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Sexual Abuse in Nursing Homes

This article describes the common characteristics of sexually abused nursing home residents and details the many physical and psychological consequences of sexual abuse. It considers the victim's ability to report the abuse and how to compassionately conduct the victim interview and collect evidence. Relevant federal and state law is discussed and various theories of liability are analyzed.

By Elizabeth A. Capezuti and Deborah J. Swedlow

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At 3:00 a.m. on October 24, 1970, an unknown assailant brutally assaulted Mrs. Ruby Collier, a 74-year-old Louisiana nursing home resident. She sustained contusions and lacerations near and in her vagina. A tear of her vaginal wall extended the length of her vagina into the peritoneal cavity. In addition, Mrs. Collier suffered facial bruises and scratches. As a result of the attack, a large blood clot and one of her ovaries were surgically removed. She endured a 40-day hospital stay because of her injuries and a subsequent infected surgical incision.¹

Although Mrs. Collier “unquestionably sustained serious and painful injuries,” Louisiana’s appellate court affirmed a jury verdict finding neither the defendant nursing home nor its employees liable for the attack or resulting injuries.² In 1971, a private nursing home in Louisiana was not “an insurer of a patient’s safety” and was not “required to guard against or take measures to avert that which a reasonable person . . . would not anticipate as likely to happen.”³ Fifteen years later, in a case involving multiple sexual assaults committed by a nursing home resident’s son, the same court affirmed a verdict against a nursing home reasoning that the facility had been negligent in failing to notify family members and employees when evidence of sexual assault first surfaced.⁴ Today, a nursing home’s civil liability exposure is more complicated. During the 1990s, national print and electronic media as well as federal and state lawmakers increasingly focused their attention on protecting nursing home residents from mistreatment, including sexual abuse.⁵ This scrutiny improved detection of sexual abuse among the nursing home population and spurred

increased prosecution of the facility and its staff for these acts.

Sexual abuse encompasses a wide range of acts ranging from forced penetration to offensive sexual behavior. For the purposes of this paper, however, sexual abuse is limited to rape or sexual assault, which has been defined in Massachusetts as sexual intercourse or unnatural sexual intercourse with a person, during which one is compelled to submit by force and against his or her will, or compelled to submit by threat of bodily injury.⁶ The legal definition, however, varies from state to state.

Victim Profiles

The three most common nursing home sexual abuse victim profiles include the physically disabled older resident, the cognitively impaired resident, and the physically impaired younger resident.

Studies highlight the significant impact these victim profiles have on jurors. One study concluded that jurors might render a harsher judgment against a defendant if the rape victim is old and/or dependent.⁷

Physically Disabled Older Resident

One of the authors, Elizabeth A. Capezuti, served as a nurse consultant in the case of Mrs. Jane Doe who was admitted to a nursing home for physical rehabilitation of her right arm following a fracture. During her six-week stay, the head of a facility department raped her approximately ten times. Although Mrs. Doe was not mentally impaired, she did not report the repeated rapes because she was afraid of the rapist's reprisal and felt shame over the acts. The parties reached an out-of-court settlement in this case.⁸

Cognitively Impaired Resident

Consider, for example, the sexual abuse of a cognitively impaired nursing home resident with Alzheimer's disease or other dementia. Behavioral reactions are similar to those of the cognitively intact resident, including avoidance and hyperarousal symptoms when confronted with a person similar to the assailant.⁹ The major difference is that the cognitively impaired resident is unable to describe the assault event, the fears, or the feelings of helplessness.¹⁰ Instead, the demented abuse victim displays new and troublesome behaviors that

reflect his or her emotional distress post-rape, including disorganized or agitated behaviors, sleep disturbance, and extreme avoidance of certain staff members.¹¹

Physically Impaired Younger Resident

In this category, the younger resident may have a physical impairment due to a chronic neuromuscular disorder such as multiple sclerosis or amyotrophic lateral sclerosis (also known as ALS or Lou Gehrig's disease). Another possibility is physical impairment as a result of trauma such as paralysis secondary to a gunshot wound to the spine. In *Andrea N. v. Laurelwood Convalescent Center*,¹² an eighteen-year-old disabled resident, institutionalized after being seriously injured in a car accident, was raped by another nursing home resident. The young victim, Andrea, was bedridden and physically incapable of caring for herself. She communicated with family only through gestures and smiles. Andrea's family noticed that she seemed restless, cried often, and had missed her menstrual periods. Pregnancy was confirmed, rape assumed, and an abortion followed.¹³ Liability was based on the facts that the offending resident had been known to molest other residents and that the facility failed to take action.¹⁴

Physical and Psychological Consequences

Sexual abuse has profound physical and psychological consequences as summarized in Table 1.¹⁵

Physical Consequences

Studies conducted in hospital emergency departments report that between one-quarter and two-thirds of rape victims sustain physical injuries.¹⁶ Several studies demonstrate that older women are more likely, when compared to younger victims, to have injuries of the genitalia¹⁷ and increased frequency of vaginal lacerations or tears; one-quarter of such injuries requiring surgical repair.¹⁸ Decreased strength of the vaginal tissue due to reduced estrogen in postmenopausal women is the major contributor to genital tract trauma.¹⁹ Genital trauma may result in vaginal bleeding as well as swelling, bruising, abrasions, and lacerations of the genital area. Appropriate treatment for pain should be administered as well as antibiotic therapy for possible sexually transmitted disease.

Table 1. Signs and Symptoms of Sexual Assault**Physical**

- Vaginal and/or rectal bleeding
- Vaginal and/or rectal discharge
- Genital, rectal, or urinary irritation, injury, infection, or scarring
- Presence of sexually transmitted disease
- Pregnancy (in premenopausal resident)

Psychological/Emotional

- Denial and disbelief (especially immediately following the assault)
- Embarrassment and humiliation
- Intrusive recurrent recollections about the assault
- Difficulty making decisions to seek medical assistance or counseling
- Intense fear reaction such as physical (e.g., combative) or verbal aggression (e.g., cursing) to persons that look like the assailant
- Guilt, self-blame, low self-esteem
- Anxiety (e.g., mild expression of apprehension, exaggerated startle response, panic attack)
- Depression (crying, sobbing or "flat affect," i.e., demonstrating little or no emotion)
- Expressions of hopelessness or helplessness
- Phobias or avoidance behaviors (fear of being alone, in a crowd, indoors, outdoors, or global fear of everyone)
- Anger (feelings of resentment to homicidal rage against the assailant)

Related Physical Abuse

- Bruises, abrasions, lacerations of the neck, trunk, or extremities
- Fractures
- General body soreness or specific sites vulnerable during the attack
- Exacerbation of underlying chronic illness such as hypertension and diabetes
- Fatigue
- Rope burns of wrist and/or ankles (where victim was tied down during assault)

Other forms of physical abuse often accompany rape. Trauma consequences can be linked to the victim's health status prior to the rape. For example, a woman with osteoporosis whose chest was held down by the assailant is likely to have rib fractures. Also, the injuries or stress associated with the

assault can exacerbate symptoms of underlying chronic illness such as hypertension and diabetes.²⁰

Psychological, Emotional, and Behavioral Reactions

Psychological, emotional, and behavioral reactions to rape have been described as rape trauma syndrome²¹ or post-traumatic stress syndrome.²² During the period initially following the rape, victims are in psychological shock, expressing denial and disbelief.²³ Victims are next consumed with feelings of anxiety, anger, fear, and eventually, hopelessness.²⁴ These feelings may manifest as depression as well as phobias.²⁵ The latter may be expressed as a fear of being alone or excessive reaction to those with similar characteristics of the rapist. For example, the sexually abused nursing home resident may refuse to be bathed or dressed by a nurse's aide whose physical characteristics resemble those of the rapist.²⁶

After caring for the victim's immediate physical injuries, psychological and emotional reactions must be addressed through crisis counseling. The goal of treatment is to assist the victim in regaining his or her emotional and social equilibrium and returning to prior levels of functioning.²⁷ After the immediate postassault period, many victims, especially those with continued symptoms of anxiety and depression, benefit from psychological counseling and psychopharmacological therapy.²⁸ The latter includes antidepressant, anti-anxiety, and hypnotic agents.²⁹ In a clinical study of a rape victim with dementia, an antidepressant successfully reduced behavioral symptoms of verbal and physical aggression.³⁰ Psychopharmacological drug treatment for rape trauma syndrome, however, has not undergone rigorous empirical investigation.³¹

Victims, as well as family members, should be offered counseling, preferably from an agency outside the facility with expertise in rape trauma syndrome. Victim acceptance of counseling may depend on an introduction of the counselor by a trusted family or staff member. Recognize that the victim may not feel comfortable talking to a nursing home staff member about the assault experience. The victim and his or her family may want to leave the facility immediately. The nursing home should be prepared for this decision and assist the victim in relocation.

Victim's Ability to Report Sexual Abuse

The sexual abuse victim's age, assault history, physical status, and cognitive ability affects the ability to report the abuse. Social values of the victim's age cohort or generation also may influence the response. Viewing the sexual victimization as shameful reduces the victim's likelihood to report.³² One victim related, "I should have told you the first time but I was scared . . . I believed it was my cross to bear."³³ Socioeconomic status as well as ethnicity and race may influence the victim's willingness to report the rape or, when reported by others, to discuss the assault. Race may play a key role in the rapist's ability to instill fear in the victim and delay reporting of the sexual assault. Consider the repeated rape of an older African-American woman by a blond-haired, blue-eyed white man whose racial epithets contributed to the victim's fear of reporting.³⁴ The older black woman firmly believed that no one would believe her accusations levied against a white man.³⁵ Fear of retaliation may have deterred this victim, as well as her family, from legally pursuing the issue.

Interviewing the Sexual Abuse Victim

The nursing home administrative staff must know that the final determination of sexual assault lies with the state or local agency (for example, police, state health department, or adult protective services) and is not solely dependent on the facility's own internal evaluation. Staff members lacking specialized training in this area should not be allowed to conduct numerous "interrogations" of the victim. The evaluation of the sexual assault case must be done in a thoughtful, yet systematic manner. It should not be a second assault on the resident with multiple interviews and examinations.³⁶ Rather, the victim assessment should seek to reduce the trauma or, at the very least, lead to appropriate treatment as soon as possible. Law enforcement personnel (preferably of the same sex as the victim) with specific training in this area should conduct the victim interview in a supportive environment.³⁷ In most localities, a rape crisis counselor can assist the police officer in the interview while also providing psychological and emotional intervention. A family member or trusted staff member should introduce the police officer or counselor to the victim to facilitate rapport between the interviewer and the victim.³⁸ If the victim does not feel safe discussing her experience at the nursing home,

arrange transfer to another more comfortable location.³⁹

The resident in early stages of dementia may only be able to describe some parts of the assault and, therefore, the story may be dismissed as inaccurate.⁴⁰ Do not discount a demented victim's repeated recitation of the same information (for example, "I've got to get away from him . . . he's bad . . . I'm afraid").⁴¹ Also, any victim, regardless of mental status prior to the rape, can experience a period of crisis following the rape that may mimic confusion or disorientation.⁴² Thus, full disclosure of the sexual assault may not occur immediately; the victim may take several weeks before being able to describe the event.⁴³

Evidence Collection

Only clinicians with rape assault assessment training, expertise in the collection of specimen evidence, and compassionate communication techniques should examine the sexual abuse victim. Many university-affiliated or trauma-certified medical centers have specialized rape examination centers. Evidentiary examinations can also occur in a local emergency department, rape crisis center, hospital clinic, private office, or on-site at the nursing home by a specially trained sexual assault nurse examiner.⁴⁴ The timing of the examination is critical. One clinical study reports that sperm were present up to twenty-four hours after an assault.⁴⁵ The increased prevalence of vaginal injury and bleeding in postmenopausal women, however, may reduce the time that sperm are motile in the vagina.⁴⁶

The nursing home should not collect or store evidence without the direction of specially trained law enforcement officers or other agency responsible for the investigation. Related evidence such as clothing and bed linens must be stored in a paper bag because plastic retains moisture that encourages bacterial growth that may destroy the integrity of body fluid evidence.⁴⁷ The facility should keep potential evidence until it is determined not useful to the investigation.⁴⁸ Destroying evidence may increase facility liability.⁴⁹

Relevant Laws

Nursing home residents are theoretically sheltered by a broad web of protective laws and regulations at the federal and state levels. Nursing homes, administrators, and facility employees are all subject to varying levels of criminal and civil liability

as well as civil penalties and fines for failing to abide by reporting and investigatory requirements. Attorneys prosecuting or defending against nursing facility-related sexual abuse allegations should understand the entire protective scheme to both vindicate and protect the rights of victims, nursing homes, and employees accused of sexually abusing residents.

Federal Law and Regulation

Detection of nursing home abuse and the regulation of nursing facilities changed radically in 1987 with passage of the Omnibus Budget Reconciliation Act (OBRA '87).⁵⁰ OBRA '87 established a Nursing Home Bill of Rights for residents of Medicaid and Medicare certified facilities.⁵¹ The Nursing Home Bill of Rights states that residents, among other things, have the right to be free from physical and mental abuse.⁵²

Federal regulations mandate reporting of "all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source" to nursing home administrators and to other officials in accordance with state law.⁵³ Moreover, the nursing home "must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress."⁵⁴ Investigation results must be reported within five working days of the incident to statutorily designated parties.⁵⁵

The federal Nursing Home Care Act, enacted as part of the OBRA '87, established a national standard of care applicable to nursing home care.⁵⁶ The federal statutory and regulatory scheme requires that nursing facilities promote the maintenance and enhancement of residents' quality of life.⁵⁷ "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being" for individual residents.⁵⁸ Neither OBRA '87 nor its companion regulations establish a private cause of action for standard of care violations. Therefore, victims of nursing home abuse rely on state statutory civil remedies or tort remedies to redress their injuries.

State Law and Regulation

Reporting and Investigating Sexual Abuse

Some state laws supplement federal reporting and investigatory regulations with more rigorous

schemes for detecting, investigating, and reporting allegations of sexual abuse. For example, in Wisconsin, upon receiving a report of abuse,⁵⁹ county agencies charged with oversight of the state elder abuse reporting system must begin their investigation within five days.⁶⁰ If the allegation involves an elder nursing home resident, the county agency must report the incident within twenty-four hours to the state department of social services, who in turn must commence an investigation within twenty-four hours.⁶¹

In New Hampshire, any person having reason to believe that an incapacitated adult has been subjected to physical abuse shall report the incident(s) to the State Department of Health and Human Services.⁶² This reporting obligation is taken seriously; any person who knowingly fails to make a report as required is guilty of a misdemeanor.⁶³ California, like New Hampshire, requires care custodians, health practitioners, adult protective services personnel, and law enforcement personnel to report elder abuse.⁶⁴

Adult Protective Services

With encouragement, although not financial assistance from the federal government, all fifty states have passed some form of an adult protective services (APS) act, designed to, among other things, investigate reports of abuse, neglect, or exploitation, and to assist in obtaining protective services for endangered adults.⁶⁵ The level of protection and the quality of APS programs vary from state to state. States independently classify service eligibility and may define abuse, neglect, or mistreatment differently. All states define elder abuse to include physical abuse. However, sexual abuse may be categorized as physical abuse or may be a separate type of abuse.⁶⁶ Forty-two states require mandatory reporting of suspected or actual abuse.⁶⁷

Penalties for violations of the APS schemes vary. Alabama, California, Georgia, Michigan, and Rhode Island, for example, provide for civil fines and/or jail time.⁶⁸ Violators in Arkansas, Arizona, New Hampshire, and Texas are guilty of a misdemeanor.⁶⁹

APS laws establish a *de facto* standard of care for nursing facilities to meet when presented with abuse allegations. Nursing home employees, administrators, and owners who do not satisfy APS obligations may be exposed to increased civil liability for resident abuse. Compliance with APS

laws will not immunize a nursing facility from liability; however, the converse may be true.

State Nursing Home/Institutional Abuse Laws

Not all APS laws protect elderly nursing home residents. Therefore, many states have separate abuse prevention laws that respond to the threat of nursing home abuses. These facility-based abuse laws require reporting and investigations of elder abuse incidents. For example, in Massachusetts and Illinois, physicians, medical interns or residents, physician assistants, registered nurses, licensed practical nurses, and nurse aides, among others, who have reasonable cause to believe that a nursing home resident has been abused, must report such abuse to the proper authorities.⁷⁰

State Registries

A number of states maintain a centralized listing of all abuse reports and information concerning any subsequent investigation.⁷¹ This system hopes to avoid the fragmentation of information or a failure to follow up on repeated reports of potential abuse.⁷² Some state laws establish a statewide registry of abusive nursing home aides. The Texas Department of Human Services, for example, maintains a nurse-aide registry to verify, monitor, and track the employability of nurse aides who are in direct patient contact with vulnerable persons.⁷³

Theories of Liability

Despite significant federal and state regulation of the nursing home industry, some facilities are unable to provide adequate levels of security, supervision, and training to prevent sexual abuse of elderly and incapacitated residents. Courts fill the gap when administrative mechanisms fail to protect nursing home residents—resolving civil disputes between nursing homes and the victims (and victims' families).

Traditional tort remedies are a viable means of addressing nursing home culpability for the sexual abuse of facility residents. Whether the alleged perpetrator is a stranger, visitor, or employee of the facility, attorneys representing victims and families should consider several tort theories, including, traditional negligence, negligent hiring and supervision, and vicarious liability or respondeat superior.

Negligence

Negligence requires that an injured party establish that the defendant had a duty of care, which was breached and proximately caused the injuries. In the context of a civil suit brought by a nursing home resident against the facility for injuries sustained as a result of sexual abuse, the resident must establish that the nursing home, in its caretaker capacity, failed to adequately protect the resident from a foreseeable harm.

In general, one owes no duty to control the conduct of a third person to prevent that person from causing physical harm to another unless a "special relationship" exists between the actor and the third person that imposes a duty upon the actor to control the third person's conduct, or a special relationship exists between the actor and the other that gives to the other a right to protection.⁷⁴ Nursing homes have a special relationship with their residents. Relying on a special relationship between a resident and a nursing home, an appellate court affirmed a verdict against a facility in a case in which one resident attacked another resident.⁷⁵

A nursing home's duty and responsibility to protect vulnerable residents is limited by the legal concept of foreseeability.⁷⁶ Sexual assault, like other intentional and criminal conduct, is foreseeable if the harm at issue is within the range of expectability. In *Niece v. Elmvie Group Home*, the Washington Supreme Court relied on the special relationship between a group home for the developmentally disabled and its residents in holding that prior sexual assaults at the home, facility policy prohibiting unsupervised contact with residents, and legislative recognition of sexual abuse in nursing homes, demonstrated that sexual abuse by a staff member was a foreseeable hazard against which the facility should have taken precautions.⁷⁷

In *Shepard v. Mielke*, a resident was sexually assaulted by a person who was visiting another resident.⁷⁸ In denying summary judgment to the nursing home defendant, the court noted a triable issue existed as to the foreseeability of the occurrence.⁷⁹ Significantly, the physically incapacitated resident could not lock her doors or screen visitors.⁸⁰ Thus, the facility had a responsibility to take measures to protect her.⁸¹

It may be more difficult to establish the foreseeability of sexual assault than a duty to care for and protect vulnerable residents from known or knowable harms. Evidence of prior assaults at the facility, institutional policy regarding the kinds of contact with vulnerable residents, poor or nonexistent security, slack hiring procedures, and legislative definitions of elder abuse that incorporate sexual abuse advance foreseeability arguments.

Negligent Hiring, Retention, and Supervision of Employees

A nursing home has a duty to exercise reasonable care in selecting and supervising medical and non-medical personnel.⁸² Federal regulations prohibit facilities from hiring individuals who have been found guilty of abuse, neglect, or mistreatment or who have a finding entered into the state nurse-aide registry concerning abuse.⁸³ In addition, federal law requires facilities to report to state licensing authorities any knowledge of legal proceedings against an employee that indicates “unfitness for service as a nurse aide or other facility staff.”⁸⁴

In *Deerings West Nursing Center v. Scott*,⁸⁵ a Texas court found a nursing home liable for an assault on an elderly visitor committed by an unlicensed aide with past criminal convictions for theft. The court reasoned that the “basis of responsibility under the doctrine of negligent hiring is the employer’s own negligence in hiring or retaining in its employ an . . . employee who the employer knows or . . . should have known was incompetent or unfit, and thereby, causing an unreasonable risk of harm to others.”⁸⁶

The first step in preventing sexual abuse and reducing facility exposure to liability involves establishing rigorous hiring and supervision policies that meet and exceed state and federal regulations regarding background checks and credentialing. Second, staff training should include sexual abuse prevention.⁸⁷ Early detection of sexual assault requires staff to be knowledgeable to the signs and symptoms referenced in Table 1. Finally, the facility should provide adequate staffing and, most importantly, adequate supervision of staff to deter assaults on residents.⁸⁸

Respondeat Superior and the Non-Delegable Duty Exception

The doctrine of respondeat superior imposes liability, where none would otherwise exist, on an employ-

er for the wrongful acts of employees committed within the scope of employment.⁸⁹ Employers are traditionally immune from liability for acts performed on the employee’s own initiative. While sexual abuse is certainly not an act committed within the scope of employment, the doctrine of respondeat superior has been applied successfully to hold nursing homes and health care providers liable for the sexual assaults committed by facility employees.⁹⁰

In *Stropes v. Heritage House Children’s Center of Shelbyville, Inc.*, a staff member sexually assaulted a severely retarded nursing home resident.⁹¹ The employee, a nurse’s aide, was expected to bathe, feed, and care for the resident.⁹² The aide entered the resident’s room during his shift, stripped the sheets, and performed oral and anal sex upon the resident.⁹³ The aide stopped when he heard a sound from the resident, a minor, indicating he was in pain.⁹⁴ The Indiana court, upholding a claim based on respondeat superior, extended the non-delegable duty exception to the health care provider–patient relationship.⁹⁵

The non-delegable duty exception imposes liability on an employer for the acts committed by an employee, even if outside the scope of employment, but premised on the control and autonomy surrendered by the plaintiff. This exception is most frequently applied to common carriers and innkeepers. The justification for the exception is that passengers and guests surrender control and autonomy to the carrier and the innkeeper for the period of the accommodation.⁹⁶ Given the lack of autonomy and control the plaintiff had in *Stropes*, as well as his level of dependence on the nursing home for his care, the court found that the nursing home assumed a duty to provide care and protection, one that it could not delegate or deny simply because the conduct was arguably outside the scope of the aide’s employment.⁹⁷

Not all courts accept the extension of the common carrier/innkeeper non-delegable duty exception. Washington,⁹⁸ Montana,⁹⁹ and Oregon¹⁰⁰ reject the doctrine’s application to health care providers largely based on deference to legislative authority. The doctrine remains, however, intriguing and one which plaintiffs are likely to continue to explore.

Criminal Statutes

Although this article addresses civil liability for sexual abuse of primarily older nursing home resi-

dents, nursing home administrators, nurses, and staff members may be exposed to significant criminal liability as well. In addition to traditional criminal prosecution for assault, battery, and sexual assault/rape, a number of states have enacted statutes that make the commission of assault or battery on an older adult person or nursing home resident an aggravated offense with enhanced penalties.¹⁰¹ Such statutes have generally survived constitutional challenges brought on due process and equal protection.¹⁰²

Conclusion

As law enforcement personnel, government agencies, and nursing home advocacy groups respond to this horrific crime, nursing homes are increasingly held responsible for sexual abuse in their facilities. Nursing homes are obligated to provide a safe environment that minimizes the likelihood of sexual abuse of their vulnerable residents.

Endnotes

1. See *Collier v. Ami, Inc.*, 254 So. 2d 170 (La. Ct. App. 1971).
2. See *id.* at 171.
3. See *id.* at 174 (quoting 41 C.J.S. Hospitals § 8 at 349–50).
4. See *Lemoine v. Ins. Co. of North America*, 499 So. 2d 1004, 1007–08 (La. Ct. App. 1986).
5. See, e.g., LAWRENCE A. FROLIK & RICHARD L. KAPLAN, *ELDER LAW IN A NUTSHELL* 393–94 (2d ed. 1999) (discussing action by U.S. House of Representatives Select Committee on Aging).
6. See MASS. GEN. LAWS ch. 265, § 22 (1999).
7. See Lawrence G. Calhoun et al., *Reactions to the Rape Victim as a Function of Victim Age*, 8 J. COMMUNITY PSYCHOL. 175, 175 (1980).
8. See *Jane Doe v. Retirement Care Assocs., Inc.*, No. 96 VS-120733-G (Ga. Fulton Co. St. Ct. filed Nov. 26, 1996 (settled)).
9. See Marion Zucker Goldstein, *Elder Maltreatment and Posttraumatic Stress Disorder*, in *AGING & POSTTRAUMATIC STRESS DISORDER* 132, 132 (P.E. Ruskin & J.A. Talbott eds., 1996).
10. See James R. McCartney & Karen Severson, *Sexual Violence, Post-traumatic Stress Disorder and Dementia*, 45 J. AM. GERIATRICS SOC'Y 76, 77 (1997); Goldstein, *supra* note 8.
11. McCartney & Severson, *supra* note 9, at 76–78.
12. 16 Cal. Rptr. 2d 894 (Ct. App. 1994).
13. See *id.*
14. See Ralph Gerstein, *Nursing Home Litigation*, in *THE ELDER LAW PORTFOLIO SERIES* § 13-7.3 (Harry S. Margolis ed. 1996) (citing *Andrea N. v. Laurelwood Convalescent Ctr.*, 16 Cal. Rptr. 2d 894 (Ct. App. 1994)).
15. TABLE 1 was adapted from Holly Ramsey-Klawnsnik, *Interviewing Elders and Suspected Sexual Abuse: Guidelines and Techniques*, 5 J. ELDER ABUSE & NEGLECT 5, 7 (1993); Kathy Simmelink, *Lessons Learned from Three Elderly Sexual Assault Survivors*, 22 J. EMERGENCY NURSING 619, 620 (1996); Patricia A. Tyra, *Older Women: Victims of Rape*, 19 J. GERONTOLOGICAL NURSING 9, 11 (1993).
16. See Peter S. Cartwright & Royanne A. Moore, *The Elderly Victim of Rape*, 82 S. MED. J. 988, 988–89 (1989); Susan M. Ramin et al., *Sexual Assault in Postmenopausal Women*, 80 OBSTETRICS & GYNECOLOGY 860, 862 (1992).
17. See Ramin et al., *supra* note 16, at 861; Cartwright & Moore, *supra* note 16, at 988–89; David Muram et al., *Sexual Assault of the Elderly Victim*, 7 J. INTERPERSONAL VIOLENCE 75, 75 (1992).
18. See Ramin et al., *supra* note 16, at 863.
19. See *id.*
20. See Simmelink, *supra* note 15, at 621.
21. See Ann W. Burgess & L. Holmstrom, *Rape Trauma Syndrome*, 131 AM. J. PSYCHIATRY 981, 981 (1974).
22. See AMERICAN PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDER* at 424–29 (4th ed. 1994).

23. See Tyra, *supra* note 15, at 9.
24. See *id.*
25. See *id.*
26. See *id.*
27. See Patricia A. Tyra, *Helping Elderly Women Survive Rape Using a Crisis Framework*, 34 J. PSYCHOSOCIAL NURSING 20, 22 (1996).
28. See *id.* at 24.
29. See *id.*; Dorothy Hicks, *The Patient Who's Been Raped*, 6 EMERGENCY MED. 120, 120 (1988).
30. See McCartney & Severson, *supra* note 9, at 77.
31. See Tyra, *supra* note 27, at 24.
32. See A. Nicholas Groth, *The Older Rape Victim and Her Assailant*, 11 J. GERIATRIC PSYCHIATRY 203, 213 (1978).
33. *Jane Doe v. Retirement Care Assocs., Inc.*, No. 96 VS-120733-G (Ga. Fulton Co. St. Ct. filed Nov. 26, 1996 (settled)).
34. See *id.*
35. See *id.*
36. See FROLIK & KAPLAN, *supra* note 5, at 408-09.
37. See Ramsey-Klawnsnik, *supra* note 15, at 10.
38. See *id.* at 11.
39. See *id.* at 10-11.
40. See McCartney & Severson, *supra* note 9, at 77; Simmelink, *supra* note 18, at 620.
41. See McCartney & Severson, *supra* note 9, at 77.
42. See Ramsey-Klawnsnik, *supra* note 15, at 15.
43. See *id.*
44. See generally Linda E. Ledray, *SANE Program Locations: Pros and Cons*, 23 J. EMERGENCY NURSING 182, 182-86 (1997) (discussing sexual assault nurse examiner or SANE programs throughout the United States); Susan Hohenhaus, *SANE Legislation and Lessons Learned*, 24 J. EMERGENCY NURSING 463, 463-64 (1998).
45. See Ramin et al., *supra* note 16, at 862.
46. See *id.* at 864.
47. Linda E. Ledray, *Sexual Assault Evidentiary Exam and Treatment Protocol*, 21 J. EMERGENCY NURSING 355, 355-59 (1995).
48. See *id.*
49. See Patricia W. Iyer, *Nursing Liability Issues, in NURSING HOME LITIGATION: INVESTIGATION AND CASE PREPARATION* 151, 180 (Patricia W. Iyer ed., 1999).
50. See Pub. L. No. 100-203, §§ 4201-4218, 101 Stat. 1330, 160-22 (codified as 42 U.S.C. §§ 1395i, 1396r (1987)).
51. See 42 U.S.C. §§ 1395i-3, 1396r.
52. See 42 U.S.C. § 1395i-3(c)(1)(A)(ii).
53. 42 C.F.R. § 483.13(c)(2).
54. 42 C.F.R. § 483.13(c)(3).
55. See 42 C.F.R. § 483.13(c)(4).
56. See 42 U.S.C. §§ 1395i, 1396r.
57. See 42 C.F.R. § 483.15.
58. 42 C.F.R. § 483.25.
59. See WIS. STAT. § 46.90(4)(a)(1) (1999).
60. See WIS. STAT. §§ 46.90(3), 46.90(5)(a) (1999).
61. See WIS. STAT. § 46.90(5)(a) (1999).
62. See N.H. REV. STAT. ANN. § 161-F:46 (1999).
63. See N.H. REV. STAT. ANN. § 161-F:50 (1999).
64. See CAL. WELF. & INST. CODE § 15630 (1999).
65. See FROLIK & KAPLAN, *supra* note 5, at 406-11.
66. See *id.* at 407.
67. See Elizabeth Capezuti et al., *Reporting Elder Mistreatment*, 23 J. GERONTOLOGIC NURSING 24, 24-32 (1997).
68. See LORI A. STIEGEL, AM. BAR ASS'N, RECOMMENDED GUIDELINES FOR STATE COURTS

HANDLING CASES INVOLVING ELDER ABUSE 74, 74-91 (1995).

69. *See id.*
70. *See* MASS. GEN. LAWS. ch. 111, § 72G (1999); ILL. COMP. STAT. ANN. 210/30-4 (West 1999).
71. *See* FROLIK & KAPLAN, *supra* note 5, at 408-09.
72. *See id.*
73. *See* TEX. HEALTH & SAFETY CODE ANN. § 250 (West 1999).
74. *See* RESTATEMENT (SECOND) OF TORTS § 315 (1963).
75. *See* ERIC M. CARLSON, LONG-TERM CARE ADVOCACY § 10.11[4] (1999) (citing *Associated Health Systems v. Jones*, 366 S.E.2d 147, 149-51 (Ga. Ct. App. 1988)).
76. *See, e.g.*, *Niece v. Elmview Group Home*, 929 P.2d 420, 424 (Wash. 1997).
77. *Id.* at 427.
78. *See* Gerstein, *supra* note 13, at §13-7.2, (citing *Shepard v. Mielke*, 877 P.2d 220 (1994)).
79. *See id.*
80. *See id.*
81. *See id.*
82. *See* *Deerings West Nursing Ctr. v. Scott*, 787 S.W.2d 494, 498 (Tx. Ct. App. 1990).
83. *See* 42 C.F.R. § 483.13(c)(1)(ii).
84. 42 C.F.R. § 483.13(c)(1)(iii).
85. *Deerings*, 787 S.W.2d at 498; *cf.* *Lacy v. District of Columbia*, 424 A.2d 317, 323 (D.C. App. 1980) (finding liability for negligent hiring of janitor who raped school child required past acts that indicated sexually assaultive behavior).
86. *Deerings*, 787 S.W.2d at 498.
87. *See* 42 U.S.C. § 1395i-3(c)(1)(A)(ii); *see also* Karl Pillemer & Beth Hudson, *A Model Abuse Prevention Program for Nursing Assistants*, 33 GERONTOLOGY 128, 128-131 (1993); Elizabeth Capezuti & Eugenia L. Siegler, *Educating Health and Social Service Professionals in the Detection and Management of Mistreated Nursing Home Residents*, 8 J. ELDER ABUSE & NEGLECT 73, 73 (1996).
88. *See* Duncan S. Maclean, *Preventing Abuse and Neglect in Long-Term Care Part II: Clinical and Administrative Aspects*, 8 ANNALS LONG-TERM CARE 68, 68 (2000).
89. *See* RESTATEMENT (SECOND) OF AGENCY § 219 (1958).
90. *See, e.g.*, *Stropes v. Heritage House Children's Ctr. of Shelbyville, Inc.*, 547 N.E.2d 244 (Ind. 1990).
91. *Id.* at 245.
92. *See id.*
93. *See id.*
94. *See id.*
95. *See id.* at 254.
96. *See* Adam A. Milani, *Patient Assaults: Health Care Providers Owe a Non-Delegable Duty to Their Patients and Should Be Held Strictly Liable for Employee Assaults Whether or Not Within the Scope of Employment*, 21 OHIO N.U. L. REV. 1147, 1153 (1995).
97. *Stropes*, 547 N.E.2d at 254.
98. *See, e.g.*, *Neice v. Elmview Grove Home*, 929 P.2d 420, 431 (Wash. 1997).
99. *See, e.g.*, *Maguire v. State*, 835 P.2d 755 (Mont. 1992).
100. *See, e.g.*, *G.L. v. Kaiser Found. Hosps., Inc.*, 757 P.2d 1347 (Or. 1988).
101. *See, e.g.*, 20 ILL. COMP. STAT. 5/12-2(a)(11)-(12) (West 1999) (noting that a person commits an aggravated assault, when, in committing an assault, he: knowingly and without legal justification, commits an assault on a physically handicapped person or a person sixty years of age or older); NEV. REV. STAT. § 200.5099 (1999) (conveying that one who abuses an older person is guilty of a category B felony, punishable by a minimum term of not less than two years and a

maximum term of not more than six years “unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse,” and “any person who has assumed responsibility . . . pursuant to a contract, to care for an older person and who: (a) Neglects the older person, causing the older person to suffer physical pain or mental suffering; (b) Permits or allows the older person to suffer unjustifiable physical pain or mental suffering; or (c) Permits or allows the older person to be placed in a situation where the older person may suffer physical pain or mental suffering as the result of abuse or neglect, is guilty of a gross misdemeanor unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse or neglect.”); TEX. PENAL CODE ANN. § Sec. 22.04

(West 1999) (stating that a person commits an offense if he intentionally, knowingly, recklessly, or with criminal negligence, by act or intentionally, knowingly, or recklessly by omission, causes to an elderly or disabled individual, *inter alia*, bodily or serious bodily injury); WIS. STAT.

§ 940.225(2)(g) (1999) (specifying that an employee of a nursing facility or program who has sexual contact or sexual intercourse with a person who is a patient or resident of the facility or program is guilty of second degree sexual assault).

102. See Ana Kellia Ramares, Annotation, *Criminal Assault or Battery Statutes Making Attack on Elderly Person a Special or Aggravated Offense*, 73 A.L.R. 4th 1123, § 2 (1989).