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THE MEDICO-LEGAL ASPECTS OF DEMENTIA-DRIVEN SEXUAL ABUSE IN NURSING HOMES

Lisa Tripp*

Human Dignity
Like the moon her kindness is,
If kindness I may call
What has no comprehension in’t,
But is the same for all
As though my sorrow were a scene
Upon a painted wall.
So like a bit of stone I lie
Under a broken tree.
I could recover if I shrieked
My heart’s agony
To passing bird, but I am dumb
From human dignity.¹

INTRODUCTION

Between two and three o’clock in the morning on April 1, 1998, in a Lexington, Kentucky nursing home, three nurse aides gathered excitedly in the East Wing hallway, as they peered into an elderly woman’s room.² Apparently talking and laughing too

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2. Sunrise Care & Rehabilitation – Cambridge Drive, Docket No. XC-99-161 (Dep’t of Health & Human Servs. Feb. 23, 2001), http://www.hhs.gov/dab/decisions/cr747.html. The official government report of this matter does not identify the residents by name to protect their privacy. The monikers “Residents A and B” are from the official government report, called a Statement of Deficiencies, CMS Form 2567.
excitedly, and fearful the noise would stop the action they were
watching, one of them tapped the other on the shoulder and said
"shhh – be quiet, [Resident B] is getting a piece of ass."3

Resident B was a violent, sexually aggressive, demented
resident. In his first eleven days as a resident of the Sunrise Care
& Rehabilitation Center in Lexington, he swung scissors at staff
members, threw a water pitcher at staff members, and tried to
hit them with his cane. He used the medication cart as a
battering ram against residents.4 He also grabbed a woman’s
breast and was generally known to be sexually abusive.5

On the night in question, nurse aides Tomeka, Michael, and
William gathered around the entrance of Resident A’s room and
watched as she was sexually assaulted by Resident B. They saw
“Resident B laying behind and on top of Resident A . . . with his
belly touching her back. She was not awake. NA Michael
testified that ‘it looked . . . like he had an erection.’”6 The three
staff members did nothing but giggle and laugh as the assault
continued.7 They saw another nurse aide coming down the hall
and invited him to watch the show.8 When that nurse aide saw
what was happening, he starting crying and yelling and ran
from the room because he was so distraught.9 After this, the
nurse aides finally pulled Resident B off Resident A; Resident B
kicked one of the nurse aides when she tried to pull him off of
the other resident.10

The nurse aides gave statements indicating that they had

3. Id.
4. Id.
5. Id. “In total, six incidents of anti-social behavior were charted prior to the
April 1, 1998 incident. A Social Services Assessment dated March 31, 1998 included
comments that Resident B was both combative and sexually abusive.” Id. (citation
omitted).
6. Id.
7. Id.
8. Id.
9. Id. “Then, NA Gary came to the East Wing hall. NA Tomeka waited for
him to come down the hall so she could show him what was going on. When he
looked into the room, NA Gary began yelling, crying, and threw a chair and ran out
of the room and was upset.” Id.
10. Id.
seen both residents naked from the waist down; Resident B had an erection; Resident A's diaper had been taken off and was on the floor; they also said Resident B's penis was touching the other resident's bare vaginal area. Several staff members also reported seeing semen on the female victim.

The facility administration reported the incident to state officials and this is how they described what happened:

Resident B found in bed with Resident A sleeping. Neither patient is [unreadable] and both suffer from dementia. Neither patient recalls the incident and neither appear to be traumatized. The residents were examined and there are no signs of trauma or sexual assault. [The Physician] examined two residents and found no injuries.

State officials accepted this information and, having no reason to believe any harm had occurred, had no plans to investigate. Had it not been for two staff members who anonymously reported the incident as it really occurred, there would have been no administrative action taken against facility.

As it happened, the Centers for Medicare & Medicaid Services (CMS) did impose an administrative penalty against the facility; the fine was $3,050. That is the lowest possible daily fine that the federal government could have imposed under the circumstances.

11. Id.
12. Id. "Three of Petitioner's employees, Licensed Practical Nurse (LPN)s Janet and Mona, and NA Tomeka, testified that they saw and smelled semen on the inner thighs of Resident A. The Director of Nursing (DON) viewed Resident A approximately 45 minutes after the alleged incident and declared that the wetness was cotton lint and urine." Id. (citation omitted).
13. Id.
14. Id.
15. Id.
16. Sections 1819(h) and 1919(h) of the Social Security Act authorize imposition of CMPs to remedy noncompliance at amounts not to exceed $10,000 per day. 42 U.S.C. § 1395i-3 (1997); 42 U.S.C. § 1396r (1997). Regulations provide for different ranges of per day CMPs depending on the nature and seriousness of the deficiencies identified by CMS. 42 C.F.R. § 488.408 (1995). In cases involving immediate jeopardy determinations, if CMS decides to impose a per day CMP, CMS must impose at least a $3,050 CMP and can go as high as $10,000 per day. 42
(CMP) and CMS's findings that the facility was out of compliance with abuse and administrative regulations. The Administrative Law Judge (ALJ) upheld the CMP and the findings of noncompliance related to administration, but overturned all of the findings related to the abuse. The ALJ rejected the government's argument that Resident A had been abused, in part because Resident B's dementia prevented him from forming the intent necessary to willfully abuse the victim.

This case reveals failures and tragedies on every conceivable level. What happened to Resident A is, of course, heartbreaking. No one should be sexually assaulted while the people who are supposed to take care of you stand by and laugh and joke like they were watching a funny spectator sport.

The written opinion in this case does not tell us much about Resident B's diagnoses, but we do know that he had subcortical

17. Sunrise Care & Rehabilitation – Cambridge Drive, Docket No. XC-99-161 (The facility was cited for violating six separate regulations).
18. Id.
19. Id. The ALJ's consideration of the abuse deficiency is brief because she sustained the full CMP imposed by the government on other grounds. Her entire analysis of the abuse deficiency consisted of the following:

I find that the allegations presented by HCFA on the element of 'willful infliction of injury' inherent in the term 'abuse' is unsupported by the evidence or is speculative. The degree of active involvement of the two male NAs in promoting the prohibited contact between Resident A and Resident B cannot be determined. I follow the Board's decision regarding 'abuse' in Beverly Health and Rehabilitation Center - Williamsburg, DAB No. 1748 (2000). Because of my determination above based on Tag F-490, I need not analyze this deficiency in further detail.

Id.


20. Throughout this article, I will refer to what happened to Resident A as a sexual assault or abuse, and I will refer to Resident A as a sexual assault or abuse victim. I do not intend this to mean that a crime occurred. Whether unconsented to sexual activity constitutes a crime is irrelevant in the sense that it does not impact whether a serious invasion of one's person has occurred. Resident A's body and her personal integrity were forcibly, sexually compromised, and the fact that Resident B cannot be prosecuted because he lacks the mental state necessary for conviction does not change the violation experienced by Resident A.
dementia. Recent studies suggest that while Alzheimer’s related dementia is more prevalent in the long-term care population, those with subcortical dementia may be more dangerous to long-term care staff and residents because subcortical dementia is more often characterized by aggressive, antisocial behaviors than Alzheimer’s dementia. We also know little about Resident B prior to his admission into the nursing home, but it is reasonable to assume that Resident B was not a sexual predator in his pre-demented state but became one as a consequence of his dementia. To that extent, he is rightly viewed as a victim.

The reaction of the direct care staff that laughed at this assault is deeply disturbing, as is the administration’s filing of a false report to cover up the sexual assault. The government’s response is confounding. Federal regulations require CMS to


22. Stewart, supra note 21, at 23, 27.

Although the majority of demented individuals have [Alzheimer’s Disease] AD, there is a large group of dementing illnesses that present quite differently, with perhaps even more devastating effects on intellectual function and personality. These are the frontal/subcortical dementias—illnesses that affect the prefrontal cortex and connected subcortical structures. The qualitative differences between AD, which initially affects parietal and temporal cortex, and frontal/subcortical dementias have been appreciated for almost a century. Compared with AD patients, those with frontal/subcortical dementias lack typical posterior cortical deficits (eg, aphasia, apraxia, agnosia), but show prominent executive deficits and personality changes including sexually aggressive disinhibition. Id.

23. Most demented residents who are acting in sexually aggressive or disinhibited ways have no history of criminal activity and there is no evidence in the record to suggest that Resident B had ever been identified as a sexual predator prior to the onset of dementia. Karen A. Roberto & Pamela B. Teaster, Sexual Abuse of Vulnerable Young and Old Women: A Comparative Analysis of Circumstances and Outcomes, 11 VIOLENCE AGAINST WOMEN 473, 490 (2005).

24. See Sunrise Care & Rehabilitation, Docket No. XC-99-161. (Resident B’s dementia may have been mismanaged pharmacologically. Resident B was prescribed Ativan for his dementia and “[t]here is evidence that Ativan may have been contraindicated for Resident B’s form of dementia, especially at night.”) Id.
consider several factors when imposing CMPs. One of those factors is "the facility's degree of culpability ... which includes neglect, indifference, or disregard for resident care, comfort or safety." It is hard to imagine how CMS could come up with such a paltry penalty in response to the sexual assault of a resident that was covered up by facility management, unless CMS did not consider what happened to Resident A to be particularly egregious.

The purpose of beginning this article with this case is not to indulge in sensationalism. This case is obviously an extreme one, but it is useful because it illustrates the many problems that exist around the issue of sexual abuse of demented residents by demented residents in nursing homes. Direct care workers are not properly trained to manage sexually aggressive and sexually inappropriate demented residents. Many nursing home staff members and management officials do not view this type of conduct as sexual abuse and they do not view the residents who are the targets of this aggression as victims of sexual abuse.

25. In setting CMPs, CMS is supposed to consider (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438 (1994). The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) "the relationship of the one deficiency to other deficiencies resulting in noncompliance[]" and 3) "the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies." 42 C.F.R. §488.404 (1994).


28. There are no studies examining attitudes of staff and management toward unconsented sexual contact in nursing homes. Anecdotal evidence suggests that it is not uncommon for facility staff or management to fail to view demented women who are subject to sexual activity that they cannot consent to as victims when the sexual aggressors are also cognitively compromised residents. For example, in November 2009, in an Alabama nursing home, a newly admitted mentally retarded, schizophrenic male was found on top of a female resident in her bed. They were both nude. A staff member reported this to her supervisor, and the staff member said that the resident should be taken to the hospital and tested with a rape kit, but the supervisor refused to report the incident or do anything about it because the supervisor did not think there was any evidence that the female had been harmed. Jamie McGriff, Windsor House Nursing Home Under Investigation for Alleged Sexual Abuse, WHNT NEWS 19 (Nov. 5, 2009), http://www.whnt.com/news/whnt-windsor-
CMS and state regulatory agencies also fail to appreciate the magnitude of the offense and the harm done.29

[29. See, e.g., Alden Park Strathmoor, Docket No. C-03-057 (Dep’t of Health & Human Servs. Dec. 4, 2003), http://www.hhs.gov/dab/decisions/CR1116.html. CMS imposed a total CMP of $4,550 in a sexual abuse case where staff failed to monitor a cognitively impaired resident who exhibited sexual aggression toward female residents including findings that [o]n June 18, 2002, R1 was found to be fondling R4 in his bed[;] June 24, 2002, R1 was observed to be bringing R3 into his room[;] o[n] July 2, 2002, R1 was found to be coaxing R5 into his room[;] o[n] July 20, 2002, R1 entered a shower stall while R2 was in the stall. After R1 left the stall, Petitioner’s staff found R2 to be in the stall, naked, and extremely agitated. R2 claimed that R1 had raped her. Id. (citations omitted)

See also Lodge at Maplecreek, Docket No. C-09-516 (Dep’t of Health & Human Servs. Apr. 12, 2010), http://www.hhs.gov/dab/civildecisions/CR2110.pdf. CMS imposed a total CMP of $5,250 in response to the facility’s failure to protect residents from an eighty-two-year-old female resident with Alzheimer’s Disease who had a history of violence against staff (including choking and hitting nurses), violence against residents and their families, and sexual aggression against residents. The most egregious documented incident of sexual aggression occurred when the resident was discovered standing nude at the end of a female resident’s bed and according to the victim, the sexual aggressor had pulled down her pants, climbed on top of her nude, kissed her and touched her breasts and over her incontinence brief. The victim suffered psychological distress as a result of this molestation. The Administrative Law Judge was moved to comment on the amount of the penalty imposed. He said, [h]ere, the civil money penalty that CMS determined to impose falls more or less at the middle of the range of penalties that may be imposed for immediate jeopardy level noncompliance. It is, however, a very small penalty when measured against the duration of Petitioner's noncompliance. The persuasive evidence offered by CMS establishes that Petitioner’s immediate jeopardy level noncompliance began in November]
The final, and in some ways, most disturbing failing is with the law itself.\textsuperscript{30} Realistically, the primary laws that govern these types of sexual assaults are the federal and state regulations governing nursing homes, because other sources of law, such as criminal law and tort law, are less likely to apply for both legal and practical reasons. Regarding criminal law, the prospect of prosecuting an elderly nursing home resident, whose sexually inappropriate conduct is a function of dementia, is dubious at best.\textsuperscript{31} Leaving aside the question of whether such a prosecution would serve the ends of justice, it is doubtful that prosecutors would take up these cases for both public relations and legal reasons. It takes little effort to imagine that a prosecutor might inspire dismay in the public for bringing criminal charges against an elderly, infirmed, nursing home resident whose sexually aggressive conduct was a result of a disease process or brain damage. Such a prosecution is also unlikely because the demented perpetrator would normally lack the \textit{mens rea} necessary to be convicted of a sex crime.\textsuperscript{32}

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\textsuperscript{30} Abuse is defined as “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish” under the federal regulations governing nursing homes. 42 C.F.R. § 488.301 (2010).

\textsuperscript{31} There could be circumstances where it might be appropriate to prosecute a nursing home resident for sexual abuse, but where the assaultive behavior is a function of a disease process, prosecution seems highly inappropriate.

\textsuperscript{32} Meredith J. Duncan, \textit{Sex Crimes and Sexual Miscues: The Need for a Clearer Line between Forcible Rape and Nonconsensual Sex}, 42 WAKE FOREST L. REV. 1087, 1097-98 (2007).
Tort actions against a demented sexually aggressive resident are also a remote possibility for practical, as well as legal reasons. Practically, there are serious damages problems with these cases. The economic damages associated with an assault on an elderly nursing home resident would be de minimis because the victims are well past the earnings period in their lives. The non-economic damages could be very significant, but if the residents who are assaulted are also demented, which many are, it would probably be impossible for them to give testimony to establish those damages. Even if the victims were not demented, the fact that they are in a nursing home indicates that they have serious medical problems that, by the time depositions were scheduled or a trial was held, could make them unable to testify about the trauma of being sexually assaulted. While damages problems will probably not discourage suits in the most egregious circumstances, they are a significant impediment considering the unique frailty and vulnerability of this population.

Suing a demented resident is also unappealing from a tort perspective because of the same intent problem confronted in the criminal law. The most relevant torts would likely be assault and battery and false imprisonment. For assault and battery, many jurisdictions require the tortfeasor to intend to make a harmful or offensive contact with the victim, or the imminent apprehension of such contact, as opposed to intending contact and imposing liability if the contact turns out to be harmful or

Id.

33. Pat Lewandowski, Abuse Charge Dismissed, MONTGOMERY ADVERTISER, Dec. 7, 2006, at B1 (The inability of demented residents to testify about the assault played out tragically in the criminal context in two cases tried in Alabama. A male nurse was charged with raping a demented resident. At trial, the victim identified the judge as her attacker and a mistrial was declared. Because the nurse was not convicted of a felony, he was eligible under state and federal law to be hired by another facility. This nurse was hired by another facility, a resident was raped shortly thereafter and this same nurse was charged again. During this trial, the demented resident also identified the judge as the attacker. According to a local newspaper reporter covering the trial, Autauga County Circuit Court Judge John Bush was “[f]ighting back tears” as he dismissed the case saying “I must rule based on law, regardless of how I feel.”).
offensive. In common parlance, many jurisdictions will not impose liability unless the alleged tortfeasor was trying to harm or offend or knew that harm or offense was almost certain to occur. Making such a case – that a demented nursing home resident acted with the purpose or knew to a substantial certainty that his or her actions were harmful or offensive is daunting at best due to his or her limited comprehension, impaired mental processes and inability to appreciate the antisocial nature of the conduct. Therefore, tort actions against

34. See Ellen M. Bublick, A Restatement (Third) of Torts: Liability for Intentional Harm to Persons – Thoughts, 44 WAKE FOREST L. REV. 1335, 1337 (2009) (quoting RESTATEMENT (THIRD) OF TORTS § 5 cmt. a (2005)) (“[T]ort law treats the intentional infliction of physical harm differently than it treats the intentional causation of economic loss or the intentional infliction of emotional disturbance. In cases involving physical harm, proof of intent provides a basic case for liability.”). “Intent to harm” [under § 1] is defined as a purpose or substantial certainty of producing that result.” Bublick, supra note 34, at 1338.

35. False imprisonment is another possible tort that could be brought, and it stands on a different footing. Battery and assault often require mal-intent or the intent to do harm. False imprisonment requires the specific intent to confine and will generally be tortious so long as the confinement occurs, the defendant was conscious of it (or harmed by it) and the plaintiff neither consented, nor was the contact privileged. See Guntlow v. Barbera, 76 A.3d 760, 762 (N.Y. App. Div. 2010). A plaintiff could realistically meet these elements in a “typical” case where a demented resident has forced himself on a resident in her bed. The demented resident who is laying on top of his victim and molesting her intends to and does confine her, she is conscious of the confinement, she neither actually consents, nor manifests consent, and there is no recognizable privilege for this behavior. This meets the elements of the tort and it is well-settled that the resident’s mental infirmity would not bar liability in tort. Seals v. Snow, 254 P. 348, 349 (Kan. 1927).

It is conceded that the great weight of authority is that an insane person is civilly liable for his torts. This liability has been based on a number of grounds, one that where one of two innocent persons must suffer a loss, it should be borne by the one who occasioned it. Another, that public policy requires the enforcement of such liability in order that relatives of the insane person shall be led to restrain him and that tort-feasors shall not simulate or pretend insanity to defend their wrongfull acts causing damage to others, and that if he was not liable there would be no redress for injuries, and we might have the anomaly of an insane person having abundant wealth depriving another of his rights without compensation.

Id. In spite of the possibility of making out this tort in this setting, no such cases were found in a Westlaw search. Nursing home residents have brought false imprisonment claims against facilities for such things as being improperly restrained, Big Town Nursing Home, Inc. v Newman, 461 S.W.2d 195, 196 (Tex. Civ. App. 1970), and for involuntary confinement, see generally Cathrael Kazin, Comment, “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).
demented sexually aggressive residents are highly unlikely.\textsuperscript{36}

Nursing homes may be susceptible to a negligence suit for failing to properly monitor sexually aggressive residents.\textsuperscript{37} Although liability may be more easily established against a nursing home for failure to protect residents from other residents who are sexual predators, the damages problems remain a significant impediment to bringing suit. Thus, this unique situation, where dementia causes a person to attack another frail, vulnerable person, is most likely to be addressed through enforcement of the federal and state regulations\textsuperscript{38} governing nursing homes.

Unfortunately, although the federal regulations applicable to nursing homes explicitly give residents the right to be free of verbal, physical, and sexual abuse, what happened to Resident A is not technically considered abuse because her attacker’s dementia prevented him from forming the intent necessary to constitute abuse.\textsuperscript{39} Consequently, Resident A is no more than an accident victim.\textsuperscript{40}

Ultimately, the problems with dementia-driven sex abuse in nursing homes run broad and deep. There are serious flaws in the management of sexually aggressive demented residents and the protection of their victims. These problems run from direct

\textsuperscript{36} A Westlaw search conducted in April 2011 could not locate any reported decisions in cases where demented sexually aggressive residents had been sued by their victims under theories of battery, assault, or false imprisonment.

\textsuperscript{37} See, e.g., Harris Methodist Fort Worth v. Ollie, 270 S.W.3d 720, 724, 726-27 (Tex. App. 2008) (A resident may bring a claim against a nursing home for failing to protect her from sexual assault by a demented resident without submitting an expert report); compare Dupree v. Plantation Pointe, L.P., 892 So. 2d 228, 235-36 (Miss. 2004) (Sufficient evidence existed to support a jury verdict that the nursing home was not negligent in the treatment and protection of a resident who was the victim of a sexual assault by another demented resident).

\textsuperscript{38} A discussion of the state regulations governing nursing home sexual abuse cases is beyond the scope of this paper due to the tremendous variance in state regulations governing abuse of the elderly.

\textsuperscript{39} Again, abuse is “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” 42 C.F.R. § 488.301 (2008).

\textsuperscript{40} Woodstock Care Ctr., Docket No. A-2000-32 (Dep’t of Health & Human Servs. May 30, 2000), aff’d sub nom., Woodstock Care Ctr. v. Thompson, 363 F.3d 583, 589-90 (6th Cir. 2003).
care staff, to facility management, to government regulators, and finally even to the law itself.

This article proposes that the solution to this systemic problem can be found in the Patient Protection and Affordable Care Act (Affordable Care Act) if the parts relevant to dementia training and abuse prevention are implemented. The Affordable Care Act was signed into law by President Obama on March 23, 2010.41 Like most landmark legislation, the Act was controversial.42 The Affordable Care Act is most notable for achieving a path to universal health insurance coverage – or at least a semblance of it.43

Although little noticed by many, the law is also a watershed event for long-term care residents.44 According to a prominent

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42. Paul Krugman, Fear Strikes Out, N.Y. TIMES, Mar. 21, 2010, at A27 (discussing the vitriolic response to the Affordable Care Act, but dismissing comparison of the political fallout from President Johnson’s passage of historic civil rights legislation with the predicted fallout from President Obama’s passage of the Affordable Care Act); see also Terri Peretti, Constructing the State Action Doctrine, 1940-1990, 35 LAW & SOC. INQUIRY 273, 299 (2010) (describing President Johnson’s efforts to pass the highly controversial 1964 Civil Rights Act and Johnson’s comment to an aide upon signing the bill that “we have lost the South for a generation”); see generally David Blumenthal & James Morone, Waiting for Another L. B. J., N.Y. TIMES, July 30, 2005, at A15 (discussing President Johnson’s efforts to pass Medicare and Medicaid legislation and the legacy of those programs).
43. Mark Trumbull, Obama Signs Health Care Bill: Who Won’t Be Covered?, CHRISTIAN SCIENCE MONITOR (Mar. 23, 2010, 7:26 PM), http://www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered. Even after passing the Patient Protection and Affordable Care Act, not everyone will be covered. The bill will not provide coverage for undocumented immigrants, people who chose not to enroll in Medicaid, younger workers who may choose to opt out of this coverage in favor of other choices, and people who feel the insurance is still unaffordable. In all, the number of Americans without health insurance could still reach as high as 20 million or more.

As one about provisions that have gotten little attention, Sebelius pointed to the inclusion of the Elder Justice Act, ‘which is a framework to look at abuse of seniors in nursing homes and in home settings — people who take advantage of frail elderly seniors. ‘[It] has been an issue talked about for a very long time,’ she said. ‘It’s now the law of the land. It was part of the underlying Senate bill, and I don’t think many people have ever focused on the fact that that is an important step forward for seniors in
advocate for the elderly,

The House of Representatives' passage . . . of health care reform will create the most significant improvements and changes in long-term care in a generation . . . "This is a momentous week for millions of Americans who need long-term care today, and the millions more who will need it in the coming years." 45

Arguably the two most significant provisions affecting safety and quality care for the demented elderly in the Affordable Care Act are contained in the Elder Justice Act (EJA) 46 and the Nursing Home Transparency and Improvement Act, which are subsumed in the mammoth legislation. 47

The EJA is replete with provisions that are intended to help protect nursing home residents from abuse. Among other provisions, it authorizes $100 million for state demonstration grants to test a variety of methods to detect and prevent elder abuse and $26 million for the establishment and support of Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise and provide services relating to elder abuse, neglect, and exploitation. 48 The EJA also requires the creation of an Elder Justice Coordinating Council and an Advisory Board to make recommendations to the Secretary of Health and Human Services on the coordination of activities of federal, state, local, and private agencies and entities relating to elder abuse, neglect, and exploitation. 49 One of the functions of the Advisory Board is to develop approaches for dealing with resident-to-resident abuse and to recommend changes in laws and regulations


48. Elder Justice Act § 6703, 124 Stat. at 794-95; Id. at 790-91.

related to abuse and neglect.\textsuperscript{50} The Elder Justice Act also authorizes the creation of a National Training Institute for Surveyors that will provide training to federal and state surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property.\textsuperscript{51}

The Nursing Home Transparency and Improvement Act (NHTIA) is primarily focused on requiring owners and operators of federally-funded nursing homes to publicly disclose the people and entities who have an ownership interest or management role in the nursing home.\textsuperscript{52} This was necessary to counter a growing trend in the nursing home industry of private equity firms buying nursing home chains and structuring the corporate ownership in such a byzantine fashion that the owners were effectively operating without fear of liability for poor care.\textsuperscript{53} Care at these private equity owned facilities reportedly deteriorated after they became functionally judgment-proof.\textsuperscript{54} The NHTIA also focuses on dementia care explicitly. It provides that nurse aides must be given specialized training on dementia and abuse prevention as part of their initial training.\textsuperscript{55}

Remarkably, if Congress appropriates funds to implement the EJA and NHTIA, and if demented resident-to-resident sexual abuse is part of the focus, a lot of what is needed to address this problem is in the statute. In addition to involving virtually every agency charged with protecting elders from abuse, the EJA specifically commands the government review the issue of resident-to-resident abuse, recommend best

\begin{itemize}
\item \textsuperscript{50} Id. at 788.
\item \textsuperscript{51} Id. at 798.
\item \textsuperscript{52} Nursing Home Transparency and Improvement Act § 6101, 124 Stat. at 699-700.
\item \textsuperscript{53} See Charles Duhigg, \textit{At Many Homes, More Profit and Less Nursing}, N.Y. TIMES, Sept. 23, 2007, at N34. According to the New York Times report, private equity firms bought thousands of facilities and spread ownership and control over as many as fifteen different companies and five layers of firms. After making these facilities functionally liability proof, the new owners cut staffing dramatically, and care drastically deteriorated. \textit{Id.}
\item \textsuperscript{54} Id.
\item \textsuperscript{55} Nursing Home Transparency and Improvement Act § 6121, 124 Stat. at 720-21.
\end{itemize}
practices with respect to managing resident-to-resident abuse, determine the best way to carry out those best practices, and make "recommendations for specific modifications needed in Federal and State laws (including regulations) or for ... training to enhance prevention, detection, and ... intervention in (including investigation of), ... elder abuse, neglect, and exploitation." 56

It is the goal of this article to make the case that demented resident-to-resident sexual abuse is an important part of the problem of elder abuse and to offer solutions to this problem that can be utilized by those implementing the Affordable Care Act.

This paper will begin by examining the regulatory system that is supposed to ensure that federally funded nursing homes are providing appropriate care and protection to nursing home residents. Then, the problems with the abuse regulations will be explored. The difficulty of defining abuse as willful conduct in a population that suffers high levels of dementia will be analyzed, as will the problematic interpretation the Departmental Appeals Board (DAB) 57 has given the primary abuse regulation. The paper will then propose solutions to these problems in the form of a new definition of "sexual abuse" that includes nonconsensual sexual contact as abuse and a new regulation explicitly requiring facilities to take reasonable and necessary steps to protect residents from the risk of abuse and actual abuse. The legal problems addressed, the paper will then discuss how provisions in the Affordable Care Act will enhance awareness of the problem of elder abuse and provide much needed training of direct care providers and surveyors concerning dementia and abuse. The paper will discuss the

57. The DAB is an adjudicatory body within the U.S. Department of Health and Human Services that has the responsibility of hearing cases brought pursuant to appeals of federal nursing home enforcement actions. The cases are first brought to ALJs and then the DAB reviews those decisions upon the request of the government or a facility. Facilities may appeal adverse decisions of the DAB to U.S. federal courts.
dearth of research in the area of sexual abuse in nursing homes and will discuss how some of the existing scholarship fails to appreciate the importance of dementia, thereby advocating criminal justice-based solutions which put too much emphasis on the conduct of the demented and not enough emphasis on facilities' duty to protect residents from all sexual aggressors, be they demented or not.

**THE FEDERAL REGULATORY APPROACH TO SEXUAL ASSAULTS BY DEMENTED RESIDENTS**

In 1987, the federal government made the "most comprehensive revision to federal nursing home law since the Medicare and Medicaid programs were enacted in the 1960s." The new law drastically changed the requirements for nursing homes participating in the Medicare and Medicaid programs and the manner in which the federal government evaluated minimum standards for compliance with program requirements.

On December 22, 1987, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) was enacted. Part of OBRA '87, the Nursing Home Reform Act (NHRA), amended the Social Security Act and provided for a much more expansive survey and enforcement process that focused on health and safety regulations for nursing homes and was administered cooperatively by the state and federal governments. Prior to OBRA '87, nursing homes only had to comply with fifteen statutory requirements that were not related to resident health and safety in order to be eligible for Medicare participation.
The sanctions available for non-compliance were also extremely limited. After the passage of the OBRA '87, the regulatory environment for nursing homes receiving Medicare payments changed radically. Instead of being subject to fifteen requirements of participation, nursing homes became subject to more than 100 statutory requirements, many related to quality of care, which had to be substantially complied with in order to participate in Medicare and Medicaid programs.

OBRA '87 has a lofty directive for nursing homes; they "must care for [their] residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." To facilitate this directive, the statute dictates many specific actions that facilities must take to maintain compliance. These actions include requiring facilities to assess residents upon admission, quarterly, and at any time the resident has experienced a significant change in his or her physical or mental condition. The statute actually commands facilities to use a very detailed instrument to do the assessment. Facilities must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this

these [long-term care] facilities are specified in HCFA regulations at 42 CFR part 483, Subparts A through C." Id.; 42 C.F.R § 483.1-80 (1991); see also INST. OF MED., IMPROVING THE QUALITY OF LONG-TERM CARE 5 (Gooloo S. Wunderlich & Peter O. Kohler eds., 2001).

63. Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities, 57 Fed. Reg. at 39,279. Prior to OBRA '87, the only sanctions provided for by statute for noncompliance with requirements for participation were "termination, nonrenewal, or automatic cancellation of provider agreements; denial of participation for prospective facilities; and denial of payment for new admissions in lieu of termination when the facilities . . . did not pose an immediate and serious threat to the health and safety of residents." Id.


66. § 1396r(b)(3)(C)(i)-(ii).
section;
(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and
(iv) includes the identification of medical problems.67

OBRA '87 also requires that facilities have a very detailed written plan of care for each resident which
(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;
(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and
(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).68

OBRA '87 also requires nursing homes to provide numerous services to meet the needs identified in the resident's care plan including necessary rehabilitative services, social services, pharmaceutical services, dietary services, activities programs, routine and emergency dental services, and treatments required for the mentally ill and mentally retarded.69

In addition to an expansive list of duties, OBRA '87 also provides nursing home residents with a broad array of rights.70 Nursing homes must promote and protect each resident's right to free choice,71 right to the freedom from restraints,72 privacy,73

67. § 1396r(b)(3)(A).
68. § 1396r(b)(2).
69. § 1396r(b)(4)(A).
70. § 1396r(c)(1).
71. § 1396r(c)(1)(A)(i). The right to free choice is described as follows: The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.
72. § 1396r(c)(1)(A)(ii). The right to be free from restraints is described as follows: The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

Id.
confidentiality, right to the accommodation of needs, right to air grievances, right to participate in resident and family groups, right to participate in other activities, right to examine survey results, and right to refuse certain transfers.

(I) to ensure the physical safety of the resident or other residents, and
(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

Id.

§ 1396r(c)(1)(A)(iii). The right to privacy is described as follows: “The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.” Id. The right to privacy does not require the facility to provide a private room.

§ 1396r(c)(1)(A)(xi).

74. § 1396r(c)(1)(A)(iv). The right of confidentiality is described as follows: “The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident’s legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.” Id.

§ 1396r(c)(1)(A)(v). The right to accommodation of needs is described as follows: “The right – (I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and (II) to receive notice before the room or roommate of the resident in the facility is changed.” Id.

§ 1396r(c)(1)(A)(vi). The right to air grievances is described as follows: “The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.” Id.

§ 1396r(c)(1)(A)(vii). The right to participate in resident and family groups is described as follows: “The right of the resident to organize and participate in resident groups in the facility and the right of the resident’s family to meet in the facility with the families of other residents in the facility.” Id.

§ 1396r(c)(1)(A)(viii). The right to participate in other activities is described as follows: “The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.” Id.

§ 1396r(c)(1)(A)(ix). The right to examine survey results is described as follows: “The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.” Id.

§ 1396r(c)(1)(A)(x). The right to refuse certain transfers is described as follows:

The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is not a skilled nursing facility (for purposes of subchapter XVIII of this chapter) to a portion of the facility that is such a skilled nursing facility.
To enforce these duties and protect these rights, the federal government and the states jointly operate one of the largest regulatory law enforcement programs in the country.\textsuperscript{81} Facilities must be surveyed at least once every fifteen months.\textsuperscript{82} The surveys are performed by multi-disciplinary teams of CMS-trained and certified health professionals.\textsuperscript{83} All survey teams must have at least one registered nurse.\textsuperscript{84} Survey teams investigate whether facilities are in substantial compliance with program requirements.\textsuperscript{85} The purpose of these surveys is to genuinely assess the quality of the care the nursing home residents are receiving rather than simply ensuring that certain processes and procedures were being performed as was common prior to OBRA '87.\textsuperscript{86}

OBRA '87 also greatly expanded the type of sanctions that the government may impose for regulatory violations.\textsuperscript{87} Before OBRA '87, the primary sanction that the Secretary imposed was termination from participation in the Medicare and Medicaid programs (which was imposed very rarely).\textsuperscript{88} After the passage of OBRA '87, the government was authorized to impose CMPs of anywhere between $50 and $10,000 per day, or up to $10,000 per instance, for facilities failing to maintain substantial compliance with federal regulations.\textsuperscript{89} The concept behind the per-day penalties was to provide nursing homes with an incentive to quickly find solutions to regulatory violations so

\textsuperscript{83} § 1396r(g)(2)(E)(i).
\textsuperscript{84} Id.
\textsuperscript{85} See § 1396r(h)(4).
\textsuperscript{86} 42 C.F.R. § 488.110 (2007).
\textsuperscript{87} Jennifer Gimler Brady, Long-Term Care Under Fire: A Case for Rational Enforcement, 18 J. CONTEMP. HEALTH L. & POL'Y 1, 16 (2001); see also COMM. ON NURSING HOME REGULATION, INST. OF MED., IMPROVING THE QUALITY OF CARE IN NURSING HOMES App. at 242 (Nat'l Acad. Press 1986).
\textsuperscript{88} Brady, supra note 87, at 15.
they could keep their CMPs lower.\textsuperscript{90} CMPs are the most often used sanction provided by OBRA '87, but the statute also authorized the appointment of a substitute manager by the state survey agency,\textsuperscript{91} empowered the Secretary to direct facilities to provide in-service training of staff regarding deficient areas identified during a survey,\textsuperscript{92} and directed facilities to develop plans of correction for cited deficiencies.\textsuperscript{93} The statute also allowed for the placement of a state monitor in the nursing facility\textsuperscript{94} and the transfer of residents and closure of the facility.\textsuperscript{95}

Although there are still very serious health and safety concerns facing nursing home residents, OBRA '87 is widely acknowledged to have positively impacted care to residents.

There has been nearly a 50 percent reduction in the use of restraints, freeing 250,000 elderly patients each year. There has been a significant increase in the involvement of families and residents in care plan meetings and decisions. . . . Behavior management programs for wandering, aggression, or resisting care have increased by 27 percent. The use of hearing aids has increased by 30 percent. The use of toileting programs for incontinence has doubled.\textsuperscript{96}

THE ABUSE REGULATIONS

Although OBRA '87 did much to improve the regulation of long-term care facilities and the health of long-term care residents, one of the problem areas remaining is abuse. Abuse is still a significant problem in nursing homes despite regulations designed to prevent it.\textsuperscript{97} According to the regulations, "The

\textsuperscript{90} Brady, \textit{supra} note 87, at 16.
\textsuperscript{91} 42 C.F.R. § 488.406(a)(1).
\textsuperscript{92} Id. § 488.406(a)(8).
\textsuperscript{93} Id. § 488.406(a)(7).
\textsuperscript{94} Id. § 488.406(a)(4).
\textsuperscript{95} Id. § 488.406(a)(6).
\textsuperscript{97} Fact Sheet: Elder Abuse Prevalence and Incidence, NAT'L CTR. ON ELDER ABUSE
resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.”98 In addition to this right to be free from sexual abuse (among other abuses), the federal regulations also impose duties on facilities with respect to protecting their residents from abuse and neglect.

Facilities “must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . .”99 They “must [n]ot use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.”100 Facilities “must [also] ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures . . . .”101

The facilities must

have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with state law . . . within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.102

Facilities must also

[n]ot employ individuals who have been [f]ound guilty of abusing, neglecting, or mistreating residents by a court of law; or [h]ave had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and [they must] [r]eport any knowledge [they have] of actions by a court of law against an employee, which would indicate unfitness for service as a nurse

(2005), http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/publication
/FinalStatistics050331.pdf.

99. § 483.13(c).
100. § 483.13(c)(1)(i).
101. § 483.13(c)(2).
102. § 483.13(c)(3),(4).
aide or other facility staff to the State nurse aide registry or licensing authorities.\textsuperscript{103}

Although abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish,"\textsuperscript{104} sexual abuse is not defined in the regulations. CMS provides state surveyors with a State Operations Manual (SOM) that guides them in carrying out the survey process.\textsuperscript{105} The 665-page SOM does not define sexual abuse, and its instruction to surveyors about what constitutes sexual abuse is not particularly illuminating. The SOM merely says that sexual abuse "includes but is not limited to, sexual harassment, sexual coercion, or sexual assault."\textsuperscript{106} The SOM neither defines sexual harassment, sexual coercion, or sexual assault, nor does it provide any examples of situations that might constitute sexual harassment, sexual coercion or sexual assault.\textsuperscript{107}

The manner in which abuse is treated in the regulations is problematic. All types of abuse are grouped together; there are no definitions of critical terms such as sexual abuse, and the SOM uses terms to distill the meaning of sexual abuse (sexual harassment, sexual coercion, sexual assault) that are almost as opaque as the term sexual abuse itself. The only thing that is clear about the sexual abuse definition is that sexual abuse only occurs when the perpetrator willfully and intentionally harms the resident; this definition, although clear, is highly problematic.

\begin{thebibliography}{10}
\bibitem{103} § 483.13(c)(1)(ii)-(iii).
\bibitem{104} 42 C.F.R. § 488.301 (2008).
\bibitem{106} \textit{Id.} at 62.
\bibitem{107} \textit{See id.} at 61-64.
\end{thebibliography}
THE PROBLEM WITH REQUIRING WILLFULNESS IN THE DEFINITION OF ABUSE IN THE NURSING HOME POPULATION

In general, limiting the concept of abuse to those situations where there is clearly a willful intent to cause harm of some sort is sensible on its face and probably works well in most settings. Except for extraordinary circumstances, the overwhelming amount of abuse of children, adults, and the elderly that occurs outside of nursing homes is the product of deliberate, purposeful action. Thus, a definition that requires such intent is perfectly reasonable.

However, the same is not true in nursing homes. Studies examining abuse of the elderly in nursing homes have concluded that nursing home residents are far more likely to be physically, verbally, or sexually abused by demented residents than by facility staff, family members, or others residing outside the nursing home.\textsuperscript{108} If demented residents are driving most of the abuse in nursing homes, then the threat of abuse is directly related to the prevalence of dementia in nursing homes. The data is discouraging in terms of the mental status of nursing home residents, both now and in the future.

According to a report by the Alzheimer’s Association, more than 50 percent of residents in assisted living and nursing homes have some form of dementia or cognitive impairment, including Alzheimer’s. Available research indicates that about 67 percent of dementia-related deaths occur in nursing homes. The number of people with Alzheimer’s is projected to sharply increase from more than 5 million today to as many as 16 million by 2050, as the 78 million Baby

\textsuperscript{108} Demented residents are also more likely to be victims of sexual abuse than non-demented residents. CATHERINE HAWES & ANNE-MARIE KIMBELL, PROGRAM ON AGING & LONG-TERM CARE POLICY, SCHOOL OF RURAL PUB. HEALTH, TEX. A&M HEALTH SCI. CTR., DETECTING, ADDRESSING, AND PREVENTING ELDER ABUSE IN RESIDENTIAL CARE FACILITIES 33 (2009). “For example, between 1997 – 2002, ombudsmen reports to the Administration on Aging (AoA) indicated that physical abuse by anyone and resident-to-resident abuse were the highest rates of abuse reported.” Id. (citation omitted). See Ann. W. Burgess & Steven L. Phillips, Sexual Abuse, Trauma and Dementia in the Elderly: A Retrospective Study of 284 Cases, 1 VICTIMS & OFFENDERS 193, 198 (2006).
Boomers mature and reach the age of highest risk.109

Fortunately, baby boomers have an array of home- and community-based options that did not exist for earlier generations, and many will not have to reside in nursing homes.110

However, because of these expanded care and treatment options, and because of better health among the elderly, nursing homes are losing population, but will likely become the home of last resort for our most mentally and physically infirmed

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The number of Americans with Alzheimer’s disease and other forms of dementia is increasing at an alarming rate. Roughly ten million of the country’s seventy-nine million baby boomers can expect to develop Alzheimer’s disease or another form of dementia. Among nursing home residents, dementia is the most common diagnosis. One of eight people 65 and older – and nearly one out of two older than 85 – has Alzheimer’s disease. Of all nursing home residents 46.4 percent had a diagnosis of Alzheimer’s or other dementia in their nursing home record in June 2007, and approximately half of this group relied on Medicaid.

Id.

110. Edward Alan Miller & Lili Wang, Maximizing Federal Medicaid Dollars: Nursing Home Provider Tax Adoption, 2000-2004, 34 J. HEALTH POL., POL’Y & L. 899, 900, 909 (2009). Home- and community-based services allow residents who are eligible to live outside the nursing home and still receive Medicaid benefits. Id. Community-based services have grown substantially in the last few decades as a consequence of the Supreme Court’s 1999 decision in Olmstead v. L.C., 527 U.S. 581, 582-83 (1999), which held that using public dollars to care for the disabled in institutional settings violates the Americans with Disabilities Act of 1990 if these people could also be treated appropriately in the home or community. By providing alternatives to nursing home placement, home-and community-based services help to reduces costs because institutional care is much more expensive than providing home and community-based services. See H. Stephen Kaye et al., Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?, 28 HEALTH AFF. 262, 262 (2009).

An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings.

Id.
citizens.\textsuperscript{111}

The effect of better health among the elderly and better options for care outside the nursing home is already being felt inside the nursing home. Nursing home residents are older, sicker, and more frail than they were as recently as 1999. According to data from the most recent National Nursing Home Survey, nearly eighty-five percent of newly admitted residents in 2004 were seventy-five years old or older.\textsuperscript{112} Sixty two percent were admitted to the nursing home directly from a hospital.\textsuperscript{113}

Nursing home residents are also more likely to have serious mental or cognitive diagnoses than just a few years ago. In 1999, just over a quarter of newly admitted nursing home residents had "one or more mental or cognitive diagnoses (dementia, depression, schizophrenia, affective and other serious disorders)."\textsuperscript{114} In 2004, that number had increased to just over a third.\textsuperscript{115} Newy admitted residents diagnosed with dementia increased slightly from 10.3\% in 1999 to 11.3\% in 2004.\textsuperscript{116}

The most significant change between 1999 and 2004 occurred in residents who had serious physical and mental diagnoses. Between 1999 and 2004, the number of newly admitted residents who had both physical and mental/cognitive impairments increased from fifteen percent in 1999 to almost a quarter of the population in 2004.\textsuperscript{117}

\begin{itemize}
\item \textsuperscript{111} Adrienne L. Jones et al., Dep’t of Health & Human Servs., Ctrs. for Disease Control, DHHS Pub. No. 2009-1738: The National Nursing Home Survey: 2004 Overview at 1 (2009), available at http://www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf ("According to the 2004 [National Nursing Home Survey], there were almost 1.5 million nursing home residents in 16,100 facilities. This number of current residents is similar to survey results from 1985 but still represents a decrease of more than 136,100 residents from 1999.").
\item \textsuperscript{113} Id. at 8 tbl.1.
\item \textsuperscript{114} Id. at 9.
\item \textsuperscript{115} Id.
\item \textsuperscript{116} Id. at 10 tbl.2.
\item \textsuperscript{117} Id. at 9.
\end{itemize}
A MORE DEMENTED AND FRAIL POPULATION CREATES SIGNIFICANT RISK FOR DEMENTIA-DRIVEN RESIDENT-TO-RESIDENT SEXUAL ABUSE

As the nursing home population grows older, more feeble, and more demented, the opportunities for sexual abuse by demented residents increase. The more physically and mentally compromised you are, the harder it is to defend yourself against invasions of your person. There is also reason to believe that facilities are struggling with complications brought about by the declining status of the nursing home population. According to Otis Woods, state survey agency director for the state of Wisconsin, his office has seen an increase in serious violations in nursing homes in the latter part of 2010. Mr. Woods attributed that increase to the fact that nursing homes in Wisconsin have more physically and mentally compromised populations than before and facilities are having trouble coping with such a high volume of very ill residents.118

The main concern with having increased dementia in the nursing home population is that some level of sexual inappropriateness and violence is inevitable in this population. The ravages of dementia are evident to anyone working with the demented population and, according to the literature, they include sexually inappropriate and aggressive behavior in two to seventeen percent of the demented population.119 The reasons


Studies of the prevalence of sexually disinhibited behaviour in people with dementia report rates of 2–17%. Burns et al. (1990) found that 6.9% of 178 people with Alzheimer’s disease living at home, in residential care or in hospital showed sexually inappropriate behaviour (exposure, obscene sex language, masturbation, propositioning others), with about equal frequency in men (8%) and women (7%). There was a significant positive association with severity of dementia.

Sourander & Sjogren (1970) studied 132 cases of Alzheimer’s disease verified on post-mortem examination, reporting abnormal sexual behaviour in 17%. Rabins et al. (1982) interviewed the caregivers of 55 people with dementia and found that only one family (2%) reported the
for sexually inappropriate behavior among demented people are complex. They include disease-related factors such as frontal lobe lesions, delusions or hallucinations. Social factors such as lack of privacy or a missing former sexual partner also play a role in some sexually inappropriate activity observed in the demented population residing in nursing homes. Psychological factors such as depression and preexisting sexual patterns can also influence behavior after the onset of dementia. Pharmacological factors such as taking benzodiazepines and L-dopa may also cause sexual disinhibition among demented nursing home residents. Sexually inappropriate behavior has also been noted among those who have suffered a traumatic brain injury.

There has been very little study of dementia-driven sexually inappropriate behavior in nursing homes, but a recent study does provide some important insights into sexually inappropriate conduct of demented people in residential care facilities. In 2008, Kate de Medeiros and her colleagues at Johns Hopkins University School of Medicine studied inappropriate sexual activity in a facility with long-term care and assisted living beds that was affiliated with Johns Hopkins. The study involved the review of medical records for all 165 residents of the facility to determine which residents had notations of occurrence of inappropriate sexual behaviour. Kumar et al. (1988) compared questionnaire data relating to 28 people with Alzheimer's disease and normal controls and found no significant difference in assaultative [sic] or sexually inappropriate behaviour (7% in both groups). Drachman et al. (1992) reported hypersexual behaviour in 17% of outpatients with dementia and 8% of in-patients.

\textit{Id.}
120. \textit{See id.} at 425.
121. \textit{Id.}
122. \textit{Id.}
123. \textit{Id.}
124. \textit{Id.}
improper sexual activity in records during calendar year 2005. The authors identified twenty residents with such notations and compared those residents to a control group of another twenty residents. The authors stratified the reported improper sexual behavior into two categories, “intimacy-seeking” and “disinhibited.”

Intimacy-seeking was characterized by “behaviors that were, in their essence, consistent with normal interpersonal behavior that might be observed in persons who do not have dementia, but misplaced in social context. In contrast, the disinhibited subjects manifested rude and intrusive behaviors that would be considered abnormal in most contexts.” Examples of intimacy-seeking behaviors included handholding, kissing, and caressing; examples of disinhibited behavior included frotteurism (rubbing against another without their consent), indiscriminate groping, and lewd and vulgar talk.

The findings showed that improper sexual behavior is not uncommon in the population of demented residents residing in residential care facilities, such as nursing homes. In the one-year time frame of this study, 7.9% of all of the residents of this facility (all of whom suffer from long-term dementia) exhibited sexually inappropriate behavior. Disinhibited sexual behaviors were present in 3.6% of the population.

The study also showed that the type of dementia appears to be correlated with the type of improper sexual behavior manifested. All of the residents who exhibited intimacy-
seeking behavior had Alzheimer's disease, while all of the residents who engaged in disinhibited sexual behavior had non-Alzheimer's dementia.\textsuperscript{136} Residents who engaged in disinhibited sexual behavior also exhibited a high frequency of concurrent behavior disorders such as irritability, agitation, paranoia, and aggression, whereas residents who engaged in intimacy-seeking sexual behavior were less likely to have these types of concurrent behavior disorders.\textsuperscript{137}

The findings with respect to the severity of the dementia were also interesting and have important consequences for nursing home operators. All of the intimacy-seeking residents had either moderate to severe dementia, while half of the sexually disinhibited residents were diagnosed with mild dementia.\textsuperscript{138} Nursing home operators often set aside special units where their most demented residents live. These units often have staff that are better trained and have more experience caring for the most severely demented residents. Facilities expect the more demented residents to pose the most significant care challenges and they plan accordingly.

The findings of the de Medeiros study indicate that half of the most serious sexually-oriented behavioral problems do not

\textsuperscript{136} de Medeiros et al., \textit{supra} note 126, at 376.
\textsuperscript{137} \textit{Id.} at 374.
\textsuperscript{138} \textit{Id.} at 373. This finding caused the authors to speculate that the sexually disinhibited behavior among the mildly demented was a function of a biological phenomenon rather than cognitive deficits. \textit{See} K. Alagiakrishnan et al., \textit{Sexually Inappropriate Behavior in Demented Elderly People}, 81 POSTGRADUATE MED. J. 463, 463 (2005).

Abnormal sexual behaviour in the long term care setting includes unwanted sexual advances such as climbing into bed with other residents in a nursing home or actual attempts of intercourse and aberrant sexual behaviour such as sexual aggression. Sexual aggression manifesting itself as hypersexuality may also be attributable to drugs, psychosis, mania, and various neurological disorders including frontal lobe lesions. Inappropriate sexual behaviour in the demented person can be difficult to assess because the person may not be able to explain their [sic] actions. While most sexually aggressive behaviour/inappropriate sexual behaviour occurs in the moderate to severe stages of Alzheimer's dementia, it may also be seen in early stages of fronto-temporal dementia because of the lack of insight and disinhibition.

\textit{Id.}
emanate from the most severely demented residents. They come from the mildly demented residents who, by and large, live along with the rest of the nursing home population and do not receive the extra attention from specially trained and experienced staff.  

CMS'S APPROACH TO THE PROBLEM WITH ITS DEFINITION OF ABUSE

In spite of the current problem with dementia-driven resident-to-resident sexual abuse and the fact that it is almost certain to get worse as a greater percentage of nursing home residents will be suffering from dementia, the regulation governing abuse does not consider this type of bodily invasion abuse. CMS is aware that its definition of abuse does not cover situations where demented residents abuse other residents. Accordingly, CMS has instructed surveyors to cite abuse by demented residents under the regulation that governs the prevention of accidents. The SOM states:

An incident involving a resident who willfully inflicts injury upon another resident should be reviewed as abuse under the guidance for 42 CFR §483.13(b) at F223. "Willful" means that the individual intended the action itself that he/she knew or should have known could cause physical harm, pain, or mental anguish. Even though a resident may have a cognitive impairment, he/she could still commit a willful act. However, there are instances when a resident’s willful intent cannot be determined. In those cases, a resident-to-resident altercation should be reviewed under [the accident] tag, F323.

State agencies are following CMS's instructions and citing sexual abuse committed by demented residents as accidents.

139. Burgess & Phillips, supra note 108, at 198. Demented residents are also more likely to be victims of sexual abuse than non-demented residents. Id.
140. See CMS STATE OPERATIONS MANUAL, supra note 105, at 283.
141. Id.
142. Libertywood Nursing Center, Docket No. C-07-253 (Dep't of Health & Human Servs. May 4, 2009), www.hhs.gov/dab/decisions/civildecisions/crl945.pdf (a North Carolina state survey agency cited the facility for failing to protect
There are many problems with describing sexual abuse as an accident. Classifying abuse by demented residents as an accident understates the problem of sexual abuse in nursing homes. Understating this problem has several consequences. First and foremost, it diminishes the perception of the harm done to the residents who are the victims of the abuse. This may cause state survey agencies to impose absurdly small sanctions on facilities when this type of abuse is present. The failure to appreciate this conduct as abuse may also cause facility staff to under-react and fail to protect residents. Calling this type of abuse an accident also has the effect of misinforming the public who access CMS’s Nursing Home Compare website. Nursing Home Compare is a website operated by CMS that is designed to give the public important information about nursing homes that should enable consumers to differentiate good facilities from bad ones:

Data about any federally-certified nursing facility is available at the federal government’s Nursing Home Compare website, at www.medicare.gov/NHCompare. The data include 19 quality measures expressed in percentages, such as the percentage of residents who have pressure sores, are incontinent, have lost too much weight, or spend most of their time in bed or in a chair. The data is drawn from individual residents’ Minimum Data Set assessments, as well as from data self-reported by facilities for the Online Survey, Certification, and Reporting (OSCAR) database.

Nursing Home Compare also provides information about survey histories of facilities, but it does not go into detail about residents from accidents under 42 C.F.R. § 483.25(h)(2) based on the attack of a resident by a demented resident).

A parallel can be drawn to how Arab societies criminalize homicide but don’t view females killed in “honor” killings as victims, and therefore tolerate that form of violence. See Nadera Shalhoub-Kevorkian, Femicide and the Palestinian Criminal Justice System: Seeds of Change in the Context of State Building?, 36 LAW & SOC’Y REV. 577, 580 (2002).

See Eric M. Carlson, Negotiating For Resident-Centered Care, 10 MARQ. ELDER’S ADVISOR 21, 34 n.98 (2008) (citing Vincent Mor, Improving the Quality of Long-Term Care with Better Information, 83 MILBANK Q. 333, 348 (2005)).

Id. at 34 n.98.
DEMENTIA-DRIVEN SEXUAL ABUSE

the bases for the violations. Thus, for example, Nursing Home Compare would present what happened to Resident A in the Sunrise Care & Rehabilitation – Cambridge Drive case (discussed in the opening paragraphs of this article) and most other sexual assaults committed by demented residents as a failure to prevent avoidable accidents, without any further information.

A DEFINITION OF SEXUAL ABUSE THAT DOES NOT RELY ON WILLFULNESS OF THE PERPETRATOR, BUT ON INVASION SUFFERED BY THE VICTIM SHOULD BE ADOPTED BY CMS

Fortunately, addressing the definitional problem can be done rather easily. The existing definition of abuse can remain if CMS adds a definition for “sexual abuse.” The definition of sexual abuse used by most state Adult Protective Services (APS) agencies and the federal National Center for Elder Abuse (NCEA)\(^ {146} \) provides a good model.\(^ {147} \) Under the NCEA definition, sexual abuse is “non-consensual sexual contact of any kind with an elderly person.”\(^ {148} \) Nursing homes mostly house the elderly, but not exclusively, so this definition would need to be modified to be resident-specific, not age-specific. Thus, the definition of sexual abuse would be “non-consensual sexual contact of any kind with a resident.”

\(^ {146} \) What We Do, Nat’l Ctr. on Elder Abuse, http://www.ncea.aoa.gov/NCEAroot/Main_Site/About/What_We_Do.aspx (last updated May 25, 2010); Nat’l Ctr. on Elder Abuse, Admin. on Aging, National Center on Elder Abuse Information Sheet: Who We Are and What We Do (2010), available at http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/publication/AboutNCEA_2010.pdf. The NCEA began as a national elder resource center for the U.S. Administration on Aging (AoA) in 1988; in 1992, the NCEA was made a permanent part of AoA pursuant to amendments made to Title II of the Older Americans Act. The NCEA assists elder rights advocates, APS, law enforcement, legal professionals, policy leaders, researchers, and others to provide solutions to the problem of elder abuse.


The SOM could be easily revised to give guidance to surveyors that is consistent with the NCEA’s guidance on what constitutes sexual abuse. The NCEA provides that “[s]exual contact with any person incapable of giving consent is also considered sexual abuse. [Sexual Abuse] includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.” It would also be wise to add language indicating that sexual abuse also includes unwanted touching, where the person doing the touching is doing so to sexually arouse himself or to sexually arouse the resident. This type of language is not uncommon in criminal sex crime statutes, and this type of abuse has occurred in nursing homes.

Defining sexual abuse this way has a number of virtues, chief among them the explicit recognition that residents who are sexually molested by demented residents are in fact victims of abuse. This definition also covers the other types of sexual abuse that occur in facilities, such as sexual battery, rape, and sodomy. This definition has the benefit of achieving interagency consistency because it is the same one used by the Administration on Aging. This definition also makes it clear that comatose victims or other victims who are unable to feel pain or mental anguish can also be the victims of sexual abuse. Under the current definition of abuse, only those residents who

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149. Id.

150. A survey of the Piedmont Health Care Center revealed that two female staff members were repeatedly fondling a female resident’s breasts, touching her inappropriately in her pubic region and engaging in sexually explicit conversations with her. Staff observed these types of behaviors for months. Management was notified, but initially did nothing. After state surveyors investigated, the perpetrators were fired. At no time did staff, management, state surveyors, or CMS officials notify the local criminal authorities. The author of this article was the attorney who handled the case for CMS and notified the local prosecutor. Both perpetrators were indicted on abuse charges. The survey report is on file with the author.

151. The definition omits certain types of behavior like sexual voyeurism or “peeping toms” and exposing oneself. Admittedly, omitting any type of sexually motivated inappropriate conduct is troublesome. However serious this type of misconduct is, it does not rise to the level of seriousness of a physical invasion, and therefore, it may arguably be excluded from the definition of sexual abuse.
are injured or feel pain or mental anguish can be abused.\textsuperscript{152}

**WHEN SHOULD FACILITIES BE LIABLE FOR ABUSE COMMITTED BY DEMENTED RESIDENTS?**

Fixing the definitional problem is an important and necessary step, but the regulations as currently written still do not articulate a coherent standard by which facilities should be judged when a resident is abused. Violations that are a result of a resident actually being abused are cited under Tag F223.\textsuperscript{153} The regulation at issue in Tag F223 is 42 C.F.R. § 483.13(b). This regulation is a “rights” regulation; it says that residents have “the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.”\textsuperscript{154} While this regulation makes clear that residents have the right to be free from abuse it does not speak to the circumstances in which facilities will be found out of compliance with the federal regulations in the event a resident’s right to be free of abuse is violated. One could argue that this regulation simply does not subject facilities to liability for abuse, because it speaks only of rights of residents without a corresponding duty of facilities to protect those rights. However, as Hohfeld illuminated, legal rights must impose duties on another to act or not act for the right-holder’s benefit.\textsuperscript{155} Fundamentally, it makes no sense to read this regulation in a way that makes it meaningless in the enforcement scheme, especially since it is the only regulation that speaks directly to resident abuse.

If this regulation is to be given meaning, then what meaning should it be given? There are a number of ways this regulation can be interpreted that are arguably consistent with the text.

\begin{footnotesize}
\begin{enumerate}
\item The definition of abuse requires a victim of abuse to experience “physical harm, pain or mental anguish.” 42 C.F.R. § 488.301 (2008). Not every act of sexual abuse causes physical harm, and the most severely infirmed residents, like residents in a coma, are incapable of feeling pain or mental anguish.
\item CMS STATE OPERATIONS MANUAL, supra note 105, at 61-64.
\item 42 C.F.R. § 483.13(b) (2008).
\end{enumerate}
\end{footnotesize}
and/or purpose of the regulation. If one assumes that facilities are responsible for upholding residents’ rights, a case can be made that this regulation imposes absolute liability on facilities when the resident’s right to be free of abuse is lost. This interpretation seems somewhat consistent with the regulation’s language because the consequence (facility liability) is triggered when the right to be free from abuse is lost. It also seems consistent with the ‘OBRA ’87’s purpose of making facilities accountable for resident outcomes. However, absolute liability is generally disfavored, so a reading of the regulation that would impose absolute liability on a facility any time a resident was the victim of abuse is doubtful.

Another way to interpret this regulation is to find facilities strictly liable when their acts or omissions, or the acts or omissions of their agents, cause the loss of the right to be free from abuse. This interpretation of the regulation imposes liability when the right is lost, but only if the facility somehow caused the harm. Although this interpretation adheres to the bedrock principle of American jurisprudence that there should be no liability in the absence of causation, it still requires acceptance of liability without fault – another disfavored principle.

Arguably the most palatable interpretation of the regulation is one that sanctions facilities when, through some fault of their own, a resident is abused. This comports with the protective purpose of the OBRA ’87, and it is consistent with American jurisprudential principles that support limiting liability for harm to those who are at fault in causing the harm.

The DAB has not taken any of these approaches. Instead,
the DAB has decided that this regulation imposes liability in the
absence of any abuse, so long as the facility failed to act
reasonably with respect to protecting residents from foreseeable
risks of abuse. According to the DAB, the regulation
guaranteeing a right to be free from "verbal, sexual, physical,
and mental abuse, corporal punishment, and involuntary
seclusion... obligates the facility to take reasonable steps to
prevent abusive acts, regardless of their source." This means
that

CMS is not required to establish, and the ALJ is not
required to find, that actual abuse occurred to show
[that a facility] was not in substantial compliance with
section 483.13(b). It is sufficient for CMS to show that
that [sic] the facility failed to protect residents from
reasonably foreseeable risks of abuse.

This interpretation is only partly reasonable. It is reasonable
because imposing a duty of care on the facility saves this
regulation from meaninglessness. If the regulations were not so
interpreted, the regulation that expressly guarantees a right to be
free of abuse would be a nullity because there would be no duty
on facilities to protect that right and no sanction on facilities or
anyone else when the right is lost. The DAB decision to impose
the conventional negligence-based standard also seems
justifiable as it is certainly within long-term care facilities'
powers to act reasonably to protect residents' rights to be free of
abuse.

What is without justification, however, is the DAB's view
that "CMS is not required to establish, and the ALJ is not
required to find, that actual abuse occurred to show [a provider]
was not in substantial compliance with section 483.13(b)."

159. Holy Cross Village at Notre Dame, Inc., Docket No. A-09-102 (Dep't of
decisions/dabdecisions/dab2291.pdf.
160. Id. (citing Western Care Mgmt. Corp., Docket No. A-03-68 (Dep't of Health
omitted).
162. Id. (citing Western Care Mgmt. Corp, Docket No. A-03-68).
This construction, while surely well intended, is so far afield from the language and the purpose of the regulation that it cannot withstand scrutiny. The language of this regulation says nothing about the risk of abuse—it is concerned with abuse. If Congress or CMS had wanted to enact a statute or regulation that protects against the risk of abuse, that could have been easy to accomplish. In fact, there are regulations that do not address the risk of abuse specifically, but may be interpreted to cover situations in which no one is abused, but the facility unreasonably fails to ascertain or respond to the risk of abuse. The "abuse" regulation is clear—it says residents have the right to be free from abuse, not free from the risk of abuse.

Implying a duty where the language of the regulation does not is permissible if it is necessary to give the regulation a meaning that vindicates the right provided by the regulation. Finding a duty to protect residents from a right that is not actually part of the regulation is too much. The DAB cannot both find a duty in a regulation that is silent as to facilities' duties and then extend that duty to protect rights that are in essence created by the DAB and still be legitimately interpreting the regulation.

NEW REGULATIONS ARE NEEDED TO SOLVE THE PROBLEM WITH THE ABUSE REGULATION

The problem with the abuse regulation can also be easily fixed if CMS promulgates a new regulation that imposes a duty on facilities to protect residents from abuse. The new regulation would read,

164. E.g., 42 C.F.R. § 483.25 (2009). For example, 42 C.F.R. § 483.25 provides that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." This regulation could be interpreted to apply to situations where a facility is not providing the appropriate care and services to a sexually disinhibited resident, thereby putting that resident at an unreasonable risk for sexually assaulting another resident.
The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. To protect this right, the facility must ensure that all reasonable and necessary steps are taken to protect residents from foreseeable risks or actual occurrences of, verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

This new regulation retains the affirmation that residents have the right to be free from abuse. It also makes clear that facilities receiving federal funds have the obligation to take necessary and reasonable steps to protect residents from abuse and from foreseeable risks of abuse.\(^\text{165}\)

The revised regulation would not add anything new to the enforcement scheme, but it would provide the public, surveyors, and nursing home operators with a much clearer picture of the rights of residents and the obligations of nursing home operators with respect to abuse. The revised regulation would also provide the legitimate legal footing that is currently lacking for the finding that nursing homes are required to take reasonable steps to protect against foreseeable risks of abuse.

**The Elder Justice Act and the Nursing Home Transparency and Improvement Act Are Ideal Vehicles to Address the Problem of Sexual Abuse by Demented Residents**

*The Elder Justice Act and the NHTIA*

The Elder Justice Act (EJA), if funded, is the most important piece of legislation ever enacted with regard to the prevention of elder abuse and neglect.\(^\text{166}\) The law seeks to address the problem

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\(^{165}\) This new regulation should ameliorate the problem of not considering peeping toms and genital exposure abuse, because these activities would almost certainly present a foreseeable risk of abuse. As such, under the new regulation, facilities would absolutely have a duty to take reasonable measures to prevent their occurrence and reoccurrence.

of elder abuse and neglect through a multi-faceted, coordinated effort that involves the highest levels of the executive branch, who will participate in an Elder Justice Coordinating Council (EJCC), and private citizens with expertise in elder abuse and neglect who will sit on an Advisory Board on Elder Abuse, Neglect, and Exploitation (Advisory Board) that will provide recommendations to the EJCC,\textsuperscript{167} state adult protective services agencies, state survey agencies, state ombudsman programs, and direct care workers.\textsuperscript{168} Because of this, the EJA, in combination with dementia training provisions of the Nursing Home Transparency and Improvement Act (NHTIA), provide an ideal vehicle to correct the problems related to sexual abuse by demented nursing home residents.

The Elder Justice Act, which was first introduced in Congress in 2002,\textsuperscript{169} does a number of important things that have direct applicability to the problem of sexual abuse by demented residents. The law requires an Advisory Board to set up multidisciplinary panels “to address, and develop consensus on, subjects relating to improving the quality of long-term care.”\textsuperscript{170} The law specifically states that “[a]t least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.”\textsuperscript{171} By singling out resident-to-resident abuse for a panel, Congress, thankfully, realized what a difficult and unique problem resident-to-resident abuse is. Because the law provides for “at least” one panel on resident-to-resident abuse, Congress envisioned that more might be necessary. A panel specifically devoted to the issue of resident-to-resident sexual abuse is needed because of the complexities of this issue that are outlined in this article.

One of the difficulties this panel and any others working on this issue will confront is that, although policy makers and

\textsuperscript{168.} Elder Justice Act § 6703, 124 Stat. at 782, 791, 794, 796.
\textsuperscript{169.} Elder Justice Act, S. 2933, 107th Cong. (2002).
\textsuperscript{170.} Elder Justice Act of 2009 § 6703, 124 Stat. at 788.
\textsuperscript{171.} Id.
researchers are aware that elder abuse and mistreatment is a serious problem in the United States, there has been very little research into this area, and what research has been done is notable for its shortcomings.\textsuperscript{172}

When the body of published and unpublished research reports on elder mistreatment is examined as a whole, a number of weaknesses emerge: [u]nclear and inconsistent definitions; [u]nclear and inadequate measures, [i]ncomplete professional accounts; [l]ack of population-based data; [l]ack of prospective data; [l]ack of control groups; [a]nd [l]ack of systematic evaluation studies.

Among the factors accounting for these deficiencies are: [l]ittle funding and few investigators; [m]ethodological uncertainties, especially about surveys; [e]thical uncertainties regarding research practices; [i]nadequate links between researchers and service agencies, [i]mpoverished theory, [i]ntertwined and varying research definitions and statutory definitions; [a]nd [d]ivergent research traditions in gerontology and family violence.\textsuperscript{173}

There is also a paucity of research on the sexual abuse of older adults in nursing homes.\textsuperscript{174} Studies that do exist are based largely on anecdotal information, employing inconsistent definitions and small sample sizes.\textsuperscript{175} Accordingly, there are no reliable estimates of the prevalence, the incidence, or outcomes of sexual abuse in nursing homes.\textsuperscript{176} What constitutes sexual

\textsuperscript{172} NAT'L RESEARCH COUNCIL, ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 1-2 (Richard J. Bonnie & Robert B. Wallace eds., 2003).

\textsuperscript{173} Id. at 2.

\textsuperscript{174} Pamela B. Teaster & Karen A. Roberto, Sexual Abuse of Older Adults: APS Cases and Outcomes, 44 GERONTOLOGIST 788, 789 (2004).

\textsuperscript{175} Id. at 789, 794. See generally NAT'L RESEARCH COUNCIL, supra note 172, at 2. [E]lder mistreatment research has thus far been confined to a small community of investigators who have produced a modest body of knowledge concerning the phenomenology, magnitude, etiology, and consequences of elder mistreatment. Estimates of mistreated elders have been based on sample surveys in local areas and projected to the total U.S. population. Preventive and remedial interventions have been unsystematic, episodic, and poorly evaluated.

\textsuperscript{176} Ann Wolbert Burgess et al., Sexual Abuse of Nursing Home Residents, 38 J.
abuse is defined differently, depending on the source.177


The effectiveness of abuse reporting and investigation depends, in large part, on the ability of reporters and investigators to recognize mistreatment. However, the ambiguity of relevant protective statutes raises doubt that health care providers, other reporters, and state investigators can identify abuse or neglect. To date there has been no systematic inquiry regarding elder abuse legislation to determine whether variations in state statutes and regulations relate to differences in reporting and investigation activities.

Id.

California Elder Abuse and Dependent Adult Civil Protection Act defines "[a]buse of an elder or dependent adult" as meaning either of the following: "(a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering[, or] (b) [t]he deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering." CAL. WELF. & INST. CODE § 15610.07 (1994).

Elder abuse is defined in Arkansas as

[any intentional and unnecessary physical act that inflicts pain on or causes injury to an endangered adult or an impaired adult; ... [any intentional act that a reasonable person would believe subjects an endangered adult or an impaired adult, regardless of age, ability to comprehend, or disability, to ridicule or psychological injury in a manner likely to provoke fear or alarm; ... [any intentional threat that a reasonable person would find credible and nonfrivolous to inflict pain on or cause injury to an endangered adult or an impaired adult except in the course of medical treatment or for justifiable cause; or [any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.


North Carolina’s Protection of the Abused, Neglected or Exploited Disabled Adult Act defines abuse as “the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation by a caretaker of services which are necessary to maintain mental and physical health.” N.C. GEN. STAT. ANN. § 108A-101 (2009).

In Rhode Island, elder abuse includes

physical abuse, sexual abuse, and/or emotional abuse of an elderly person by a caregiver as defined in subsection (5). ‘Physical Abuse’ means the willful infliction of physical pain or injury (e.g. slapping, bruising or restraining) upon an elderly person. ‘Sexual Abuse’ means the infliction of
It is, therefore, difficult to know exactly how many people are sexually abused in our nation's nursing homes. The only thing we can be absolutely confident of is that whatever amount of sexual abuse is detected, it is an under-representation of what is actually occurring. Studies repeatedly show that sexual abuse is underreported in nursing homes and other institutional settings.

non-consensual sexual contact of any kind upon an elderly person. Sexual abuse includes, but is not limited to, sexual assault, rape, sexual misuse or exploitation of an elder, as well as threats of sexual abuse where the perpetrator has the intent and the capacity to carry out the threatened abuse. 'Emotional Abuse' means a pattern of willful infliction of mental or emotional harm upon an elder by threat, intimidation, isolation or other abusive conduct.


178. MINORITY STAFF, SPECIAL INVESTIGATIONS DIV., COMM. ON GOV'T REFORM, 107th CONG., ABUSE OF RESIDENTS IS A MAJOR PROBLEM IN U.S. NURSING HOMES at i (2001), available at http://www.hospicepatients.org/blaswan/nursinghomesabuse.pdf (This report analyzes the incidence of physical, sexual, and verbal abuse in nursing homes in the United States. It found that more than five thousand nursing homes, or almost one-third of all nursing homes, were cited for an abuse violation in the two-year period from January 1, 1999, through January 1, 2001. In over 1,600 of these nursing homes, the abuse violations were serious enough to cause actual harm to residents or place residents in immediate jeopardy of serious harm, injury, impairment or death. The report describes incidents of sexual abuse, including between residents, but does not provide an assessment of the prevalence of sex abuse in nursing homes.). Data on the frequency of abuse or neglect in nursing homes or residential long-term care facilities is still sketchy. However, the evidence available suggests the problem is serious and widespread. There has never been a systematic study of the frequency of abuse in nursing homes. What is known is based on individual stories or focus group interviews with residents and families. These do not provide reliable estimates of the occurrences of abuse. Elder Justice: Protecting Seniors from Abuse and Neglect: Hearing Before the S. Comm. on Finance, 107th Cong. 39-40 (2002) (statement of Catherine Hawes, Professor & Dir. of the Southwest Rural Health Research Ctr. at the Sch. of Rural Pub. Health, Tex. A&M Univ. Health Sci. Ctr.), available at http://finance.senate.gov/library/hearings.

179. Seymour Moskowitz, Golden Age in the Golden State: Contemporary Legal Developments in Elder Abuse and Neglect, 36 Loy. L.A. L. Rev. 589, 595 (2003) (In 1998, the California Department of Social Services and the GAO estimated that 225,000 incidents of adult abuse occur every year in California, and less than one-fifth of those are reported to authorities.).

To date, one of the most detailed studies of sexual abuse in nursing homes involving resident-to-resident abuse was conducted by Teaster and Roberto. Teaster and Roberto studied fifty substantiated cases of sexual abuse of women in nursing homes in Virginia over a five-year period. In that study, ninety percent of the alleged perpetrators were residents of the facility.

The vast majority, ninety percent, of the residential perpetrators, were over seventy years of age. This indicates that sexually abusive residents are more often part of the geriatric population, not the younger, but infirmed population residing in nursing homes. Ninety-six percent of the alleged perpetrators had no history of criminal activity.

The demographic composition of the victims in this study is also revealing. Fifty percent of the women abused were between seventy and seventy-nine years old, and fifty percent were between eighty and ninety years old. Most of the women who were victims of sexual abuse were disoriented; seventy-three percent were disoriented to time, and fifty-eight percent were disoriented to place. Most of these women were also dependent on assistance to move about the facility (seventy-two percent); a small percentage (six percent) could not ambulate at all.

This study also evaluated the manner in which sexual abuse occurred in nursing homes. By far the most frequent type of sexual abuse that occurred was sexualized kissing and fondling. Seventy-six percent of the women experienced this type of sexual abuse. The next most frequent type of abuse was (1988)).

182. Id. at 105.
183. Id. at 113.
184. Id. at 113.
185. Id.
186. Id. at 109-10.
187. Id. at 110.
188. Id. at 112.
unwelcome sexual interest in the victim's body, a finding that
was more prevalent among the residents who were eighty years
or older. In almost half the cases (forty-one percent) there
were multiple forms of sexual abuse, such as sexualized kissing,
fondling, and unwelcome sexual interest in the victim's body.

Women who were between eighty and ninety years old
were more likely than the younger cohort to experience multiple
forms of sexual abuse in a single incident. Women who
required assistance ambulating were also more likely to
experience multiple types of abuse in one incident. While
most of the abuse that occurred did not involve the most serious
forms of sexual abuse, six percent did involve either vaginal
rape or digital penetration of the anus or vagina.

The Teaster and Roberto study is one of the best
descriptions of sexual abuse in nursing homes that has been
done to date. However, this study has, like much of the
research in this area, significant limitations. Teaster and Roberto
found only fifty substantiated cases of sexual abuse in Virginia
nursing homes over five years. This is undoubtedly an
understatement. Many instances of sexual abuse are not
reported to anyone, and many more cases are not observed
by anyone who could report it.

These considerations aside, Teaster and Roberto limited
their sample to those cases that were reported to adult protective
services; as they admit, only 68.5% of adult protective services
agencies have legal authority to investigate in institutional
settings. In addition, it is not uncommon for sexual abuse in a
nursing home to be reported to the state survey agency and not

189. Id. at 111-12.
190. Id. at 111.
191. Id.
192. Id.
193. Id. at 112.
194. Id. at 105.
195. See U.S. GEN. ACCOUNTING OFFICE, GAO-02-312, NURSING HOMES: MORE
   CAN BE DONE TO PROTECT RESIDENTS FROM ABUSE 4 (2002), available at
196. Roberto & Teaster, supra note 23, at 479.
adult protective services. Federal law only requires nursing homes to report suspected sexual abuse to the state survey agency and commands facilities to follow state law as to what other organizations must be informed.\textsuperscript{197} Thus, if the state does not require reporting to the police or adult protective services, these entities will not necessarily be informed.\textsuperscript{198} State survey agencies typically do not work with adult protective services or the police in investigating claims of sexual abuse.\textsuperscript{199} Therefore, any study limiting its population to cases investigated and substantiated by adult protective services only cannot possibly accurately assess the scope of the problem. In spite of its limitations, however, the Teaster and Roberto study is important because of its finding that so much of the sexual abuse that nursing home residents endure is at the hands of other residents.

In addition to the paucity of research on sexual disinhibition and aggression among the demented elderly, there is also a dearth of research on the care and management of those residents and their victims in the long-term care setting.\textsuperscript{200} A recent literature review revealed that there have been no randomized controlled trials for any treatment of sexual disinhibition in dementia.\textsuperscript{201} There are also no trials comparing the efficacy of different pharmacological agents to control sexual disinhibition among the demented.\textsuperscript{202} Small case studies, however, have shown a variety of pharmacological agents, such as antipsychotics, antidepressants, anti-epileptics, and hormone therapy are effective in treating inappropriate sexual behavior.\textsuperscript{203}

\begin{thebibliography}{99}
\bibitem{197} U.S. GEN. ACCOUNTING OFFICE, \textit{supra} note 195, at 7.
\bibitem{199} U.S. GEN. ACCOUNTING OFFICE, \textit{supra} note 195, at 9-10.
\bibitem{200} See Alagiakrishnan et al., \textit{supra} note 138, at 465.
\bibitem{201} Inese Tucker, \textit{Management of Inappropriate Sexual Behaviors in Dementia: A Literature Review}, 22 INT'L PSYCHOGERIATRICS, 683, 684 (2010). Because sexually inappropriate behaviors are difficult to predict and may occur sporadically over time, observational based studies are also difficult to conduct.
\bibitem{202} \textit{Id.} at 689.
\bibitem{203} \textit{Id.} at 685-88.
\end{thebibliography}
Only one case report has been published showing a non-pharmacological strategy that was effective at managing inappropriate sexual behavior.204

"Sexual inappropriateness remains one of the least understood and most difficult to treat behavioral issues seen in [long term care] residents with dementia."205 Caregivers in one study rated managing the sexually inappropriate behaviors of demented residents as the most difficult aspect of caring for those with dementia in group homes.206 Caregivers and researchers often have difficulty "[s]eparating agitation and normal sexual expression from true sexual disinhibition . . . ."207 Caregivers also come to their jobs with pre-existing attitudes about sexuality that might inhibit them from responding appropriately to normal sexual conduct, as well as inappropriate sexual conduct. Although nursing homes are heavily federally funded,208 there has been no formal training program to sensitize or train nurses, nurse aides, or other caregivers in the proper way to respectfully care for residents engaging in sexually inappropriate activity. Similarly, there has been no formalized effort to train or sensitize caregivers about the appropriate way to care for those who are or could be victims of sexual abuse at the hands of another demented resident.

Unfortunately, staff response to sexual disinhibition sometimes runs the gamut from woefully inadequate to offensive. In a study of twenty residents who had been victims of sexual assault, the staff response to the three victims whose perpetrators were other residents was disturbing.209 Some staff expressed cynicism at the idea that the elderly infirmed could be

204. Id. at 684-85.
205. Shilpa Srinivasan & Andrew D. Weinberg, Pharmacologic Treatment of Sexual Inappropriateness in Long-Term Care Residents with Dementia, 14 ANNALS OF LONG-TERM CARE 20, 27 (2006).
206. Joji Onishi et al., Behavioral, Psychological and Physical Symptoms in Group Homes for Older Adults with Dementia, 18 INT'L PSYCHOGERIATRICS 75, 80 (2006).
207. Srinivasan & Weinberg, supra note 205, at 27.
209. Burgess et al., supra note 176, at 12, 16.
the objects of aggression that was sexual in nature. Other staff members were even worse. "In the three cases in which a resident was the perpetrator, staff either watched the sexual activity, ignored the activity, laughed about it, said it was consented, or 'blamed the victim'..."

RECONCILING THE LITERATURE AND THE LAW TO FOCUS ON FACILITY LEVEL SOLUTIONS TO THE PROBLEM OF DEMENTIA-DRIVEN RESIDENT-TO-RESIDENT SEXUAL ABUSE

One of the most important things the EJA Advisory Board panel evaluating resident-to-resident abuse and any others evaluating this problem will need to be aware of is the divide in the literature in this area. Although many studies addressing the issue of abuse in nursing homes give at least passing recognition to the fact that dementia is an important consideration in abuse of nursing home residents, there appears to be a division in the literature on the significance of this factor.

Studies on sexual abuse in nursing homes that are conducted by researchers with a clinical orientation focus heavily on the role dementia plays in causing sexual abuse. These authors, who often have appointments in medical schools or are medical doctors, approach the problem of sexual abuse as

210. Id. at 17.
211. Id. at 16.
212. Catherine Hawes, Elder Abuse in Residential Long-Term Care Settings: What Is Known and What Information Is Needed?, in ELDER MISTREATMENT: ABUSE, NEGLECT, AND EXPLOITATION IN AN AGING AMERICA 446, 451 (Richard J. Bonnie & Robert B. Wallace eds., 2003). "[T]here is strong evidence that the presence of cognitive impairment or dementia is associated with higher risk for being abused." Id.; Mark Lachs et al., Resident-to-Resident Elder Mistreatment and Police Contact in Nursing Homes: Findings from a Population-Based Cohort, 55 J. AM. GERIATRICS SOC'Y 840, 841, 843-44 (2007) (describing a typology of resident-to-resident physical abuse where a demented resident attacks another resident without provocation and indicating that dementia plays a significant role in resident-to-resident violence in nursing homes); Teaster et al., supra note 176, at 14 (indicating dementia increases the risk for being a victim of sexual abuse in nursing homes).
a manifestation of specific medical conditions or a disease process. They neither conceptualize this problem as abuse, nor do they search for legal solutions at either the resident or facility level. These researchers see sexual abuse as behavioral problems created by disease or injury, and they focus heavily on the role dementia plays in causing these behavioral problems and the role dementia management plays in controlling these problem behaviors.214

In contrast, other researchers from public health, gerontology, and the social sciences tend to approach this issue from a policy, legal, or social justice perspective.215 They spend a great deal of time trying to provide a basic understanding of the characteristics of sexual abuse in nursing homes and raising awareness of this issue because there has been so little study in the area.216 Most of the data on sexual abuse in nursing home used by these researchers comes from criminal justice sources, and a significant part of the research describes how these events are handled by the criminal justice system.217

The research done by the social scientists is far from complete, but it is critical to the understanding of this problem. Their research has revealed a lot about nursing homes that is cause for grave concern. Abuse is a “widespread and serious problem[1]” in our nation’s nursing homes, and millions of nursing home residents are at risk for abuse every day.218 Violence is not uncommon in nursing homes.219

214. See Series & Dégano, supra note 119, at 425-27; Alkhalil , supra note 213, at 231-33; Burns et al., supra note 213, at 86.
215. See e.g., Rosen et al., supra note 176, at 1398-99, 1406-07; NAT’L RESEARCH COUNCIL, supra note 172, at 2; Teaster & Roberto, supra note 174, at 788, 794-96 (2004); Teaster et al., supra note 176, at 15-16; Payne & Cikovic, supra note 176, at 64, 66-67, 69, 71.
216. See Rosen, supra note 176, at 1398-99; Hawes, supra note 212, at 446, 451; Teaster & Roberto, supra note 174, at 788-89; Teaster et al., supra note 176, at 15-16; Payne & Cikovic, supra note 176, at 61.
217. For example, the Teaster studies used APS reports, Payne and Cikovic used data from Medicaid Fraud Control Unit Reports, and Lachs et al. used data from police reports. Teaster & Roberto, supra note 174, at 788; Payne & Cikovic, supra note 176, at 61; Lachs et al., supra note 212, at 841.
218. Hawes, supra note 212, at 477.
219. Lachs et al., supra note 212, at 840 (describing nursing home residents in
Suspected abuse is underreported by facility staff, health care professionals under mandatory reporting statutes, family members, and residents.\textsuperscript{220} Abuse, even when substantiated, is undercited by state survey agencies and CMS.\textsuperscript{221} Understaffing causes or contributes to abuse.\textsuperscript{222} When nursing home staff abuse residents, they rarely receive harsh sentences.\textsuperscript{223} Although staff and other people physically and sexually abuse nursing home residents, the most common abuser is another resident.\textsuperscript{224}

In light of the evidence that most sexual abuse is perpetrated by other residents and that dementia plays a critical role in that behavior, it is appropriate to reconsider some of the focus that the social scientists have put on criminal justice solutions to the problem of sexual abuse in nursing homes. For example, in a 2004 article, Teaster and Roberto criticize law enforcement agencies for not prosecuting men who have sexually violated female residents.\textsuperscript{225} They state:

\begin{quote}
In the overwhelming majority of cases, APS investigated the allegations alone, and the cases were prosecuted in court rarely, with only one resulting in a conviction. In Virginia, as in many states, the sexual abuse of an older woman is a criminal offense. Though not all cases of sexual abuse involving the resident as perpetrator are appropriate for prosecution, such cases are appropriate when there is a credible witness who can testify to the crime. Cases involving residents as perpetrator are appropriate for prosecution if, after psychiatric examination, it is determined that they are competent to stand trial. Competency to stand trial is a simple test: does the person understand the function of the lawyer, is he or she able to assist the lawyer in the defense, and does the individual understand the function of the court and the charge against him or her? It is important that social workers dealing with cases of
\end{quote}

\begin{itemize}
\item\textsuperscript{220} Hawes, supra note 212, at 471-473; Teaster et al., supra note 176, at 15.
\item\textsuperscript{221} Hawes, supra note 212, at 475.
\item\textsuperscript{222} Id. at 484.
\item\textsuperscript{223} Payne & Cikovic, supra note 176, at 67.
\item\textsuperscript{224} Teaster & Roberto, supra note 181, at 105.
\item\textsuperscript{225} Id. at 116.
\end{itemize}
sexual abuse realize that taking cases to court, both criminally and civilly, could do much to prevent the sexual abuse of residents.\textsuperscript{226}

This analysis is appropriate where the perpetrator is not suffering from dementia, but it is also problematic on a number of fronts. First, it fails to appreciate what the medical researchers focus on almost exclusively in their study of resident-to-resident sexual abuse – that dementia was very likely responsible for the sexual assaults of these residents. If dementia is causing the behavior, prosecutions of demented residents are unlikely. If those prosecutions occurred, they would not deter other demented residents from sexually abusing others, because it is doubtful that demented people have the cognitive ability to curtail their dementia-induced behavior because of the threat of prosecution. In short, deterrence won't work on people who lack the capacity to conform their behavior to acceptable norms.

Much more importantly, focusing on criminal justice solutions misdirects our attention onto the resident perpetrator who cannot control their behavior and away from facilities whose obligation it is to prevent harm to residents. Nursing homes licensed by states and receiving federal funds have an obligation imposed by federal and state law to protect residents from abuse. This is a non-delegable duty. Facilities are also well aware that some portion of their demented population will behave in a sexually inappropriate or sexually aggressive manner. Nursing home operators must be pressed to protect residents, and arguments and scholarly research that focus primarily on the perpetrators and the criminal justice system, miss this critical point.

CONCLUSION

The purposes of this article are to raise awareness of the role that dementia plays in causing the sexual abuse of nursing home residents and to argue for much needed reforms in how the

\textsuperscript{226} Id. at 116 (emphasis added).
federal regulations governing nursing homes treat the issue of sexual abuse by demented residents. Ultimately, the EJA and the NHTIA may provide what researchers all agree is needed: a pointed focus on the problem of resident-to-resident sexual abuse and resources to better train direct care givers in abuse and managing demented residents. Whether Congress appropriates money to implement these laws and whether their implementation, if it occurs, achieves the goal of reducing sexual abuse remains to be seen. One thing is clear, though. If those who implement these statutes do not appreciate the fact that most sexual abuse of nursing home residents is at the hands of other residents suffering from dementia, they will fail to solve the problem. If they do appreciate this fact and provide the necessary training to combat it and revise the regulations to recognize that sexual abuse at the hands of the demented is still sexual abuse, then perhaps, fewer of our vulnerable elderly will have to endure this type of sexual abuse.