement of standards of care in the long-term care industry. The inability of federal and state regulatory measures to successfully and

187. *Id.*

188. Congress recently attempted to strengthen some of these initiatives through the adoption of the Older Americans Act Amendments, which were signed into law on November 13, 2000. 106 Pub. L. No. 501, 114 Stat. 2226 (2000). The amendments extend existing programs through 2005, expand caregiving services through the National Family Caregiver Support Program, and increase funding at the federal and state level. *Id.*

consistently assure compliance with standards of care necessitates the empowerment of the individual resident. Elderly residents subjected to abuse are powerless to protect themselves without consequential deterrents and incentives. A reinvigorated system of accountability that provides considerable incentives for compliance and significant deterrents for violations will help ensure that residents are protected, abusers are punished, and future abusers are put on notice. Bolstered by meaningful standards of care capable of being enforced through a private cause of action, more funding for oversight and compliance, and increased access to information, elderly residents will be in a better position to protect their rights and hold their abusers accountable.